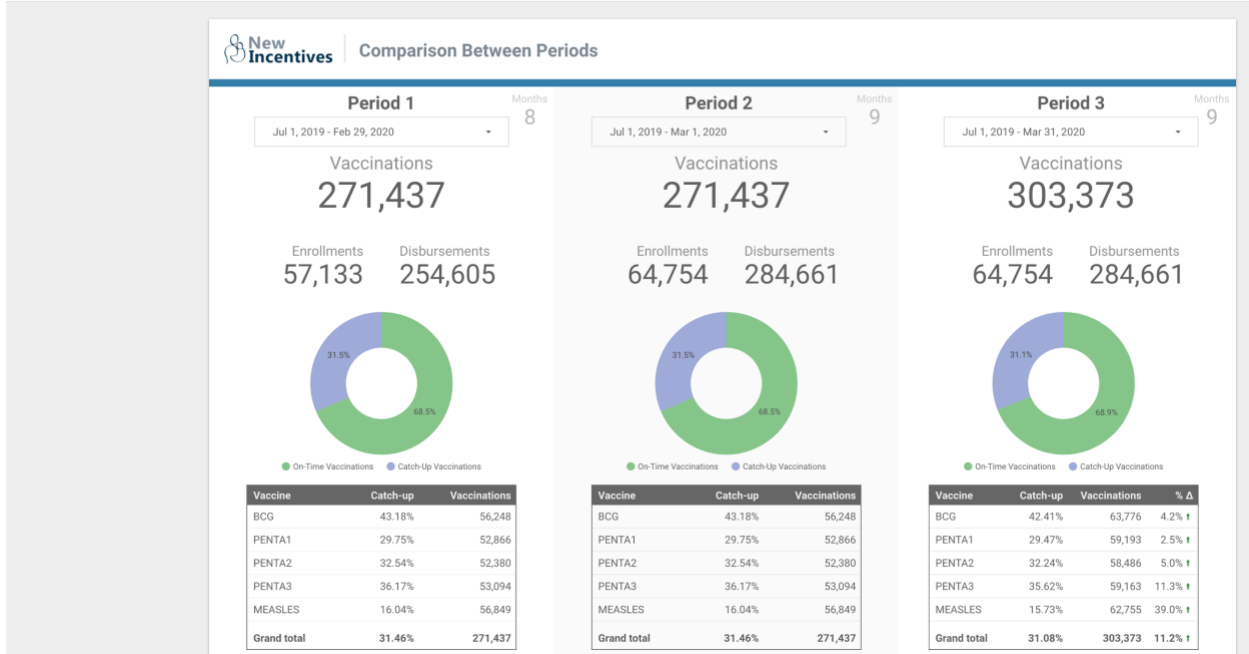
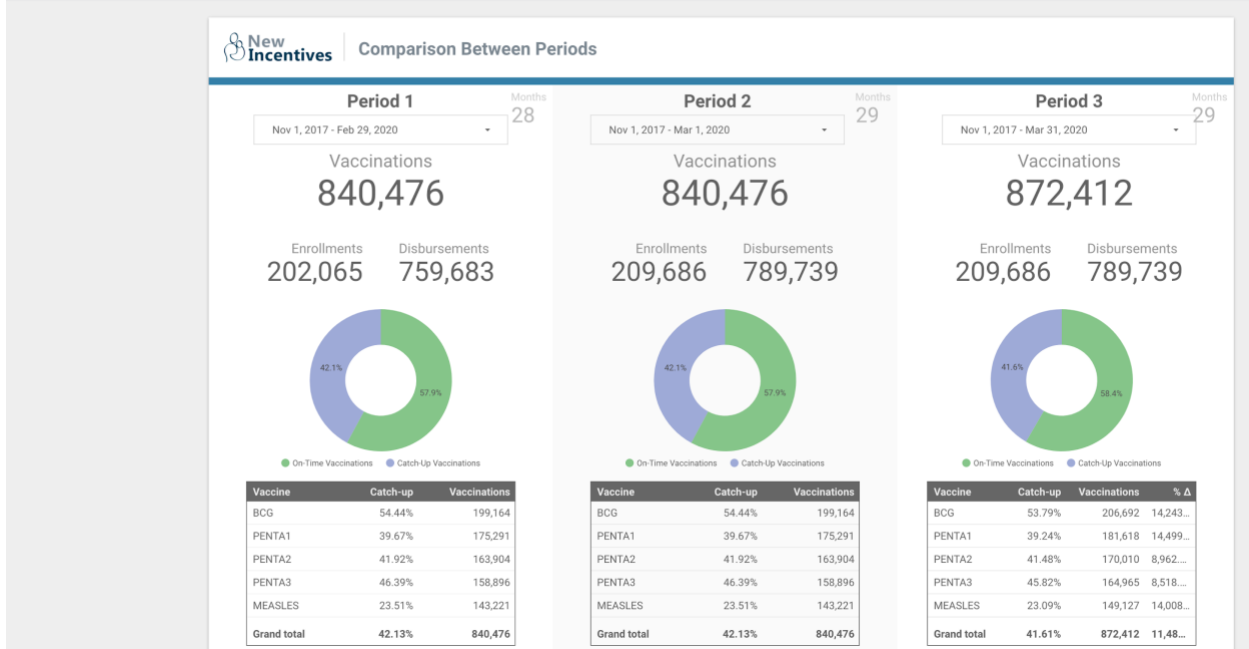


