Zero-Dose LEARNING HUB

From Evidence to Action

How Local Networks Accelerate Zero-Dose Evidence Uptake

Gavi The Vaccine Alliance

JSI

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THE GENEVA LEARNING FOUNDATION

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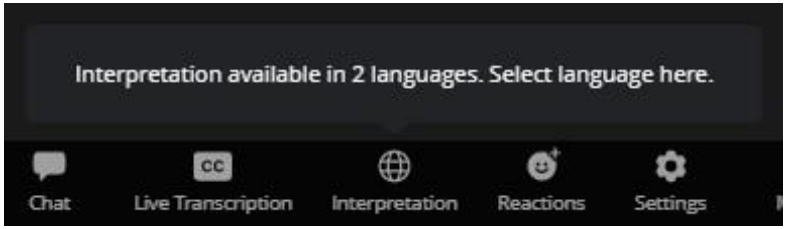

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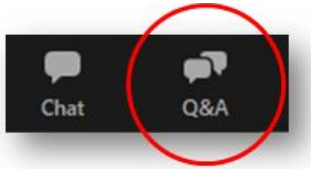

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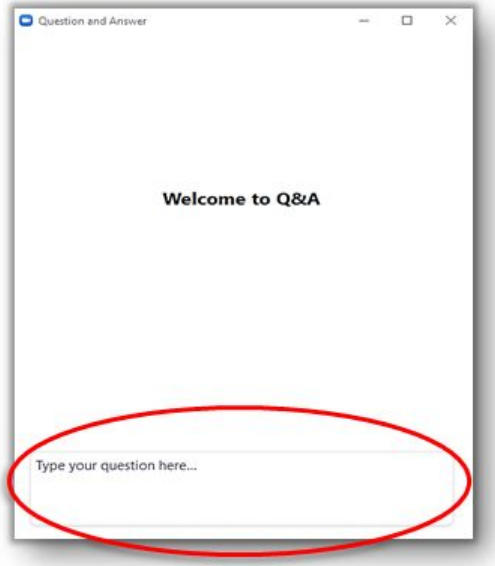

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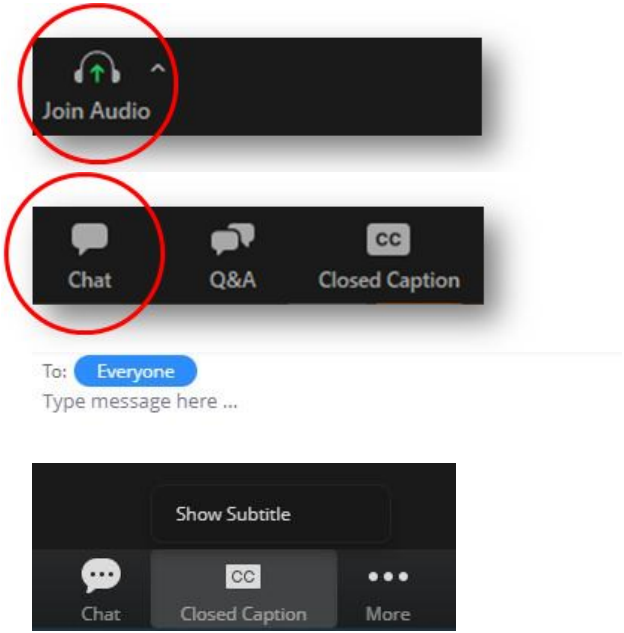

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Welcome

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Gavi's Zero-Dose Learning Hub

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Gavi The Vaccine Alliance

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The Geneva Learning Foundation

Zero-dose learning: Background & rationale

- Lessons learned from Gavi 4.0 revealed a fragmented approach to evidence generation that resulted in missed opportunities to provide more timely and complete information and improve use of evidence and learning
- Gavi's Learning System Strategy outlines a Zero-Dose Learning Agenda (ZD LEARN) which learning priorities across Identify-Reach-Monitor-Measure-Advocate (IRMMA) and processes and tools generate and synthesize evidence
- Learning Hub (LH) initiative is an important key enabler to support IRMMA framework and zero-dose learning agenda, recommended by the Programme and Policy Committee and Gavi Board in 2020
- LHs designed to ensure more timely, prospective measurement of implementation and performance and to inform the 5.0 strategy

Learning Hub Initiative: Overview

- Augment monitoring, implementation research, and other learning activities to go deeper into the factors influencing the implementation and performance of programmatic approaches to rapidly understand what works, what does not, and what are the gaps to identify and reach ZD children
- Learning priorities are **equity focused** and will answer questions about barriers and effective approaches to identifying, reaching, and monitoring zero-dose children and missed communities
- Design informed through broad consultation and agreement with Alliance and other technical partners and other donors
- Mali, Nigeria, Uganda, and Bangladesh will participate and house country **learning hubs**, which will **augment monitoring and learning activities** from 2022-2025
- The global Zero-Dose Learning Hub (ZDLH) will operate at the global level, and the provider will support to the learning hubs and will synthesize learning and translate these to lessons learned for use across learning hub and other countries (2022-2026)

Country Learning Hubs

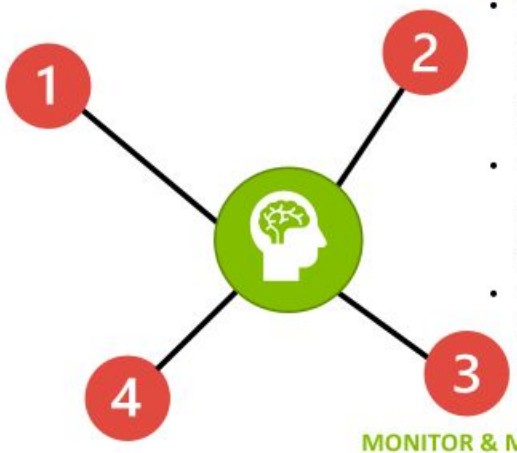
Zero-Dose Learning Hub (Global)

Awarded July 2022

ZD learning priority questions identified through consultation

IDENTIFY

- **Where, who and how many are zero-dose children**, and missed communities? **Why** are they being missed and what are the root causes?
- What are the **most effective approaches and methods** used for **identifying zero-dose** communities? What works well, what does not work well and why?
- What are the **key barriers and enabling factors** at each level (policy to community) **to identify zero-dose** communities?



REACH

- What **specific approaches are designed to reach zero-dose children** and missed communities and to bring them into the health system towards full immunization? What works well, what does not work well and why?
- What are the **key barriers and enabling factors** at community level **to reach zero-dose** children and to bring them into the health system through full immunization?
- What are effective ways to **engage with other parts of the health sector** to reach the marginalised, missed communities and zero-dose children?

ADVOCATE

- What **strategies are effective in securing and sustaining political will** across different levels to identify and reach zero dose populations?

MONITOR & MEASURE

- What are the most **effective approaches and methods to monitor and measure reaching zero-dose**, under-immunised children and missed communities? What works well, what does not work well and why?

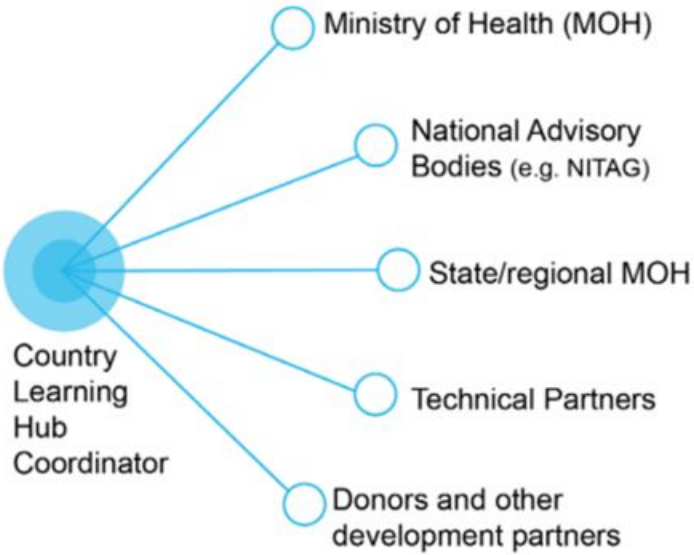
Cross cutting areas: Cost and sustainability; Gavi contribution and levers; Gavi country segments

More detailed questions align with high-level questions presented here. Country learning hubs define learning priorities aligned with a subset of these questions.

Country Learning Hubs (2022-2025): Objectives

- Generate and synthesize learning of the **barriers to reach zero-dose** children that is used to influence programme planning and tailored approaches.
- Strengthen the evidence base of **effective approaches to identify and reach zero-dose** children by understanding what works, should be scaled up, and what does not work and to do so in a timely, iterative manner.
- **Improve metrics, measures, and methods** to access and use data on a regular basis to improve reaching zero-dose children and missed communities.

Mali, Nigeria, Uganda, and Bangladesh



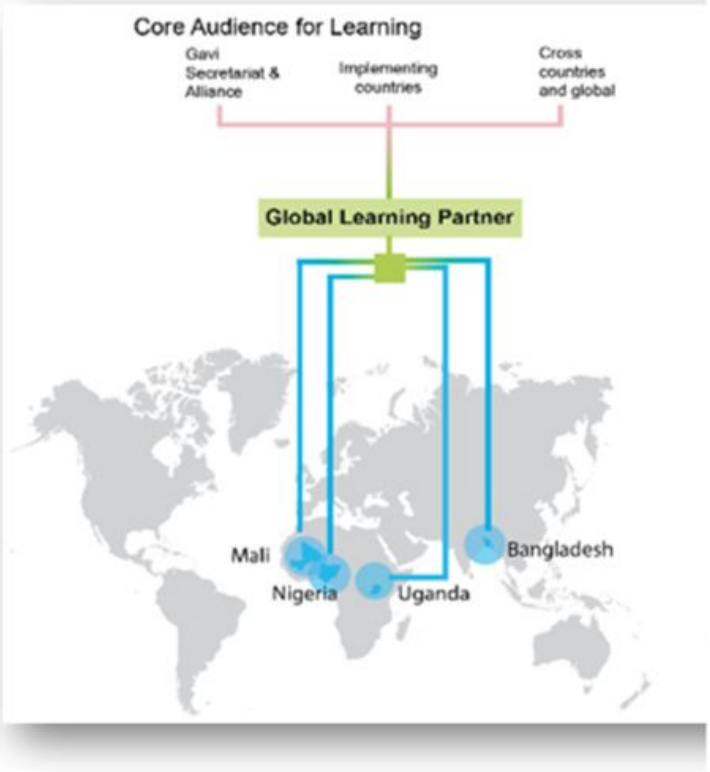
Global-level Zero-Dose Learning Hub (ZDLH) (2022-2026):

Objectives

- To support implementation of country learning hubs through technical assistance, troubleshooting, and targeted and tailored capacity strengthening activities

- To produce and share effective evidence and facilitate learning exchanges across learning hub and other Gavi countries and to synthesise and share the breadth of learning across the Alliance, other implementing partners and donors, and regional and global networks

➡ https://zdlh.gavi.org



Country LH providers and award dates

Bangladesh	Mali	Uganda	Nigeria
International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) with Jhpiego RedOrange Media and Communications *Awarded Oct. 2022*	GaneshAID with Center for Vaccine Development-Mali (CDV-Mali) Faculty of Medicine and Odonto-Stomatology/University of Sciences, Techniques and Technologies of Bamako (FMOS/USTTB) *Awarded Nov. 2022*	Infectious Diseases Research Collaboration (IDRC) with PATH Makerere University School of Public Health (MakSPH) *Awarded Feb. 2023*	African Field Epidemiology Network (AFENET) with Africa Health Budget Network (AHBN) *Awarded April 2023*

https://clh-immunisation-bd.org/

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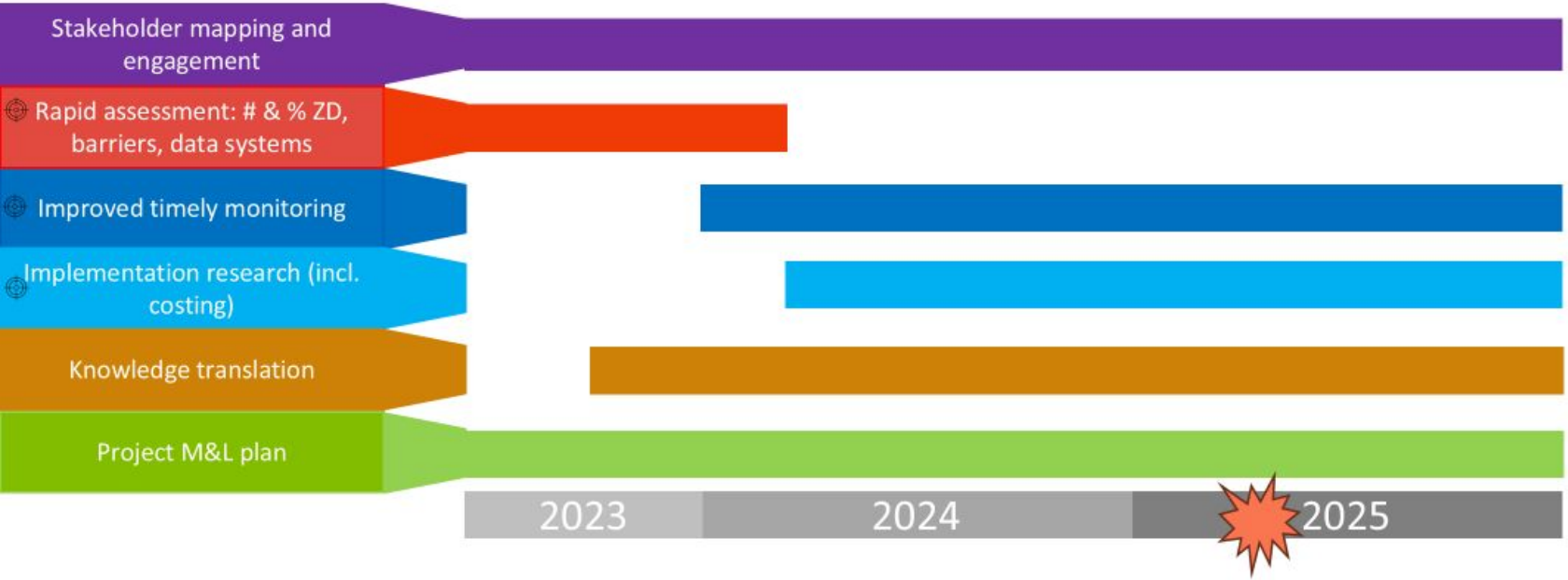
Country LHs: Scope of work & timeline



