DELTA STATE CONTRIBUTORY HEALTH COMMISSION

GOVERNMENT OF DELTA STATE NIGERIA

THE BIG HEART

SINCE 1991

HEALTH FOR ALL DELTANS

PERFORMANCE EVALUATION OF THE DELTA STATE CONTRIBUTORY HEALTH SCHEME

HSCL
Health Systems Consult Limited

CONTENTS

ACKNOWLEDGEMENTS

Health Systems Consult Limited (HSCL) is profoundly grateful to the Governing Board of the Delta State Contributory Health Commission and the Director General/CEO of the Commission – Dr. Ben Nkechika for the opportunity to execute the Performance Evaluation of the Delta State Contributory Health Scheme and Commission. Special thanks go to the staff of the Commission especially the heads of departments for their support during the entire evaluation process.

Many thanks to the other stakeholders (State and Non-state), including the State Ministry of Health, State Primary Health Care Development Agency, and Health Management Board who provided critical information upon which this report was developed.

The contributions of HSCL team – Dr. Nkata Chuku, Dr. Oluwatosin Kolade, Onyeka Ojogwu, Emmanuel Sambo, Dr. Hyginus Anedo, Ifeoma Chukwumerije, and Precious Eze is also acknowledged and appreciated for their tireless work in ensuring the successful execution of this performance evaluation.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal Care
BDM	Business Development & Marketing
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CAPI	Computer-Assisted Personal Interviewing
CEO	Chief Executive Officer
CSO	Civil Society Organisation
DAS & HR	Department of Administration and Human Resources
DG	Demand Generation
DSCHC	Delta State Contributory Health Commission
DSCHS	Delta State Contributory Health Scheme
DRF	Drug Revolving Fund
ERP	Enterprise Resource Planning
F&I	Finance and Investment
FFS	Fee-for-Service
HBP	Health Benefit Package
HCF	Health Care Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HSS&QC	Health Services, Standard and Quality Control
ICT	Information Communications Technology
IT	Information Technology
JD	Job Descriptions
KII	Key Informant Interview
LGA	Local Government Area
MNCH	Maternal and New-Born Child Health Services
NHIS	National Health Insurance Scheme
OOP	Out-of-Pocket
OPS	Organized Private Sector
PHC	Primary Health Care
PFM	Public Financial Management
PPM	Provider Payment Mechanism
PRS	Planning, Research & Statistics
SBA	Skilled Birth Attendant
SMoH	State Ministry of Health
SOP	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
SSHIS	State Social Health Insurance Schemes
TA	Technical Assistant
UHC	Universal Health Coverage
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The share of the world's population protected against the catastrophic cost of illness rose significantly during the twentieth century, with global spending on health increasing from 3 percent to 8 percent of global gross domestic product (US$2.8 trillion), or 4 percent of the GDP of developing countries (US$250 billion)[1]. At the current global growth rate for GDP of 3.5 percent, spending on health care related activities will increase annually by about $98 billion a year worldwide, or $8 billion a year in low- and middle-income countries.[1] Given Africa's low fiscal space, countries are considering new strategies for increasing the overall funding gap in the health sector and achieving Universal Health Coverage (UHC) for their citizens. Governments have therefore adopted a mix of strategies such as increased allocations from government revenues, special taxes, and the establishment of social health insurance schemes to improve resource mobilization and sustain progress towards UHC[2].

In Nigeria, the government established the National Health Insurance Scheme (NHIS) in 1999 , and provisions were made for a Basic Health Care Provision Fund (BHCPF) in the National Health Act 2014. It is expected that these health financing reforms in addition to other initiatives aimed at strengthening primary health care will serve as vehicles for the achievement of universal health coverage for all Nigerians. To further increase population coverage, the establishment of State Social Health Insurance Scheme at the sub-national levels was approved by the National Council on Health in 2015.

Delta is one of the few states in the country that has made significant progress in the implementation of its Social Health Insurance Scheme. The scheme aims to enable the provision of affordable and quality healthcare services to state residents. Since the passage of the law establishing the scheme and its governing agency in 2016, key achievements have included the completion of the design of the scheme, commencement of enrolment of residents across formal, informal, and vulnerable populations, and provision of basic health care services to enrollees through public and private health facilities.

In line with best practice, a performance evaluation of the Delta State Contributory Health Commission (DSCHC) and Delta State Contributory Health Scheme (DSCHS) was conducted to measure the performance of the Commission and Scheme over the last four years of operationalisation.

Objectives

The objectives of the performance evaluation included the following:

1. To review the organisational capacity of the DSCHC to ascertain its strengths, weakness and opportunities for improvement to enable the DSCHC deliver on its mandate.
2. To review the efficiency of the scheme's design, operationalization, identify gaps and opportunities for improvement.

[1] Health financing for poor people: resource mobilization and risk sharing, bulletin of the World Health Organization 83(3)

[2] Health Insurance for the Informal Sector in Africa: Design Features, Risk Protection and Resource Mobilisation.

3. To ascertain the impact of health insurance on utilisation of maternal and new-born child services in the state.
4. To develop recommendations based on findings which will inform decision making on course corrective actions to improve the performance of the Scheme, Commission and plan for scale-up of the operations of the Scheme.

Evaluation Methodology

A mix method approach that involves qualitative and quantitative research methodology was utilised for the performance evaluation. We conducted a desk reviews of relevant state strategic and operational documents, abstraction of quantitative data from primary and secondary sources, and key informant interviews with relevant stakeholders.

To guide the evaluation process, a framework was developed leveraging the World Health Organization (WHO)/World Bank global UHC monitoring framework and the WHO framework for Health Financing and UHC. The WHO/World Bank framework has two components – service and financial coverage across which UHC should be tracked. The WHO framework defines the policy environment of a health financing system across three key functions namely resource mobilization, purchasing, and pooling. An additional domain on organizational capacity was included to assess the governance and operational structure of the DSCHC. Also, Proxy quantitative and qualitative indicators were developed across the four domains based on the expanded framework for the evaluation.

A purposive sampling technique was used for the selection of respondents for qualitative data collection. State actors were selected based on their involvement in the implementation of the Delta State Contributory Health Scheme. Providers and enrollees were however randomly selected across three Local Government Areas (LGAs) of the state. A total of eighty-nine (89) respondents comprising of state actors, staff of the Commission, providers, and enrollees were interviewed for the evaluation.

Data collection was led by a team of health financing specialists from Health Systems Consult Limited (HSCL) for a total of 19 days. Primary data was collected through abstraction of quantitative data from relevant sources including the DSCHC IT platform, state HMIS and key informant and client exit interviews with state and non-state actors. Secondary data was collected through desk-review of relevant documents including the DSCHC law, operational guidelines, and the State Strategic Health Development Plan II. Client exit interviews were conducted using Computer-Assisted Personal Interviewing (CAPI) technique through handheld devices.

For quality assurance purposes, interviews with stakeholders were recorded with the interviewees' consent sought to ensure complete capture of relevant information. Data was analyzed using developed frameworks and recurrent themes were drawn and fleshed out into narratives. Quantitative data was analyzed using excel and presented in charts.

Key Findings & Recommendations

Table 1: Summary of findings and recommendations

Domain	Sub-Domain	Key Findings	Recommendations
Organizational Capacity	**Organization structure**	• An organizational structure that defines the levels of hierarchy, relationships and aligns with the DSCHC law & the Commission's strategic goals was present. • Each department had defined job descriptions (JD) for Roles and responsibilities of staff. • Some staff lacked clarity on their roles and responsibilities which often overlap due to a recent restructuring. • Some staff have the required qualifications & experience for their positions and budgetary provisions are made for capacity building. However, t here is, a need for continuous capacity building targeted at strengthening staff capacity in functional areas of work.	• A review of the organisation's structure should be conducted to ensure alignment with scale-up plans and ensure agility in its operations. • A reorientation of staff should be conducted to ensure staff are acquainted with their assigned roles and responsibilities. • An assessment of staff capacity should be conducted to ascertain the level of understanding of roles by the staff,gaps in knowledge and capacity in carrying out their respective responsibilities – particularly in respect to the scale-up plans of the Commission. The result of the assessments should inform the development of a capacity building curriculum and an action plan for implementation. • The Commission should also develop a performance management framework and an implementation plan to enable the tracking and measurement of results as it scales up its operations. The framework should articulate the type of data that should be maintained and staff should be trained on the analysis and use of data for decision making.

Domain	Sub-Domain	Key Findings	Recommendations
	Systems	• The commission made a transition to an information technology (IT) system named the e-clinic application in 2018. The IT application is currently managed by a third-party vendor named Inter-Switch Limited and e-Clat Healthcare and it is domiciled in the Planning, Research and Statistics (PRS), and Business Development & Marketing (BDM) departments. • The application makes provision for modules on enrolment, claims management and also enables automated messaging for policy renewals. • An Enterprise Resource Planning (ERP) system has also been deployed in a phased approach to improve efficiency in the commission's operations.	• The capacity of the IT system for enrolment and claims management should be expanded to enable the provision of disaggregated data required for performance tracking across key indicators. • There should be continuous strengthening of relevant staff to manage the Commission's IT software
	Processes	• Almost all (excluding ICT) of the Commission's operations including enrolment, accreditation, provider management, and demand generation are carried out by designated departments rather than being outsourced to third party administrators. • There are processes to guide the implementation of activities and departments have developed protocols, however, the documents are more of requirements for an activity and do not meet the standard layout of	• Standard process manuals (flowcharts) for technical and administrative functions within the Commission should be developed to facilitate the operationalisation of key processes.

Domain	Sub-Domain	Key Findings	Recommendations
		a process manual (i.e., process steps, persons responsible, required job aids etc.).	
Resource Mobilization	**Enrolment**	• The scheme is mandatory for all state residents – formal, informal and vulnerable populations in accordance with the DSCHC law. • A total of ***835,396*** state residents have been enrolled as at the end of 2020 representing a 20.3% population coverage rate. • The vulnerable population and formal public sector make up the majority of enrolees - 78% & 21% respectively with the informal sector representing only 2% of total enrolments into the scheme. • Processes for enrolment have been defined with the Commission being directly responsible for enrolling the formal and informal sectors. • 107 field agents (as at the end of 2020) have been recruited and deployed to communities for informal sector enrolment as adhoc staff of the Commission. Potential enrollees are required to make premium payments through the designated bank or pay cash directly to the agents before enrolment can be completed. • For vulnerable populations, enrolment is conducted through a mix of door-to-door and facility-based approach. There is, however, no	• A review of the current informal sector enrolment strategy to ensure it articulates multiple contextual approaches that address factors affecting enrolment, should be conducted and implemented with critical and relevant stakeholders in a bid to improve enrolment amongst the informal sector group. • The mechanism for the identification and registration of vulnerable populations should be improved to aid the development of a state-wide vulnerable population database for registration into the Commission's equity health plan.