Questions about M&E

1. My understanding is that sometimes children are enrolled even though they did not receive BCG during that immunisation session. This happens if they can prove they receive BCG elsewhere, or if they are too old to receive BCG (see Protocol, pg 64 and 69). Based on our conversation in March, my understanding is that roughly 0.2% of children fall into this category. Is this correct?
 - a. Yes, this is correct. The 432 cases here are cases where staff reported enrolling an infant who had an old BCG Scar because there was a qualifying reason. This equates to approximately 0.2% of enrolled infants. Of these 432 cases, there were 362 cases where the Field Officer reported that the infant had required documentation.
2. We have [reviewed](#) data on enrollment and BCG vaccinations on the Vaccinations Dashboard, for two periods that we are employing in our analysis: (i) 1 Nov 2017- 1 March 2020 and (ii) 1 Jul 2019 - 1 March 2020. For the first period, the enrollments are ~5% higher than BCG vaccinations; for the second, they are ~15% higher. Assuming that the estimate above is correct (i.e. only 0.2% of infants enrolled were vaccinated in other clinics or did not receive BCG), what explains the discrepancy between enrolments and BCG vaccinations? What's your best guess for why it's higher for the second period than the first?
 - a. The Vaccination Dashboard Comparison Between Periods (Page 3) requires selection of full months. Apologies that this is not noted on the page. Please see below for rates when using full months. We can provide an explanation for why the query works like this if helpful at any point. Please note that the figures below are slightly different (~50) from the above file linked to (Enrolment vs BCG disbursements) for the date ranges because of ongoing corrections to transcription errors.
 - b. The last row of the table below contains the rate of BCG. This is based on reported data from Field Officers. When we transcribe information from Child Health Cards, we see that the rate of BCG is higher: Indirectly Incentivized Vaccinations - BCG
 - c. Raw data can be shared upon request.

Date Range:	1 Nov 2017 - 29 February 2020	1 Nov 2017 - 01 March 2020	1 Nov 2017 - 31 March 2020	1 Jul 2019 - 29 February 2020	1 Jul 2019 - 01 March 2020	1 Jul 2019 - 31 March 2020
Number Enrollments	202,065	209,686	209,686	57,133	64,754	64,754
Number BCG Vaccinations	199,164	199,164	206,692	56,248	56,248	63,776
Estimate based on enrollments as a % of estimate based on BCG	101.46%	105.28%	101.45%	101.57%	115.12%	101.53%

disbursements						
Estimate based on BCG as a % of enrollments	98.56%	-	98.57%	98.45%	-	98.49%



