SOKOTO STATE CONTRIBUTORY HEALTHCARE MANAGEMENT AGENCY

[SOCHEMA]

MONITORING & EVALUATION PLAN

(BENCHMARKS FOR ROUTINE MONITORING OF SCHMS AND FEEDBACK MECHANISMS)

2018

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SECTION ONE.

INTRODUCTION/BACKGROUND

The Monitoring and Evaluation Plan of the Sokoto State Contributory Healthcare Management Agency (SOCHEMA) is geared towards providing a comprehensive framework for an M&E system that aims at improving efficiency and effectiveness, enhancing transparency, increasing accountability and ensure adequate oversight of the implementation of the contributory health scheme. This M&E framework and manual is an important leadership and governance tool that will assist the entire system to maintain a clear focus on set mandates of SOCHEMA. It shall be hinged on the Strategic Pillars of the just ratified National Strategic Health Development Plan II [NSHDP II (2018-2022)] of the Federal Ministry of Health which is geared towards the attainment of UHC by year 2030.

This document aims to illustrate how the various stakeholders involved in this scheme shall ensure the provision of strategic information to decision-makers, who will use this information to make evidence-based decisions. It shall provide the common platform for performance monitoring and evaluation by guiding all actors. A robust monitoring and evaluation system will ensure efficient and effective implementation of all planned activities and processes involved in running a successful contributory health scheme. This plan shall ensure the establishment of a robust health information system with the ability to support performance monitoring of our health programmes and to track progressive improvement.

The framework for tracking progress of the SOCHEMA implementation shall be based on the M&E logic model, which comprises of input, process, output, outcome and impact (see section 2, Figure 1). Indicators shall be developed for each level of measurement in line with the model.

1.1 RATIONALE (Why is an M&E Framework and Plan Necessary?)

The conceptual framework that informs the SOCHEMA M&E plan strives to ensure that investments/inputs in the scheme are accompanied with effective and efficient management which must translate to better health outcomes, equity in health, and financial risk protection. The Law setting up SOCHEMA also defines clear objectives, whose successful achievements will translate to the desired impact on the Sokoto State Residents.

This M&E strategic document provides a framework for the Agency to fully realize the set objectives and track the performance of the scheme, preserve institutional memory, highlight consensus on what will be monitored and the process of doing so, thus improve transparency and ownership, guide scheme implementation, strengthen coordination and standardization and help to measure achievements. By articulating how the Agency plans to monitor its

implementation of the scheme the framework and guidelines aim to ensure the provision of strategic health system information to make evidence-based decisions.

SECTION 2:
OVERVIEW OF THE M&E FRAMEWORK AND GUIDELINES

2.1 Goal of the M&E Framework.

One functional, scheme-wide Monitoring and Evaluation system for improved decision-making, transparency, accountability, efficiency and effectiveness.

2.2 Objectives of the M&E Framework

a. Align all fragmented programmatic M&E approaches to a single Agency-based M&E system.
b. Align all internal and external actors towards one M&E system.
c. Build capacity of stakeholders within the Scheme to monitor and report progress in implementation of the Contributory Health Scheme.
d. Align the M&E within overall federal level M&E, international monitoring and reporting requirements, and other inter-sectoral specific information needs.
e. Promote integration of health information systems.
f. Standardize M&E procedures at all levels of the health system and healthcare delivery.
g. Increase participation, ownership and partnership through collaboration and consensus-building.
h. Enhance institutional memory through improved documentation.

2.3 Key Outputs

a. An integrated scheme-wide M&E system that can provide timely information to all stakeholders.
b. Improved relations between M&E and research through integration of data sources.
c. Improved utilization of care data.
d. A functional surveillance and response system.
e. Regular key health surveys whose findings would be used to make evidence-based decisions.
f. Available standardized performance reports from various levels of the health system and healthcare delivery.