Domain	Sub-Domain	Key Findings	Recommendations
		reliable database for the vulnerable population in the state and the Commission is planning to conduct a re-validation of the state's existing social register to create the database. • Challenges with formal sector enrolment/validation have included apathy towards the scheme despite deductions from salary, low perception of service quality available in empaneled health facilities due to unavailability of twenty four (24) hour health services, health workers attitude and existing mistrust in the system as a result of the experience with the failed contributory pension scheme in the state. • For the informal sector, challenges have included religious and cultural beliefs, inability to afford premium payments, poor perception on quality-of-service delivery, mistrust of field agents, poor attitude of the field agents & providers, and insufficient options of mediums for enrolment.	
	Contributions	• The revenue sources for the scheme have included: (i) equity fund contribution of not less than 0.5% of the consolidated revenue of the State Government on behalf of vulnerable persons (ii) monthly deductions of 1.75% gross salary of formal sector (public) and government subsidy of 1.75% (iii) annual premium payment of N7,000 premium by the none-poor informal sector (iv) periodic	• Strategies that enable the Commission to diversify and grow its revenue base through sources provided in the law and other innovative mechanisms should be developed and implemented. These could include mechanisms for enforcing enrolment of employees of the organised private sector (such as oil & gas companies and banks) and investing pooled resources in investment instruments approved by the law.

Domain	Sub-Domain	Key Findings	Recommendations
		contributions by philanthropists for the vulnerable within communities. • Premium payments by the formal sector & government contributions for the vulnerable population and public sector employees contribute 51.9% and 47.9% of funding for the DSCHS respectively. This implies that there is an opportunity to diversify and grow the revenue base of the Scheme. • The disbursement of funds by the government has been consistent and this is largely due to the strong political will of the current administration which has health as one of its top policy agenda for all Deltans.	
	Demand generation	• Several initiatives to generate awareness and demand for the scheme have been deployed. These include the conduct of road shows & town hall meetings, advocacy to informal sector groups, religious/community leaders, the use of traditional (radio/TV shows) and new media (social media) and partnerships with relevant government ministries & parastatals - Civil Society Organisations (CSOs). • Most of the planned demand generation (DG) activities were conducted in the Delta North senatorial zone (234) while Delta South and Central had the same number of implemented DG activities (208) over the 4-year Evaluation period.	• A review of the current demand generation and communication strategy articulating contextual approaches for targeting the various population groups should be conducted. This will help to understand the current situation and obtain evidence for an improved redesign of the various DG activities as well as improve the knowledge of beneficiaries on the scope of the benefit package. The review & implementation of the strategy should be a collaborative effort involving relevant departments, community structures, ministries, and agencies within the state. Implementation should also be recalibrated to include more of less targeted zones with low enrolment rates.

Domain	Sub-Domain	Key Findings	Recommendations
		• Knowledge and awareness of the scheme is however low particularly amongst the informal sector despite the DG activities that have been implemented. • Challenges that have affected the impact of activities include the inadequacy of implemented activities which could be as a result of design decisions , yet to be reviewed to reflect implementation realities, DG strategy and waning interest of the public due to negative word-of-mouth on the quality of services available in empanelled health facilities.	• As a part of the DG strategy, the development of sensitisation messages should be guided by contextual information (knowledge of behaviour, cultural/religious norms and perspectives on available health care etc) per population group.
	Beneficiary management	• There are dedicated phone lines for communication and management of enrollee complaints and feedback. • Staff managing the dedicated call lines provided on the enrollee ID card are reported to be overburdened. • There is possibly inadequate awareness amongst enrollees on other communication options. • In addition, there are no documented processes for the institutionalisation of mechanisms for beneficiary complaints & feedback management	• Consider conducting a workload analysis to address the mismatch between the available human resource, and what is required to deliver quality service. The analysis will enable an optimized workforce planning & management strategies including ensuring availability of dedicated persons for the call-centre in the case of a scale up. • In addition, the Commission should consider organising periodic stakeholder engagement sessions. These sessions will provide an opportunity to sensitise enrollees on the scheme and receive feedback that can be leveraged to improve performance.
Pooling	**Pooling arrangement**	• Accumulated funds are deposited a designated bank where separate accounts are maintained for contributions by the formal and informal sectors, and vulnerable population.	

Domain	Sub-Domain	Key Findings	Recommendations
	Fund management	• Processes have been defined for expenditure management in line with the government's general procedures for Ministries, Agencies and Parastatals. • Internal controls have also been put in place for all expenditures and the DSCHC law provides ring-fencing accumulated funds.	
Purchasing	**Benefit package**	• The legal framework and operational guideline for the DSCHS make provision for four health plans namely (1) formal health plan (2) informal sector plan (3) equity health plan (4) private health plan. • A comprehensive benefit package comprising of preventive and curative health services (including selected maternal and new-born child health services - MNCH) and accessible by all enrollees has, however, been developed for operationalization of the scheme. • The benefit package was considered to be adequate in meeting the health needs of enrollees by the majority of respondents. • There is a lack of clarity on the scope of services amongst providers and enrollees, given the frequent requests on provision of services not covered by the scheme. This often creates the impression that the facilities do not want to provide services for which they are paid.	• A mechanism for stakeholder engagements that can be leveraged to provide up-to-date information on the scheme should be developed and institutionalized. • As the Commission plans to scale-up its operations, consideration should be given for the evaluation of the health benefit package. In doing this, salient factors such as the available resources, disease burden and supply-side readiness across the state must be taken into consideration to guide decisions on expansion/revision of the health benefit package (HBP).

Domain	Sub-Domain	Key Findings	Recommendations
	Provider purchasing mechanism	• Health care providers are paid or reimbursed for purchased services through a hybrid of capitation for primary healthcare services and fee-for-service (FFS) for secondary healthcare services. • Primary healthcare facilities that can provide secondary health care services are however, also reimbursed through FFS for such services. • The payment to healthcare providers is managed directly by the DSCHC through the BDM (claims management) while the Finance & Investment departments is responsible for effecting payment of approved processed claims. • Potential cases of fraud that could arise from the use of capitation and FFS is checked through pre-authorisation of referrals for capitated services and the claims vetting process for FFS. • There is some level of dissatisfaction over the low rates for capitation and fee-for-service amongst providers. This perception seems to influence the quality of services offered by such providers as some respondents reported cases of long waiting time and purchase of drugs through out-of-pocket payments.	• A review of the current mechanism for fraud prevention by providers through the provider payment mechanisms (PPMs) should be conducted. • Providers' capacity on the business of health insurance could be strengthened to address provider perception on low payment rates which is likely a key contributing factor to the low quality of service delivery.

Domain	Sub-Domain	Key Findings	Recommendations
	Provider management	• 489 health care facilities of the 803 health facilities in the state have been accredited and empanelled on the scheme's providers directory – a 61% accreditation rate. • Ownership of empanelled health facilities is disaggregated by ownership into 79 private health care facilities and 410 public health care facilities. • Majority (345 out of 489) of the accredited health care facilities are empanelled at the primary health care level which enables the Commission's approach of using the primary health care system as a gatekeeper for access to care.	• The contracting process of the Commission should be strengthened through the inclusion of a performance management framework that enables incentivising positive provider behaviour and improving service provision by empanelled health facilities.
	Claims management	• A defined process for claims management is captured in a flowchart. • Tariffs for services and drugs have been developed and reviewed once since operationalization of the scheme commenced. • The claims management process has been digitized and health care facilities have been provided with requisite tools to facilitate the transition to the IT-based system. This process usually takes an average of 6 months based on data provided by the Commission. These delays were largely due to poor knowledge of claims filing by the providers.	• To avoid disruptions in service provision to enrollees, the claims management cycle should be reviewed and revised with a view to reducing timelines for processing payments and instituting a functional feedback mechanism. • In addition, the knowledge and capacity of providers on the operational modalities of the claims cycle and use of the IT software should be continuously strengthened to address poor capacity issues. This should include the development of a detailed process manual on the claims processing cycle.

Domain	Sub-Domain	Key Findings	Recommendations
		• A total of *1,277,188* (as at the end of 2020) number of claims have been submitted by health facilities over the four-year evaluation period. Facilities in Delta Central and Delta North senatorial zones had the highest number of submitted claims, while Delta South had the lowest. • Challenges identified with claims management included lack of adherence to treatment guidelines by the providers, inability of the providers to meet up with the deadlines for claims submission, poor quality of submitted data, low capacity of the providers to navigate the IT software and delays in receipt of payments from the Commission.	• Providers need to be trained on claims filing and processing to reduce iterations between the commission and the providers.
	Quality Assurance	• There is no defined mechanism for quality assurance management for empanelled health facilities. • Provider monitoring visits which are done mostly on a needs basis is infrequent and there is no mechanism for follow-up to ensure implementation of feedback to erring health care facilities (HCFs). • The claims vetting process is leveraged to review adherence to protocol for standard treatment. • The percentage of enrollees requesting for a change in health facility is low - averaging 1.5% over the evaluation period. This could be	• Explore the development of a treatment protocol /guideline and use of the document by empanelled providers should be institutionalised for quality assurance. • In addition, a quality assurance management system that enables the effective tracking of providers adherence to the operational modalities of the scheme should be developed & implemented in collaboration with relevant supply-side stakeholders.

Domain	Sub-Domain	Key Findings	Recommendations
		attributed to a possible improvement in the quality of care resulting in fewer enrolees requesting for change in provider or low knowledge on how such requests can be made since service quality was a significant issue raised by respondents.	
	Stakeholder satisfaction with service quality	• Satisfaction with the quality of service was expressed by some enrollees across the parameters of quality of drugs received, waiting time and availability of services that met their health needs. • However, the issue of low quality of care was a common challenge raised across all stakeholders interviewed. Challenges mentioned included - unavailability of some desired services not covered in the health benefit package (HBP), cases of external purchase of drugs and poor attitude of health workers. • On the side of the healthcare providers, common challenges mentioned included delays in the provision of monthly enrollee lists which often causes disruption of service provision to enrollees and absence of channels for complaint resolution. • The low quality of services provided by health facilities was noted as a major challenge which has impacted on willingness of state residents to enrol on the scheme.	• Implementation of mechanisms that enable strategic purchasing will contribute to improving the quality-of-service provision under the scheme.

