Case study **August 2011**

Innovative & Sustainable Financing Mechanism in Health: A case study of the "Basket fund" in Zamfara State, Nigeria

Context

Zamfara State is one of the 36 States (provinces) in Nigeria. It a largely rural State located in the Northwest region of the country. It covers a landmass of about 38,000 square kilometers and has a 2010 population of about 3,697,565 with about 147,903 being infants (under one).
The State is administratively divided into 14 LGAs (districts) and 147 political wards (sub districts). It has a total of 696 'functional' health facilities. The Chief Executive of the State is the Executive Governor who heads the State Executive Council, the highest policy decision making body in the State.

Health activities are coordinated by the State Ministry of Health which is headed by the Honourable Commissioner, a member of the State Executive council. The MOH has 8 key departments, one of which is that of Primary Health Care (PHC) where maternal and child health including immunization services lie. A Hospital Services Management Board also exists which coordinates activities of all the secondary health care facilities in the State. There is also a Ministry for Local Government and Chieftaincy Affairs that coordinates the activities of the 14 LGAs in the State.

The chief Executive of an LGA, which is the third tier of Government in Nigeria (the first being the Federal Government and the second, State Government) is the LGA Chairman. Each LGA is semi-autonomous, and has an LGA PHC department headed by a LGA Director, who coordinates health activities within the LGA.

PHC services are statutorily under the LGAs, which is the closest to the people, but the weakest and least funded of the three tiers. This apparent fragmentation of health services creates a challenging environment for coordinated decision making and implementation of health activities in the State. The biggest causality of this fragmentation is the PHC system which is now dysfunctional.

This is a common challenge in most States in the country and they (States) are putting in place mechanisms to address it. For Zamfara, the State has recently (2011) established a State PHC Board which is to be responsible for the coordination of PHC services at both the State and LGA levels; hopefully this will eliminate the fragmentation with respect to PHC services.

Although fund allocation to the health sector has been on the increase since 2007, with the sector receiving about 9% of the State budget each in 2009 and 2010 (compared to 5% in 2006); fund release remains a challenge. The budget performance for 2009 and 2010 were 58% and 56% respectively[1&2]

The State has a number of international development partners working in the area of maternal and child health including immunization. They include the World Health Organization (WHO); United Nation Children Fund (UNICEF); the joint DFID and Government of Norway funded Partnership for Reviving Routine Immunization in Northern Nigeria and the Maternal, Newborn and Child Health (PRRINN-MNCH) programme; and the

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USAID funded Maternal and Child Health Integrated Project (MCHIP). The EU-PRIME project and the USAID funded COMPASS project were also in the State but have wound up in late 2010 and 2009 respectively. These partners work together through the State Partners coordination forum

This collaboration between the State and partners has yielded significant success in coverage routine immunization, particularly in 2010, based on both administrative and survey findings in the State.

Introduction

This case study is aimed at sharing our success in implementing an innovative financing and disbursement mechanism in PHC service delivery in Zamfara state. It also highlights some of the challenges and lessons learnt with the hope that it will be beneficial to others interested in establishing a similar funding mechanism.

The problem

Routine immunization, which has been described as one of the most cost effective public health intervention, has generally been on the decline in Nigeria with the northwest region where Zamfara State is located and the northeast being the worst off. Although the country attained a universal coverage of 81.5% for all antigens in 1990, the fully immunized coverage (FIC) by 2006 dropped to 42% while that of Zamfara State was 11%[3].

Reasons for the poor immunization in Zamfara State were due to challenges on both the supply and demand sides. Although there are underlining problems with adequacy of staff (there is an average of 3 health workers per facility but the majority are manned by one staff member[4]), coupled with low public awareness on routine immunization; the single biggest challenge to effective immunization service delivery is the near absolute lack of funds dedicated to finance key recurrent activities of routine immunization, particularly distribution of vaccines from the LGAs cold stores to the health facilities (which will enable the few available staff to conduct immunization services as most of the health facilities lack storage facilities), transportation cost and feeding allowance to staff to conduct outreach services, transportation cost for supportive supervision particularly by the LGAs to the health facilities, fuelling to maintain generators at the LGA cold store (particularly to power freezers used in producing ice packs and vaccines storage) and demand creation activities, mainly payment of town announcers.

The LGAs are statutory responsible to finance most of these activities, however feedback reports from LGA immunization officers during monthly review meetings and similar for a have persistently revealed inadequate funds as one of the key problems of PHC services particularly routine

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immunization. Reports of partner agencies also corroborate this. For instance, in the Jul-Dec 2008 PRRINN-MNCH report states *"…… A very significant challenge is the availability of funds for key recurrent activities especially at the LGA level. This is even more relevant now that there is significant improvement in Vaccine Storage capacities of the LGAs, the support to LGA teams by engagement officers as well as the Community Engagement activities which were all supported by PRRINN. What is missing is the funds (which have to be available regularly) for indispensable activities such as vaccine distribution to health facilities, supervision of the health staff in the various Health facilities, fueling of generators (to support the freezing of ice packs)".*[5]

The situation is further compounded by the inability of the LGA management to distinguish moneys spent on supplemental immunization campaigns, particularly polio campaigns, from that spent on routine immunization services.
Partners working in the State have been providing technical and financial support in the areas of planning and budgeting, training of staff on the different aspects of immunization, strengthening of the health management information system, strengthening of the cold chain system, especially provision and repair of solar refrigerators, demand creation etc. while the Federal Ministry of Health provides all the bundled routine immunization vaccines and waste management materials. However, the impact of all these interventions on immunization coverage was eclipsed by the near absence of funds to ensure the availability of vaccines at the point of service delivery or in the case of outreach services, availability of both the staff and the vaccines.