3. I have a few questions about audits I was hoping you could help me with: how many caregivers are interviewed during audits (I know the [old protocol](#) requires 3 interviews but I am unsure this is still the case)? Can the interview be overheard by clinic and NI staff? Do FOs know the auditor/do they know when they will audit the clinic? Could auditors detect cases of double enrolments, by observing behaviour at clinics (i.e. independently from clinic and NI staff interviews)? If so, how?
 - a. The training given to Auditors asks them to interview at least 3 caregivers, and when feasible, more caregivers. These interviews are done one at a time with caregivers and usually with those who are waiting outside the clinic, while the clinic staff and NI staff are often stationed indoors. There have been several cases where findings from auditors have shown complaints regarding clinic staff and NI staff.
 - i. Note: We are currently rolling out an updated audit protocol as part of the myDay app. The new form will collect the number of caregivers interviewed during audits. Another change is that the questions asked will be the same set of questions asked by Field Managers during manager supervisions and Auditors during program audits. Questions will be less text-based. The response options are based on operational protocols and disbursement quality factors most important to monitor as well as problematic areas to date. The response options that indicate concerns are coded to myTransfer where discrepancies flagged have a trigger-based escalation or yield a 'Transfer Block' for the relevant staff member's upcoming office money transfer. This is our sixth week of testing myTransfer and we are seeing that this has led to improvements in reporting and compliance.
 - b. As per Key Guidelines in the Audit Protocol (Page 1), the Audit Team and Auditors are required to maintain strict confidentiality of the Work Plan and Audit findings. No one in the Operations Unit is aware of the schedule, including FOs and Senior Managers. This has resulted in a handful of occasions whereby an Auditor went to the clinic on a day that the immunization day was cancelled at the last minute due to unexpected reasons.
 - c. Could auditors detect cases of double enrolments, by observing behaviour at clinics (i.e. independently from clinic and NI staff interviews)?
 - i. The cases of caregivers trying to either enroll the same infants twice or the same infant (typically the same ABAE ID) getting disbursements twice can be found by filtering for 'Re-enrolling / attempting to re-enroll infants to get disbursement benefits' and 'Disbursement: Multiple disbursements for same vaccine to a beneficiary' in Column G 'Issue' of Inquiries Pool. We created an extract of the suspected and confirmed cases of double enrollments in the [11-Jun-2020] Extract: Multiple Enrollments tab with an additional column for Identification Source (Audit - 19, Console - 70, FO - 8, Manager - 1). By selecting for Audit in Column A, you will be able to see the cases identified during Audits (most of these were observed by the Auditor and not through interviews).
 - ii. Below are some notes regarding this:
 1. We find that cases of multiple disbursements and re-enrolling happen more frequently (as defined by more than 10 times) in around 10/98 of our clinics. All Inquiries by Clinic Code can be reviewed here, multiple 'Issue' types can be selected by using Ctrl (Windows) or Command (Mac).
 2. Some ways that these can occur:

- a. Claiming that either the Child Health Card or ABAE Card was lost to get another issued, and then returning with the other card on a future date. This is the most common reason for the 436 occurrences of 'Disbursement: Multiple disbursements for same vaccine to a beneficiary' (Inquiries Dashboard)
 - b. Negligence of Field Officer not following operational protocols like checking both arms of the infant during enrollment
 - c. Collusion between Clinic Staff and Caregivers, with Clinic staff extracting small bribes as a result of this
 - 3. Some ways that Auditors and Managers have been able to identify cases of multiple enrollments by the same infant are:
 - a. Observing caregivers with multiple cards and then interviewing them
 - b. Observing clinic staff's enrollment process
 - c. Observing the process of vaccination
 - d. Asking questions to figure out the cause behind multiple disbursements as requested through inquiries by Console
 - e. Interviewing other caregivers and community members
 - 4. With the new form (as noted in the previous response) and training, we expect to get significantly more observations coming from Managers. This should also resolve the issue of managers resolving cases without adequate documentation.
- 4. When we last spoke about multiple enrolment, you mentioned:
 - a. Clinic staff would be able to detect this by checking the Child Immunisation Register. We were wondering: is clinic staff required to check the list of children to verify the child is not already registered? Could caregivers provide a false name?
 - i. Clinic staff are required to check the Child Immunization Register in cases where an infant has a BCG mark and claims to have not received BCG before or claims to have lost their Child Health Card. Sometimes, this is also found at the point of issuing a card if there are obvious errors in what a caregiver is saying (e.g. giving a female name when the infant is male). The degree of diligence with which this is done varies by the clinic staff and the volume, clinics with higher volume can be busier such that the clinic staff registering the infants might not prioritize this if the clinic is understaffed.
 - ii. Caregivers can provide a false name for infants as well as for themselves since no form of identification is required to enroll a new infant. This is because most infants and caregivers do not have or carry official forms of identification like birth certificates. We do not think that this is done frequently based on the cases that we have reviewed where we have identified the same mother coming in multiple photos with different ABAE IDs.
 - iii. We have identified cases where we have found the same caregiver registering different infants. What we typically find is that some caregivers might bring in infants that are not their children, possibly because the mother was unable to travel to the clinic due to cultural restrictions or medical reasons. These caregivers tend to be TBAs and older women in