Targeted subnational (below district) areas

ZDLH stakeholder engagement methods to accelerate evidence use

Stakeholder Engagement and Mapping

Sharing ZDLH findings with Senator Munguno (Nigeria)

Purpose:
Ensure evidence meets information needs, timing, and use cases

Activities/Data sources:

- Stakeholder mapping, incl. level of influence, communication approach, engagement plan
- Meeting notes documenting decisions/actions
- Learning agendas
- Co-creation/design

Knowledge Translation and Use

Purpose: Communicate evidence in an understandable and relevant way to inform decisions and apply in policy and practice

Activities/Data sources:

- Policy briefs, memos
- Digital platforms
- Meetings, peer-to-peer learning and mentoring
- Systematic documentation of changes in policies or practices

Zero-Dose LEARNING HUB

Today's Contributors

- Jenny Sequeira, Gates Foundation ZDLA consultant
- Prof. Yahaya Mohammed, AFENET
- Dr. Salisu Ya'u Sulaiman, CHAI
- Dorothy Leab, CEO, GaneshAID
- Dr. Gustavo Corrêa – Discussant, GAVI and ZDLH

Zero-Dose Learning Agenda (ZDLA)

Overview of a "Learn by Doing" approach in 6 high-burden countries

Jenny Sequeira, on behalf of the ZDLA team

June 2025

Gates Foundation

THE ZD LEARNING AGENDA IS A SPRINT TO IDENTIFY ACTIONS GF AND GAVI CAN TAKE TO ACHIEVE 50% REDUCTION IN ZD BY 2030

*To reach our **overall strategic goal** in 2030…*

*We are in a 24-month sprint to answer **two core questions**…*

*…Informed by work across **complementary workstreams.***

Restore and sustain trajectory towards 50% reduction in zero dose children by 2030

(IA 2030 target)

*How should **Gavi strategy, policy, funding and implementation** adapt to meet 2030 target?*

*What is **GF's comparative advantage** in accelerating progress on zero dose?*

Subnational Programmatic Implementation
Identifying granular drivers of ZD and 'what works' to durably reach communities

Gavi Funding Mechanisms and Implementation
Supporting Gavi to deliver on 5.0/5.1 strategies + identifying areas for adaptation

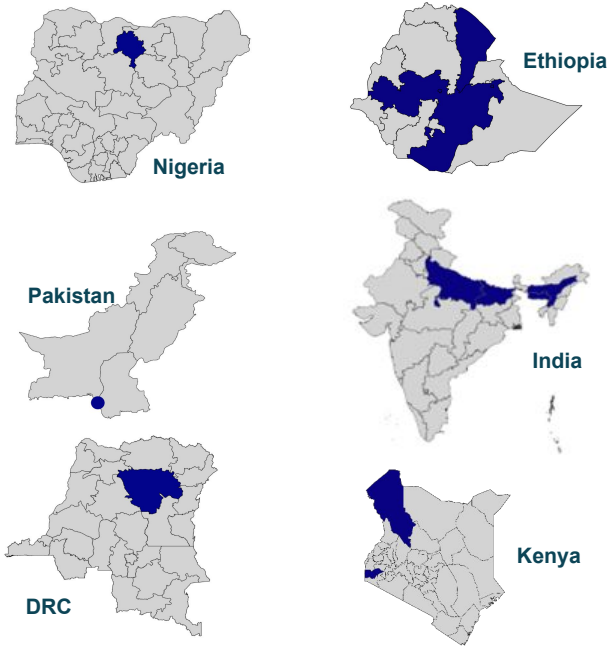
WE AIM TO DIRECTLY LEARN ABOUT THE ROOT CAUSES FOR ZD AND TEST INTERVENTIONS IN SUBNATIONAL AREAS IN 6 COUNTRIES

Approaches vary based on partner and context, but all projects are:

1. Diagnosing **drivers and root causes** of ZD
2. Developing **interventions through direct engagement** with caregivers, community leaders, health workers and government officials
3. Working in **iterative cycles to test and refine interventions**, building on past learnings
4. Emphasizing **gender considerations**
5. Capturing **costing** information

Looking for indications* of this leading to **novel, better-targeted and effective programming?**

We are locating projects in sub-national areas with high ZD burden



*Note: We are **NOT** expecting to be able to measure ZD coverage impact.*

ZERO DOSE LEARNING QUESTIONS FOCUS ON FIVE MAJOR AREAS

Priority Learning Areas + What we seek to learn	
Subnational Focus	How to center the province, district and health facility as the nexus for locally-relevant programming and implementation.
ZD Drivers	How to go beyond the 'where' of ZD children, gaining insight into the 'why' for programming decisions.
Demand	How to better implement demand evals in root cause reviews + embed community engagement and human centered design.
Gender	How to support meaningful review of gender-related drivers and program to address them.
Iterative Learning	How to enable learning processes that routinely check performance and reevaluate underlying assumptions.

Across each of these, we hope to learn:

- **What does it take** to implement these strategies in concert?
- Are there indications* this leads to **novel, better-targeted, and effective programming?**
- What implications does this have for GF strategy and **Gavi 6.0 design and implementation?**

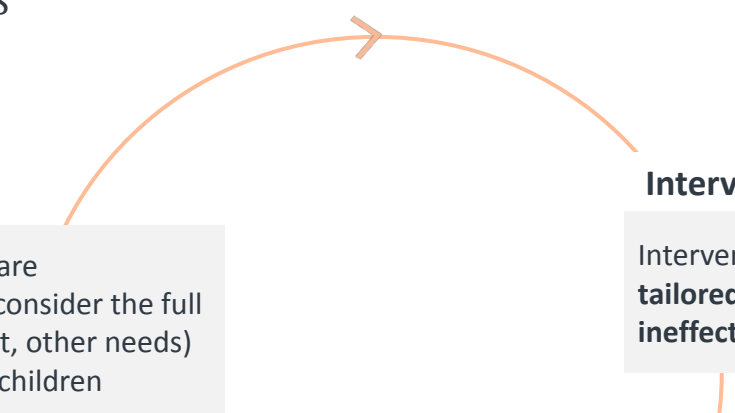
Note: We are **NOT expecting to be able to measure ZD coverage impact.*

Other Questions

- What is the **cost** of ZD solutions?
- For areas with very low coverage, what is an **effective balance** of traditional (often, supply-side) strengthening activities and more refined targeting reflected in our priority learning areas?

MOTIVATING HYPOTHESES TO ADDRESS MANY ZD CHALLENGES:

A need to move away from "status-quo', top-down immunization programming towards more bottom-up approaches



Driver Identification

Current ZD identification methods are **insufficiently granular** and do not consider the full range of drivers (e.g., gender, intent, other needs) **– failing to get to the "why"** of ZD children

Intervention Development & Implementation

Interventions to reach ZD children are **insufficiently tailored to local drivers and contexts,** leading to **ineffective and/or unsustainable** interventions

Intervention Monitoring & Adaptation

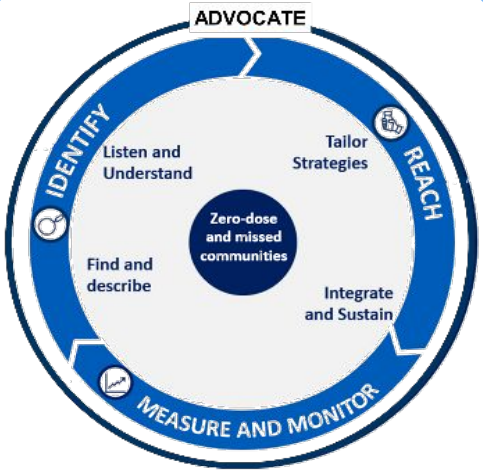
ZD strategies are often **nationally-driven and inflexible** – with few mechanisms for measurement, review and iteration leading to **'cookie cutter' approaches** that fail to reach ZD children

IMPLEMENTATION APPROACH FOCUSES ON BEING MORE RESPONSIVE & ADAPTIVE TO LOCAL NEEDS – LEARN BY DOING (LxD)

Gavi's IRMMA framework

Driver Identification

Assess key drivers (and causes) **through direct engagement with local communities** and existing quantitative data



Intervention Development & Implementation

Working with a range of stakeholders (e.g., caregivers, community leaders, HCWs, EPI managers, government), to **co-design interventions that prioritize addressing leading drivers and causes** (with a strong focus on gender-related issues)

Intervention Monitoring & Adaptation

Continuous review of interventions for signals of change, utilizing existing review platforms (e.g., monthly review meetings) or community groups, and **regular review of data to identify potential adaptations**

ZDLA hypothesis that our LxD approach will support more durable programming that addresses drivers and causes of ZD by:

- Deliberately and sustainably **engaging the people and systems to understand drivers and co-develop solutions**
- Enabling **continuous learning and adaptation**

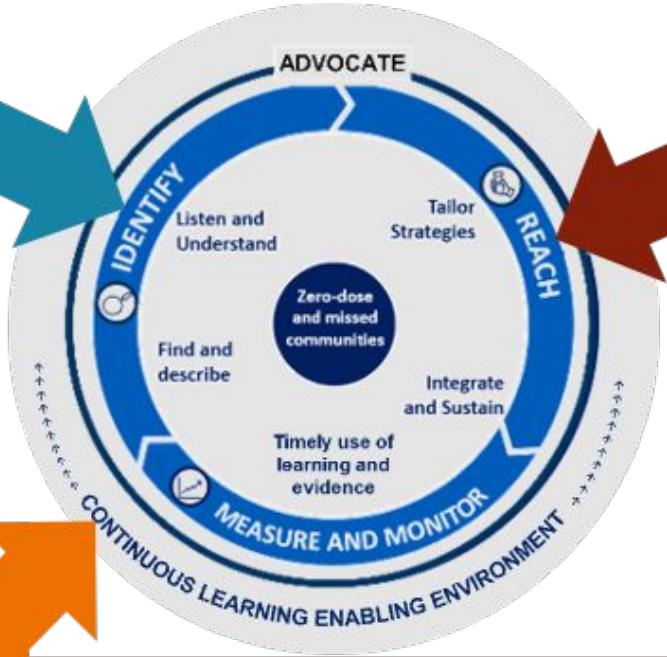
IRMMA Source: Zero-Dose Funding Guidelines (cdn-website.com)

LxD APPROACH OVERVIEW: CONNECTS 3 LEARNING AREAS TO GAVI'S IRMMA FRAMEWORK BY AIMING TO FOLLOW KEY PRINCIPLES

See Appendix for complete list of LxD principles

Learning about & using ZD driver insights

KEY PRINCIPLE: The approach addresses drivers & root causes as a team (communities inclusive) + regularly revisits root causes



Testing & learning about driver-informed ZD interventions

KEY PRINCIPLES: The approach incorporates human centered design (end user perspectives), connects to the local immunization program's workflow, and reduces gender barriers

Applying & learning about continuous learning (CL) with ZD drivers and interventions

KEY PRINCIPLE: The approach promotes a continuous review and revision process (with health workers & community group decisions); plus, a focus on strengthening the local learning culture

CORE TECHNIQUES/TOOLS ZDLA TEAMS ARE USING TO FOSTER AN LxD MINDSET

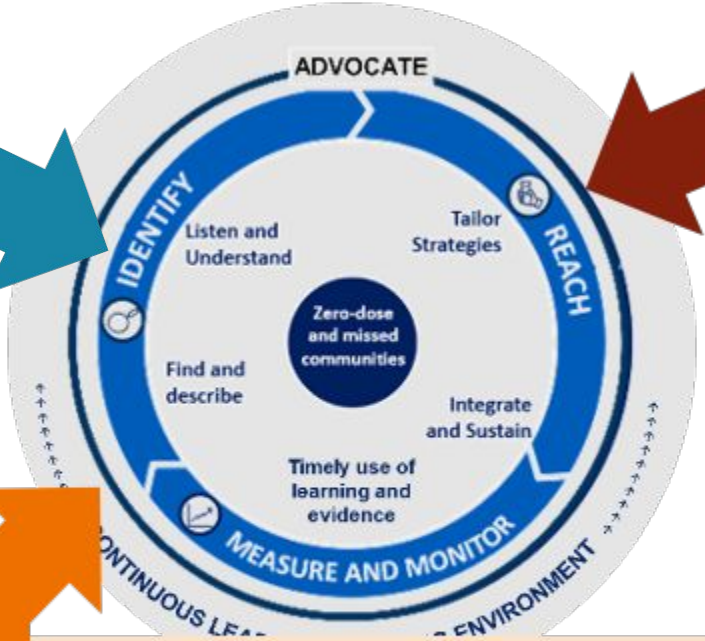
See Appendix for examples

ZD Drivers

- **Root cause analysis** (5 Whys, Diagramming)
- **Theory of change** (including assumptions & key indicators)