The challenge of the near-absence of funds was twofold; first was the issue of getting the funds and second was ensuring that funds released are disbursed transparently and made available for the activities they were meant for. This is important because several studies have shown that corruption has a significant effect on immunization services.[6]

An effective mechanism was thus required that will address the twin problems to smooth the path for an effective routine immunization service delivery system. This led to the creation of the PHC service delivery fund, aka Basket Fund.

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The intervention (the Basket Fund)

To resolve the problems highlighted above, the following key actions were undertaken:

1. ***Development of Proposal:*** [7]

The State technical team on immunization, made of up stakeholders from the State Ministry of Health, the State Ministry for Local Government and Chieftaincy Affairs, NPHCDA and Partners (WHO, UNICEF, EU-PRIME and PRRINN-MNCH) deliberated upon the issue and adopted the proposal from the PRRINN-MNCH programme, which came up with the idea of a pooled funding mechanism referred as to as the "PHC service delivery fund" that later came to be known as "Basket Fund". Some of it features include:

- Meant to finance vaccines distribution, generator maintenance, outreach services (immunization and antenatal services), supervision, monitoring and evaluation, and demand creation activities.
- Receives contributions from the State, 14 LGAs and Partners in an agreed ratio of 20%, 70% and 10% respectively. (Table 1)
- Maintains a pooled account domiciled within the MFLG, with three sets of signatories each from the MOH, MFLG and partners (represented by WHO).
- All three categories must sign before money can be released.
- Operations are guided by financial guidelines and all finance clerks were trained.
- Each of the 14 LGAs maintains individual accounts with the director PHC and financial clerk being joint signatories.
- Funds are disbursed monthly from the LGA finance clerks directly to beneficiaries (as opposed to the situation where funds are collected and disbursed by technical health staff)
- Funds are retired monthly by the finance clerks and endorsed by the LGA chairmen and director of PHC.
- Release of funds is subject to the retirement of the previous tranche of funds received
- The state technical team monitors compliance.

2. *Advocacy to MOH, MFLG, LGAs and Partners*

The development of the proposal was followed by series of advocacy visits to the honorable Commissioners of the MOH and that of MFLG&CA; chairmen of the 14 LGA councils as well as the management team of the partners working in the State especially WHO and PRRINN-MNCH. Consensus was reached and all stakeholders agreed to the concepts as well as their expected roles. For the LGAs, which are the major source of the funding, it was agreed that the funds will be deducted at source and remitted in to the bank account of the fund. The agreed contribution into the basket fund is shown in Table 1.

3. *Commencement of fund remittance*

Central deductions of funds from the 14 LGAs commenced in September 2009. The GAVI funds for immunization system

strengthening of about 4.5 million naira (about 15,000 USD) was received and was calculated as part of the expected contributions of the Partners. The State Executive Governor approved the sum of 10.4 million which was the expected annual contribution of the State government. This thus set the stage for the commencement of disbursement.

4. *Development of operational manuals and financial guidelines*

An operational manual, which includes financial guidelines for the funds, was developed with support from PRRINN-MNCH. All relevant tools

Table 1: Table Showing the Expected Contributions into the Basket Fund

Contributors	Expected Monthly Amount in Naira ($)	%
State	₦873,900.00 ($5,826)	20%
LGAs (all 14)	₦ 3,058,650.00 ($ 20,391)	70%
Partners	₦ 436,950.00 ($2,913)	10%
Total	**₦ 4,369,500.00 ($29,130)**	**100%**

Source: *Ministry of Health, Zamfara. Draft Proposal for the PHC Service delivery*

were printed and relevant accounts opened before commencement of fund disbursement.
There are three categories of signatories to the accounts i.e. Commissioner and DPHC (representing MOH); Commissioner and DPHC (representing the MFLG) and the WHO State Coordinator and Surveillance Officers (representing Partners). One person must sign from each category before funds are released.

5. Briefing of LGA technical team and the Financial Clerks

The LGA health teams of the 14 LGAs, each made up of the DPHC, the immunization officer, the MCH coordinator, the M&E officer and Health Educator were briefed on the operations of the fund and the expected roles and responsibilities were discussed and agreed upon.

6. Monthly disbursement of funds

Funds are remitted from the State account into the respective LGAs after received funds have been satisfactorily retired. The funds are then withdrawn by the respective financial clerks and disbursed to the beneficiaries. The table of fund disbursement is displayed publicly in the PHC department and can be accessed by any interested party.
Similarly the expenditures of the fund is computerized at the State level and is accessible to any interested party.