the community. Examples of such cases can be found in the Log of Inquiries by filtering Column G for 'Same caregiver in multiple disbursements on a day'.

- b. Partner clinics are roughly 30 mins/1 hour away from each other, if taking public transport. Roughly, how expensive would that journey be (both ways)?
 - i. We interpret partner clinics as program clinics (not neighboring clinics that do not have the program). Based on the discussion with some of our team members, the typical driving distance between NI program clinics is around 20-30km (~15 miles) and in most cases it would likely take an hour or more to travel this distance in public transportation (which is shared private transportation, not a government service). We expect such a journey to typically cost 400 Naira both ways. This amount can be higher in states like Jigawa and between clinics that are further apart, we don't expect it to be much lower for such distances.
 - ii. Clinic Radius Estimates contains 'as the crow flies' distance (as against distance via road travel) between our clinics.
 - 1. We found that there are 42 pairs of clinics that are at a distance of less than 16km (as the crow flies). 27 of these are either Complementary clinics (so designed to be close) or Learning Sites (all in the same LGA).
5. Based on the [Inquiries Pool](#):
- a. My understanding is that you estimate ~1,500,000 naira was misappropriated by clinic and NI staff during the RCT. This is based on 10 of the 63 investigations that resulted in detection of NI and clinic staff fraud (you were unable to estimate fraud for the remaining cases). Could you confirm the above is correct? In particular, I am unsure whether I might be double-counting some of the estimates of the money misappropriated (for rows 2428-2431).
 - i. Row 2429 was duplicated and has now been corrected to avoid the duplication. Overview of Key Investigation Cases is a cleaner list of highlighted cases with investigation reports and estimated amounts. It totals to ~1,868,000 Naira as of 11-June-2020.
 - b. We would find it helpful to read information about how you addressed the cases of fraud you identified. I was able to find a full investigation report for 13 of the 63 investigations that resulted in detection of NI and clinic staff fraud. If available, would it be possible to see information about the steps taken in the other cases?
 - i. Each case of potential fraud is added to the Inquiries Pool and reviewed based on Protocol: Inquiries and Investigations. This then leads to the staff member or their manager receiving an inquiry, summary of which gets briefly recorded in the 'Issue details' and 'Comments/ Discussion' columns. Through the inquiries, the Audits and Investigations Unit tries to identify the 'Root Cause' (Column O of the Inquiries Pool tab). Based on the assessment, Investigations are initiated, particularly for cases of NI Staff Fraud and for frequent Clinic Staff fraud (based on the Concluding Investigations section on Page 3). If the fraud can be avoided or detected through a modification in protocol or systems, then systems are modified based on findings and recommendations. Since most of the cases are not cases of NI Staff Fraud, these do not have Investigation reports. Instead, the Manager is asked to resolve these issues by logging them as myDay

Issues, which the Manager is able to review on their app when visiting the clinic or when making Work Plan requests. The Auditor reviews the previously closed cases for each clinic before visiting and reports on them in the myDay Audit Output Column G, which is reviewed by the Audit Supervisor.

