Sample Diagnostic Report

Executive Summary

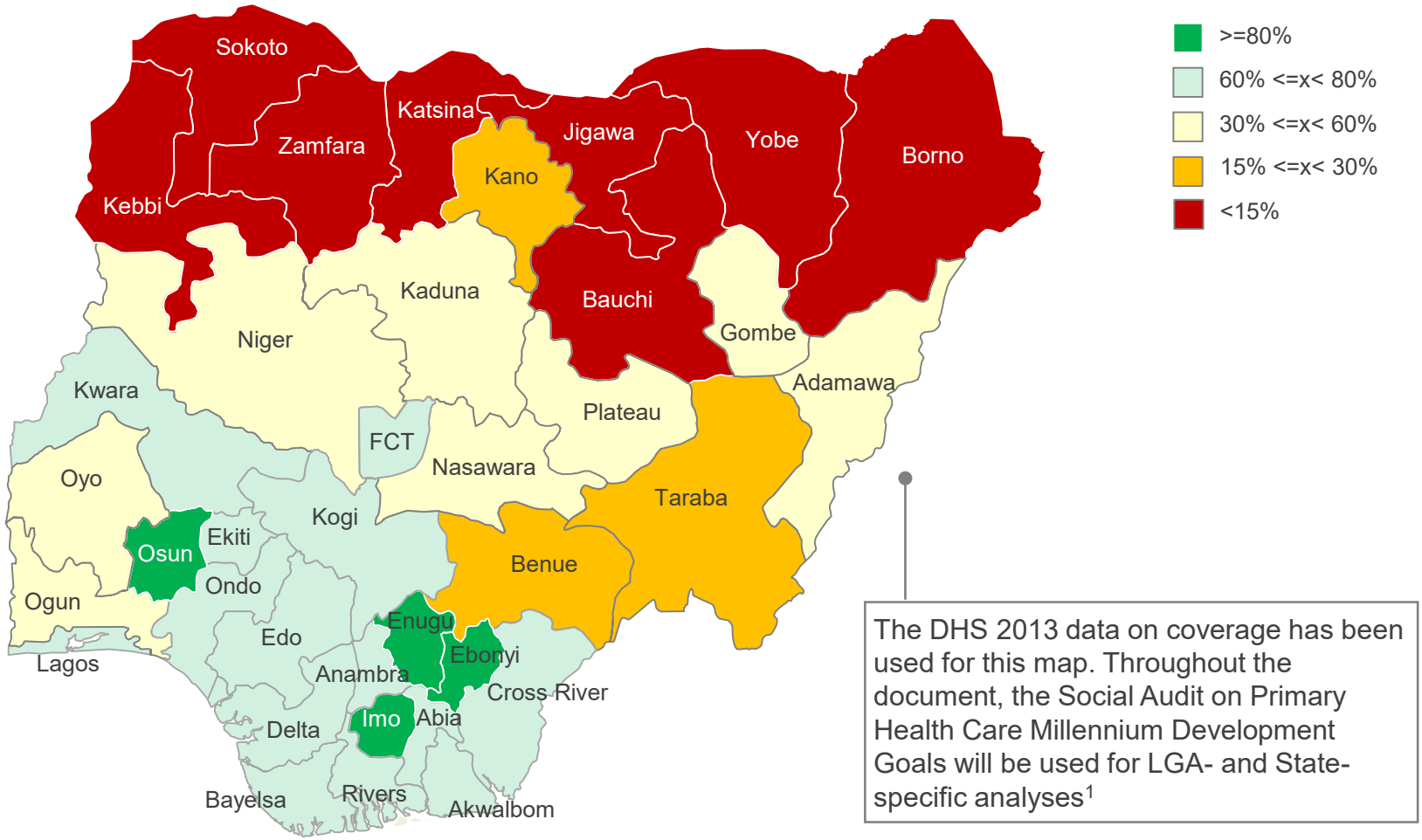
Executive summary

- **State X** is among the **poor performing states** in terms of Immunisation coverage – **only 6.1% of children under the age of 1 are fully immunised;** 90% of LGAs in the state have less than 15% of full immunisation
- A **tripartite agreement** between Dangote Foundation, Bill & Melinda Gates Foundation, and the State government will be established with the objective of reaching a sustainable rate of 80% immunisation within the next three and a half years
  - Programme is **estimated to cost ~ NGN 797 million/year**, which the parties will split 30/70, 50/50, 15/85, 100/0 for Government and Dangote/Gates respectively over the coming 3 years, starting on July 1, XXXX
  - The **State Primary Healthcare Development Agency (SPHCDA) will set up a Basket Fund** with direct funding from the State and funding partners
- The partnership will address **different challenges** in terms of availability of resources, demand, and performance management that could increase the immunisation coverage in the state
- The state can increase immunisation by adjusting the usual 1-2-3- strategy in practice; otherwise, that strategy would only provide a 34% coverage
  - The **population distribution around facilities** should determine the type of immunisation sessions. A rural facility with high potential demand should leverage fixed, outreach, and mobile sessions, while an urban facility with high potential demand should focus on more frequent fixed sessions
- As part of **the agreement**, the state is recommended to open bank accounts for direct disbursements at 3 levels of government; set up working groups that will be in charge of implementation of the RI program; and complete yearly workplan for Routine Immunisation (RI)

SOURCE: Team analysis

State X is among the poor performing states in terms of immunisation, with less than 15% of children immunised

2013 DPT3 coverage, by state



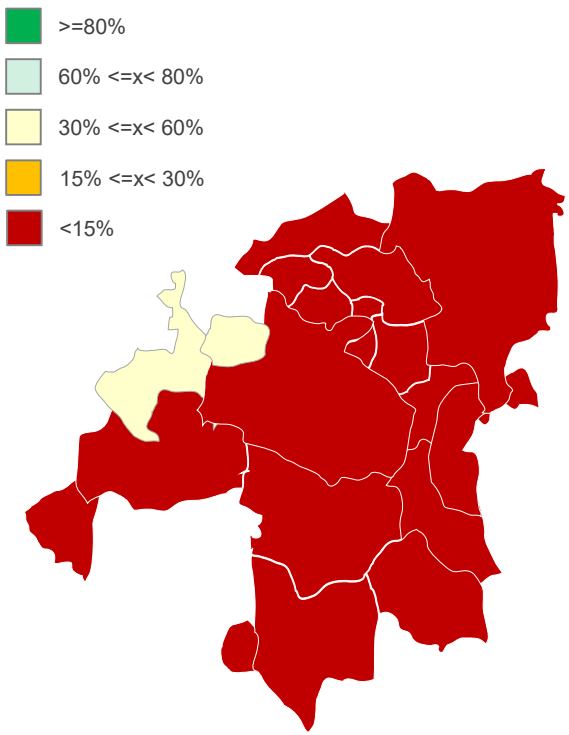
The DHS 2013 data on coverage has been used for this map. Throughout the document, the Social Audit on Primary Health Care Millennium Development Goals will be used for LGA- and State-specific analyses[1]