ZD interventions

- **Detailed Concept Sheets**
- **HCD tools/techniques**
- **Gender intentionality tools/techniques**

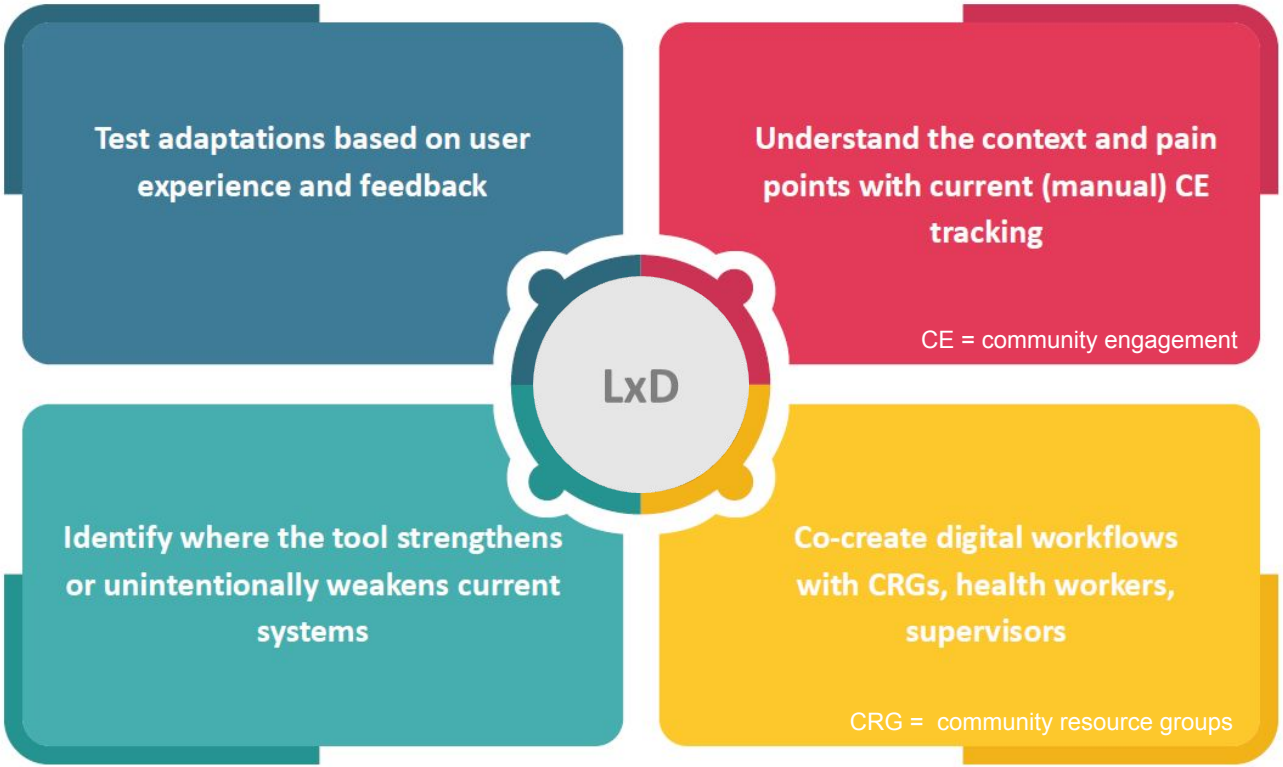


Continuous learning

- **User Advisory Groups/equivalent** who use pause-and-reflect & after-action reviews to discuss & decide on changes or updates that need to be made to an intervention or drivers
- **Change log** to track if changes are leading to improvements
- **Learning culture reflections** (Learning Loops)

WE ARE ALSO TESTING HOW LxD CAN BE APPLIED TO EXISTING INTERVENTIONS

Example from Kano State, Nigeria, early feedback on how applying a simplified set of LxD concepts is helping improve an existing technology-based intervention to:



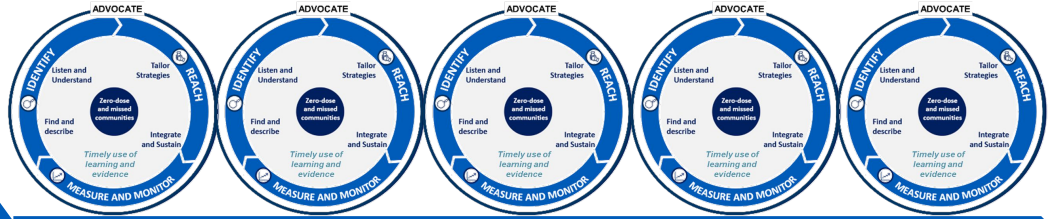
Source: Datharm

WHAT LxD LOOKS LIKE IN-COUNTRY 2023-2025

Iterative learning by doing around drivers, ZD interventions, and continuous learning interventions

2023-2024

- ZD driver analysis
- Intervention co-creation
- Assess learning culture



Q4 2024 – 2025

- Implement ZD & continuous learning (CL) interventions
- Iteratively refine understanding of drivers & ZD + CL interventions & revise as needed
- In-depth documentation of priority learning interventions

Q3/4 2025

- Final analysis
- Reflections
- Dissemination

Thank you

From Evidence to Action:

How the Learning Hub Accelerates Zero-Dose Evidence Uptake in Nigeria

11th June 2025

AFENET
African Field Epidemiology Network
A healthier Africa

AFRICA HEALTH BUDGET NETWORK

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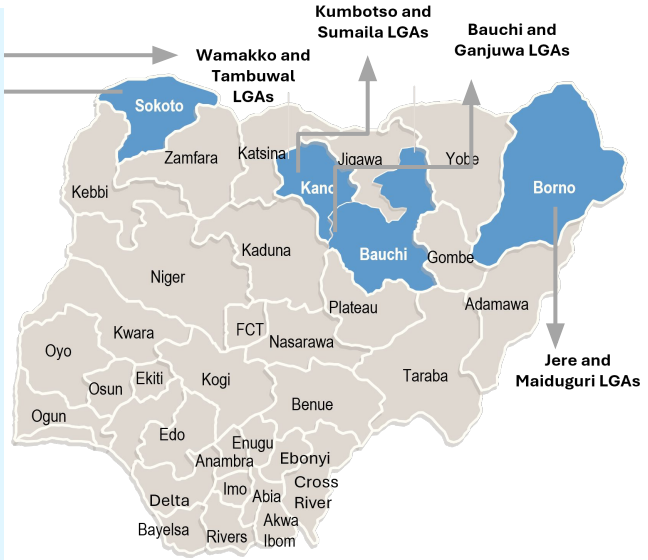
Introduction

- Global immunization coverage remains a persistent challenge, despite substantial efforts
- Two-thirds of unvaccinated children in Gavi-implementing countries are concentrated in just five low and middle-income countries (LMICs): Nigeria inclusive
- Nigeria accounts for 2.1m estimated zero dose children (ZDC) with 70% Penta 1 coverage and 57% Penta 3 coverage[1]
- **Insecurity, limited healthcare access, vaccine hesitancy, weak demand generation and distrust in vaccine safety and efficacy, along with behavioral and gender related factors,** have significantly contributed to high zero-dose rates and poor immunization coverage
- NPHCDA[1] inline with Immunization Agenda 2030 and GAVI 5.0 has developed different strategies
  - NSIPSS 2.0 aimed at reducing the number of ZD children to less than 10% of the target cohort by 2024[2]



Targeted Subnational Areas

1. WHO/UNICEF estimates of national immunization coverage (2024)

2. National Strategic Plan to Optimize Routine Immunization in Nigeria (2021-2024)

Goal, Objectives, & Strategic Pillars

GOAL: To provide a framework for Nigeria to promptly generate evidence on strategies that can be leveraged to successfully identify, measure, monitor and reach “zero dose” children and the “missed” communities in which they live

OBJECTIVE 1

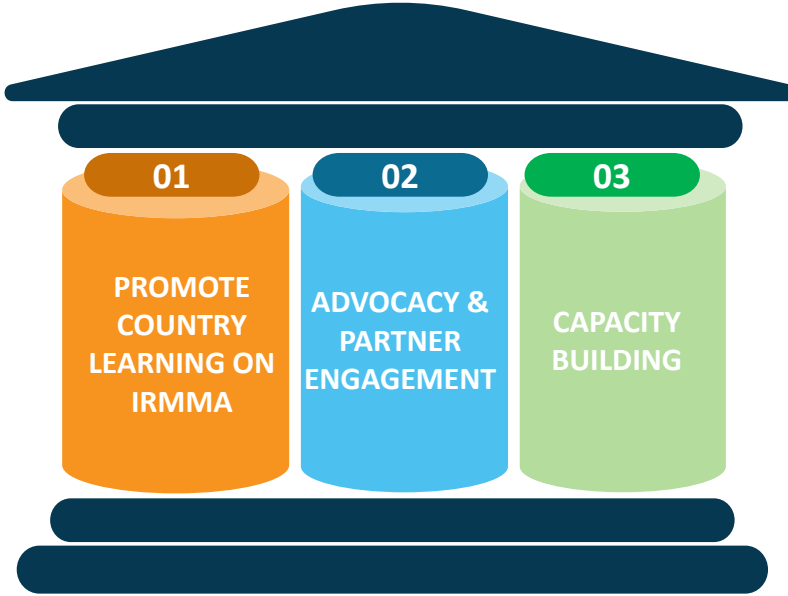
To generate learning on barriers to reaching children, thereby influencing program planning and implement tailored strategies to identify and reach zero-dose children and missed communities

OBJECTIVE 2

To generate evidence for the effective strategies for identifying and reaching zero-dose children and missed communities by identifying successful, scalable, and effective/ineffective methods

OBJECTIVE 3

To improve metrics, measures & methods to enhance regular data access and utilization to reach of zero-dose children and missed communities



Strategic Pillars

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Activity Overview

Activity Overview

Rapid Assessment

- Scoping Review
- Subnational Budget Analysis

Decentralized Immunization Monitoring (DIM) using LQAS

- A cross-sectional study conducted at the ward level in all the 8 LGAs across 4 states
- 19 Interview locations (IL) were selected per ward using PPS sampling (418 ILs)
- Master list of settlements + estimated number of HH retrieved from State
- Eligible Households were randomly selected in each interview locations using segmentation sampling
- In each selected HH, one caregiver from the target populations (children 4.5-11 months or 12-23 months) sampled. Next closest house visited to find the caregiver of remaining eligible child (parallel sampling)

Immunization Budget Accountability & Advocacy

- Findings from Rapid Assessment and DIM were triangulated with subnational budget analysis and an immunization scorecard was developed to be used for tracking, advocacy and accountability to the political, traditional and religious leaders using the platform of the Community of Practice (CoP)

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Evidence Use: Results & Changes

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Rapid Assessment Findings (Scoping Review):
Regional Variations & Identified Barriers vs. Facilitators

NORTH-WEST

Barriers
- Low trust in healthcare workers & poor vaccine confidence
- Gender inequality & economic barriers

Facilitators
- Engage community influencers (religious & traditional leaders as vaccine advocates)
- Empower women (education & economic)

NORTH-EAST

Barriers
- Vaccine Stockout
- Low trust in healthcare workers & poor vaccine confidence

Facilitators
- Novel vaccine delivery methods
- Engage community influencers (religious & traditional leaders as vaccine advocates)

NORTH-CENTRAL

Barriers
- Geographic & Economic disparities

Facilitators
- Improve Access & Financial incentives for immunization

SOUTH-WEST

Barriers
- Long queues
- Poor access in rural areas

Facilitators
- Increased skilled workforce
- Improved access in rural areas

SOUTH-EAST

Barriers
- Concerns about Vaccine safety & benefits

Facilitators
- Leveraging existing communication channels (WhatsApp & SMS) for reminder systems & education campaigns)

SOUTH-SOUTH

Barriers
- Inconvenient timing of vaccination session

Facilitators
- Leveraging existing communication channels (WhatsApp & SMS) for reminder systems & education campaigns

Excerpt from the Subnational Budget Analysis

Proportion Of Annual Health Budget

#	Focal State	Proportion of Budget Allocated to Health		
		2021	2022	2023
1	Bauchi	11.2%	11.4%	15.0%
2	Borno	15.8%	9.1%	7.4%
3	Kano	17.3%	15.4%	14.7%
4	Sokoto	11.8%	15.7%	13.5%