Domain	Sub-Domain	Key Findings	Recommendations
	Service utilization (MNCH)	• Majority of the empanelled facilities in the LGAs across the state provide ante-natal care (ANC) services. • Number of deliveries by skilled birth attendants (SBAs) across most LGAs was low with Ughelli North in Delta Central having the highest number of deliveries by SBAs while LGAs within Delta South had the lowest number of deliveries by SBAs. • To improve utilisation of MNCH services & reduce maternal deaths, the state government recently approved the recruitment of community midwives. • Majority of the respondents expressed satisfaction with the quality of MNCH services received under the scheme due to ease of access. However, a few respondents mentioned challenges with poor health workers attitude and cases of non-provision of expected services for pregnant women.	• A study should be conducted to ascertain the factors that are influencing the low ANC and facility deliveries. The results of the study can be used to inform the development of contextual strategies across LGAs to drive the uptake of services.

1.0 INTRODUCTION

1.1 Background

State Profile

Delta state is one of six states within the South-South Geo-political zone of the country with Asaba as its capital city. The state has a landmass of 18,050 square kilometres and comprises of twenty-five (25) local government areas (LGAs), nine (9) of which are in riverine and coastal areas with challenging terrains that make them difficult to access with amenities and services.

Figure 1: Map of Delta State Showing Major Ethnic Tribes & LGAs

With a growth rate of 3.2%, the estimated population of the state is 4,112,445[3]. This comprises mainly of a young population (15 – 59 years) that account for about 64% of the total population. The state is ethnically diverse with seven (7) major ethnic tribes spread across the three senatorial zones - Delta South, Delta North and Delta Central

Delta is one of the major oil and gas producing states in the country providing about 30% of Nigeria's total oil and gas output[4]. This accounts for the bulk of the state's statutory revenues in addition to the revenue received from the derivation fund for oil producing states. The state has the second lowest poverty rate in the country according to the Poverty and Inequality Report published in 2019 by the National Bureau of Statistics[5]. This has been linked to the initiatives implemented by the current administration in fulfilment of its *Prosperity for all Deltans* agenda.

[3] https://www.deltastate.gov.ng/
[4] Delta State Medium Term Development Plan (2016 – 2019)
[5] 2019 Poverty and Inequality in Nigeria. National Bureau of Statistics

Majority of the population are engaged in small-scale agriculture, fishing and informal businesses that are key contributors of employment and source of livelihood of the people.

State Health Landscape

The Delta State Ministry of Health (SMoH) serves as the regulatory body of the health sector. The Ministry is responsible for the development and implementation of polices and strategies for the achievement of the government's health agenda which is aimed at improving health outcomes in the state. A second State Strategic Health Development Plan (2018 – 2022) has been developed as a guidance document for the achievement of the health sector's objectives. Significant progress has also been made in the implementation of national health policies including the Primary Health Care Under One Roof policy (PHCUOR) as part of efforts to integrate the governance, financing, management and provision of primary health care (PHC) services under one state-level administration[6].

State residents have access to primary, secondary and tertiary health services that are provided by the public and private health facilities in the state. There are 449 PHC centres, 64 government general hospitals, 290 private clinics and hospitals and two tertiary hospitals in the state[3]. The number of hospital beds is estimated at 9,811 and the state has a total of 1,500 doctors, 344 pharmacists and 3,207 nurses[3]. The state is faced with poor but improving health indices among women and children as seen from its maternal mortality ratio, infant mortality ratio and immunisation coverage which stand at 188/100,000 live births, 48/1000 live births and 36%[7] respectively. These indices are however better than national averages. Delta state also has a HIV/AIDS prevalence rate of 3.6% which is slightly higher than the national prevalence rate of 3.0% and a Malaria prevalence rate among children under 5 of 27.5%[3].

Several initiatives have been implemented by the government in a bid to improve access to quality health care and the health outcome of state residents. Some of these include – the Free Rural Health Scheme; Free Maternal Healthcare Programme; Free Under-5 Healthcare Programme; Free Ambulance Service; Subsidized Renal Dialysis; the establishment of the Delta State Contributory Health Scheme and a Drug Revolving Fund (DRF). These initiatives have collectively contributed towards achieving desired outcomes in the state's health sector.

Universal Health Coverage and Health Insurance in Delta State

Over the last decade, Universal Health Coverage (UHC) has become a priority policy agenda for governments around the world including sub-Saharan Africa. The goal of UHC is to ensure that every individual and community, irrespective of their circumstance, receive the health services they need without risking financial hardship[8]. The key to protecting people from financial hardship

[6] Delta State Strategic Health Development Plan II
[7] MICS 2016-17; NDHS 2013
[8] Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2017. Licence: CC BY-NC-SA 3.0 IGO.

is to enable prepayment and pooling of resources for health, rather than relying on people paying for health services out-of-pocket (OOP) at the time of use[9].

Social health insurance is one of the principal means of financing health and achieving UHC[10]. In recognition of this, the Nigerian government has made the achievement of UHC a priority through several initiatives including the establishment of the National Health Insurance Scheme (NHIS) r Act 35 of 1999. The mandate of the NHIS is to promote, regulate and administer the effective implementation of Social Health Insurance Programs in order to ensure easy access to quality-assured and affordable healthcare services by all Nigerians. In furtherance of its commitment to make UHC a part of its priority health interventions, the government also made provisions for the establishment of the Basic Health Care Provision Fund (BHCPF) within the National Health Act of 2014[11]. The fund will serve as the principal funding vehicle for the provision of Basic Minimum Package of Health Services (BMPHS) with the aim of moving Nigeria closer to UHC.

Key challenges have however been experienced with the operationalisation of the NHIS, principally of which is the low population coverage that is estimated at 5% of the population with revenue for the scheme relying mainly on formal-sector payroll contributions and general government revenues[12]. To improve population coverage, the NHIS at the National Council for Health (NCH) Memo 58 in March 2015 which gave birth to the establishment of the State Social Health Insurance Scheme (SSHIS). To this end, governments at the sub-national level have in recent years, established state social health insurance schemes aimed at improving access to affordable and quality healthcare services by state residents.

Delta state is one of the few states in the country that has made significant progress with the implementation of its SSHIS. The bill establishing the Delta State Contributory Health Scheme (DSCHS) and the Delta State Contributory Health Commission (DSCHC) was passed into law in 2016. To enable the implementation of a scheme that aligns with the contextualised evidence on the health needs of the state, a baseline assessment was commissioned by the Delta State Contributory Health Commission (DSCHC) in 2016. The assessment comprised of a household expenditure survey & facility assessment and findings informed the development of an implementation plan to guide the design and operationalisation of the scheme. Implementation of the scheme commenced in 2017 with the enrolment of population groups across the formal and informal sectors. Over the course of implementation, over 800,000 Deltans had been enrolled on the scheme as at the end of year 2020, to receive health services through accredited public and private healthcare providers.

[9] Tracking universal health coverage: first global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2015

[10] Health financing for universal coverage and health system performance: concepts and implications for policy. Joseph Kutzin 2013. *Bulletin of the World Health Organization* 2013;91:602-611. doi:http://dx.doi.org/10.2471/BLT.12.113985

[11] National Health Act (2014)

[12] Performance evaluation of a health Insurance in Nigeria using Optimal resource use: Health care providers perspective. Mohammed et al. BMC Health Services Research 2014, 14:127. http://www.biomedcentral.com/1472-6963/14/127

The state has also met the requirements for the operationalisation of the BHCPF. The programme is to be integrated with the Commission's current programme for vulnerable populations and is expected to contribute significantly to enabling Delta state achieve UHC for its residents.

1.2 Objectives of the Performance Evaluation

Performance evaluations of social health insurance schemes are fundamental to generating evidence that can be used by policy and decision makers on measures that should be taken to achieve objectives of such schemes. Thus, in line with best practice, the DSCHC commissioned a performance evaluation of the DSCHS and the DSCHC. The objectives of the Evaluation include the following:

1. Review the organisational capacity of the DSCHC to ascertain its strengths, weakness and opportunities for improvement to enable the DSCHC deliver on its mandate.
2. Review the efficiency of the scheme's design and operationalization, identify gaps and opportunities for improvement.
3. Ascertain the impact of health insurance on utilisation of Maternal, New-born and Child Health (MNCH) services in the state.
4. Develop recommendations based on findings that will inform decision making on course corrective actions to improve the performance of the DSCHS, DSCHC and plan for the scale-up of the operations of the Scheme.

1.3 Expected Outputs

The aim of the performance evaluation was to generate evidence that will be leveraged to;

- Inform decision making on course corrective actions to improve the performance of the Scheme and Commission and
- Plan for the scale-up of the operations of the Scheme.

2.0 EVALUATION METHODOLOGY

The performance evaluation was a mixed study that employed quantitative and qualitative research approaches involving primary and secondary data collection. The evaluation covered a period of four years (2017 – 2020).

2.1 Evaluation Framework

A framework for the evaluation of the DSCHC and DSCHS was developed by adapting two frameworks – the WHO/World Bank global UHC monitoring framework[2] and the WHO framework for Health Financing and UHC[13].

The WHO/World Bank monitoring framework focuses on the two key components of UHC comprising of coverage of the population with quality essential health services and coverage of the population with financial protection. The framework also defines indicators for tracking UHC progress across both components. On the other hand, the WHO framework for Health Financing & UHC defines the health financing policy system as comprising of three key functions - revenue generation, pooling and purchasing and aligns these functions to the objectives and goals of UHC. The adapted framework for the evaluation was expanded to include a domain on organizational development which sought to assess the capacity of the Commission to achieve its set mandate. The schema below shows the adapted/expanded framework:

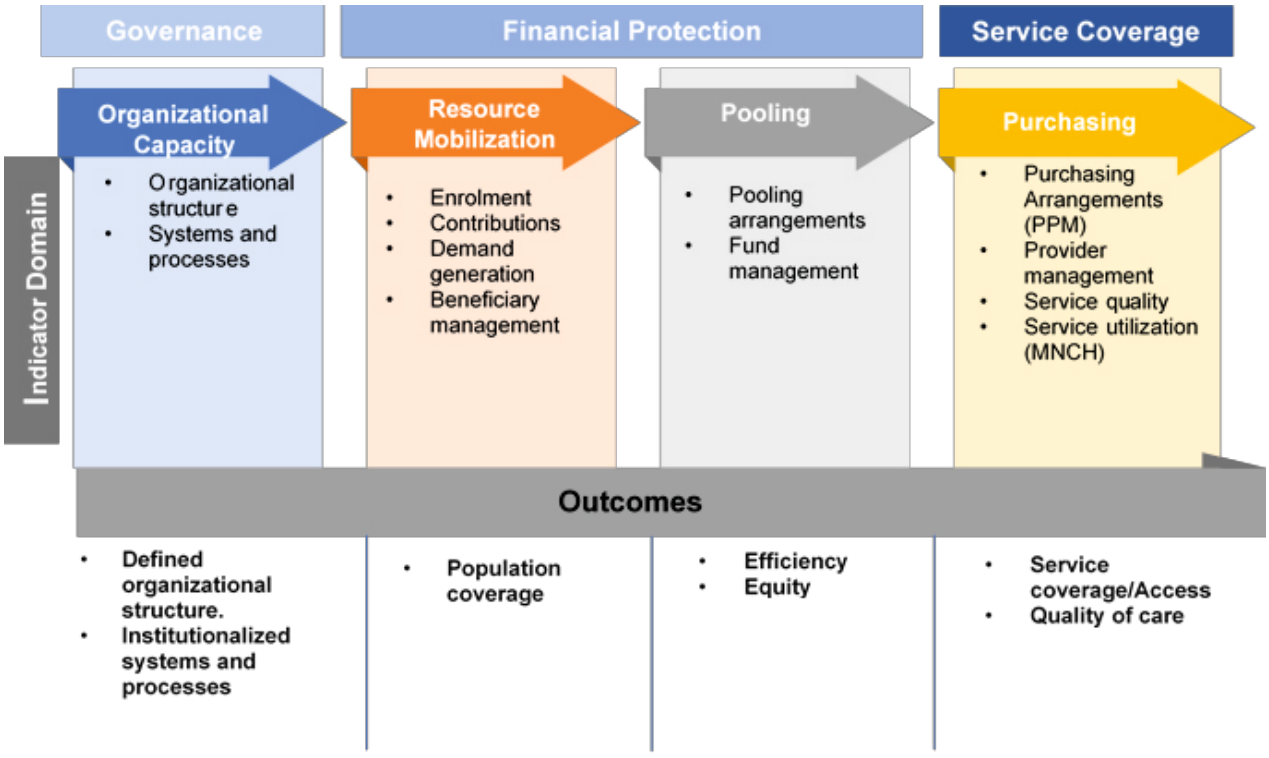


Figure 2: Performance evaluation framework

[13] Health financing for universal coverage and health system performance: concepts and implications for policy. Joseph Kutzin 2013. *Bulletin of the World Health Organization* 2013;91:602-611. doi:http://dx.doi.org/10.2471/BLT.12.113985

Based on the framework above, quantitative and qualitative indicators were developed across the four domains for the evaluation. Given that one of the key challenges of monitoring progress on UHC is the relative scarcity of reliable data on a broad set of health service coverage and financial protection indicators[6], proxy quantitative indicators were developed for the evaluation.

Qualitative indicators assessed the efficiency of existing systems and processes of the commission for the operationalization of the scheme while quantitative indicators assessed the progress of the commission in achieving service coverage and financial protection for Deltans. The list of indicators was reviewed with relevant staff of the DSCHC and finalised based on feedback on the availability of required data.

2.2 Study Team

The study team comprised of staff of the Health Financing Department of Health Systems Consult Limited (HSCL) and an accompanying team of research assistants.

2.3 Data Sources

a) Primary data

Primary data collection involved the abstraction of quantitative data from relevant sources and the conduct of key informant interviews (KIIs) and client exit interviews with relevant stakeholders.

- **Quantitative data collection:** This component of data collection focused on eliciting information on performance across key operational areas of the scheme such as enrolment, demand generation and claims management as well as the impact of health insurance on utilization of MNCH services. Four (4) year data (2017 – 2020) was extracted from departmental documents and ICT platform of the Commission as well as the state's health management information system (HMIS) platform across relevant indicator domains.
- **Qualitative data collection:** KIIs were conducted to elicit information on the organizational capacity of the DSCHC and the efficiency of the design/operationalization of the scheme. The respondents for the KII were drawn from the DSCHC, state ministry of health and relevant agencies, service providers and the scheme's enrollees to ensure wide representation of perspectives as well as reasonable degree of confidence in results of the assessment.

b) Secondary data

Secondary data collection involved the review of relevant regulatory and operational documents such as the law establishing the Scheme and Commission, operational guideline, state strategic health development plan and operational protocols and tools. Documents were retrieved from the DSCHC, SMOH and other sources and a desk review framework was developed to guide the abstraction of data from the documents.

2.4 Sampling & Selection of Respondents

A purposive sampling technique was used for the selection of state actors for the qualitative data collection. Respondents were selected based on their involvement in the implementation of the Delta State Contributory Health Scheme. The list of stakeholders interviewed is shown in the table below:

	Respondents	No. Interviewed
KII	State actors	5
	DSCHC	12
	Providers (health facilities)	11
	Enrollees	28
Client exit interviews	Enrollees (MNCH)	33
Total		**89**

Table 2: List of Stakeholders Interviewed

Four health care providers were selected from each of the three senatorial zones of the state based on level of care (primary/secondary) and ownership (public/private). Health care providers were selected from the available provider database for the DSCHS and only facilities that had been providing services on the scheme for at least two years were selected.

For client exit interviews, enrollees were selected across two population groups – formal and informal - to assess their level of satisfaction with the scheme. The enrollees were selected from the same health facilities for the evaluation and only enrollees who had been registered on the scheme for at least two years were interviewed for the evaluation.

2.5 Tools for Data Collection

Following the validation and finalisation of the evaluation framework with the DSCHC, data collection tools were developed for the performance evaluation. These included:

- **Quantitative data abstraction tool**: An excel-based tool was developed to abstract data across defined indicators from the DSCHC IT database and other available sources.
- **Key informant interview (KII) guides**: A semi-structured interview guide was developed for the qualitative component of the evaluation.
- **Client exit interviews**: A questionnaire was developed for client exit interviews to ascertain the enrollees satisfaction with the scheme.

The tools were developed in line with the data collection framework below:

Evaluation component	Data Source	Measurement
Data Abstraction	DSCHC/SMOH/SPHCDA	• Assess performance across key scheme functions (enrolment, service delivery etc.) • Assess impact of the scheme on utilisation of MNCH services
KII	DSCHC staff/ departmental heads	• Perspectives on the efficiency of existing operational processes, challenges,

		recommendations for improvement, insight on scale-up plans of the Commission.
	State actors	• Perspectives on the performance of the DSCHC, experience as enrollees of the scheme and recommendations for improvement.
	Providers	• Perspectives on efficiency of the scheme's operations such as accreditation/re-accreditation, enrollee management & funds disbursement as well as recommendations for improvement.
Client exit interviews	Enrollees	• Perspectives on the performance of the scheme with respect to enrolment, renewal of policies, service delivery including MNCH services and beneficiary management

Table 3: Data Collection Framework

2.6 Data Collection

Data was abstracted from various sources over a period of fourteen (14) days using the excel-based tool while KIIs and client exit interviews took place over a period of five (5) days. The data collection team worked in close collaboration with the DSCHC to schedule interviews with respondents. KIIs were conducted with staff of the DSCHC, state actors and providers using semi-structured guides that aligned with their organisations while client exit interviews were conducted with enrollees using Computer-Assisted Personal Interviewing (CAPI) through handheld devices. Data for KIIs was gathered through a well-documented meeting note and field notes were taken to highlight each day's activities and challenges. The challenges were communicated as they occurred, and recommendations were proffered in real time to ensure activities flowed as planned.

For quality assurance purposes, interviews with stakeholders were recorded with the interviewees' consent sought to ensure complete capture of relevant information. Interview notes and transcribed recordings were immediately transferred into a structured framework for ease of analysis and report writing.

2.7 Data Management & Analysis

A data analysis framework for quantitative and qualitative data was developed for data analysis by the evaluation team based on assessment questions. The data analysis approach adopted involved the following:

- **Organizing the data:** This involved review, cleaning of the data to check for correctness and completeness of collected data. Thereafter the data was collated into the respective frameworks in readiness for analysis. Members of the data analysis team read the data in its entirety to allow each team member familiarize themselves with the data.
- **Analysis of quantitative data:** An excel-based analysis framework was used to analyse quantitative data. Analysed data was then presented in graphical representation in readiness for the reporting of findings from the evaluation.
- **Analysis of qualitative data:** A thematic content analysis was conducted to draw out patterns and recurrent themes. This involved identifying sentences or paragraphs

containing aspects related to each and aligning with the evaluation's objectives. Emerging themes and subthemes were then developed and for each theme, a detailed analysis/write up was done to determine the "story" i.e., establish related themes in the data set. Variations and contradictions in the data were also investigated to further understand emerging themes.

- **Writing up the data analysis findings**: This final phase involved, putting narrative and data findings together and contextualizing the analysis in relation to the existing literature.

2.8 Evaluation Limitations

This assessment's findings were found in the light of the general limitations implicit in qualitative methodologies. These include:

- **Unavailability of and provision of inaccurate/incomplete quantitative primary data and some selected key informants** for interviewing. To mitigate these, qualitative data was leveraged to provide broader context to the available primary data.
- **Risk of researcher and respondent bias** which was mitigated by triangulating findings with some secondary data.
- **Assumption of the loss of some information** due to transcription typing errors. However, this was mitigated by cataloguing and safe storage of audio files which were reached for in the face of incomplete information within transcripts.

3.0 FINDINGS & DISCUSSION

This section of the report presents findings on the performance of the DSCHC in the implementation and management of the DSCHS. The findings will be presented across the domains of the evaluation framework - Organisational Capacity, Revenue Mobilisation, Pooling and Purchasing and highlights design aspects, progress, key achievements as well as challenges with the operationalisation of the scheme.

3.1 Organizational Capacity

A. Structure

An organisational structure can be referred to as a system that shows how an organisation should function in order to achieve the goal/mandate of the organization. A well-defined structure should therefore articulate levels of hierarchy, relationships and responsibilities, that exist across an organization as well as align with the organisation's strategic goal. The existing organisational structure of the Commission aligns with the administrative structure defined in section 12 of the law[14] establishing the DSCHC. The Commission is headed by the Director General (DG)/Chief Executive Officer (CEO) who is responsible for overseeing the general day-to-day affairs of the Commission. There are six departments comprising of the departments of Administration and Human Resources (AD & HR), Finance and Investment (F&I), Legal Services, Health Services, Standards and Quality Control (HSS&QC), Business Development and Marketing (BDM) and the Department of Planning Research and Statistics (DPRS&ICT). These departments are headed by Directors who report directly to the DG/CEO and are responsible for managing the day-to-day operations of their respective departments. The law also permits the DG to setup units under his office such as the Technical Compliance Team, the Media Unit, Protocol Unit and positions of Technical Assistants, to support the office of the DG.

Supervisory control over the activities of the Agency is vested by the law on a Governing Board comprising of stakeholders across the Government and Non-Government bodies. The board has been inaugurated and is functional with meetings held monthly to meet with the current requirements of the Commission. The availability of the defined structure could not be ascertained as the document could not be provided for sighting at the time of data collection. The structure as provided by respondents does however seem to clearly define hierarchical levels and align with the strategic goals of the Commission. Respondents did state that the ***"as-is"*** organisational structure of the Commission was adequate for current and future operations particularly as it aligned with the law which also made provision for amendments as the need arises.