1 The numbers from these two data sources differ slightly

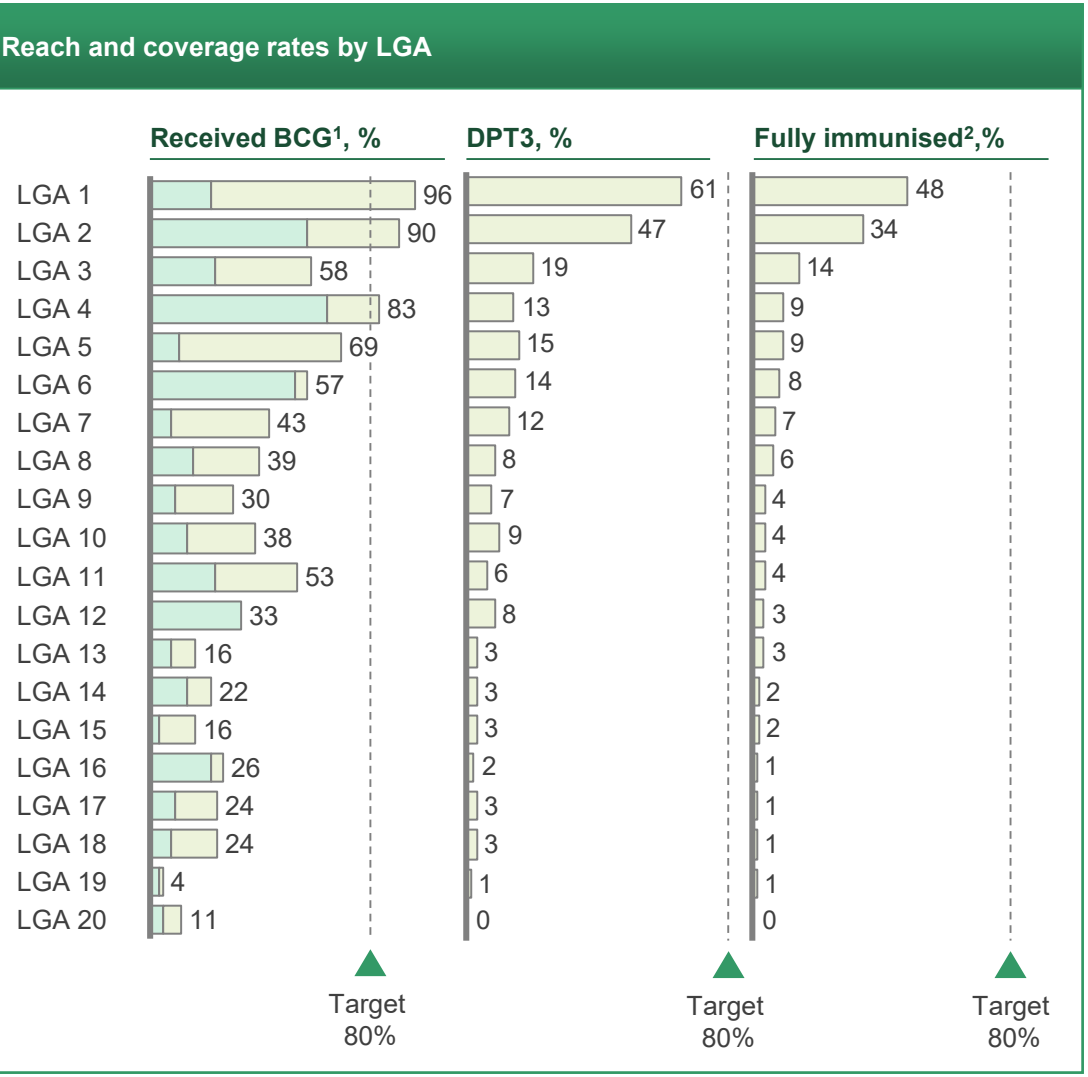
SOURCE: Nigeria Demographic and Health Survey, 2013

Except for 2 LGAs, coverage rates are below 15%

Full immunisation coverage by LGA in State X[1]



Reach and coverage rates by LGA



1 The percentage of women who delivered at a Health Care facilities is lower than the coverage of BCG but both indicators highly correlate with each other. The difference reflects the possible coverage of BCG done through RI

2 The fully immunised rate includes immunisation of BCG, DPT, Hep+B, YF, Measles and Polio drops

SOURCE: Social Audit on primary health care Millennium Development Goals – State Ministry of Health

The State's RI program faces 5 main challenges to improve immunisation coverage

NON-EXHAUSTIVE

	Description
1 **Poor cool chain equipment**	▪ 7 LGAs have no functioning storage while 9 LGAs fall between 16% and 100% below the required storage capacity for target population ▪ Only 30-50% of facilities receive their vaccine needs; those facilities with cold chain equipments need to visit the cold chain store of its LGA to pick up vaccines
2 **Inadequate funding**	▪ There is no predictable funding for the program on an annual basis ▪ There are no funds available at the health facility level ▪ The SPHCDA received N 1.6 billion for all activities in 2013; the state estimates N 5 billion are required to complete all their activities. Governor approved only N 2.4 billion ▪ Currently facilities receive N 3,000 (USD 18) per month to carry out RI activities
3 **Poor supervision**	▪ On average, healthcare facilities have only 1 supervision session per month instead of 3 ▪ In interviews, immunisation team reported few consequences for underperforming and no incentives for good performance
4 **Poor coverage**	▪ Only 6.1% of children in the state obtain all vaccinations ▪ Under current demand patterns, the 1-2-3-strategy would only reach a coverage of 34% ▪ Changing to 1-4-3-strategy would significantly improve the situation, but without increasing the number of children per session and launching targeted mobile sessions, the 80% target would not be reached
5 **Low demand**	▪ Although more than 90% of mothers believe vaccination is worthwhile, more than 44% of children have not taken any vaccine at all ▪ There are different causes that explain why mother do not get their children vaccinated: – 40% is due to lack of information, 17% due to fear of side effects, 15% due to location of post being too far

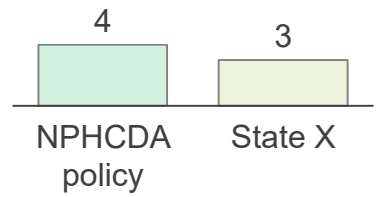
SOURCE: Solina Health 2014; BMGF "Hard to reach areas", T-Ship project (2010); DHS 2008; Interviews with Health Facility Managers and local officials from the state

Currently State X's RI program is based on a mix of fixed and outreach sessions that have reached a rate of ~6.1% full immunisation

	Description of NPHCDA policy to achieve 80% coverage	Currently observed in State X[3]
Fixed session	▪ 4 scheduled sessions per month at each health care facility ▪ Offer routine immunisation for population within a 5 km distance of HCF	▪ 843 facilities offer RI ▪ ~3 sessions per month ▪ ~5 children immunised per session
Outreach session	▪ 2 scheduled outreach sessions per month ▪ OfferrRoutine immunisation to population between 5 and 10 km distance from the facility	▪ 843 facilities offer RI[1] ▪ ~1 session per month ▪ ~10 children immunised per session
Mobile session	▪ Mobile sessions organized according to needs ▪ Offer routine immunisation to population that is not in the catchment area of the HCF and that is at more than 10 km from the facility	▪ Not currently in place

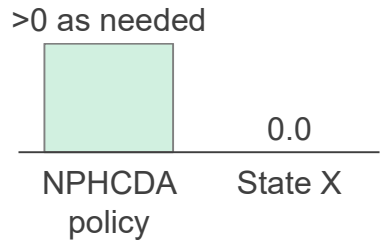
Current RI fully immunised rate is estimated at 6.1%[2]