2.4 The Process of Developing the M&E Framework

The purpose of the SOCHEMA M&E Plan is to provide a framework through which actors in the scheme can monitor the implementation of the contributory health programmes at all levels of care. The M&E Framework was developed through a consultative process spearheaded by the Standard and Quality Assurance Department and the Planning, Research and Statistics Department of SOCHEMA, with the active participation of international partners, technical experts, staff of the State Ministry of Health and other key stakeholders.

2.5 Components of the Framework

The Agency M&E Framework describes in detail the methodology or processes for collecting and using data, including purpose/uses of the data collected, type of data to be collected (both qualitative and quantitative), and frequency of data collection. The M&E Framework aims to operationalize the M&E requirements of the contributory scheme, including the processes and mechanisms through which the core indicators will be monitored and reported. It also specifies, for the monitoring requirements of the Scheme, additional details and specificity, such as:

i. Data collection methods and approaches
ii. What tools will be used to collect data
iii. Key M&E roles and responsibilities; and
iv. The types of reports that will be prepared, including for whom, why and how often.

2.6 M&E Conceptual Framework

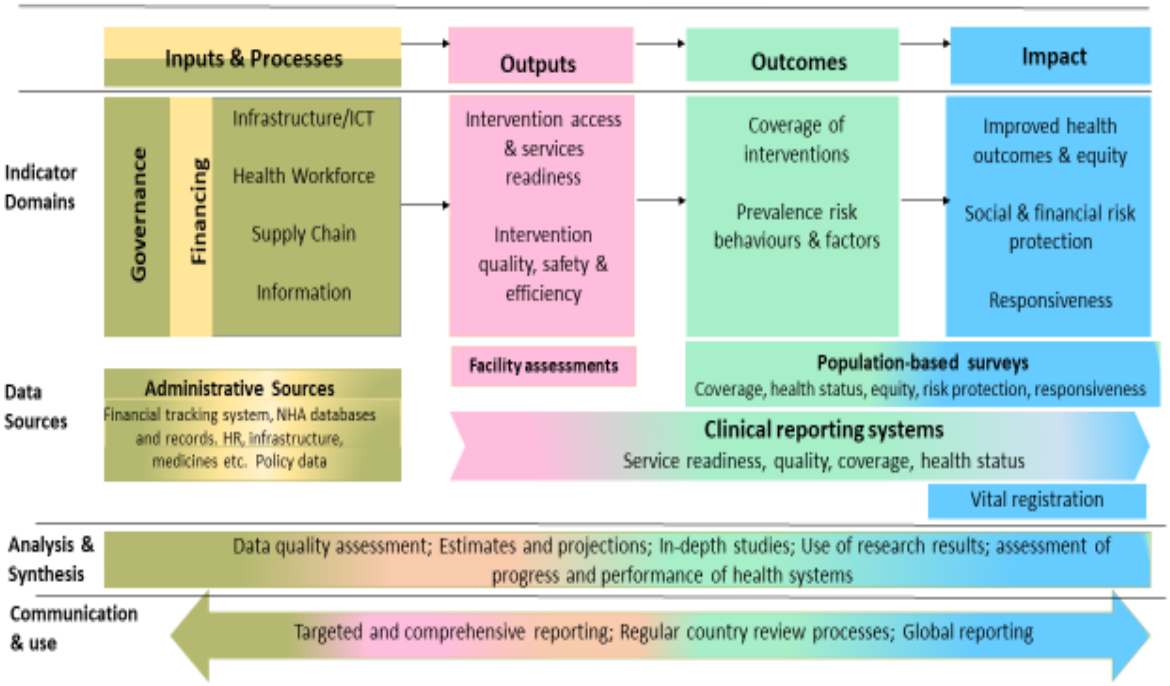


Figure 1: Logic Model for Monitoring and Evaluating Health Systems Strengthening

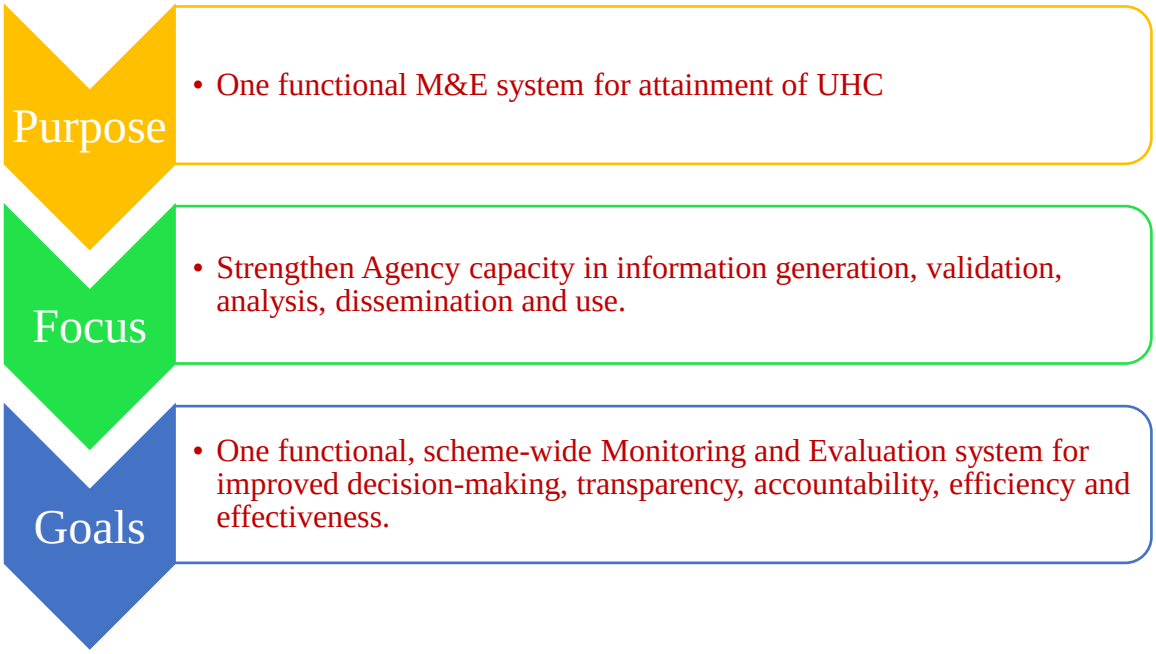
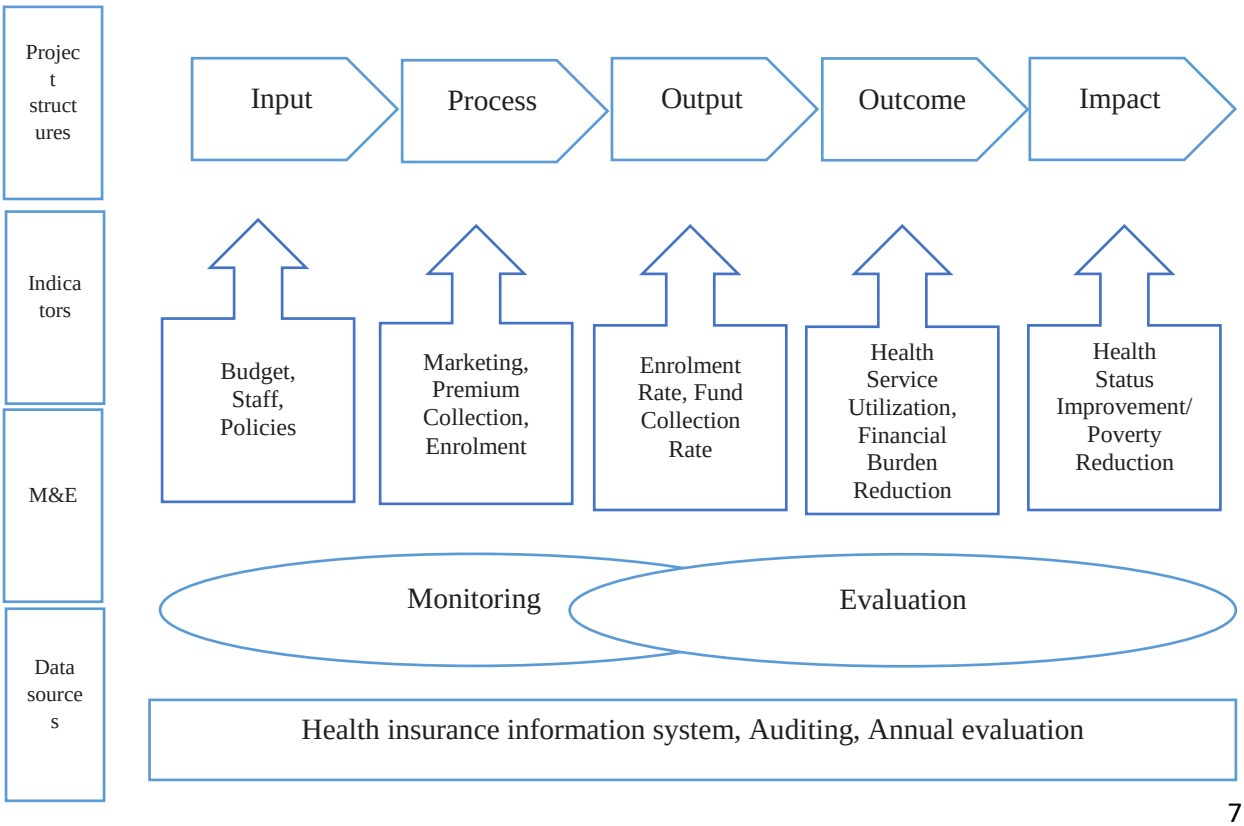