> *Yes, this structure is adequate because it is expanded. The law was well thought out these six departments covers every operation of the commission so nothing new that will come that cannot fit into any of the departments and the DG has the authority to create units and sections. So, when we face new challenges, we create some structures, some sections, and some units.*
>
> *- Regulator 8*

[14] A Law to Establish the Delta State Contributory Health Commission 2015 and Other Matters Connected Thereto

The current staff comprises of civil servants deployed to the Commission by the government and external hires from the private sector. Respondents stated that roles and responsibilities of staff have been defined through job descriptions (JD) across each department. The JDs were developed at the start of the Commission and used to guide staff placement across departments. Despite the existence of departmental JDs and due to a recent re-structuring, there seems to be a lack of clarity amongst some staff on their roles and responsibilities which often overlap. A reorientation of staff should be conducted to ensure staff are clear on their assigned roles and responsibilities. There also seems to be a lack of a system for information sharing amongst departments that share similar functions.

Some staff have the requisite qualification and required experience for their positions, and budgetary provisions are made for staff development as stated by a few respondents. Staff are exposed to trainings relevant to their work conducted by professional bodies/Institutions such as Institute of Chartered Accountants of Nigeria (ICAN) for Accountants, Medical Laboratory Science Council of Nigeria (MLSCN) for Medical Laboratory Scientist and Administrative Staff College of Nigeria (ASCON) for Administrative and other Management Personnel. Internal trainings on the operations of the Commission are also frequently organised as a means of building staff capacity. The perspective on staffing adequacy was mixed amongst respondents with some stating that the available staff in their departments was adequate and others stating that while staffing was not adequate, the prospective growth in the operations of the Commission presented an opportunity for recruitment of additional personnel particularly for units like the call centre.

B. Systems

The implementation of the scheme commenced in 2017 using manual based systems for its operations. However, a transition to an IT system named the e-clinic application was made in 2018. The IT application is currently managed by a third-party vendor - Inter Switch Limited and e-Clat Healthcare - and is domiciled in the DPRS and BDM departments. In view of the Commission aiming to transition to its consolidation and sustainability phase, it is imperative that there is continuous capacity strengthening of relevant staff for the management of the IT application.

> *"we are currently having a contractor a partner managing the process per say, what we see is we can view results we cannot actually work into the system and work on the system so if we can train personal in the commission, commission staffs to handle that process it will actually be a big plus... So to translate ownership is very important"*
>
> *- Regulator 9*

The application makes provision for modules on enrolment and claims management. Resources required for the deployment of the application - desktop computers and handheld devices have been provided to providers and field agents, respectively. The application for enrolment enables validation of formal sector enrolees as well as online and offline enrolments for residents of hard-to-reach areas (hinterlands) and locations with poor internet connectivity. However, in line with NHIS information communication technology (ICT) requirements for enrolment, the existing IT application does not allow for biometric capturing although the Commission is working towards enabling this functionality. The application is also enabled to facilitate policy renewals for the informal sector through automated text messaging. Trainings on the use of the application have also been conducted for field agents and providers across the 25 LGAs.

In addition, to improve efficiency in its operations, an Enterprise Resource Planning (ERP) system has been deployed in a phased approach.

C. Processes

Standardized procedures drive business processes, enable consistency in achieving results and reduce the possibility of variations that impact on the quality of operations of an organisation. Findings from the evaluation showed that almost all (excluding ICT) of the Commission's operations including enrolment, accreditation, provider management and demand generation are carried out by designated departments rather than being outsourced to third party administrators.

Processes do exist for standard activities and departments have developed protocols that are process manuals. These protocols, however, provide information on requirements for an activity such as requirements for enrolling a prospect, and do not clearly define process steps, persons responsible and required job aids for carrying out the activity as would be laid out in a standard process manual. A few respondents stated that the Commission adopts a flexible approach in processes for activity implementation which gives room to align the process with real-time context. This approach, however, has the potential to create inconsistency and inefficiencies in processes adopted for key activities which is particularly important in light of the scale-up plans of the Commission. As such, the Commission should consider the development of standard process manuals (flowcharts) for key activities which can be reviewed periodically to ensure adaption of implementation realities.

3.2 Scheme Design and Operationalization

3.2.1 Stakeholders Perception on the Scheme's Performance

Most respondents provided positive feedback on the performance of the DSCHS. This was intricately linked to their ability to access affordable health care services when required without having to make out-of-pocket payments. A few respondents mentioned that more work needed to be done to improve the quality of services provided by empanelled health care facilities as well as expand enrolment to the informal sector.

> *"The truth is that this scheme is still better than when we were paying directly. For me, it is a bit cheaper than when we are paying from your pocket because sometimes, you will not have money and if you fall sick that period, you are at least sure of receiving some treatment."*
>
> *- Informal sector enrollee 10*

3.2.2 Resource Mobilization

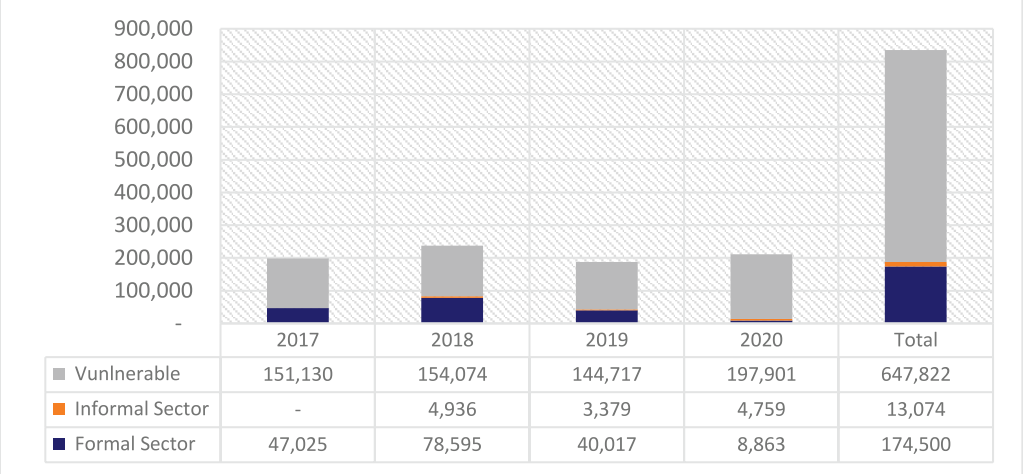
3.2.2.1 Enrolment

Enrolment into the DSCHS is mandatory for all state residents as stated in section 18(1) of the law. This is in line with best practice as mandatory enrolment enables the establishment of a risk pool that includes both healthy and unhealthy enrolees thereby avoiding the risk of adverse selection. Coverage of the DSCHS is therefore expected to include the following population groups[15]:

[15] Operational Guidelines of the Delta State Contributory Health Scheme

i. Employees in the public sector and private sector organizations with 10 employees and above;
ii. Workers in the informal sector such as artisans, self-employed, farmers, rural community dwellers etc.; and
iii. Vulnerable persons as may be defined from time to time for inclusion after approval by the State Executive Council on the recommendation of the Commission.

Since the commencement of the operationalisation of the scheme, ***835,396*** state residents had been enrolled as of 2020 representing a 20.3% population coverage rate. This is shown in figure 3 below:



	2017	2018	2019	2020	Total
Vunlnerable	151,130	154,074	144,717	197,901	647,822
Informal Sector	-	4,936	3,379	4,759	13,074
Formal Sector	47,025	78,595	40,017	8,863	174,500

Figure 3: Total number of enrollees

The vulnerable population and formal sector employees make up the majority of enrollees with the informal sector representing only 2% of total enrolments into the scheme as seen in figure 4.

While informal sector coverage is expectedly low as this is a common challenge for states that have commenced operationalisation of their scheme, the DSCHC is also yet to achieve full coverage of the formal sector and there was a significant decline in enrolments in 2020 as shown in figure 3. The low population coverage levels can be linked to the attitude of residents and the adequacy of processes that exist for enrolment – particularly for the informal sector as stated by respondents.

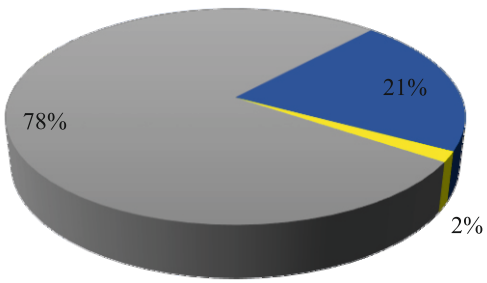


Figure 4: Total enrollees per population group

For the public formal sector, enrolment into the scheme is automatic with the civil servants required to visit the offices of the Commission which are located across the 25 LGAs of the state to complete the enrolment process. In the case of the paying informal sector, residents can register through the one hundred and seven (107) field agents that have been recruited and deployed to the communities by the Commission (as at the end of 2020). The Commission also has an online registration portal "DSCHC" hosted on Google Play Store for online self-registration, HCF selection and Premium Payment.

Individuals interested in registering can also either make premium payments through the designated bank or pay cash directly to the agents. For bank payments, residents are required to visit an agent to complete the enrolment process. Prior to the Covid-19 pandemic, the bank had been designated as an enrolment centre however this had to be discontinued to enable the adherence to the state's Covid-19 protocols. Automated reminders for policy renewals are sent to enrollees at least 2 months before the expiration of an existing policy. Enrollees interested in renewing their policy are required to visit the designated bank or locate a field agent to pay the premium while the Commission receives an automatic notification of payment. Enrollees who do not renew their policy on expiration are delisted from the enrolment register. The Commission is directly responsible for group enrolments. Premium payments have been linked to levies paid by members of informal sector groups.

Enrolment of the vulnerable persons (pregnant women and children under 5) into the equity plan of the scheme is also conducted by the field agents using a door-to-door and facility-based approach. The unavailability of an accurate database and unwillingness of the target population to pre-register until services are needed are key challenges that have been encountered. These challenges resulted in the use of a manual system for enrolment and fee-for-service as a payment mechanism rather than Capitation. To address the challenges, the Commission has transitioned enrolment to an electronic platform, provided the facilities with required tools for enrolment (computers) and trained them on their use and instituted a time-based enrolment approach. This is to enable the creation of a reliable database that can be leveraged for a transition to a Capitation payment system as a cost control mechanism. In view of scaling-up access to the vulnerable population, the Commission intends to integrate the equity plan with the BHCPF. There is however no reliable database for the vulnerable population in the state and the Commission is planning to conduct a re-validation of the state's existing social register to create the database.