Fixed session, #



Outreach session, #

Mobile session, #



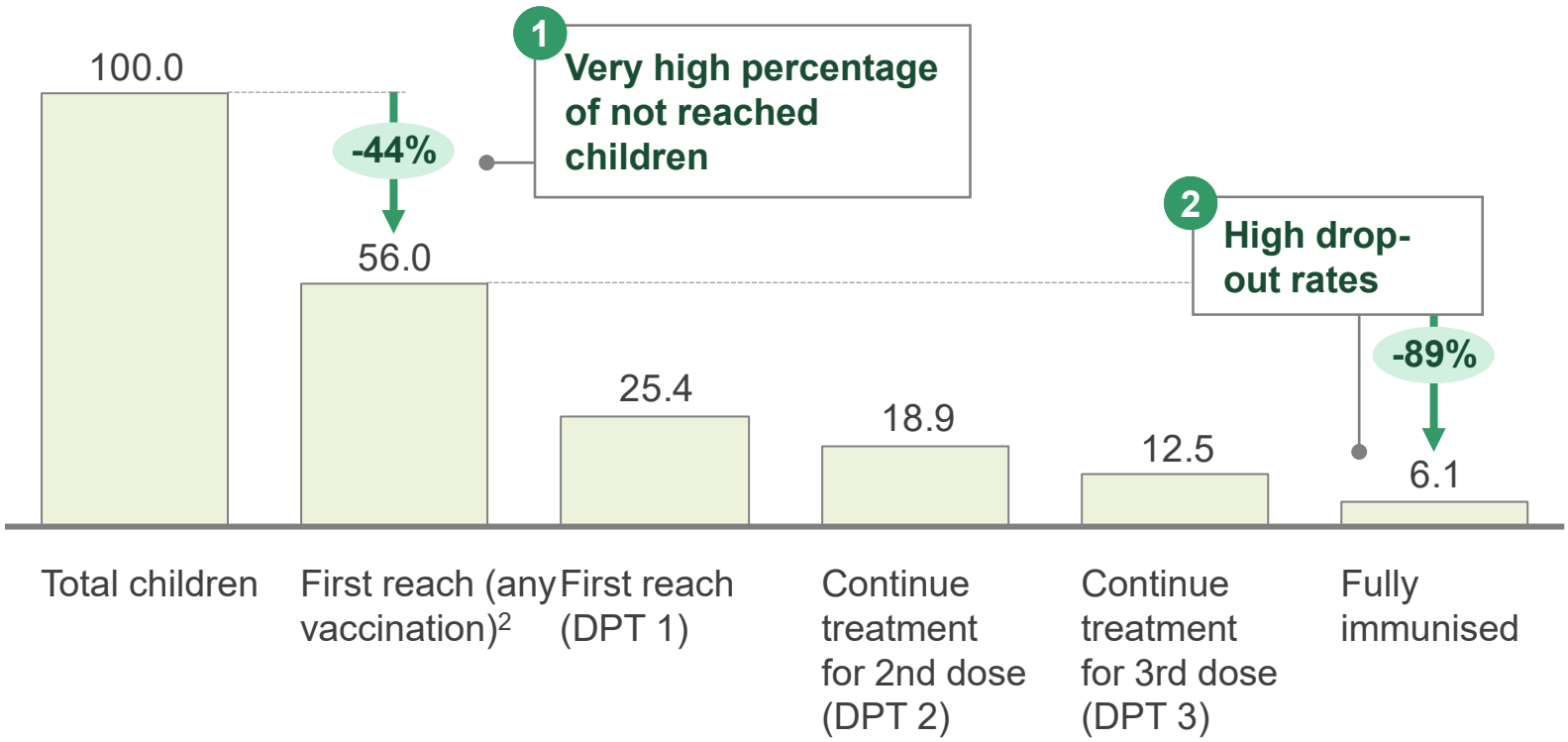
1 All facilities offering fixed session claim to have outreach session however the national average shows that only 57% of the facilities offering RI have outreach sessions.

2 Estimated as the percentage of children who received all vaccines from DHS 2013

SOURCE:

Low catchment and high drop-out rates are the key problems faced by the RI program

Coverage rates by level of completion[1], %



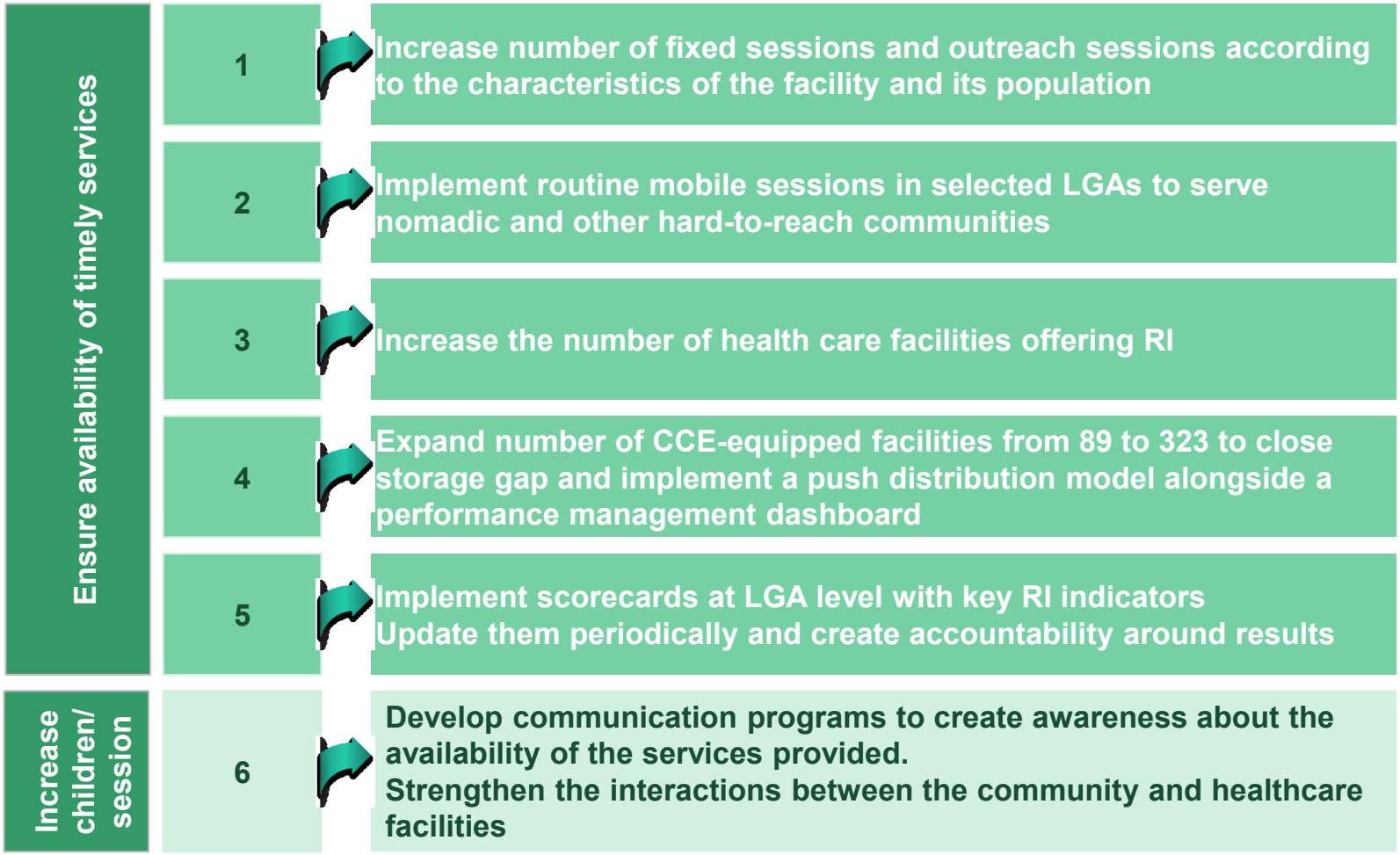
Both problems are likely caused by vaccine shortages due to the lack of cold chain equipment. The lack of reliable distribution decreases the credibility of the program and population's interest

1 Data from DHS 2013, local figures are lower
2 From DHS 2013, rate of un-immunised children is 44%, therefore the rate of children that received at least 1 vaccination is 56%. BDG coverage rate is 26%

SOURCE: Nigeria Demographic and Health Survey, 2013

A strategy using multiple levers according to needs of the LGAs could be implemented in State X

NOT EXHAUSTIVE



SOURCE: XSPHCDA, Solina Health 2014

In the future, the RI strategy could change according to the main characteristics of the health care facility

xx% % of facilities

Archetypes of health care facilities

Facilities with more access to resources:
- General hospitals and larger HCF
- Usually in urban areas and therefore have better access to LGA stores, or equipped facilities
- Cater to population with higher awareness

Facilities with less access to resources:
- MCHC and Dispensaries
- Often in rural areas
- Have limited access to vaccine supply
- Have more hard-to-reach population
- Cater to population with lower awareness of the benefits of RI.