Figure 2: Conceptual framework

2.7 What is to be measured through the Agency M&E Framework?

The underlying architecture of the M&E Framework is driven by the SOCHEMA Results Framework (see Figure 3 below). This results framework provides the basic structure of the contributory health scheme M&E approach.

Figure 3: Health Insurance M&E Structure (World Bank Working Paper)



2.8 SOCHEMA Performance Result Framework:

To achieve its **overall objective** of providing universal healthcare coverage, the SOCHEMA has set itself to accomplish the following **specific objectives:**

1. ensure that all residents of Sokoto State have access to effective, quality and affordable services;
2. protect families from the financial hardship of huge medical bills;
3. limit the inflationary rise in the cost of healthcare services;
4. ensure equitable distribution of health care costs across different income groups;
5. maintain high standard of health care delivery services within the Health Sector;
6. improve and harness private sector participation in the provision of health care services;
7. ensure adequate improvement of health facilities within the State;
8. ensure appropriate patronage at all levels of the health care delivery system;
9. ensure the availability of alternate sources of funding to the health sector for improved services.

Table 1: Key Indicators for the M&E System. (NB: Not all the indicators shall be operationalized. At least one or two indicators per core activity and chosen according to need and budget)

Indicators	Remarks
A. PROCESS INDICATORS	
1. Membership and Enrolment	
Total Formal Sector Members enrolled per month	Active cardholding members. Cards are required by law to be processed within 90 days
Total Informal Sector members enrolled per month	They are the only group that pay direct premiums
Total Renewals (Informal sector only)	
Drop-out rate (Informal sector only)	% of active participants in the previous year who cannot renew their health plan.
Number of poor and vulnerable enrolled yearly per total active members • Indigents • School children • Orphans • Under 5 year • Pregnant women	These are all free riders (voluntary group) and it is part of the government strategy to achieve UHC.
Enrolment Ratio	Enrolled clients/Target beneficiaries
Enrolment conversion Ratio	Issued cards as a percentage of enrolment list. (Monitor quarterly)
2. Fund mobilisation and fund efficiency	
Total Income	