Decentralized Immunization Monitoring

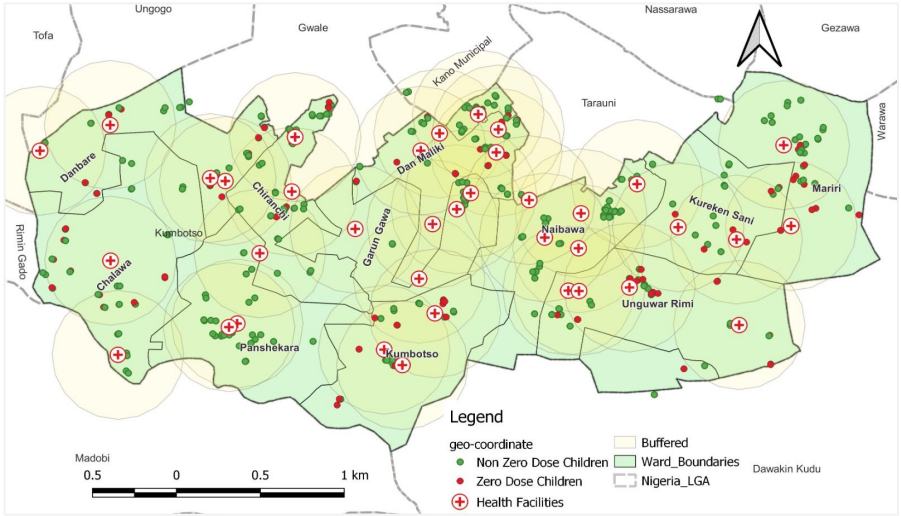
- AFENET, in close collaboration with JSI and LSTM implemented DIM across the 8 LHs using LQAS approach with 2 cohort of children; 4.5-11 and 12-23 months
- ZD Prevalence was estimated at 33.6% amongst children 12-23 months

Key Findings

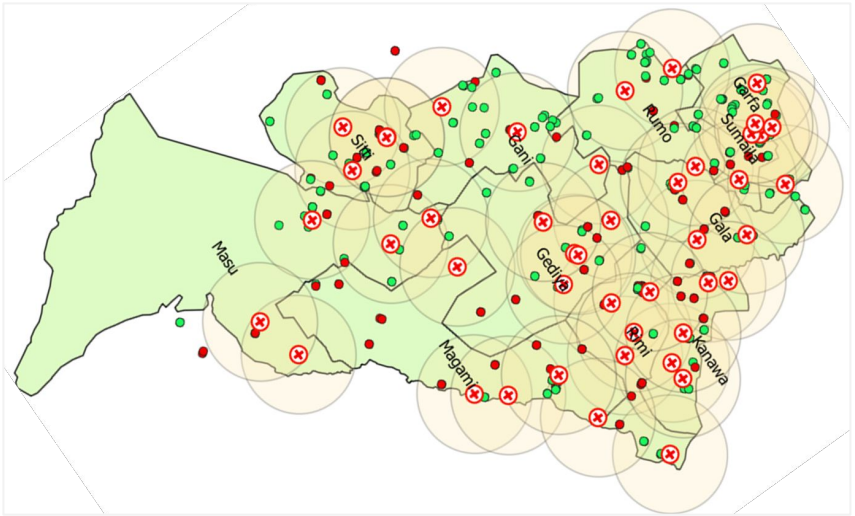
- 84% of ZD caregivers had no formal education
- Only 40% had institutional delivery
- 45% of ZD caregivers had no contact with HF for ANC services
- Despite high knowledge of where to vaccinate (94%), intention to vaccinate was 67.8% with over 65% of ZD not willing to vaccine
- Trust in HCWs was found to be lower amongst ZD caregivers
- 56.7% of ZD caregivers had issues with vaccine benefits
- Over 56% of ZD providers were identified to live <5km to a RI HF

LQAS: Lot Quality Assurance Sampling

Maps of Kumbotso & Samaila LGAs; Kano State

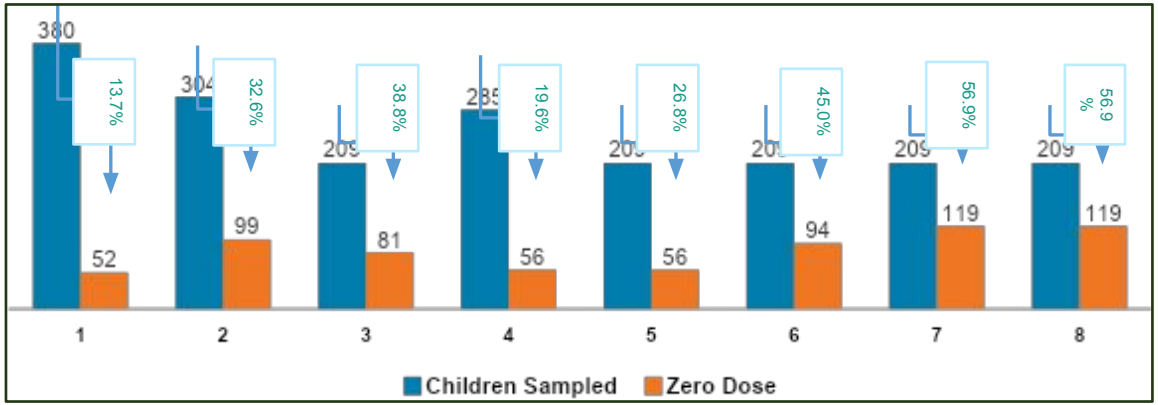


Map of Kumbotso LGA in Kano State showing distribution of 418 children sampled across the 11 wards



Map of Sumaila LGA in Kano State showing distribution of 418 children sampled across the 11 wards

Decentralized Immunization Monitoring



USE CASES

- Sokoto – Chairman held Meeting with all religious and community leaders in Tambuwal LGA
- Expanded RI Health facility from **27** to **32** out of **47 HFs (VCM Trained)**
- Bauchi – increase in outreach stipend from **1,500 NGN** to **4000 NGN** in the 2025 Annual Operational Plan developed
- Disseminated at the National and Subnational RIWG across the states
- Bauchi - Annual Primary Health Care Retreat (Chaired by Deputy Governor), Vice Chairman Bauchi LGA

- Sokoto - Taskforce Review Meeting (Chaired by Deputy Governor) and Chairman Tambuwal LGA
- **Manuscripts/Abstracts:**
  - Decentralized Immunization Monitoring: Lessons Learnt from a Pilot implementation in Kumbotso LGA, Kano State, Nigeria
  - Decentralized Immunization Monitoring: Lessons Learnt from four States, Nigeria

Immunization Budget Accountability & Advocacy:
Stakeholder Engagement Landscape

Core Advocacy Focus	•Advocacy and stakeholder engagement remain pivotal in ZDLH's Theory of Change, concentrating efforts on optimizing resource allocation, timely fund release, and enhancing accountability systems across all implementing state
Key Priorities	•We emphasized budget advocacy, validating subnational immunization scorecard data, engaging both traditional and donor partners, and embedding ZDLH Community of Practice (CoP) structures institutionally for sustained impact
Stakeholder Mapping	•Mapped over 100 key stakeholders spanning Ministries of Health, Budget and Finance, Donor Partners, and Civil Society Organizations (CSOs), highlighting expanding CSO interest driven by the rise in ZDLH CoP visibility and impact
Engagement Events	•108+ engagements including 29 advocacy visits to key stakeholders •4 Immunization scorecard developed and validated •18+ RI Technical Working Group and RI task force meetings

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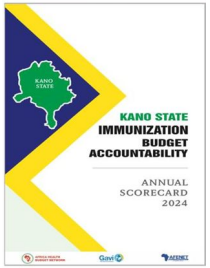
Scorecard on Immunization Budget Accountability



Budget Allocation

- Total Annual State Budget in Absolute Figures
- Total Approved Health Budget for State in Absolute Figure
- Total Budget Allocated to PHC Agency by State in Absolute Figure
- Total Budget Allocated to Immunization Services by State in Absolute Figure
- Absolute Amount contributed by the (MoU) partners in the immunization basket fund

Health Financing and Accountability

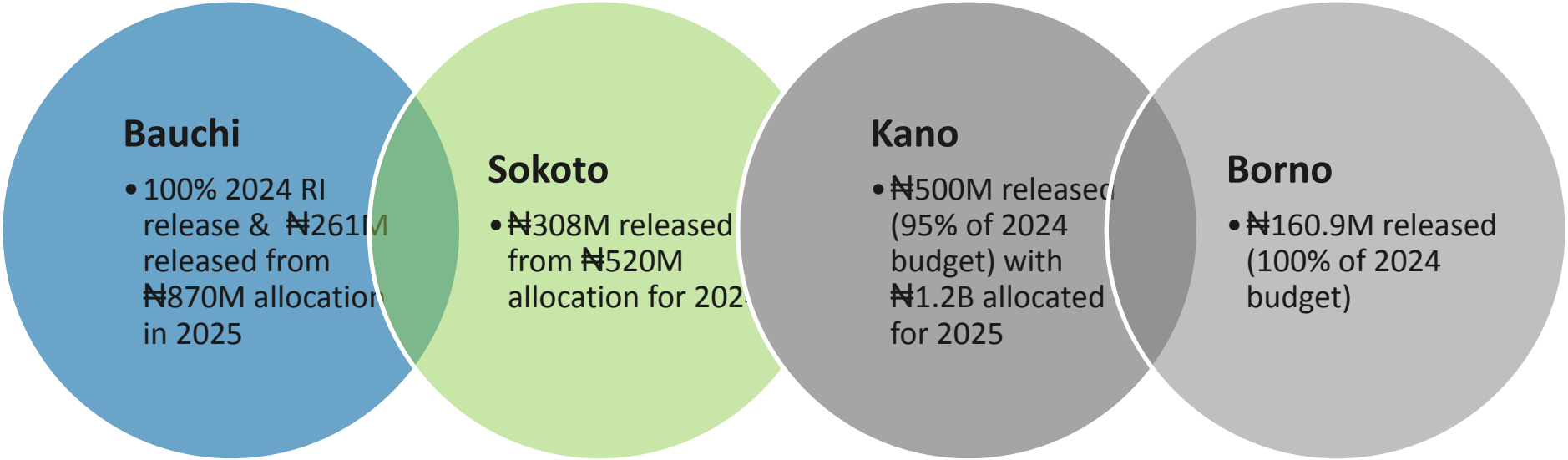
- Proportion of approved State budget allocated to the health sector
- Proportion of the health sector budget allocated to State Primary Health Care(SPHCDA) Agency
- Proportion of the SPHCDA budget allocated specifically for immunization in the State
- Proportion of health sector budget released by State government quarterly

Service Delivery and Transparency

- Proportion of Under 1 years that received Penta 1 in the BHCF health facilities in the ZD LGAs
- Percentage of caregivers interviewed and satisfied with immunization services received in the BHCPF implementing facility at zero dose affected LGAs

Highlights of Advocacy Achievements

RI Budget Release Successes



Challenges, Mitigation, & Response Plan

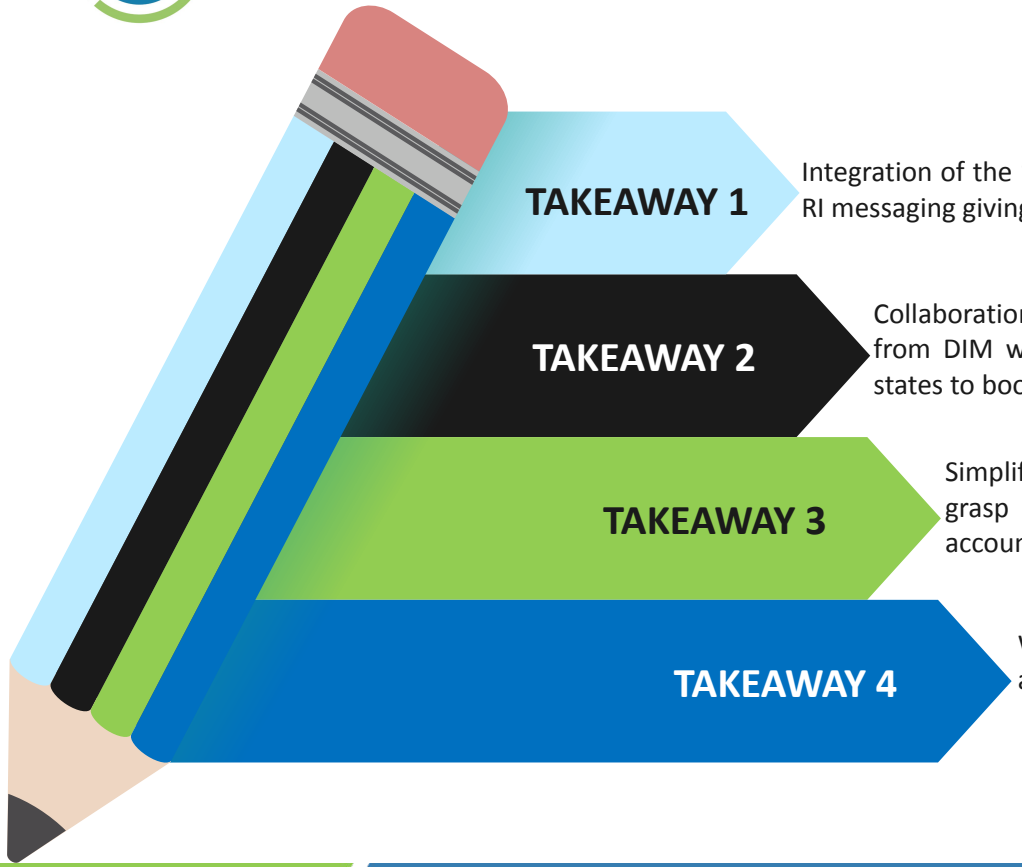
Challenges

1. **Insecurity**
2. **Resistance**
3. **Dependence on donor funding**
4. **Delayed RI fund releases**
5. **Inadequate CSO presence**