More resources +

Health facility resources

Less resources -

1 "Low risk"

5%

2 "Congested"

16%

4 "Lonely"

20%

3 "High risk"

59%

Low - ← *Potential demand per facility* → High+

Facilities with low potential demand:
- Have less potential demand and could be less congested
- Ratio of population per facility is low

Facilities with high potential demand :
- Have more potential demand and could be more congested
- Ratio population per facility is high
- Need for more frequent re-supply of vaccines or larger CCE equipment

SOURCE: Team analysis based on XSPHCDA facility data, and interviews with XSPHCDA officials.

Potential RI strategy guidelines by facility archetypes

RI strategy should be targeted to the archetype of the health care facility

	Key challenges to address	Main focus of strategy	
1 "Low risk" (more resources & low potential demand)	▪ **Enough supply chain to cover needs**	▪ Fixed: >2 per week ▪ Outreach: 3 per month ▪ Mobile: 0	**Always at least 2 fixe sessions to set higher expectations**
2 "Congested" (more resources & high potential demand)	▪ **Higher probability of running out of supplies due to higher demand** – Poor supply chain could detriment population's interest	▪ Fixed: 4 per week ▪ Outreach:3 per month ▪ Mobile: 0	**Focus on more fixed sessions and less focus on outreach sessions**
3 "High Risk" (less resources & high potential demand)	▪ **Low access to vaccine supply** – Higher probability of running out of supplies due to higher demand – Outreach sessions might require additional staff members	▪ Fixed:4 per week ▪ Outreach:4 per month ▪ Mobile:1 month	
4 "Lonely" (less resources & low potential demand)	▪ **Low access vaccine supply** ▪ **More hard to reach population** – Transportation is required to reach remote settlements – Outreach sessions might require additional staff members	▪ Fixed: >2 per week ▪ Outreach: 4 per month ▪ Mobile: >1 per month	**Always at least 2 fixed sessions to set higher expectations and more mobile sessions**

SOURCE: Team analysis

There are different issues with the current funding and financial flow processes, which must be addressed going forward

Main issues with funding and financial flows

1 Difficulties with fund disbursement

- **Non-recurrent funds require approval from Governor**
  - Once approval is completed, it **could take up to 7 months to receive the requested amount**
  - Funds for some activities (such as training) are then not requested because the slow disbursement system would not provide funds on time

2 Lack of clarity

- There is no budget line for RI in the XSPHCDA
  - There is n**o clear visibility on total budget and total released funds for RI**
  - People at the **frontline** (HCFs) have no channel to raise concerns about funds received

3 Insufficient fund allocation

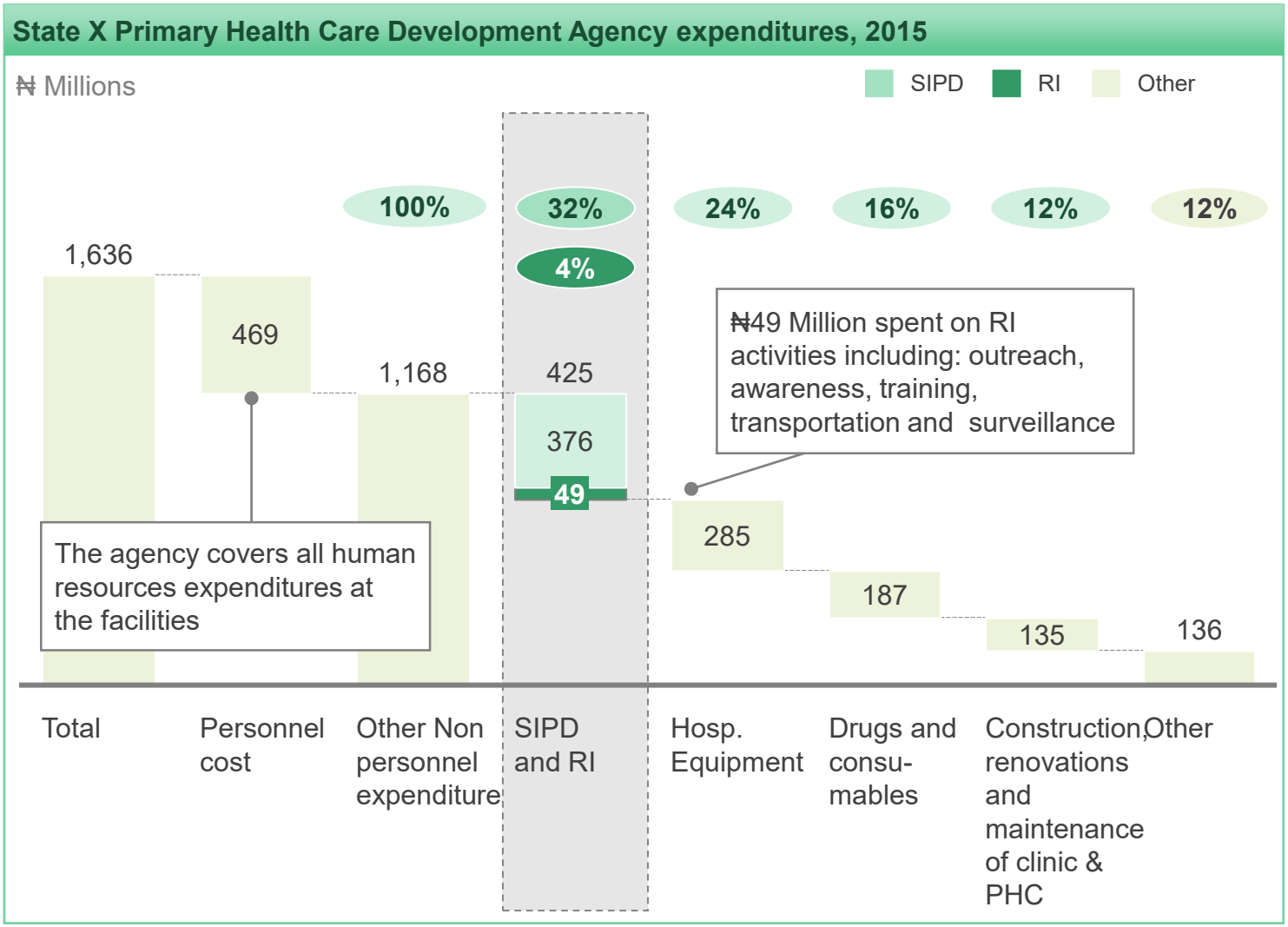
- **RI spending per capita in State X is significantly lower** than the per capita spending on RI by **other countries**
  - Staff members have reported to use personal expenses to cover program's need, such as paying to pick up vaccines

4 Weak tracking mechanism

- **There is no central tracking system of resources** allocated to RI
  - It is not possible to **track whether LGAs disburse budgeted funds** to PHCs
  - There is no consolidated information about how HCF spend the money