7. Review meetings

Regular meetings were held at the State level to review the activities of the fund and its impact on PHC services, particularly immunization services and appropriate actions instituted as might be deemed necessary. Indicators being monitored include the DPT3 and OPV3 coverage by LGA and by political wards as well as the overall State DPT3 and OPV3 coverage (which are adjusted based on the validation through data quality assessments conducted by the HMIS unit who are not involved in immunization

activities). Feedback meetings were also held intermittently with the chairmen of the 14 LGAs on the activities of the fund as well as with traditional leaders.

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The outcome

The impact of the basket fund as reviewed in 2010 is presented in Table 2 below. From the table, it can be seen that there was a remarkable increase in the immunization coverage based on the OPV3 and DPT3 with the former increasing from 28% to 58% and the later from 38% to 65%. Similarly the immunization coverage based on geographical spread also improved remarkable following the introduction of the funds, the number of ward with DPT3 coverage more than or equal to 80% increased from 6% before the introduction to 31% after the introduction.

It needs to be pointed out that the increases are directly attributable to the introductions of the fund for the following two reason: 1. There was no other state wide intervention going on at the same time that will have significantly confound the results and 2. The activities supported by the funds in the areas of immunization are holistic as it included both supply and demand side interventions using the principles of the WHO recommended Reaching Every District (RED) Strategy which in Nigeria is modified as the Reaching Every Ward (REW) Strategy.

It is worth noting that data are regularly validated by the Zamfara State databank through regular data quality self-assessments (DQS). This has resulted in an increase in the quality of the administrative data submitted to the State as shown in chart 1. The success of the immunization services in Zamfara was also corroborated by the results of the 2010 NICS survey which showed that immunization coverage has improved from about 11% in 2006 to 61% in 2011.[8]

Table 2: Table comparing the performance before and after the introduction of the Basket Fund

Indicators	Before Introduction of the Funds (Q1 2009)	After introduction of the Funds (Q1 2010)
State DPT 3 Coverage	38%	65%
State OPV3 Coverage	28%	58%
Proportion of Wards with OPV3 Coverage >=80%	6%	31%
Proportion of Wards with DPT3 Coverage >= 80%	11%	42%
Proportion of Wards with OPV3 Coverage < 50%	87%	39%
Proportion of Wards with DPT3 Coverage < 50%	74%	36%
Proportion of Wards with DPT Dropout of less or equal to 10%	28%	43%

Source: SMOH Databank, Total number of wards (N) =147

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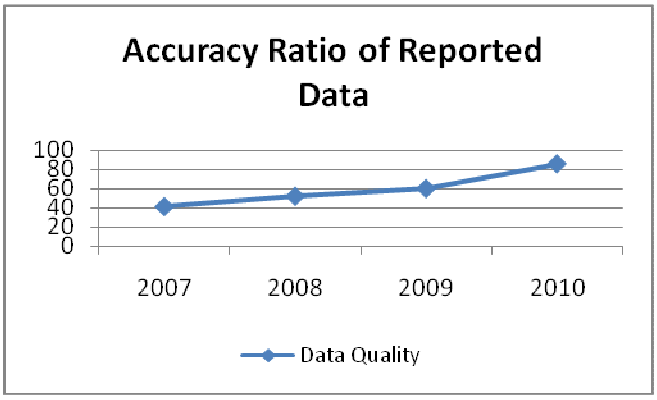
Current Status of the Fund

The fund is still functioning and has indeed been expanded to funding polio campaign activities and payment of the LGA allowances of midwives in the midwives service scheme (MSS). The basket fund has also been commended and recommended separately by an assessment team from WHO Geneva, the DFID constituted midterm review team that assessed the activities of the PRRINN-MNCH programme and UNICEF. They all recommended it to other States.

Chart 1: Trend in Accuracy ratio of Reported Data in Zamfara State 2007 to 2010.



Source: SMOH Databank.

The challenges

Some of the challenges faced by the basket fund include:

- Securing the release of the state contribution of the funds which was approved but yet to be released. This was however compensated by the funds received from GAVI which was more than what was expected from Partners.
- Weak capacity of some of the financial clerks

The lessons learnt

- Success of the fund with respect to immunization was principally because of the comprehensiveness of the interventions supported by the Fund i.e. vaccine distribution, outreach services, demand creation and supervision.
- The provision of international development Partners, Ministries of Health and Local Government as mandatory signatories provided stability for the fund. The role of the international partners was very crucial.
- The use of finance clerks to disburse funds, despite the stiff opposition from health workers, was a huge success as it made retirement much easier and motivating for the finance clerks.
- Involvement of the top management ensures sustainability
- The harmonization of the GAVI ISS funds with the Basket fund strengthened the operations and functionality of the Basket fund. It also eliminates duplicate funding of activities.

Conclusions

The basket fund is a remarkable success as it has transformed immunizations in Zamfara State and plans are under way to use the mechanism to finance free MNCH services in the State.

Acknowledgement

The members of Zamfara ORAC are grateful to Dr Ahmad Abdulwahab of the PRRINN-MNCH programme for his inputs in putting this document together.

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