The Commission has ensured that the field agents have tools required to carry-out their roles through the provision of hand-held devices that have a modified version of the e-clinic suites application pre-installed on them. The application allows for online and offline enrolments which are necessary for the hard-to-reach areas with internet connectivity challenges. To track performance of the agents, senatorial and LGA coordinators have been assigned the responsibility of reporting on the activities of the field agents.

Respondents from the formal sector stated that they found the enrolment process easy due to lack of queues experienced during validation exercises. However, challenges with formal sector enrolment/validation have included apathy towards the scheme despite deductions from salary, low perception of service quality available in empanelled health facilities (unavailability of 24/7 health services, health workers attitude etc.) and existing mistrust in the system due to experience with the failed contributory pension scheme in the state. Factors that have influenced the low enrolment rate for the informal sector are more peculiar. The opinion amongst informal sector respondents on reasons for low enrolment was mixed with some stating that they found the enrolment process easy while a few others mentioned the process and length of time it had taken to complete enrolment as well as collect ID cards from designated LGAs as challenges. Despite the adoption of different approaches to addressing the complex issue of providing health coverage to the informal sector, successfully reaching the non-poor within this sector remains a challenge in many countries. Some of the reasons for this have included – the difficulty in identification and enrolment due to the huge amount of diversity of this population that makes it administratively difficult to reach them. For the DSCHC, additional challenges have included religious and cultural beliefs, lack of financial capacity to pay, perception on quality-of-service delivery, mistrust of field agents and poor attitude of the field agents & providers, and insufficient enrolment mechanisms. Furthermore, there are consistent challenges with the capturing of inaccurate data by agents, despite the existence of senatorial and LGA coordinators to report on the activities of the field agents.

> *"No it was easy, it was actually easy, actually it was indeed very easy as at the time we did the enrolment…. not like go and come go and come, I did everything…. the whole thing they asked me to provide and immediately they were done within an hour or so. It didn't take any stress to get through all the processes as at that time."*
>
> *- Formal sector enrollee 7*

> *"for the informal sector the challenge with the enrolment we are having I will say first is beliefs system. People are saying why should I register are you saying I will fall sick, Its not my portion. Then two, also financial issues then lastly those that are already accessing care their perception and feedback also affect to a large extent people that have not registered to register into the scheme".*
>
> *- Regulator 2*
>
> *"Some people don't want to go to the bank, you will see process that their data is already in our data base, for months or years, let me not say years, but for months and they will not make payment because they can't find out time to go to the bank and they did not trust the person that, or interested in giving their money to an individual they do not know".*
>
> *- Regulator 4*

To address challenges with formal sector enrolment, an additional enrolment centre has been set-up in Asaba and a labour committee has been set-up to enable frequent sensitization on the scheme to formal sector employees. There have also been attempts to enforce formal sector enrolment by linking ownership of indentity cards (ID) cards to eligibility for official attendance – results of this could not however be ascertained. To increase informal sector coverage, the Commission is considering adopting a door-to-door approach as well as increase the number of field agents for enrolment. In addition to these interventions, the DSCHS should also consider expanding the use of enrolment enhancing interventions such as the current use of the self-enrolment and agent tracking applications, adopting phased premium payment to tackle the challenge of financial

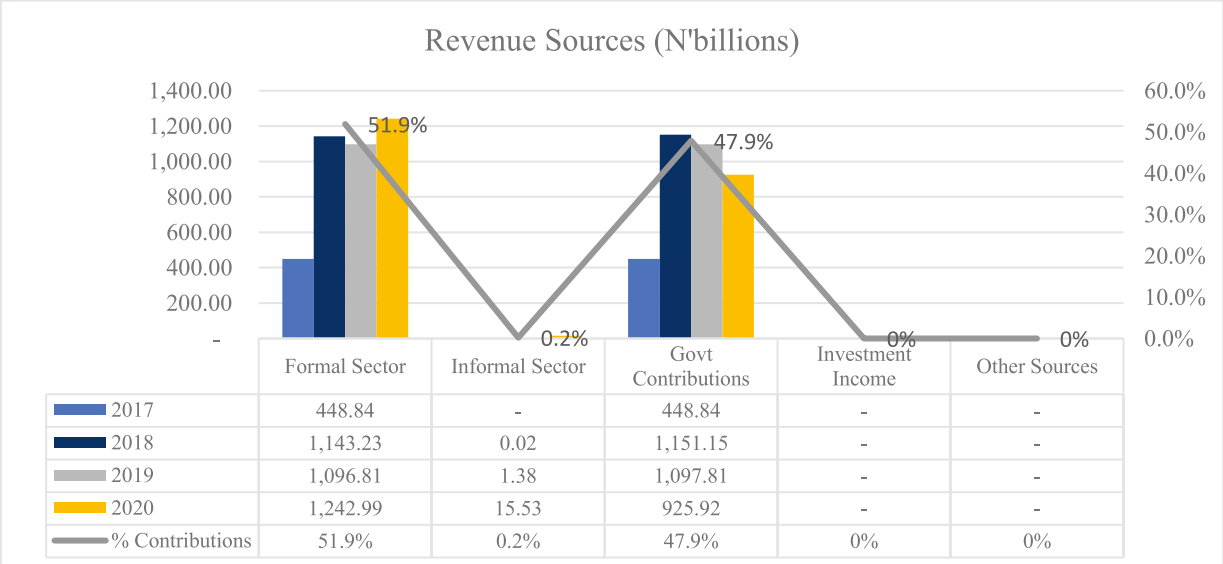
capacity to pay and deploying context specific strategies for group enrolment & premium collection. In addition, periodic training for field agents should be conducted.

3.2.2.2 Contributions

The key sources of revenue for the DSCHS as articulated in the DSCHC legal framework include the following[11]:

- Contributions from the earnings of public sector and earmarked general government contributions for the public formal sector.
- Earmarked government contributions for the vulnerable population.
- Contributions from the earnings of organized private sector (OPS) employees.
- Contributions from income earned by the non-poor informal sector.

Over the last four years of operationalisation, the revenue sources for the scheme have included: (i) equity fund contribution of not less than 0.5% of the consolidated revenue of the State Government on behalf of vulnerable persons (ii) monthly deductions of 1.75% gross salary of formal public sector and government subsidy of 1.75% (iii) annual premium payment of N7,000 premium by the none-poor informal sector and (iv) periodic contributions by philanthropists for the vulnerable within communities. Premium payments by the public formal sector & government contributions for the vulnerable population being the main source of funding for the DSCHS as seen in figure 5 below:



	Formal Sector	Informal Sector	Govt Contributions	Investment Income	Other Sources
2017	448.84	-	448.84	-	-
2018	1,143.23	0.02	1,151.15	-	-
2019	1,096.81	1.38	1,097.81	-	-
2020	1,242.99	15.53	925.92	-	-
% Contributions	51.9%	0.2%	47.9%	0%	0%

Figure 5: Contributions for the DSCHC

The release of contributions by the government have been consistent and this is largely due to the political will of the current administration which has health as one its top policy agenda for all Deltans. Owing to challenges with informal sector enrolment, contributions from the sector has been low at 0.2%. Evidence has shown that progress towards the two indicators central to UHC - population and service coverage requires health systems to

> *"it has to do with the governor, his political will, without it, every other thing is zero, so that we had access to the fund, we had access to everything is his political will."*
> *- Regulator 1*

be funded predominantly by public sources i.e., compulsory government revenues and pre-paid payments by the formal and informal sector. Direct contributions for health coverage, such as payroll taxes for health insurance, will not generate sizable revenues given the very narrow levy base in low- and middle-income countries[16]. As such, while government contributions & formal sector premium payments have been consistent it is imperative that the DSCHC develop strategies that facilitate the expansion of resource mobilisation options in its scale-up plans. The strategies could include – (i) introducing a government subsidy for the informal sector to encourage premium payments - given the limited fiscal space of most states in the country, the subsidy could be funded through an earmarked revenue source (ii) generating data on the informal sector to improve public financial management (PFM) systems (tax administration) and enable effective targeting of the informal sector (iii) instituting mechanisms to enforce mandatory enrolment into the scheme which is backed by the law, (iv) leveraging the private sector organisations to raise additional revenue and (v) activating other funding sources provided for in the DSCHC law. Efforts must also be made to address issues with the quality-of-service delivery which is a key contributing factor to reluctance/apathy towards enrolment.

3.2.2.3 Demand Generation

Available evidence shows a strong relationship between awareness and participation in a health insurance scheme[17]. To create awareness of and demand for the DSCHS, the Commission has leveraged several mediums including the conduct of road shows & town hall meetings, advocacy to informal sector groups, religious/community leaders, as well as the use of traditional (radio/TV shows) and new media (social media). Partnerships with relevant government ministries & parastatals - Bureau of Public Orientation, Ministry of Information's and several Civil Society Organisations have also been utilised for the implementation of demand generation activities. In addition, the informal sector field agents are tasked with the responsibility of carrying-out advocacy and sensitisation activities within the communities.

[16] Jowett M, Kutzin K. Raising Revenue for Health in Support of UHC: Strategic Issues for Policy Makers. World Health Organization; 2015.
[17] David Ayobami Adewole et al (2017). Expanding Health Insurance Scheme in the Informal Sector in Nigeria. Awareness as a Potential Demand-Side Tool. The Pan African Medical Journal - ISSN 1937-8688

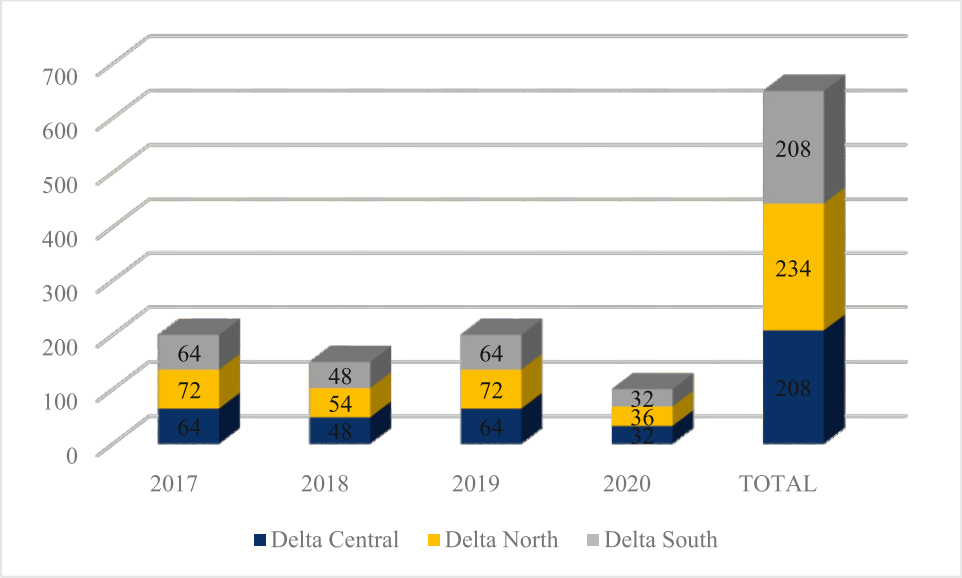


Figure 6: Total demand generation activities conducted

Findings from the evaluation show that the Commission successfully implemented all demand generation (DG) activities that were planned over the evaluation period as shown in figure 6. Most of the planned DG activities were conducted in the Delta North senatorial zone, and this seems to have impacted the high enrolment rates in the senatorial zone over the other two zones.