SOURCE: Interviews with Health Care Facility Managers and XSPHCDA officers

Out of the total SPHCDA expenditure, 4% is spent on RI activities[1]



- SIPD resources represent 32% of the agency's expenditure while RI resources represent 4% of the total expenditure[1]
- Since 2013 all human resources for the health care facilities are paid by SPHCDA
- Some very small operational resources for RI are funded from other budget lines

1 Excluding personnel costs

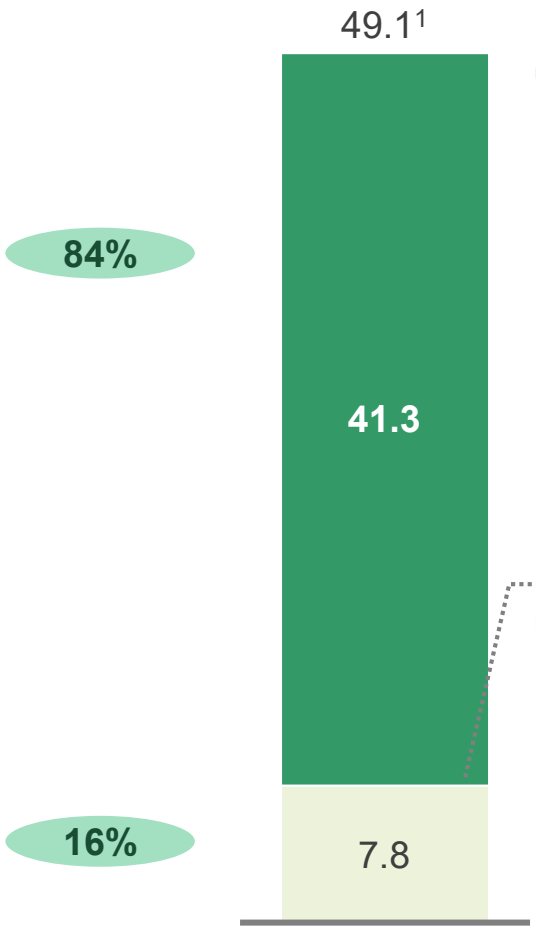
SOURCE: SPHCDA real expenditure

The SPHDCA is the largest funding source for RI and accounts for ~84% of current expenditures

% Percentage

Disbursements '13

2013, ₦ mn



Detail

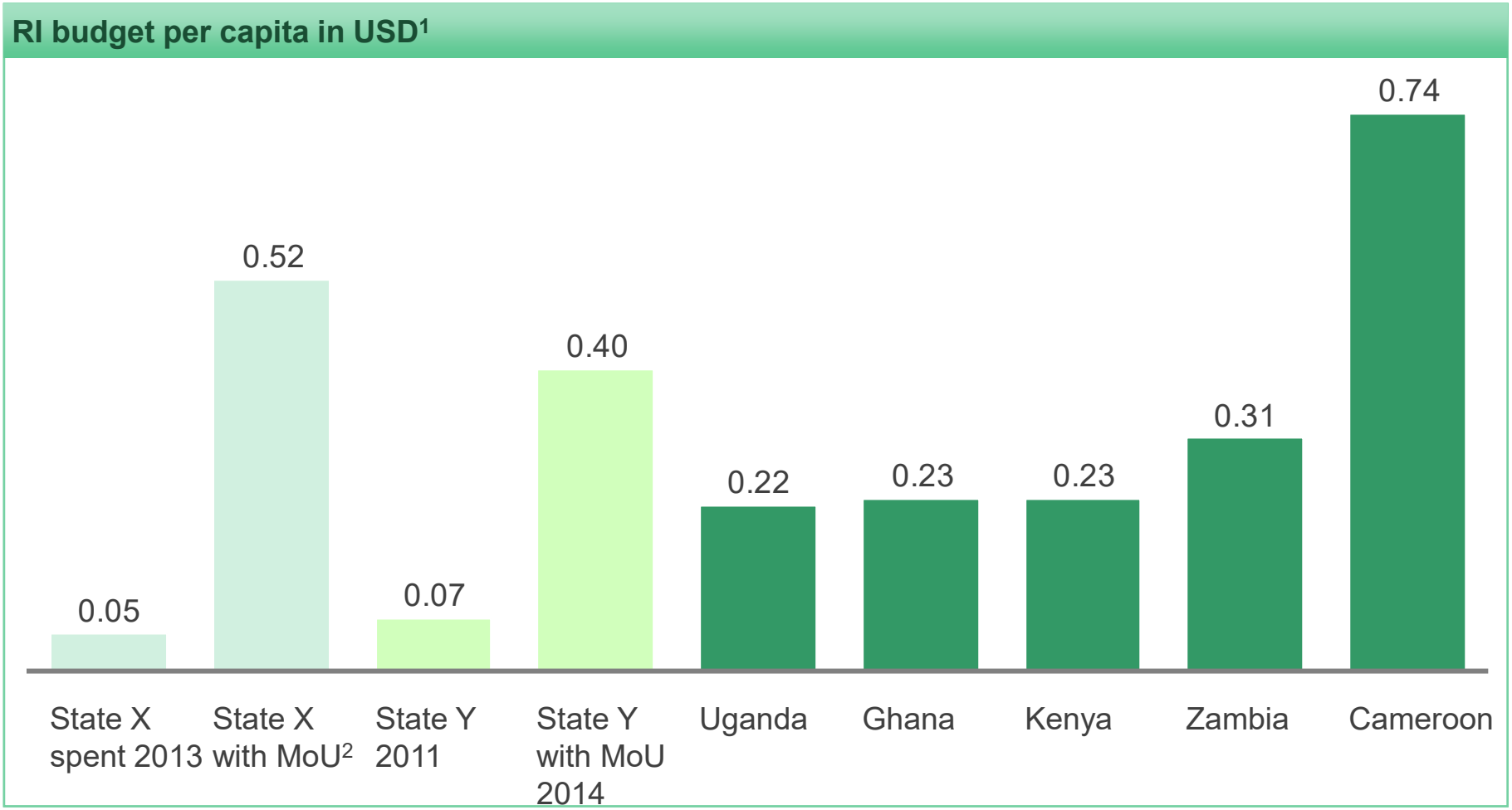
Other donors distribute funds directly to specific **facilities** through the LGAs[1]

- **SPHCDA through SIPD funding:**
  - The SPHCDA distributes ₦5,200 per facility at the same time as the SIPD funds are disbursed
  - Resources are supposed to cover vaccine supply, supervision, social mobilisation and transportation
  - The Ministry of Local Government does not distribute funds directly to the facilities for RI
  - Financing for staff and overhead are not included in these numbers
- **NPHCDA through GAVI funding:**
  - The NPHCDA, through GAVI, is supposed to provide quarterly funds but in reality these funds have only been disbursed once due to retirement issues

1 UNICEF distributed ₦ 12 million in 2013 directly to 5 LGAs

SOURCE: XSPHCDA

Current RI expenditure per capita in State X is significantly lower than the per capita expenditure on RI by other countries



1 Assumes 1 USD = 155 NGN
2 Assumes only OPEX costs for State X

SOURCE: Team analysis; Multi –year CMYP, from UNICEF; Costs and Financing of Routine immunisation (L. Brenzel)

Initiatives to address the challenges

Initiatives

A Difficulties with fund disbursement

- **Distribute funds directly** to facilities and LGAs through **bank accounts**
- **Disburse fix amount every month to facilities and LGA** with resources linked to pre-specified activities related to RI