Total premium	
Premium as a percentage of total income	
Investment income	
Investment income as a percentage of total income	
% of funds received from Government	Government subsidies as a percentage of total income
Total Equity fund mobilized • % of total equity fund from 1% CRF • % of total equity fund from international grants • % of total equity fund from local charity • % of total equity fund from Zakat Commission • % of total equity fund from Min. of Social Welfare	
Expenditure	
• Cost of premium mobilisation	
• Cost of claims	
• Operating cost	
• Total claims (reimbursements & transfers): Health Centres, Clinics, Referral Hospitals	
• Overhead cost	
• Incurred expenses	
• Net income (income – expenditure)	
Ratios	
• Incurred expense ratio (incurred expenses/earned premium)	
• Claims ratio	
• Liquidity ratio	
• Solvency ratio	
• Percentage of insured below the poverty line	
Reserve	% of total premium reserved
3. Claims	
Incurred claims • Disease/diagnosis categories	
• Total authorization code issued	Source from Agency Contact Centre
Total claims submitted • Secondary care	
Fee for Service paid monthly	
Claims paid as a percentage of total income	
Claims turn-around time (% of claims processed in a certain period)	Date of claim received to when it was processed.
% of claims processed electronically	
% of claims processed manually	

Claims Ratio	Claims paid as a percentage of premium received
• Primary care Capitation paid monthly	
4. Public Education and communication	
No. of media campaigns/year	
No. of publications/year	
No. of stakeholders engagements/year	
No. of community sensitisation/year	
No of Public Relations Activities/year	
No of Enrolee Sensitization/year	
No of Providers Fora/year	
5. Health Personnel Ratio	
Doctor-patient ratio (per 100,000 people)	
Nurse-patient ratio (per 100,000 people)	
6. Service quality and Customer satisfaction	
Number of complaints received	
Number of complains resolved	A call centre has been established. Data from the centre are analysed periodically
Periodic customer satisfaction surveys	
No. of meetings with credential service providers	
No. of non-complaint schemes sanctioned	
No. of credential providers monitored during the period	Periodic claims verification
No. of credentialed facilities audited	Post credentialing monitoring tools to be developed and pre-tested.
No. of accredited health services providers	
Type of health care providers credentialed (% of each type)	1^0, 2^0, and 3^0
B. OUTPUT INDICATORS	
Population Coverage rate	% of total population covered
Growth rate	% of total population covered per annum
No. of In-patient (IPD) admissions per year	Encounter data to be used.
No. of OPD visit per year	Encounter data to be used.
Utilisation rate	No. of visits/Total enrolled clients
C. OUTCOME INDICATORS	
1. Service Coverage Utilisation rate	
i. Births delivered in a health facility	Percentage of live births in the previous five years delivered in a health facility
ii. Births assisted by a skilled provider	Percentage of live births in the previous five

	years attended by a skilled health provider
iii. Women receiving any antenatal care (ANC) from a skilled provider	
iv. Married women in reproductive age using modern family planning (FP) method	
v. Received all basic vaccines	Percentage of children aged 12–23 months who received a BCG vaccine, a measles vaccine and three doses each of DPT and polio vaccine excluding polio vaccine given at birth.
vi. Received 3 doses of DPT vaccine	Percentage of children aged 12–23 months who received three doses of diphtheria, pertussis, and tetanus vaccine
vii. Received anti-malarial drugs	Percentage of children aged 0–59 months who had fever in the two weeks preceding the survey who received anti-malarial drugs
D. IMPACT INDICATORS	
1. Infant mortality rate	
2. Maternal mortality rate	
3. Neonatal mortality rate	
4. Under 5 mortality rate	
E. FINANCIAL RISK PROTECTION	
Out-of-pocket payees per total population	External partners
% of people who use health services at any given time	
% of the voluntary group who actually receive medical care	
% of people who actually need health services who receive it without payment of user fees	
% of prescriptions on medicine list	OOP spending will increase if most prescriptions are outside the medicine list. SOCHEMA is required to review the medicine list annually.
F. OTHER INDICATORS TO BE MEASURED BY EXTERNAL PARTNERS	
Out-of-pocket health expenditure	
Cost per hospital visit	
Prenatal visits per pregnancy	
Deliveries at health centres	
Knowledge and awareness	
Clients satisfaction	