Mitigation & Response Plan

1. Security network and community guides were used to navigate areas of difficulty in access
2. Local guides and community leaders were engaged to address and mitigate resistance
3. Strengthened push for domestic budget commitment
4. Addressed through intensified high-level advocacy and scorecard use
5. Enhanced CSO integration into key accountability structures

Key Takeaways & Recommendations



TAKEAWAY 1

Integration of the “promotion of ANC and hospital delivery messaging” as a component of RI messaging giving to caregivers based on DIM results in Bauchi State

TAKEAWAY 2

Collaboration unlock potentials; CHAN in Borno State vaccinated ZD children tracked from DIM while existing social protection programs were leveraged in the four states to boost caregivers economic and education status

TAKEAWAY 3

Simplify data visualization “one pages advocacy brief” to improve stakeholder grasp and encourage use in annual operational planning and joint accountability using community led platforms like the CoP

TAKEAWAY 4

We leverage local champions, including legislators & executives to advocate for evidence informed decisions and unlock investment

Webinar, Newsletter, Manuscript, & Abstract

- **Webinars:** Webinar Resources: https://bit.ly/4hrFXGF (7 Webinars with 1000 +) ***Webinar Finale on 25th June 2025***
- **Knowledge Products:**
  - Abstracts (Gavi ZD Week; 10 accepted; Global; 2, Regional; 1, Local; 4)
  - A scoping review of barriers and facilitators. Vaccine X. 2024 Sep 26; 20:100563
  - Doi:10.1016/j.jvacx.2024.100563. PMID: 39430738; PMCID: PMC11488437
  - Published Abstract: Decentralized Immunization Monitoring: Lessons Learned From Four States - Nigeria
  - West Afr J Med. 2024 Nov 10;41(11 Suppl 1): S54. PMID: 39545323
- **Rapid Assessment:** https://zdlh.gavi.org/resources/closing-immunization-gap-enhancing-routine-immunization-nigeria-reaching-zero-dose-and
- **Subnational Budget Analysis:** https://zdlh.gavi.org/resources/sub-national-budget-analysis-focusing-immunization-under-nigeria-zero-dose-learning-hub
- **Learning Agenda Workshop:** https://zdlh.gavi.org/sites/default/files/2024-09/ZDLH%20Nigeria%20Learning%20Agenda%20Workshop%20Report.pdf
- **Learning Agenda Resources:** https://zdlh.gavi.org/sites/default/files/2024-09/Zero-Dose%20Learning%20Hub%20Learning%20Agenda%20Slide%20Deck.pdf
- **Newsletter:** https://zdlhintranet.org/libraries/resources/zdlh-nigeria-quarterly-newsletter-q1-q2-2024
- **Newspaper Publication:** https://healthreporters.info/bauchi-govt-creates-budget-line-for-immunisation-to-curb-zero-dose/

Conclusion

- The rapid assessment helped inform the design of the subnational advocacy efforts through stakeholder identification & mapping and budget analysis.
- DIM provided timely information about low performing wards, ZD prevalence, and behavioral and social drivers.
- Findings from DIM were used for targeted advocacy in addition to dissemination to national and sub-national stakeholders.
- Advocacy contributed to increased immunization funding in the four states.
- Efforts by members of the COP were able to document more timely releases of funding that resulted in the ability for outreach sessions to be carried out which should drive improvements in immunization coverage and reduce ZD.

References

- WHO/UNICEF estimates of national immunization coverage (2024).
- National Strategic Plan to Optimize Routine Immunization in Nigeria (2021-2024).
- The DHS Program - Nigeria Demographic and Health Survey 2023-24 - Key Indicators Report (English) [Internet]. [cited 2025 Mar 8]. Available from: https://www.dhsprogram.com/publications/publication-pr157-preliminary-reports-key-indicators-reports.cfm?cssearch=1586477_1.
- Mohammed Y, Reynolds HW, Waziri H, Attahiru A, Olowo-okere A, Kamateeka M, et al. Exploring the landscape of routine immunization in Nigeria: A scoping review of barriers and facilitators. Vaccine X. 2024 Oct 1;20:100563
- Zero-Dose Funding Guidelines Guidance on Use of Gavi Support to Reach Zero Dose Children and Missed Communities. 2021 [cited 2025 Mar 8].
- JSI. Turning Research into Action: How to Build an Effective Knowledge Translation Plan. Available from: https://www.jsi.org/turning-research-into-action-knowledge-translation.

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Gavi The Vaccine Alliance JSI IIHMR DELHI THE GENEVA LEARNING FOUNDATION

Data Evidence in Decision Making – Kano ZDLA (Male Caregivers)

May 2025

Our LXD approach - How we gather evidence, test, iterate and refine our intervention

Our approach

- **A stakeholder-led approach** where users use HCD to develop and drive interventions, promoting community/local ownership through data sharing
- A bottom-up model where solutions are developed at the **grassroots level** with an iterative process of learning by doing with stakeholder inputs

Caregiver Perspectives

Puts the **ZD caregiver and family at the centre of the design and implementation** of an improved system, addressing caregiver pain points and developing fit-for-purpose solutions

Health Worker Insights

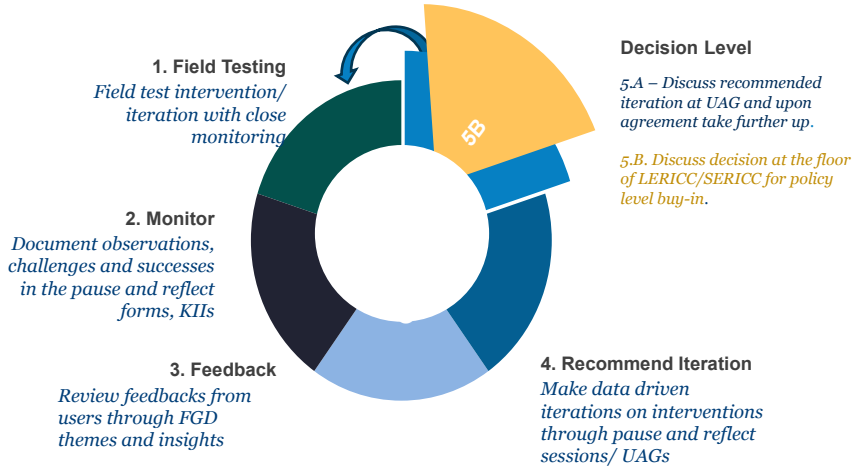
Leverages **a human-centered approach that incorporates the perspectives of the health workers** in facilities and communities

Learning by Doing (LxD) Approach

Adheres to the LxD principles to create a **dynamic, self-correcting immunization model that continuously improves** over time

Integrative Approach

Leverages **existing networks, interventions and systems** (e.g., CRoWN, VCMs), also innovating on approaches to improve execution, and incorporating novel interventions, where applicable



While 4 HCD interventions are currently implemented, this illustration will focus on one community level intervention championed by male caregivers

Data flow - How we are aligning implementation decisions with policy direction both community and state levels

Decision-making process for iteration implementation

- ❑ To ensure that iteration decisions are both relevant and systematically aligned with the broader immunization program, a structured process was developed to serve as a guide to the group on decision making
- ❑ All proposed iteration decisions are to be reviewed against the **decision guide**.

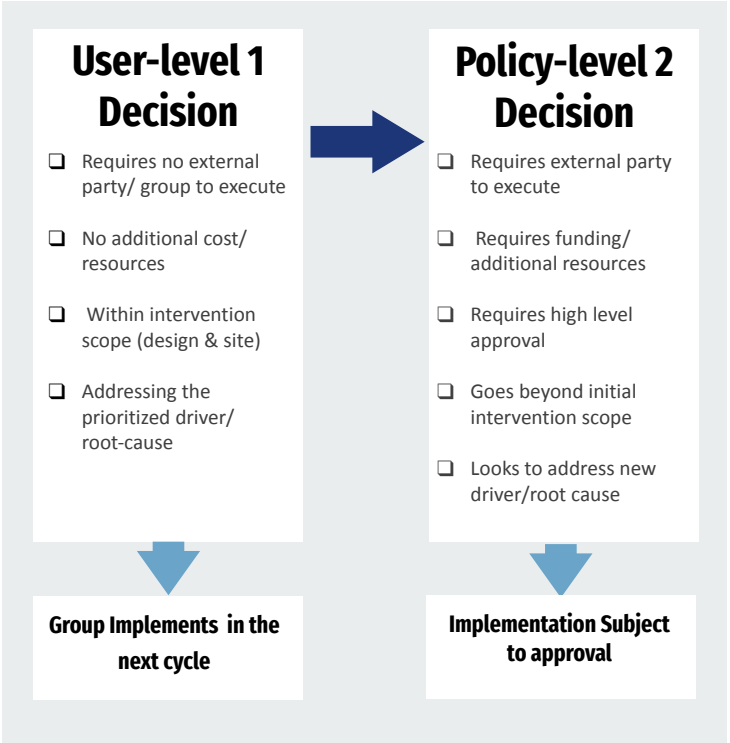
User-level 1 iteration

- Iterations that **fall within the operational capacity and mandate of the user group** may be adopted and implemented immediately in the next cycle following agreement with group member at the pause and reflect sessions. These typically involve low-level, low-resource adjustments

Policy-level 2 iteration

- For iterations that **require higher coordination, significant resource allocation, or policy-level implications**, a broader stakeholder review is necessary. Such iterations will be presented to the **UAG (User Advisory Group)** and upon alignment is channeled to policy levels like the **LERICC and/or SERICC.** Approval is required here before proceeding with implementation

Iteration Decision Guide



Overview of Focus Intervention - Immunization Advocacy Network (Male Caregivers)

Gaya LGA, Balan Ward, Balan and Jibawa Facilities

Overview of Intervention

This intervention seeks to empower **male caregivers** to become more involved in promoting messages to the community around the importance of childhood vaccination. This involves sensitization at the Friday mosque on key topics approved by service providers

This is to be done every week, and also looking to address permission issues among zero-dose caregivers.

Associated ZD Drivers / Prioritized Root Cause

1. Perceive immunization as women's responsibility
2. Limited engagement with community, religious, and traditional leaders
3. Poor awareness of immunization services in the community
4. Lack of community (male) participation in RI services sessions

Objectives of Interventions

1. Male caregivers expected to coordinate with service providers to develop weekly sensitization sessions in local mosques on Friday
2. Traditional and religious leaders to provide support through User Advisory Groups (UAG) monthly meetings

Intended Outcome

1. Increased involvement of male caregivers in RI services and immunization advocacy
2. Increased ownership and support for vaccination among male caregivers and religious leaders
3. Increased collaboration between community, HF staff and LGA staff

What does success look like? | Improved ownership of male caregivers in routine immunization services in the community resulting in reduction of ZD burden in Kano

Stakeholders Involved in the Immunization Advocacy Network

Non-State Actors

1. Male Caregivers/Community Members

Male champions driving the sensitization and other community members

2. Religious Leaders

Local authorities whose influences are leveraged to access other men both at the mosque and the community

3. Traditional Leaders

Local authorities whose influences are leveraged to access other men both at the mosque and the community

State Actors

4. Service Providers

Provides capacity building to male champions and technical support in delivering sensitization messages at the community level