Majority of respondents noted that despite all these activities, knowledge and awareness of the DSCHS is still low particularly amongst the informal sector. Challenges that have affected the impact of activities include the inadequate penetration of demand generation interventions and waning interest of the public due to negative word-of-mouth on the quality of services available in empanelled health facilities. In addition, the Commission is yet to conduct an evaluation of the communications and demand generation strategy to inform an updated implementation of targeted demand generation activities. To improve awareness and drive uptake of the DSCHS particularly amongst the informal sector, respondents recommended that the DSCHC employ the use of relevant channels such as mass media, radio jingles, social media and leverage on existing platforms at the informal and grass-root level such as the ward & facility health committees and community influencers/gate keepers in the communities. However, targeting enrollees with adequate information and using

> *"Personally, I feel we are not doing enough in media. Since I came here, we have not had a sustainable program or let us use this program to inform people. Personally, when I discuss with people they don't even know about the scheme (low level of awareness) that is the real concern here, so we are not doing enough to let the people know."*
>
> *- Policy Maker 2*

> *"..and what we noticed is that, each time we do it (advocacy and sensitisation), there is an interest, overtime the interest goes down, so that is how we started realizing what was happening and it was just through the fact that the people who go to the facility they don't get care so they become your negative advocate, they will come and say, no go there, see as them dey do, so that was what we felt before we do any further thing, let's make sure the facilities are providing quality care, because if you don't do that, for every advocacy you do it's a waste of money".*
>
> *- Regulator 1*

target group demography in planning for and designing demand generation activities, can enable an increase in awareness and uptake of health insurance schemes. Thus, to ensure the effectiveness of communication channels as well as enable targeted DG activities, review of the current demand generation and communication strategy articulating contextual approaches and messaging per population segment (knowledge of behaviour, cultural/religious norms and perspectives on available health care etc) should be conducted by the Commission.

3.2.2.4 Beneficiary Management

Improving transparency and accountability amongst stakeholders is an important health systems objective. It is therefore imperative for enrollees to have access to information on the scheme as well as an avenue to provide feedback on the scheme's operations to enable performance improvement. The management of enrollees of the DSCHS is the primary responsibility of the department of BDM through its call centre. There is a dedicated phone line for communications with enrollees, including receiving and resolving complaints. Mechanisms used for addressing beneficiary complaints differ based on the nature of the complaints. Departmental heads and other top management staff also function as call agents to provide top level beneficiary management support. Data provided by the DSCHC shows 100% performance on enrollee complaints resolution. A few enrollees stated that they had never been contacted by the Commission for feedback while a few others stated that feedback on logged complaints was never received and that they had no clarity on channels for communicating challenges to the DSCHC. The dedicated phone was reported to be overburdened and there are no documented processes for the institutionalisation of mechanisms for beneficiary complaints & feedback management.

> *"Yes, I wanted to last year (to log a complaint), but I didn't get that opportunity. i have demanded to know what this package really covers so i can be better prepared when coming to the hospital. It was not resolved and i still don't know the services that the package covers."*
>
> *- Informal sector enrollee 10*

3.2.3 Pooling

As one of the sub-functions of health financing, pooling aims to promote equitable access to health care by accumulating financial resources for health into a single pool or cross-subsidizing available funds among various population groups. Critical decisions that enable effective pooling arrangements include decisions on where funds will be pooled, responsibility for pool management and utilisation of pooled funds in a manner that promotes equitable access. This section of the report provides details on the pooling and fund management arrangements for the DSCHS:

3.2.3.1 Pooling Arrangements

UHC requires the establishment or expansion of a pool of finance with which to fund the health services to be made available[18]. In line with leading practice, the maintenance of single pools is often promoted because it enables cross-subsidization and equitable access to service and financial coverage across all population groups.

The mandatory nature of the DSCHS is geared to ensure the availability of health care for the various population groups through the pooling of resources for the scheme into the Delta State

[18] Amanda Glassman, Ursula Giedion, Yuna Sakuma & Peter C. Smith (2016) Defining a Health Benefits Package: What Are the Nec essary Processes?, Health Systems & Reform, 2:1, 39-50, DOI: 10.1080/23288604.2016.1124171

Contributory Health Fund. Under the current pooling design, accumulated funds are warehoused in a designated bank in which separate accounts are maintained for contributions by the formal, informal sector and vulnerable population. The central objective of pooling is to maximize redistributive capacity by de-linking contributions, such as taxes or insurance premiums, from a person's health status or health risks.

3.2.3.2 Fund Management

Pooled funds are currently managed by the F&I department which aligns with the provisions of the DSCHC law. According to respondents, processes have been defined for expenditure management in line with the government's general procedures for Ministries, Departments and Agencies. SOPs for general financial processes such as budgeting, revenue and expenditure management, reconciliation and reporting are however yet to be developed.

Internal controls have also been put in place for all expenditures by ensuring that all expenditures are approved by the DG/CEO before payments are processed. The Commission does comply with provisions of the law on the conduct of independent annual audits which are submitted to the Office of the Accountant General. The DSCHC law provides for ring-fencing of the pooled funds and as such only the Board approves the utilization of the funds.

3.2.4 Purchasing

Purchasing is a core health financing function that refers to the allocation of pooled funds to public and private health care providers for the health services they provide. There is a growing consensus that purchasing of health services must be more active or strategic if countries are to make progress towards UHC[19]. This means that payments made to provides must be linked to their performance to incentivize them to provide quality health services. Core areas of strategic purchasing that should be aligned include - specification of services and interventions ("what to buy"), choice of providers ("from whom to buy"); and design of financial and non-financial incentives ("how to buy") – this refers to provider payment mechanisms and contractual arrangements[16]. This section will provide information on significant progress that have been made by the DSCHC to make purchasing of health services more active across each of these core areas to achieve expected outcomes of improved service coverage & quality of care:

3.2.4.1 Benefit Package

A major policy focus in moving toward UHC has been on which services should be made available to the population and the conditions under which the services should be provided[15]. The legal framework and operational guideline for the DSCHS make provision for four health plans namely; (1) the formal sector health plan which is a contributory plan for all public-sector and organized private sector employees (2) the informal sector plan which is accessible to all residents not covered by the other health plans (3) the equity health plan which has been integrated with the state's free MNCH programme for coverage of the vulnerable population and (4) the private health

[19] Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing of health services for universal health coverage: How to make it more strategic? Policy Brief, Department of Health Systems Governance and Financing, Geneva: World Health Organization; 2019 (WHO/UHC/HGF/PolicyBrief/19.6). Licence: CC BY-NCSA 3.0 IGO.

plan comprising of a variety of packages aimed at providing services not covered by the scheme to contributors[12].

Policy on benefit design, as with all health financing policy, should be guided by health system goals and objectives ultimately contributing to improvements in population health status and reduced inequities in the distribution of health[20]. As such, for the operationalisation of the DSCHS, the Commission has designed a comprehensive benefit package comprising of preventive and curative health services (including selected maternal and new-born child health services - MNCH) that are accessible by all enrollees at primary and secondary health care facilities. In designing the benefit package, the prevailing disease burden and morbidity in Delta was taken into consideration and an actuarial analysis was conducted to ascertain the cost of the health benefit package (HBP). The existing benefit package therefore has the potential to improve the health indices of the state and enables equity in access to health services as all enrollees can access the same health services regardless of premium amount paid for the scheme. Furthermore, as a cost control mechanism, enrollees are required to first seek care at the primary health facilities and are not required to pay user fees to access services. Majority of the respondents stated that the benefit package was adequate for meeting their health needs and the most frequently utilised services mentioned included MNCH, malaria, and typhoid services. A few respondents were however of the opinion that the HBP could be expanded to include some required services such as x-rays, diabetes, fibroid and physiotherapy. On further review, we observed that the health benefit package includes x-rays, diabetes, fibroid and physiotherapy for secondary care inferring a possible gap in referring enrolees from primary to secondary healthcare.

> *"Yes, I think so, I think it is meeting my health needs and that of my family. Because whenever, we are sick, when we come here, the drug they will give us will heal our sickness. So to me it is okay."*
>
> *- Informal sector enrollee 8*

However, there seems to be a lack of clarity on the scope of services amongst providers and enrollees, given the frequent requests for provision of services not covered on the scheme. This often creates the impression that the facilities do not want to provide services for which they are paid. A prerequisite for benefit design to be effective is that people clearly understand the services and products they are entitled to, as well as any conditions of access[16]. Thus, to address this challenge, respondents recommended the organisation of sessions with enrollees & providers to sensitise them on the scope of the HBP. In addition, as the Commission plans to scale-up its operations, consideration should be given for the update of the benefit package as new evidence becomes available and as societal preferences change. In doing this however, the available resources and supply-side readiness across the state must be taken into consideration to guide decisions on expansion of the HBP.

> *"The enrolees need to be enlightened more because some believe that all the health services are covered and that unbranded drugs given to them are of less quality."*
>
> *- Provider 4*

[20] M. Jowett, J. Kutzin et al. Benefit Design: The perspectives from health financing policy. WHO Health Financing Policy Brief No. 7. World Health Organization: Geneva, Switzerland

3.2.4.2 Purchasing Arrangements (Provider Payment Mechanisms)

Providers are paid or reimbursed for services provided to enrollees through a hybrid of capitation and fee-for service payment mechanisms. Capitation is paid for primary healthcare and fee-for-service (FFS) for secondary healthcare services. Primary healthcare facilities that can provide secondary health care services are however, also reimbursed through FFS for such services. The payment to healthcare providers is managed directly by the DSCHC through the BDM & F&I departments.

The ways in which resources flow to providers—provider payment mechanisms (PPM)—create incentives that influence the providers' behaviour, thereby affecting system efficiency and equity. While financial incentives are not the only factor in provider behaviour, they are important and often problematic[21]. To address this potential situation, a mechanism that requires pre-authorization for all referrals from services that are covered under capitation to those covered by FFS has been put in place by the Commission. In addition, claims vetting for FFS is also used to check abuse. This involves the review of submitted claims to check for adherence to clinical protocols and tariffs.