B Lack of clarity

- **Create a dedicated budget line for RI** on SPHCDA budget to increase transparency on funding
- **Make full annual approved RI budget available** at the beginning of the year

C Insufficient fund allocation

- **Increase** RI spending per child <1 year from 0.05 to 0.52 USD

D Weak tracking mechanism

- **Distribute funds directly** to facilities and LGAs through **bank accounts**
- **Attach proofs and receipts to all major expenditures**
- **Verify spending** by **recurrent supervision activities**
- **Implement regular audits** at all levels

SOURCE: Team analysis

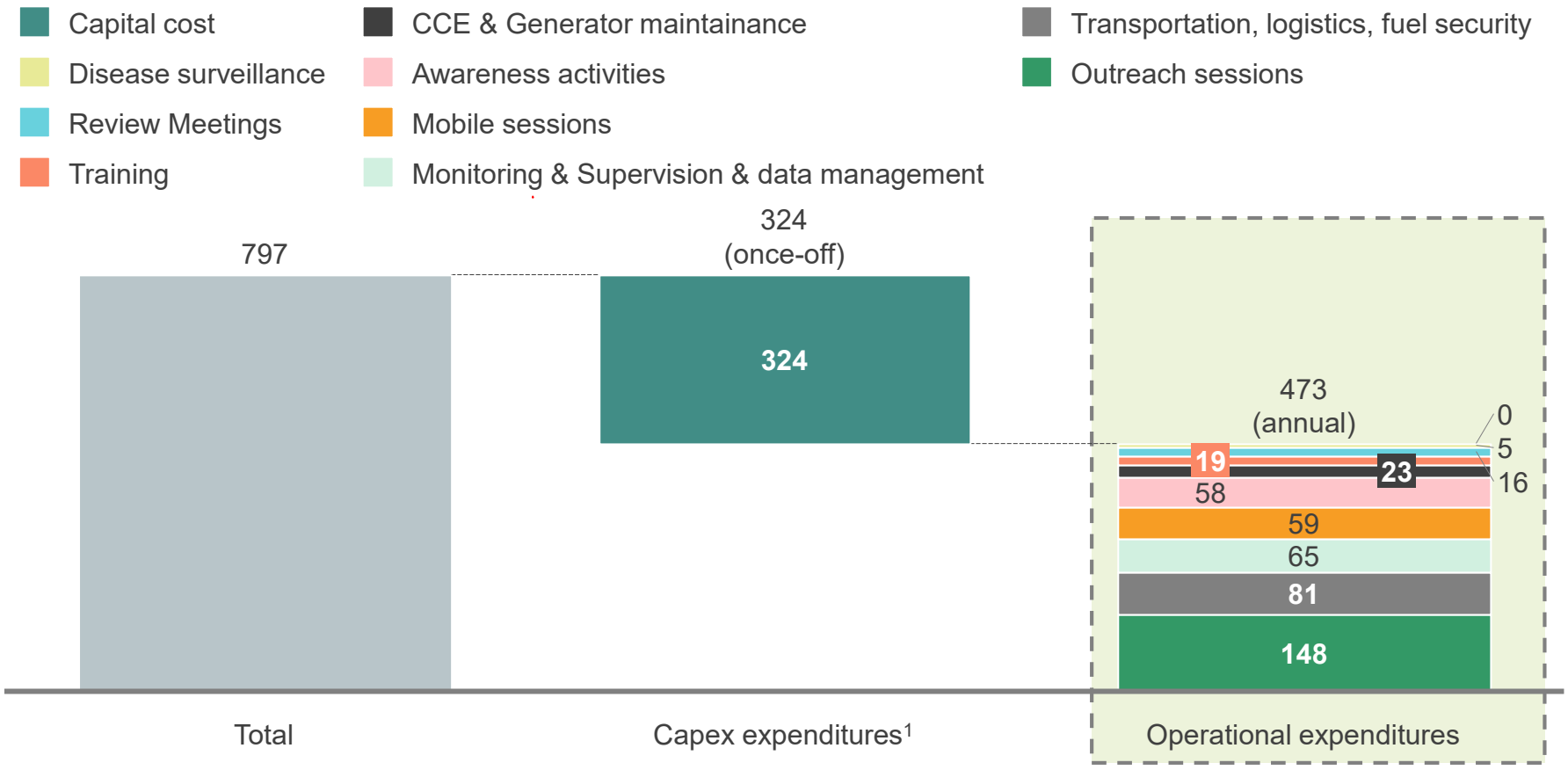
Base scenario estimates suggest that State X would require ~₦797m to reach RI coverage target of >80%

PRELIMINARY

Deep dive

Routine immunisation costing – Capital & Operational expenditures

year, ₦ mn



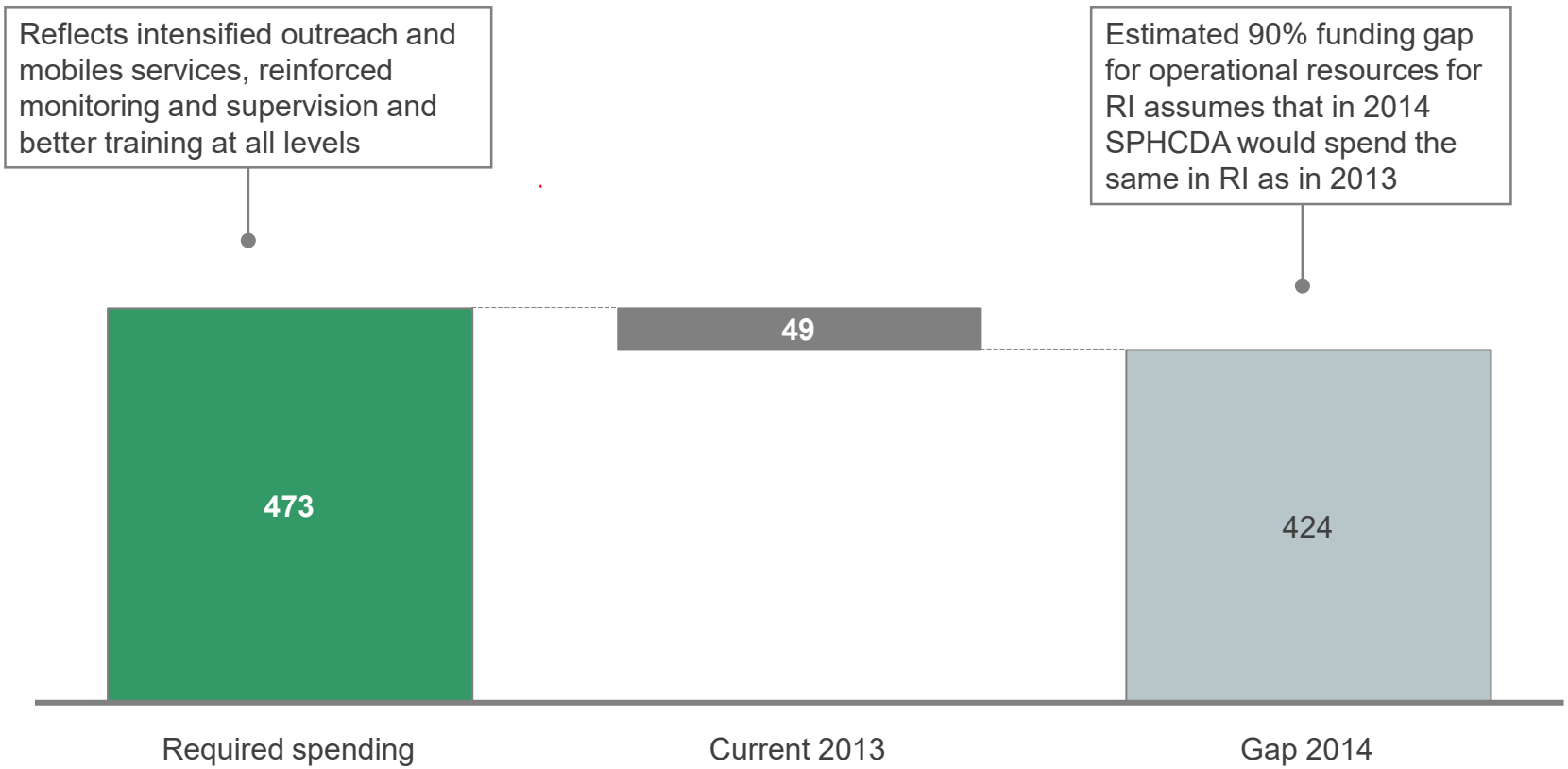
1 Excludes costs of vaccines as provided by NPHCDA, includes vehicles, CCE, generators, infrastructure upgrades to facilities, data management equipment