5. LERICC (LGA Immunization Program)

Providers oversight and supervisory functions at the LGA level

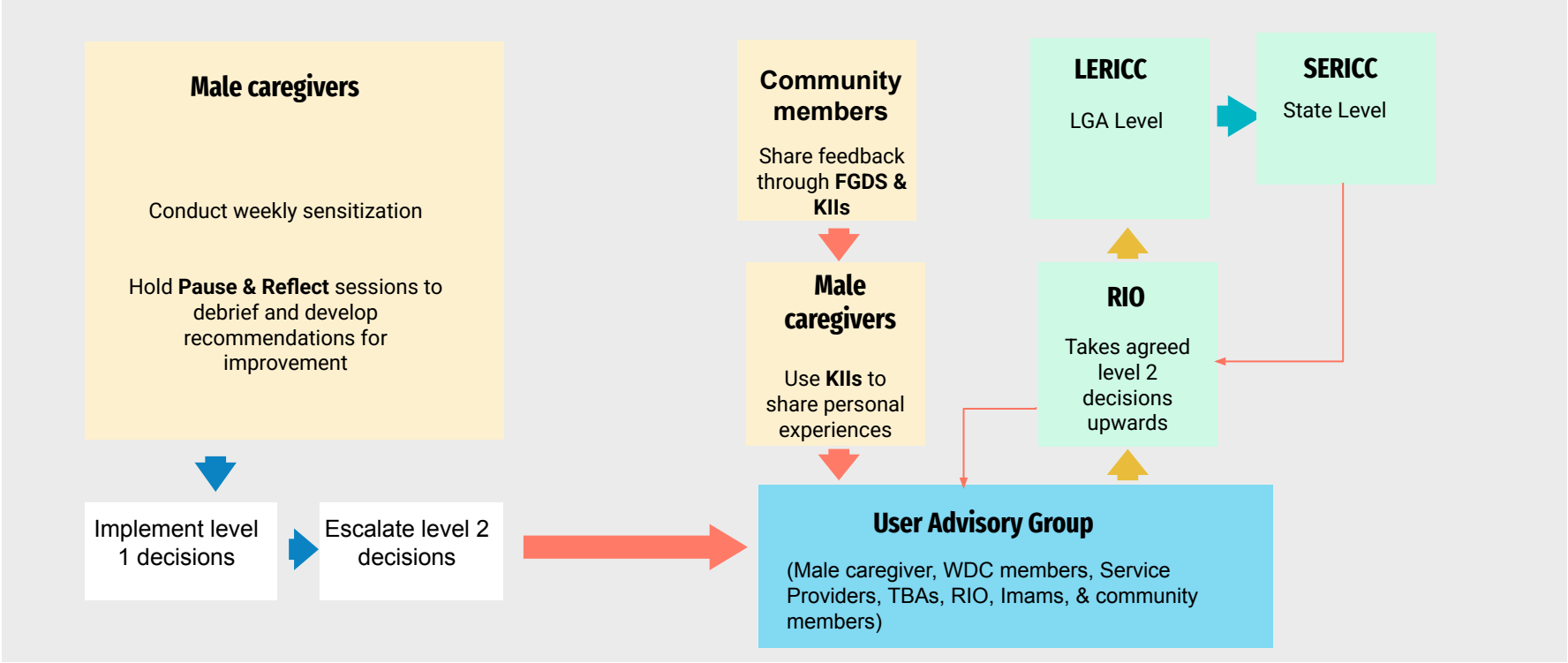
6. SPHCMB (State Immunization Program)

Providers oversight and supervisory functions at the state level

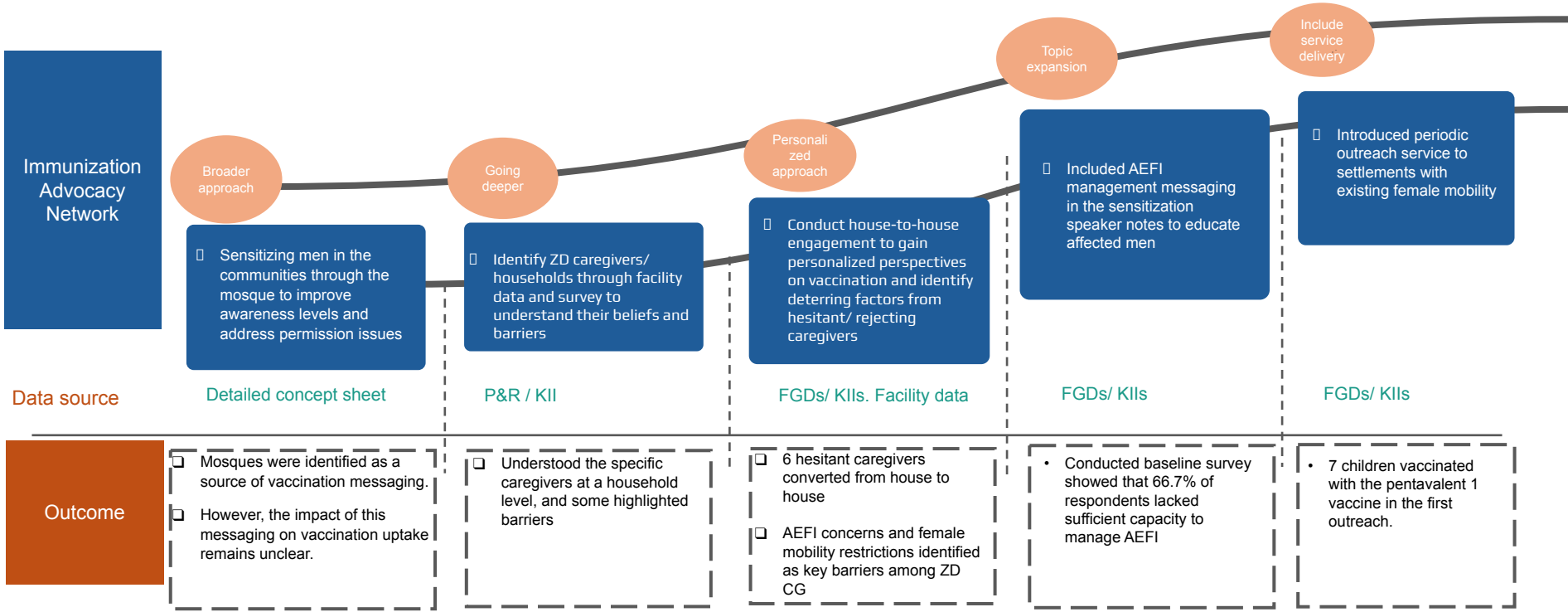
Feedback Mechanism – Data Points, Data Types, Parties Involved, and Outputs

Data point	Description	Data Use	Frequency	Participants	Output
Pause & Reflect	Post-activity debrief to assess weekly intervention performance	To get quick feedback on implementation activities (what went well, what needs to changes)	Weekly	Male Caregiver Group	Documentation of what is working and what is not
Focus Group Discussions (FGDs)	Gather community feedback on key drivers and implementation activities	To assess impact from the community/ stakeholder perspective	Monthly	Community Members (including Zero-Dose Caregivers)	Deeper insights on drivers, vaccination barriers and implementation result
Key Informant Interviews (KIIs)	Capture targeted insights from core user group members on intervention drivers	To assess perspectives of key individuals/ stakeholders	Monthly	Male Caregiver Group/ community members	Deeper insights on drivers, vaccination barriers and implementation result
Facility Registers	Vaccination data and a list of non-compliant households	To assess change in vaccination culture/ identify hesitant caregivers	Monthly	Service providers, male caregivers	Vaccination trends to assess intervention and key target individuals
User Advisory Group (UAG)	Broader stakeholder feedback on implementation and strategic recommendations	For collective decision making and buy-in on key decisions	Monthly	Male Caregivers, WDCs, Service Providers, RIOs, Imams, TBAs	Collective decision on intervention implementation approach

Implementation cycle - How we test implementation decision and gather evidence to sustain or iterate



Data use in intervention iteration and refinement



Thank you

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Centre d'Apprentissage pour l'Equité en Vaccination - Mali
MALI LEARNING HUB

From Evidence to Action: Strengthening Immunisation Equity in Mali through Mali Learning Hub/CAPEV

GaneshAID
Our Innovations Are Yours

CVD-MALI

U.S.T.T-B

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Introduction

- **Mali ranks 7th in Africa** for the highest number of zero-dose children (IHME, 2022).
- In **2023**, an estimated **288,444 zero-dose children (ZDC)** were identified (IHME projections).
- **70%** of ZDCs live in **conflict-affected or rural/remote** areas.
- ZDC numbers have grown by over 20% between 2018 and 2022
  - **Projection:** If unaddressed, the number may exceed 300,000 by 2026
  - **Districts with highest ZDC:** Gao, Douentza, Mopti, Kayes, Commune I/IV of Bamako.
- The **Mali Learning Hub (CAPEV)**, led by **CNI**, is funded by **Gavi** and coordinated by **GaneshAID**, **CVD-Mali**, and the **University of Science, Technology and Techniques of Bamako (USTTB)**.

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Objectives

1. Generate and synthesise learning on the barriers to children being reached

2. Strengthen the evidence base of effective approaches to identify and reach zero-dose children and missed communities

3. Improve metrics, measures, and methods to access and use data on a regular basis to improve reaching zero-dose children and missed communities.

Activity Overview & Stakeholder Engagement

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Implementation research on 2 innovations driving equity

- **Geographic focus**: 4 district archetypes in Mali – urban, rural remote, conflict, special populations
- **Objectives:** Evaluate the strategies for deploying C2P and MEDEXIS, measure their immediate outcomes, and conduct a vaccination coverage survey across eight health areas representing four types of district archetypes.

C2P
Coaching de Performance

Coaching for Performance (C2P) – Enhancing Microplanning Capacities

A digital coaching model to strengthen local planning and service delivery

- Supports frontline health workers and district teams to improve **microplanning quality** through structured coaching.
- Uses a mobile and desktop platform to guide vaccinators in analyzing data, identifying zero-dose children, and adapting outreach strategies.
- Encourages regular team reflection, prioritization of hard-to-reach populations, and localized decision-making aligned with FPP goals.

MEDEXIS

MEDEXIS – Real-Time Visibility of Vaccine Stocks

An eLMIS to improve vaccine availability and reduce service interruptions

- Tracks vaccine stock levels across facilities to prevent stockouts and enhance microplanning accuracy.
- Dashboards help align stock availability with planned outreach sessions.
- Supports integration with DHIS2 and other routine planning systems.

Stakeholder Engagement in C2P

Coaching for Smarter Microplanning

Who was engaged?

- National & District Level: Centre National d'Immunisation (CNI), DRS, MCDs
- Local Level: CSCom staff, vaccinators, ASC, community leaders
- Partners: GaneshAID, UNICEF, WHO

How were they engaged?

- Participatory co-design of coaching content aligned with local microplanning cycles
- District-level workshops to adapt tools for identifying zero-dose children (FPP supported interventions)
- Onsite and virtual coaching sessions linked to routine microplanning reviews
- Joint analysis of coverage gaps and refinement of outreach maps

Knowledge sharing methods

- Policy and technical briefs targeted to Minister of health, CNI Director, CNI head of departments, District Medical officers, vaccinators, communities
- C2P dashboard reviews with health facility staff
- C2P Visual coaching summaries used in monthly team briefs
- Field-based coaching visits to reinforce learning loops

Stakeholder Engagement in MEDEXIS

Linking Data to Stock and Planning

Who was engaged?

- Central & Regional Supply Chain Teams: CNI, DRS logisticians
- Facility-Level Users: Data managers, stock officers, vaccinators
- Partners: JSI, Gavi, technical teams supporting eLMIS in Mali

How were they engaged?

- National orientation sessions on MEDEXIS and its link to planning
- Cascade trainings for district logisticians and CSCom staff
- Supervision visits to monitor data entry and resolve use barriers
- Inclusion of MEDEXIS indicators in joint monitoring reviews

Knowledge sharing methods

- Real-time dashboards shared in monthly review meetings
- Alerts used to coordinate rapid restocking before outreach campaigns
- Data used in microplanning sessions to ensure supply aligns with demand

Evidence Use: Results & Changes

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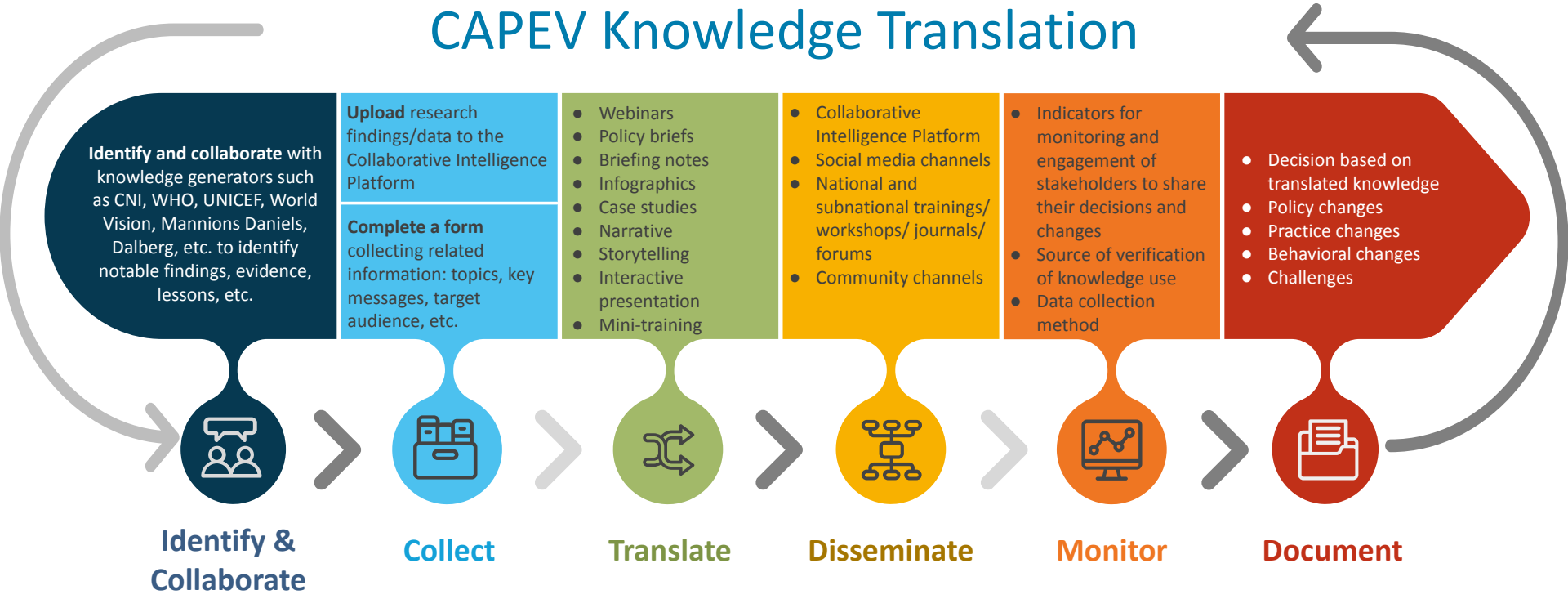
Embedding KT in Mali EPI and Partners Operations