SECTION 3
M&E IMPLEMENTATION FRAMEWORK

3.1 Key Activities.

a. Develop data exchange standards.
b. Develop new M&E tools.
c. Orient key stakeholders on the use of tools.
d. Train and build capacity of the SQA department the indicators list.
e. Develop business process / standard operations procedures to guide M&E.
f. Develop a joint supervision checklist
g. Set up the Joint Annual Review committee.
h. Ensure periodic performance review forums at all levels.
i. Develop SOPs and guidelines on data management, data quality assurance, and performance reviews.
j. Develop and disseminate appropriate information products.
k. Ensure the integration of State actors (Agency and Public Health Facilities), Non-state actors (civil society organisations, NGOs, for-profit and not-for-profit organisations), and External actors (bilateral and multilateral development partners)

3.2 Standard Operating Procedures to be developed to Guide M&E Implementation

The following SOPs and templates shall be developed to further operationalize this M&E Framework

a. Data management SOPs
b. Data quality protocol
c. Data review templates and procedures
d. Joint supervision checklists
e. Annual performance review templates and guidelines

3.3 M&E Tools

The following tools for M&E purposes shall be developed.

a. Core Scheme Indicators and targets tools
b. Data Management, Data Quality tools
c. Project Specific tools e.g. Client Satisfaction Survey tool

3.4 Core Scheme Indicator Matrix

Selected core scheme indicators from section 2 table 1 shall be expanded using the matrix below:

Table 2. Indicator Matrix

S/N	Process Indicators	Indicator Definition		Data Source	Data Collection Method	Freq. of Data	Responsible Party	Scope	Baseline 2018	Target 2019
		Numerator	Denominator							
1	No of formal sector members enrolled	N/A	N/A	ICT Dept. of SOCHEMA	Forms, Portal.	Monthly	SQA Dept.	State	Nil	100%
2	Enrolment Ratio (formal sector)	Enrolled formal sector members	Target beneficiaries (Total number of civil servants)	ICT Dept. of SOCHEMA and Office of the Head of Service	Forms, Portal and review meetings	Quarterly	SQA Dept.	State	Nil	100%
3	Enrolment conversion Ratio (formal sector)	Members Issued with ID cards	Enrolment list.	ICT Dept. of SOCHEMA	Forms, Portal, Enrolee forum and client satisfaction surveys	Quarterly	SQA Dept.	State	Nil	100%
4	Total income	N/A	N/A	Finance/Account Dept. of SOCHEMA	Account books, annual financial reports, etc	Annual	SQA Dept.	State	Nil	TBD
5	Total premium (from informal sector)	N/A	N/A	Finance/Account Dept. of SOCHEMA	Account books, annual financial reports, etc	Annual	SQA Dept.	State	Nil	TBD
6	% of funds received from Government	Government subsidies	Total income	Finance/Account Dept. of SOCHEMA	Account books, annual financial reports, etc	Annual	SQA Dept.	State	Nil	TBD
etc										

SECTION 4

ORGANISATIONAL REQUIREMENTS FOR A ROBUST M&E FRAMEWORK

4.1 Key responsibilities of SOCHEMA and other Stakeholders.

This section outlines the key responsibilities of various stakeholders under which M&E functions fall at levels.