- ii. Managers are able to resolve these cases through a variety of ways, some are covered below:
 1. Reinforcing protocols with clinic staff and NI Staff, as applicable, during their visits or through 1-1s
 2. Using community volunteers (like TBAs) to identify cases of caregivers attempting to come multiple times or to filter caregivers from outside the catchment
 3. Using established influence with LGAs to advocate for clinic staff replacement if found asking beneficiaries for cash or attempting multiple cases of fraud, these are escalated to the Stakeholder Relations and Supply-Side team if needed
 - iii. Our processes for addressing fraud before 2019 were less established which led to fewer of these getting clear next steps and actions, especially in cases that were out of catchment fraud. This means that the actions were discussed via email, meetings, and phone calls without proper documentation. The reason for the inconsistency is that these are merged across different periods. We plan to continue centralizing this information and also update the escalation and reporting process for out-of-catchment and multiple enrollment fraud such that clinics with frequent cases have documented reports and investigations.
6. My understanding is that Immunisation Rates in the [Progress Dashboard](#) refer to the number of children who received BCG who went on to receive the other vaccines, and are calculated on the basis of disbursements data, and ABAE ID information. Is this correct?
- a. The Immunization Rates in the Progress Dashboard are based on the number of children enrolled who went on to receive the other vaccines. The rest of the understanding is correct.
 - b. All enrollments require BCG. BCG is indicated on the Child Health Card approximately 99.79% of the time. The remainder is either errors made by staff or cases of infants who are from the catchment but received BCG elsewhere with required documentation.
7. Based on the [Sample Clinic Daily Form](#), my understanding is that FOs collect information on whether some infants were not served, for each immunisation day, but not the number of infants not served. The [Supply-Side Dashboard](#) (Pg2) includes information on "Infants not served". Is this the number of children not served, or the number of immunisation days during which at least one child was not served? If the former, how is this information collected? [Addendum 06/08: I now see that the form asks for an estimate of the number of children who left, in the "Midday Section." I would guess this means that the number of infants not served includes infants who left without being served before midday, but not the ones who left without being served after mid-day. Is this right?].
- a. The Supply-Side Dashboard Page 2 shows the information from Q.84 and Q.85 in Program Protocols Page 90. I have pasted a screenshot of the questions below. This includes all of the infants that were not served for any reason on a

particular day. Each such case is investigated by the Supply-Side team. In addition to that, a similar question is asked by the line manager during FM Check-ins, the discrepancies in the responses can be found in Supply-Side Dashboard (Page 7); significant differences are investigated by the Supply-Side team. These are documented in the Clinic level Case Log.

- b. The cases of Infants Not Served reported during the Midday Section of Clinic Daily can be found under the 'Left Mid Day' column of Page 7 (recently added) and is also being added to the table in the bottom of Page 2. In June 2019, some challenges were identified and reinforcement was done to ensure FOs report the total number of Infants Not Served as part of Q.84 and Q.85 at the end of the day. We find that this receives good adherence, there are less than 10 immunization days where the Infants Not Reported in Q.84 was lower than the 'Left Mid Day' question (Q.56) since June 2019.

Reference (Program Protocols Page 87 and 90, screenshots below):

- 56.** How many caretakers had left by midday without vaccinating their infants because of the waiting time? Enter 0 if none of the caretakers had left. Enter 99 if the answer is unclear. (Only count women that will not return on the same day. Do not count women that only briefly leave the clinic but return for the infant's vaccination).
- 57.** [Show question only if answer to 54 is not 0] What are the reasons that caretakers left without vaccinating their infants? Select all that apply.
 - a. Waiting time seemed too long
 - b. Nurse told them to come back another time (daily maximum of infants)
 - c. Vaccinations not available
 - d. Child Health Cards not available
 - e. Left because not eligible for cash transfer

- 84.** Were all mothers/infants served today or did the immunization day end prematurely (e.g. no time; ran out of vaccines)?
 - a. All served
 - b. Not all served
 - i. Approximately how many mothers were not served, i.e. sent home?

- 85.** Why did the immunization day end prematurely?
 - i. Nurses were unable to serve all women due to high volume
 - ii. Nurses decided to end clinic day much earlier than usually (unclear reason)
 - iii. Nurses ran out of vaccines
 - iv. Nurses ran out of Child Health Cards
 - v. Field Officer ran out of cash
 - vi. Other _____