CAPEV Knowledge Translation



Engaging evidence generators to share existing knowledge and co-create new knowledge for impact

An Innovative and Participatory approach

Learning Products from IR Phase 1

Learning Products		Knowledge Users	Expected Changes
Policy briefs (2)	• Renforcer la vaccination au Mali	Minister of Health and Social Development, Mali	**Conflict Zones**: Collaborate with humanitarian actors and adapt strategies to local realities. **Rural/Remote**: Improve logistics, use mobile clinics, engage local leaders **Urban/Peri-Urban**: Combat misinformation, offer flexible hours, and use urban-friendly communication channels. **Specific Populations**: Tailor interventions, involve local NGOs/CSOs, and ensure culturally appropriate messaging.
	• Renforcer la vaccination au Mali	Director of the National Immunisation Center in Mali	**Strengthen Supervision & Health Worker Support** Monitor C2P/MEDEXIS use, provide equipment, and train coaches in key skills **Improve Vaccine Stock Management** Use MEDEXIS alerts, partner with suppliers, and apply clear response protocols **Boost Community Engagement** Involve local leaders, CSOs, and media in culturally adapted communication **Target Zero-Dose Children** Use innovative outreach, mobile clinics, and partnerships tailored to local contexts
Technical briefs (7)	• Renforcer la vaccination au Mali	• Heads of the Planning and Coordination Division, CNI • Heads of the Training and Supervision Division, CNI • Heads of the Logistics and Supply Division, CNI • Heads of the Communication Division, CNI	**Data-Driven Targeting:** Use vaccination data to target resources and create digital microplans. **Enhanced Training & Supervision:** Provide tailored training and regular supervision on C2P and MEDEXIS. **Optimize vaccine supply** with MEDEXIS and improve stock management. **Targeted Communication:** Customize communication using local insights and engage community leaders. **Strengthened Coordination:** Strengthen cross-division and community coordination.
	• Renforcer la vaccination au Mali	• Regional Health Directors • Center Technical Directors • District Chief Physicians	**District Health:** Use C2P & MEDEXIS data for targeted action plans, supervision, stock management, and monthly reviews with local leaders. **Health Centers:** Integrate data in microplans, engage in coaching, track progress via C2P, and collaborate with community actors. **Regional Health:** Focus micro planning on high zero-dose concentration areas, strengthen supervision, and hold regional performance reviews.

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Turning Evidence into Action

- C2P pilot led to refinement of coaching tools for local contexts.
- MEDEXIS findings accelerated national eLMIS plans for vaccination.
- Coverage survey data prompted prioritization of mobile outreach in Niono & Bougouni.
- Evidence supported adjustment of FPP strategies in conflict and remote areas.

Key Takeaways & Recommendations

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Lessons from the Field

Successes

- Embedded research + service delivery
- Government ownership
- Partner collaboration on implementation and analysis

Challenges

- Digital literacy gaps among health workers
- Equipment and Internet access in rural/conflict areas
- Resistance to new digital tools (C2P, MEDEXIS) initially due to fear of evaluation

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Key Takeaways & Recommendations

Improving Stakeholder Engagement for Evidence Uptake

1. **Local Co-Ownership**: Involve district and community actors early in tool design and evidence interpretation.
2. **Tailored Feedback Loops**: Use adapted dashboards and coaching visits to explain results and plan improvements.
3. **Flexible Digital Tools**: Design for offline/low-tech environments to ensure equitable access to innovations.

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Key Takeaways & Recommendations

CAPEV: A Model for Evidence-Informed Action

1. CAPEV is a scalable model for linking data to frontline change.
2. Our experience shows: co-learning, digital support, and local voice matter.
3. Mali CNI envisions to lead CAPEV and continue sharing, adapting, and scaling evidence-driven solutions with EAF re-allocation (2026-2027).

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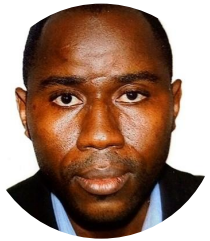

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Together for vaccine equity in Mali!

GaneshAID
Nos Innovations Sont Les Vôtres

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LinkedIn : linkedin.com/company/ganeshaid-a-nonprofit-consultancy-company

CVD-MALI

Website: https://cvd-mali.org/

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Facebook : https://www.facebook.com/usttb.edu/
Twitter : https://twitter.com/ComUSTTB

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Discussion

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Please share your questions in the Q&A box

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APPENDIX

- ZDLA: Implementation contexts
- ZDLA: LxD principles
- ZDLA: Featured tools & resources commonly used in LxD approaches

ZDLA teams are working across a wide range of contexts

Country	ZDLA team	Subnational locations	ZDLA sites		Estimated ZD prevalence*
DRC	PATH Living Labs	Tshopo province	**4 health zones** (admin 2)	3 rural	44-62%
				1 urban	45%
Nigeria	Kano ZDLA consortium (*including* CHAI Nigeria, Solina, Datharm)	Kano state	**3 LGAs** (admin 2)	2 rural	42-46%
				1 urban	31%
Ethiopia	CHAI Ethiopia	Afar, Oromia, Addis Ababa regions	**3 woredas** (admin 3), 1 per region	2 rural	24-25%
				1 urban	3%
Kenya	PATH Living Labs	Homa Bay, Turkana counties	**2 sub-counties** (admin2), 1 per county	2 rural	2-6%
India	IHAT-TSU	UP state	**4 blocks** (admin 3), 1 per sampled district	4 rural	1-3%
	WJCF India	Bihar, UP states	**4 districts** (admin 2), 2 in each state	4 rural	2-17%
	JSI India	Bihar, UP states	**3 districts** (admin2), 2 UPHCs per district	3 urban	6-16%
Pakistan	Impetus	Karachi division	**3 SHRUCs** (admin 5)	3 urban	13%

9 sites in higher ZD prevalence (>20%) settings (DRC, Nigeria, Ethiopia)

- *7 rural (DRC, Nigeria, Ethiopia)*
- *2 urban (DRC, Nigeria)*

17 sites in lower ZD prevalence (≤20%) settings (Ethiopia, Kenya, India, Pakistan)

- *7 urban (Ethiopia; Pakistan; India)*
- *10 rural (India; Kenya)*

***ZD prevalence estimates originated from difference sources and may not be directly comparable across countries or contexts.** For DRC, Nigeria, and Kenya, estimates are for the year 2023 from IHME's December 2024 update. For Ethiopia, estimates are from the CHAI 2024 household surveys conducted in each woreda. For Pakistan, estimates are for year 2023 from the TPVICS SHRUCS R3 survey. For India (JSI), estimates are from JSI HTH monitoring from 2021-2023. For India (WJCF), estimates are from NFHS 2019. For India (IHAT-TSU), estimates are based on WHO concurrent monitoring data for FY 2023-2024.

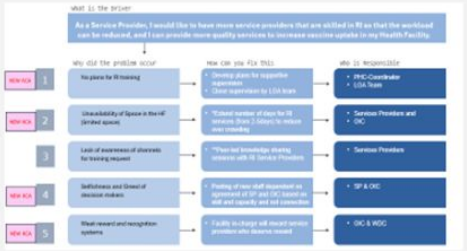
9 Principles that guide LxD approaches (light blue rows = key principles)

GROUP 1: Principles 1-3 Understanding the problem [these especially link to IDENTIFY in Gavi's IRMMA Framework, and "Learning about ZD Drivers"]
1. They are **problem-oriented**; they may build on solutions / promising practices from similar contexts (either from past on-site experience or adapt practices from other locations) or could be a new idea. But the problem relates to that particular site, not generically to several districts/equivalents.
2. They **break larger more complex challenges into smaller, more doable actions** and focus on what is doable at that level, or they team with other levels to address larger challenges together (e.g., a health facility with community representatives and its district jointly addressing a common challenge)
3. They find and address ZD **drivers** as a team, with local communities involved in determining the drivers and interventions to test; any adjustment or changes are made by collective, not individual, decisions, and are based on agreed-upon markers of progress.
GROUP 2: Principles 4-6 Designing & implementing interventions [these especially link to REACH in the IRMMA Framework, and "Learning about ZD Interventions"]
4. They incorporate **human centered design** techniques/tools/methods throughout, of which communities are a key piece (not only linking with health professionals).
5. They connect to how a program and its processes normally **function "in the workflow"** (e.g., is not a project intervention requiring new touchpoints and/or major "heavy" ongoing external support that is unsustainable); the speed of rapid learning or iterative interventions will vary, but must adhere to being embedded in programmatic functions—exploring new or better ways to utilize programmatic touchpoints; any data tracking/measures that intend to be mainstreamed must fit within this principle.
6. They **reduce gender gaps/barriers** in access to resources or increase the evidence base around gender gaps/barriers (is at minimum gender intentional; see Gender Integration Guide – Gender Equality Toolbox; https://www.gatesgenderequalitytoolbox.org/)
GROUP 3: Principles 7-9 Continuous local learning and adaptation [these especially link to MONITOR AND MEASURE in the IRMMA Framework, and "Learning about Learning"]
7. They promote a **continuous review process** where information is regularly updated by the users (e.g., health staff, communities, etc.), and where any promising approach is collectively decided to be mainstreamed, and any not-so-promising approach is re-strategized and tested or dropped; if you are thinking of scaling an LxD approach, it is this continuous review process that should be at the heart of the scaling model (along with the technical intervention you are addressing and processes to uncover emergent drivers).
8. They happen **in real time,** where and when health workers and communities/stakeholders need it.
9. They strengthen **local autonomy** for ongoing adaptation to plans, practices, and processes (and policies at highest levels)

Featured LxD tool

5-WHYs ROOT CAUSE ANALYSIS

Approach: We applied the 5 Whys method with the Users to systematically trace logical pathways and uncover the fundamental causes related to their point of view and underlying behavioral drivers by iteratively asking 'why'.



Impact & Example

During an M&E workshop, RCA helped uncover that one of the drivers for service providers wasn't "insufficient skilled SPs" but rather SPs needing an additional RI days as it reduces long wait times, overcrowding and the SPs are not as overwhelmed. This insight also informed the need to use the RCA in a new intervention site to uncover similarly hidden causes.

Where we have used it

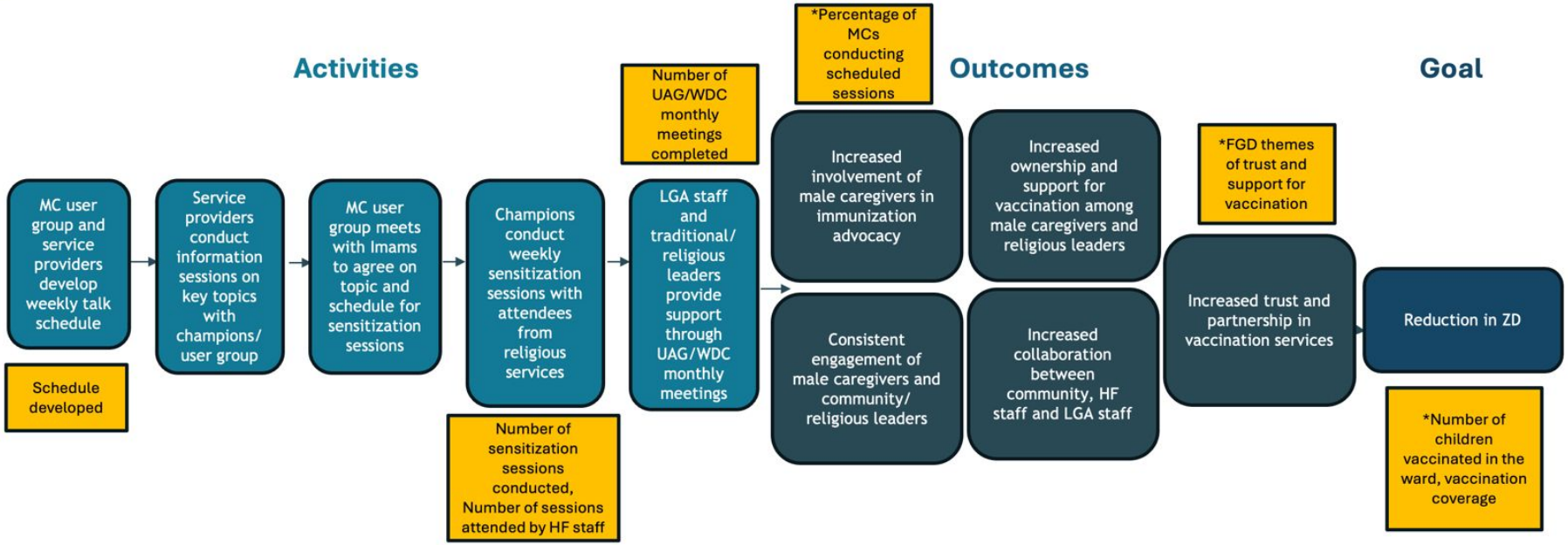
This tool has been utilized during the HCD co-creation and during subsequent M&E workshops to help guide beyond the surface and get to the Key Driver of the intervention

Sustainability & Adaptability

RCA is a low-tech, user-friendly tool that fits seamlessly into routine workflows. It requires no special technology or infrastructure—just time for structured reflection.