Table 3:

KEY STAKEHOLDERS	RESPONSIBILITIES
SOCHEMA	1. Define standards for data sharing between aggregate and patient-level data. 2. Coordinate development of minimum data sets and data requirements of the scheme. 3. Create and maintain a data repository of health and health related information. 4. Carry out oversight functions to manage all health and health-related data from service providers at all levels to inform policy formulation. 5. Aggregate, analyse, disseminate and use health and health-related data on the performance of the scheme from all hospitals, PHCs and others. 6. Compile all reports at the agency level on performance tracking of the strategic plan. 7. Analyse the quality of all reports received and ensure follow-up in case of incompleteness, problems with validity and quality, and delays. 8. Provide technical support to all levels of care and their operational units in monitoring and evaluation. 9. Develop and review M&E-related guidelines and policies. 10. Prepare and disseminate annual and quarterly performance review reports. 11. Ensure proper information flow from various levels in accordance with national and international data

	reporting standards and obligations. (This includes, specifically, forwarding hospital level data and information as required to the Agency's Director of SQA) 12. Provide capacity-building in M&E.
Partners (DPs, IPs, NGOs)	1. Provide technical, material and financial support to strengthen monitoring and evaluation. 2. Promote one integrated health information system. 3. Work collaboratively with the Agency SQA to provide data, as appropriate, on population- based surveys and on vital events (births and deaths), and provide health-related research data for comparative analysis and warehousing 4. Work within the existing M&E framework and meet the reporting requirements as defined by minimum datasets. 5. Participate in generation of the reports. 6. Provide support to strengthen the Agency M&E in its areas of operation (e.g., through provision of technical support and capacity building). 7. Participate in dissemination of data, research and performance reports.
Healthcare Facilities	1. Maintain and update the Health Information System, including records, filing system(s) and registry for primary data collection tools (such as registers, cards, file folders), and summary forms (such as reporting forms, utilization data forms etc 2. Safeguard data and information system from any risks, e.g., fire, floods, access by unauthorized persons. 3. Compile all reports from the Technical Officers into a single health facility report. 4. Ensure compilation and processing of minutes, inventory, supervision and other activity reports.

	5. Analyse the quality of all reports received from various health facility units and ensure follow-up in case of incompleteness, problems with validity and quality, or delays. 6. Ensure that data is summarised; analysed; and disseminated; and use the information for decision-making and facility level; provide feedback; and transmits summaries to the Agency timely. 7. Prepare an analysis of the data for discussion during staff and board meetings for decision-making. 8. Forward health and health-related reports to the Agency. 9. Do a quarterly and annual review and reports 10. Disseminate annual report to the health facility committee and Agency

ANNEXURES

A. Standard Operating Procedures (SOPs) for Data Management

Data collation

This should be a daily activity in all Service Delivery Points.

1. Enable stakeholders to become jointly responsible for monitoring, reviews and reporting.
2. Use standard tally sheet or registers
3. Under each event/disease, count the number of events. Do this by drawing tally marks to keep an accurate account of the data being collated using the five bar gate system, e.g., Sum up the tallies daily and at the end of every week.
4. Sum up the weekly summaries at the end of the month.
5. Collate data from the first to the last day of the month (e.g., 1st to 31st of Jan). Data collated for a particular month should not overlap into the next month.
6. Recheck totals of every event/disease.
7. Add the outreach, emergency and other services rendered in various parts of the facility.
8. Keep tally sheets/registers filed for audit purposes.
9. Transfer totals unto appropriate standard reporting forms at the end of the month.
10. Complete ALL fields that require data in the standard reporting forms.
11. Facility In-Charge or a designated person should cross- check and sign all reporting forms.
12. Hospitals and other health facilities with the capacities to do so should enter data from the reporting forms into the M&E portal of the Agency.
13. Complete ALL data fields in the portal or submit hard copy form to Agency.

Data cleaning and validation

Data cleaning and data validation are steps in the process of collecting data either from routine surveillance systems or periodically from surveys. These processes should ensure that the highest possible quality of data is collected and processed in the routine surveillance system. The collection of high quality data starts at the source of information, where direct contact with the patient, diagnosis and/or treatment as well as data registration takes place and is conducted. All staff members involved in the data collection are responsible for the quality of data in the health information system. The Data Management Unit of the Agency is responsible for the final cleaning and validation of the data set.