SOURCE: Team Analysis

For operating expenses, base scenario suggest that State X would require additional ~₦ 473 million

PRELIMINARY

Routine immunisation costing – Estimated operational expenditures
year, ₦ mn[1]



SOURCE: Team Analysis

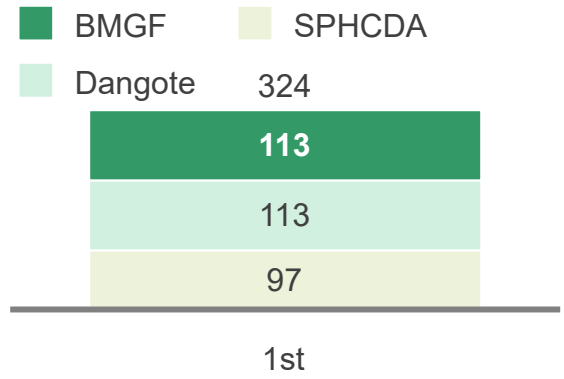
Capex will be fully covered in the first disbursement while the donors contribution in opex will be faced out after the third disbursement

Description

Capital cost

- **All capex is distributed among the 3 partners under a 35%, 35%, 30% during the first year of the MOU**

Capex contributions, Mn Naira

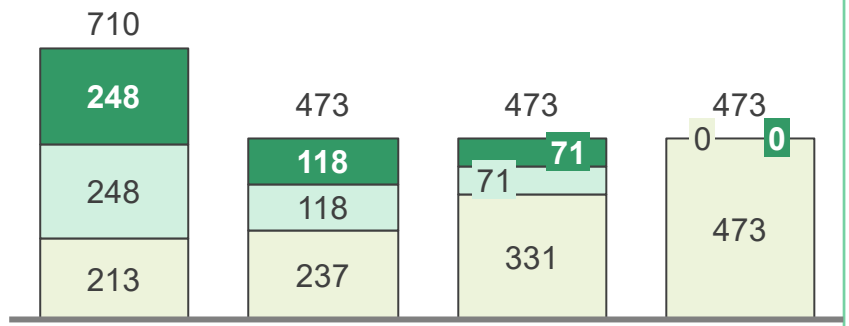


Operating cost

- **1st disbursement covers 18 months** – July 2014 to December 2015
- **2nd disbursement covers 12 months** until December 2016
- **3rd disbursement cover 12 months**[1]

- With this option, resources for 18 months are up fronted in the first disbursement
- The tri part agreement extends to the end of 2017

Opex contributions, Mn Naira



1 Tri-part funding will cover 42 months instead of 36 in order to fund all 2017
2 Real numbers, operational expenditure does not consider inflation
SOURCE: Team analysis

Content of the MoU

NOT EXHAUSTIVE

	Description
Program period	▪ Effective from **July 1, XXXX (or date of signing)** to **31 December XXXY**
Governance, leadership, and management support	▪ The **RI implementation will be overseen by the State Immunisation Task Force** (SITF), which is chaired by His Excellency, the Deputy Governor – **Mr. Dangote** will attend **at least 2 meetings per year** in person or via VC – **Mr. Gates** will attend **at least 2 meetings per year each** in person or via VC ▪ A state routine immunisation working group, chaired by the Executive Chairman of the SPHCDA board will serve as the technical body for the SITF ▪ The RI program will be **managed by** a qualified **Dep. Dir. immunisation and SIO** under the SPHCDA
Funding and financial management	▪ Program is estimated to cost ~ N 797 million/year. Dangote/Gates and State X will respectively contribute 30/70, 50/50, 70/30, 100/0 over 3 and a half years ▪ The SPHCDA will establish a **"Basket Fund"** and **an annual budget line** for immunisation in the SPHCDA budget ▪ A new system with **direct disbursement of predetermined amounts via bank accounts** to all levels in the system will be implemented. **Withdrawal** of funds will require **signatures from the officer in charge** (OIC) at the LGA and HCF levels to ensure accountability ▪ Financial oversight will consist of supervision of activities; accounting spotchecks, provision of receipts at LGA, zonal and central levels, recording of activities by communities and OICs at HCF level – Accountability boards will be used at a state, LGA, and facility level to register money received, withdrawals, and expenses. Those boards should be located in visible places
Operations	▪ The **SPHCDA will** run the **operations** of the program ▪ It is recommended for the program to have a **strategic** and **operational plan** to **implement routine immunisation, manage HR,** and ensure a **functional cold chain**
Data management	▪ The SPHCDA will ensure timely and accurate data and will produce monthly reports to be shared widely

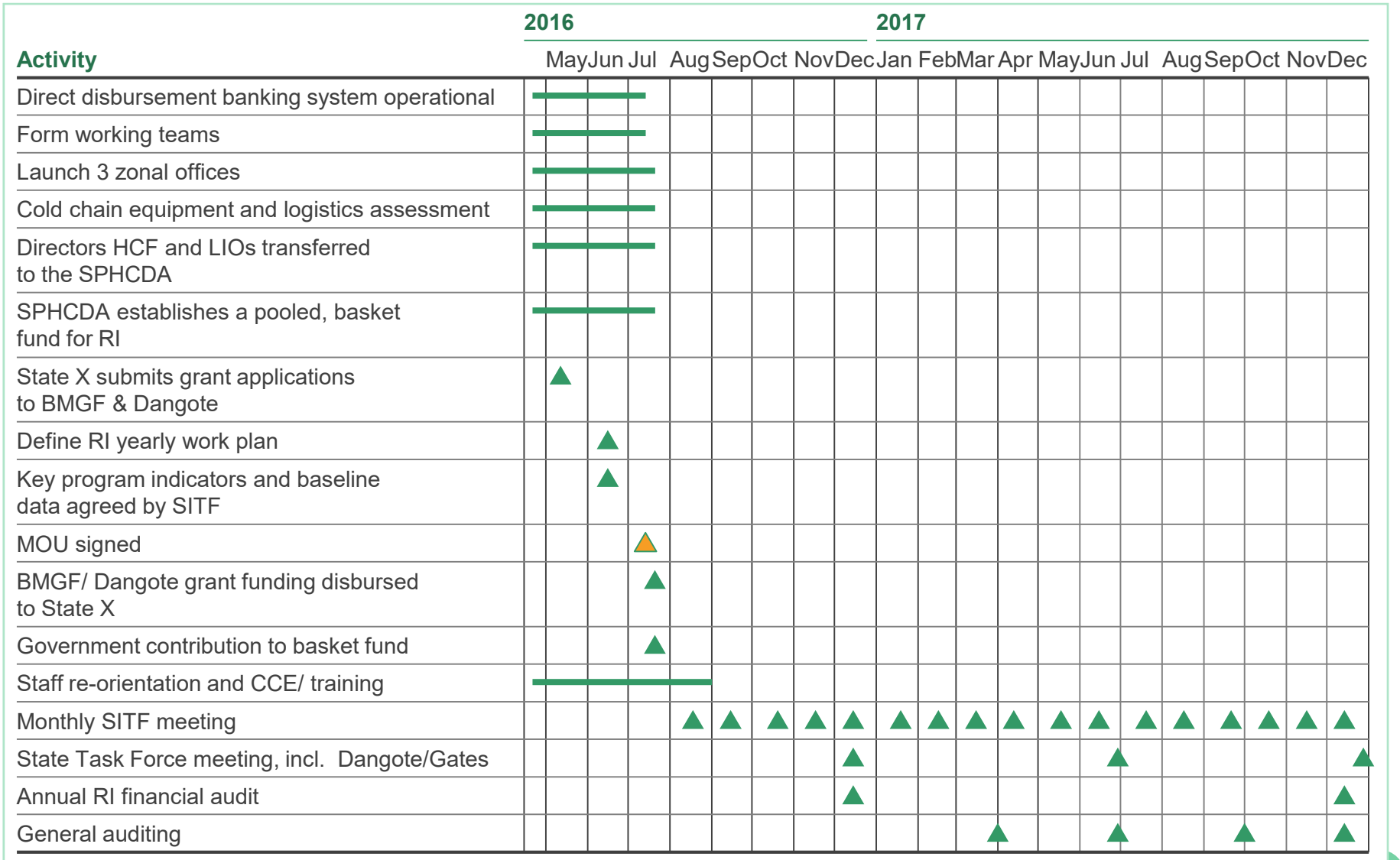
The implementation of the MOU will require stakeholders to take specific roles and responsibilities