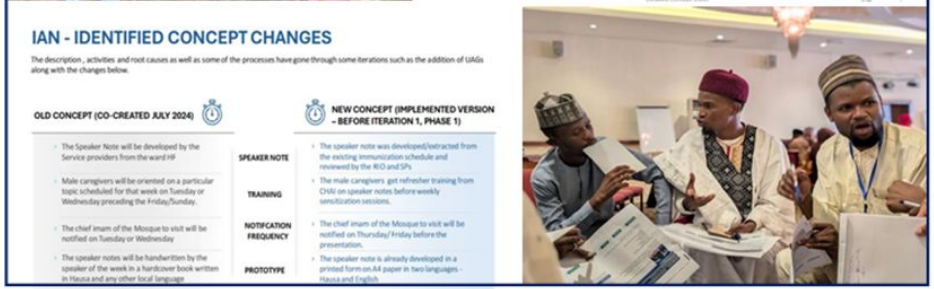
Featured LxD tool

Theory of Change example (indicators in yellow boxes) for an Immunization Advocacy Network for Male Caregivers (MCs)



Source: CHAI Nigeria

Featured LxD tool



Approach:

We co-developed the Detailed Concept Sheet with the Users to clearly define the concept behind each intervention, outline key design features, and map out how it would work in practice.. It serves as a bridge between field realities and decision-making spaces.

Source: CHAI Nigeria

DETAILED CONCEPT SHEET

Impact & Example

During HCD co-creation user groups initially developed separate Lean Concept Sheets, each reflecting their own priorities and insights. The Detailed Concept Sheet helped harmonize these perspectives into a single, unified plan for each user group—ensuring clarity on the intervention's purpose, design, and implementation steps. Later, during M&E workshops, the tool was revisited to reflect shifts in strategy based on emerging insights. The tool servs as a central reference that captured the full evolution of the intervention.

Where we have used it

The Detailed Concept Sheet serves as the operational plan for each intervention, ensuring alignment from co-creation through to implementation. It also functions as a summary document, capturing key adaptations over time and feeding directly into the ZDLA workbook to reflect the intervention's evolution

Sustainability & Adaptability

Its format is deliberately simple and replicable, allowing for updates and reuse across different contexts without the need for additional training or resources.

Featured LxD tool

CHANGE LOG

Change Log

CHANGE LOG

DATE	WHAT IS NOT WORKING	SOURCE OF INFORMATION	WHAT WILL WE CHANGE	STATUS AND DATE COMPLETED	WHAT HAPPENED AS A RESULT
2/25/2025	CHAI and Datharm are collaborating in Gabasawa LGA, but Datharm's CRGs cover some settlements not all, excluding our mobile outreach sites. This may create data gaps for planning mobile sessions, especially around community engagement and social mobilization	The pause and reflect engagement with the users, service providers, and other partners in the LGA	**1. Flexible Mobile Outreach Planning –** Prioritizing settlements with more under-one children rather than strictly those beyond 5km. **2. Stronger CHAI-Datharm Collaboration –** Enhancing coordination for more effective implementation. **3. Data-Driven Decision-Making –** Using accurate data to inform outreach site selection. **4. Tailored Community Engagement –** Adapting strategies to better mobilize and involve communities.	The selection process has begun, with facilities already chosen, and implementation is expected to commence this month. This was completed on 11th March 2025	As a result of this change, more zero-dose children will be reached. Based on the facilities' target population estimates, approximately **148 children under one year** are expected to be reached through these mobile sessions.

Approach: We use a real-time documentation tool to capture emerging shifts in behavior, practices, and systems—creating a live feedback loop that supports ongoing learning and rapid iteration

Impact & Example

In Gabasawa, the LGA Users noticed gaps in settlement coverage. response, teams shifted to a more flexible planning approach, prioritizing settlements with higher numbers of under-one childre As a result, revised mobile sessions are expected to reach approximately 148 zero-dose children, improving equity in servic delivery

Where we have used it

The Change Log is imbedded into the weekly Pause & Reflects utilized by the Users on a weekly basis

Sustainability & Adaptability

The Change Log tool is seamlessly integrated into the routine reporting structure (Pause & Reflect), featuring streamlined, purpose-driven questions that encourage users to document what's working—and what's not—in the intervention. This approach not only ensures ongoing reflection but also fosters adaptability.

Source: CHAI Nigeria

CHANGE LOG – TRACKING IMPLEMENTATION CHANGES

THEME	WHAT WAS NOT WORKING	SOURCE OF INFORMATION	WHAT TO CHANGE	STATUS AND DATE COMPLETED	WHAT HAPPENED AS A RESULT
Approach	Messages were scheduled post-prayer using handwritten speaker notes, which caused inconsistency in delivery because facilitators lacked standardized content.	Weekly pause and reflect sessions and User Advisory Group meetings	Developed and implemented a 10-15 minute structured sensitization session using standardized speaker notes.	Completed	The standardized speaker notes led to more coherent and consistent messaging.
Users Engaged	Male caregivers were engaged from only one ward (Balan), without accounting for differences between communities—this reduced relevance and reach because local dynamics were not considered.	Weekly pause and reflect sessions and User Advisory Group meetings	Engagement expanded to include caregivers from multiple communities (Balan, Niima, Moda, Jibawa) and included youth participants to diversify input.	Completed	Increased inclusiveness and community relevance strengthened male caregiver support for immunization.
Target Audience	Targeting was limited to male caregivers attending Friday/Sunday prayers, which excluded others because outreach was not designed to reach caregivers outside these settings.	Weekly pause and reflect sessions and Key Informant Interviews	General sensitization that does not separate approach for ZD and non-ZD caregivers. Conduct survey to understand ZD caregivers perspectives	Ongoing	Conducted surveys revealed that zero dose caregivers understand the benefit of vaccines, but these have not translated to vaccination
Engagement touchpoint	General sensitization not taking account of reaching zero dose and hesitant male caregivers	Weekly pause and reflect sessions and Key Informant Interviews	Expanding engagement session beyond the mosque, leveraging list of hesitant households from the facility to conduct engagements to houses and local relaxation centers	Ongoing	Expecting to track conversation rates and specific reasons for hesitancy

Source: CHAI Nigeria

GENDER SCORING: Users are taken through a gender scoring process and review prioritized interventions to be at least gender intentional

Featured LxD tool

GENDER QUESTIONS	VALIDATION
Does the intervention have at least one primary outcome that has the explicit intention of reducing the identified gender barriers to accessing immunization services and reaching zero-dose children?	• Review intervention activities for outcomes with the explicit intention of reducing gender barriers
Does the intervention engage with the community to understand the difference in gender dynamics that might affect the reach of immunization services?	• Review of Community Engagement Report • Review of Model Strategies
Does the intervention include strategies and outcomes that result in the reduction of gender gaps in accessing resources during the implementation of the intervention model?	• 1. Review Model Activities 2. Review Result/ Outcome Framework of model intervention
Does the intervention track gender-related outcomes and incorporate mechanisms for feedback?	• 1. Sex- Disaggregated data 2. Review of documented Lessons Learned
Does the intervention monitor and evaluate the impact of its gender-responsive strategies on the community and develop appropriate mitigation strategies?	• 1. Review model specific M&E plan for gender specific indicators
Does the M&E plan include sex- and age - disaggregated indicators?	• 1. Sex Disaggregated data
Does the intervention include a gender expert to inform decisions throughout the design and implementation?	• 1. No HCW training on gender (training agenda, attendance, training report) • 2. Presence of gender expert during co-creation (co-creation report)

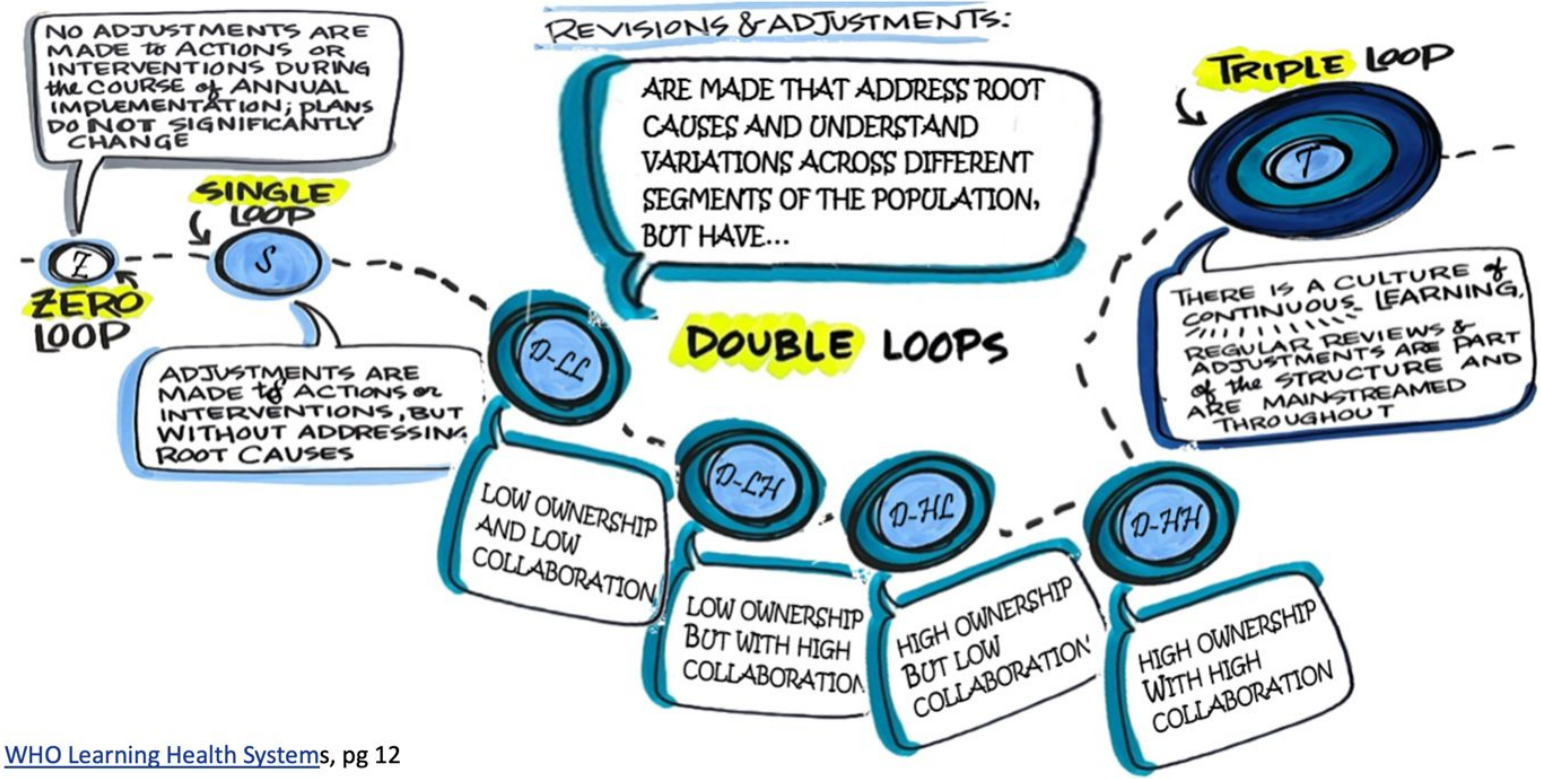
Gender Assessment Markers

- 'NO' to more than two questions, means the intervention is likely *gender unintentional.*
- 'YES' to at least 5 questions, then the intervention is at least *gender intentional.*
- 'YES' to all questions, then the intervention is very likely *gender transformative*

Source: CHAI Nigeria

LEARNING CULTURE: ZDLA uses WHO's Learning Loops to regularly assess how learning culture is evolving at the district/equivalent level; this helps gauge how sustainable the continuous learning interventions are within and across district equivalents

Featured LxD tool



Source: WHO Learning Health Systems, pg 12

RESOURCES to support gender integration, human centered design, and root cause analysis

Gender intentionality and integration

- Gates Foundation: Gender Integration Marker - Gender Equality Toolbox
- UNICEF ROSA's Immunization and Gender: A Practical Guide to Integrate a Gender Lens into Immunization Programmes.
- WHO, UNICEF, and Gavi's Why Gender Matters: Immunization Agenda 2030.
- WHO, UNICEF, and Gavi's Gender analysis of the World Health Organization online learning program on Immunization Agenda 2030

Human centered design

- PATH's Living_Labs_PATHOS_toolkit__Mar_2023.pdf

Root cause analysis

- Diagnostics worksheet in UNICEF's Demand for Health Services Workbook: A human-centred approach
- PATH Root Cause Analysis Toolkit
- JSI fishbone diagram guide for immunization
- Mothers' vaccination ecosystem (HCD tool used by Shearer et al 2023)
- CMS Five Whys Tool for Root Cause Analysis
- CMS How to Use the Fishbone Tool For Root Cause Analysis