Details in next page

Stakeholders	Roles & responsibilities	Frequency of meetings
State immunisation Task Force (polio + Routine immunisation)	**The current State immunisation Task Force for polio should include the analysis of Routine immunisation activities** ▪ Provides overall strategic guidance ▪ Oversee overall implementation of polio and RI program ▪ Resolves escalated risks and issues	▪ **Monthly meetings** with governor and full immunisation Task Force
Funding partners (Dangote Foundation & BMGF)	▪ Approves significant cost, schedule and scope changes for projects ▪ Approves milestone completions	▪ **Every six months,** funding partners will attend the State immunisation Task Force meeting (in person or VC) – Mr. Gates will attend twice a year – Mr. Dangote will attend twice a year
The SPHCDA	▪ Accountable for the implementation of the MOU and the Routine immunisation program ▪ Day-to-day management of projects, including planning, execution and management ▪ Determines what gets escalated ▪ Oversee prioritization and sequencing of projects across different working teams	▪ **Weekly meetings** of the working groups

SOURCE: Team analysis

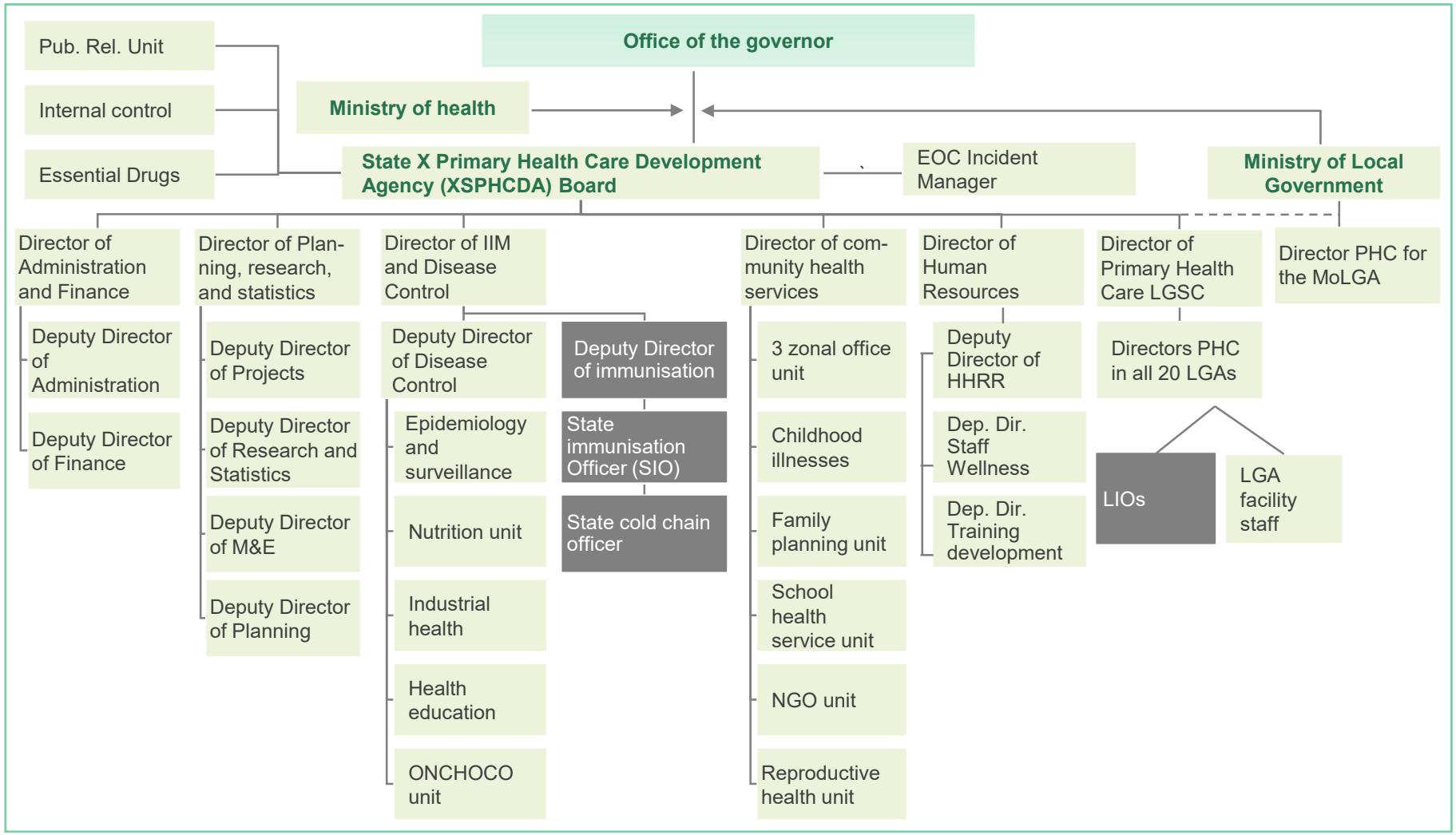
Timelines for the next year



Back-up

All the Routine immunisation staff is under the umbrella of the Primary Health Care Development Agency[1]

Elements related to RI



1 The current structure results from a reorganization that was implemented in 2013

SOURCE: Interviews with Executive Chairman and directors of the SPHCDA

Although the new structure moved almost all PHC staff under the agency, there are still some challenges

1

There is no direct reporting line from zonal officers and Directors of PHC at each LGA

- ✓ The Zone Units should be reactivated
- ✓ The zonal officer should sit at the zone, not at the capital LGA
- ✓ The zonal officer will be in charge of Directors of PHC for each LGA, the zonal office staff, and zonal cold chain coordinator

2

The **directors of PHC at each LGA** (20) and the **LIOs** are still **paid by the Ministry of Local Government**

- ✓ All employees under the SPHCDA should be paid by the Agency to reinforce accountability (except DAF and internal control)

SOURCE: Team analysis