Respondents expressed satisfaction with both payment systems however, concerns were raised over the low rates for capitation and fee-for-service. This perception seems to influence the quality of services provided by facilities as some respondents reported cases of long waiting time and purchase of drugs through out-of-pocket payments from outside the facility. Furthermore, providers may have this view of inadequacy in payment rates due to low understanding of the business of health insurance. Recommendations made by respondents to improve the situation included an upward review of rates to reflect changes in the economic situation of the country as well as enable them provide quality health care services to enrollees on the scheme.

3.2.4.3 Provider Management

Accreditation and Empanelment

Accreditation, which is a process of evaluating healthcare providers to ascertain their ability to meet defined quality standards[22], is a key instrument of strategic purchasing. Under the DSCHS, services are purchased from public and private health facilities. The Commission has defined the criteria and developed a checklist for the accreditation of health care facilities. At the commencement of the scheme, all public health care facilities were automatically enlisted while an accreditation exercise was conducted for private facilities that expressed interest in participating in the scheme.

Over the four-year evaluation period, the number of health facilities accredited and empanelled by the Commission has progressively increased totalling four hundred and eighty-nine (489) health care facilities of the eight hundred and three (803) health facilities in the state – 61% accreditation

[21] Financing for Universal Health Coverage: Dos and Don'ts. Health Financing Guidance Note No. 9. World Health Organization 2019.

[22] Velasco-Garrido, M., et al., Purchasing for quality of care, in Purchasing to improve health systems performance J. Figueras, R. Robinson, and E. Jakubowski, Editors. 2005, Open University Press Berkshire, England

rate. This comprises of seventy-nine (79) private health care facilities and four hundred and ten (410) public health care facilities as shown in figure 7 below:

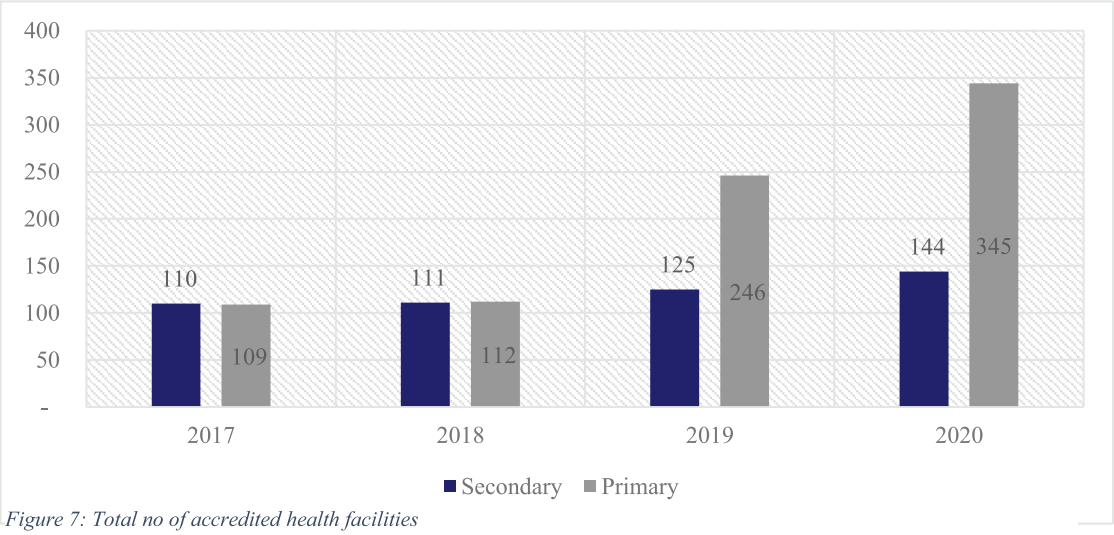


Figure 7: Total no of accredited health facilities

Majority of the accredited health care facilities (three hundred & forty-four – 345) are located at the primary health care level as shown in figure 8 below. This enables the Commission's approach of using the primary health care as a point of entry into the scheme in a bid to strengthen the health system.

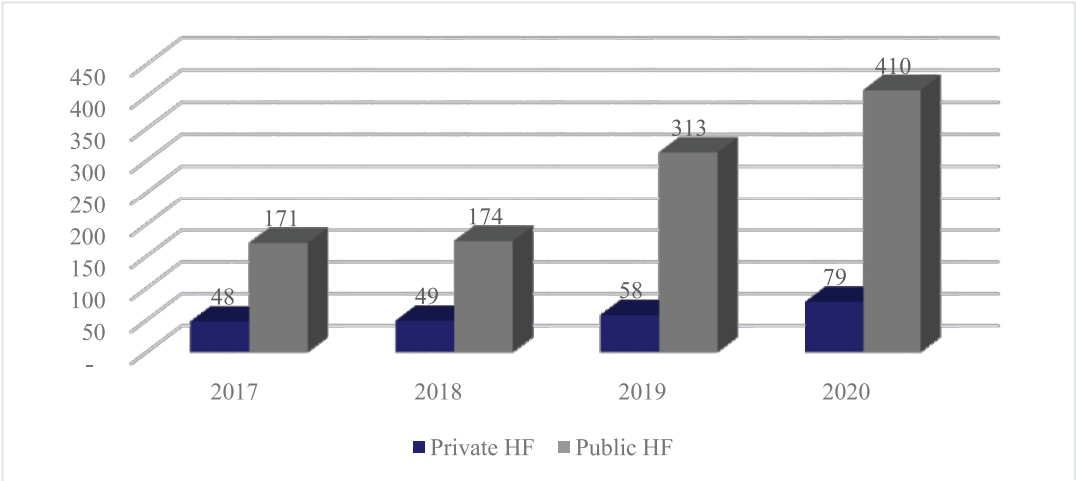


Figure 8: Accredited health facilities per level of care

Due to inadequate availability of sufficient capacitated health care facilities across the senatorial zones, some facilities were accredited to provide both primary and secondary healthcare facilities. Delta central senatorial zone has the highest number of accredited health facilities (171) while Delta South has the lowest (150) as shown in figure 9. Data on the spread of the health facilities across wards which is also necessary to ascertain the level of access & service coverage, could not be provided at the time of data collection. Contracts detailing the terms of engagement are signed with all health facilities and lives are allocated to complete the accreditation and empanelment process. These contracts which serve as an opportunity to enable strategic purchasing do not however, articulate terms for quality improvement and performance management.

> *"some facilities can be accredited to both primary and secondary depending on infrastructure and resources. Because for you to get accreditation there are certain you can need to met. So, one facility can have both primary and secondary accreditation from the one facility."*
>
> *- Regulator 9*

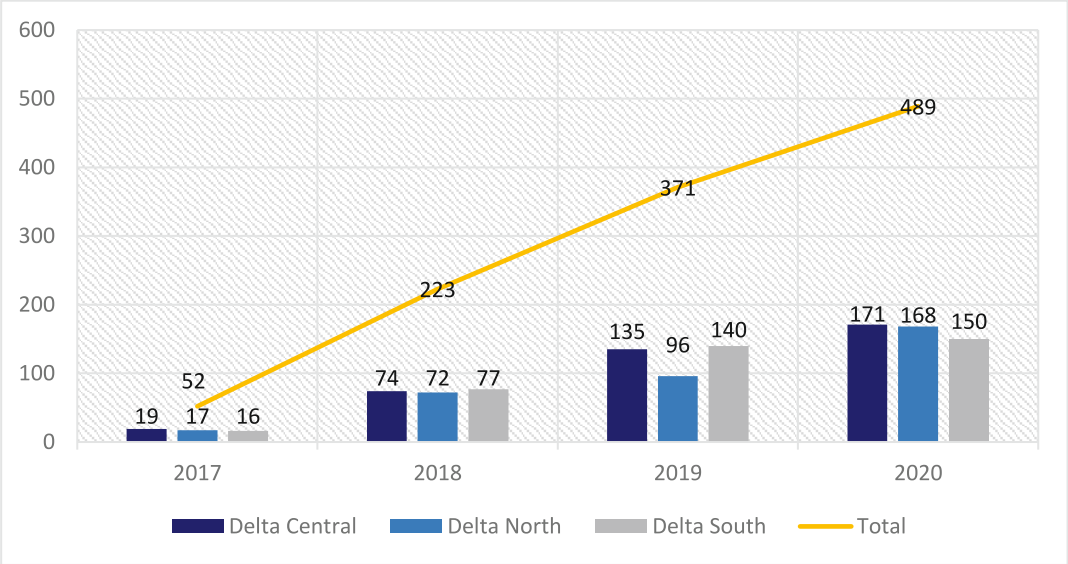


Figure 9: Total no. of health facilities across senatorial zones

Majority of the lives - *227,045* - are allocated to public health care facilities.

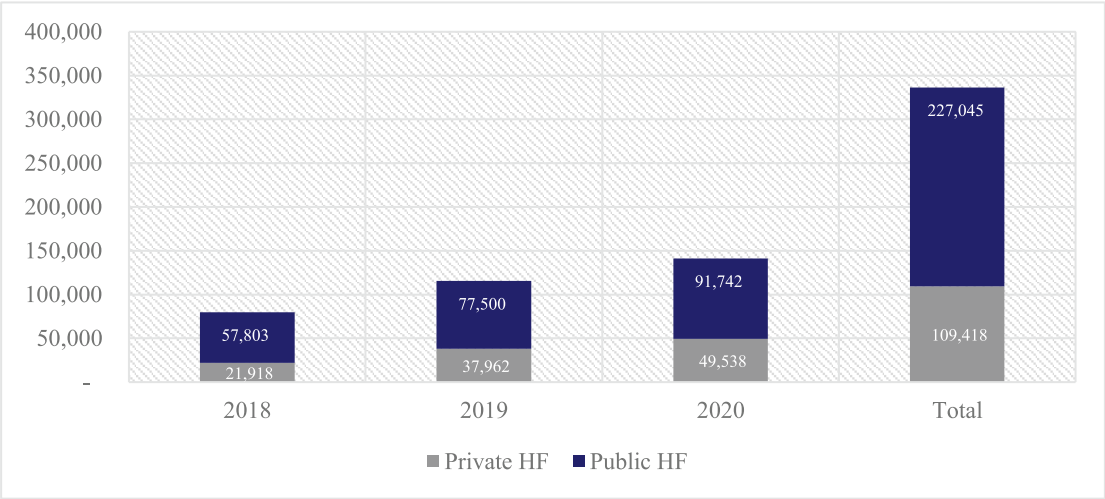


Figure 10: Total allocated lives per facility ownership

However, at the level of care, secondary health facilities have more assigned lives than the primary health care facilities as shown in figure 11 below. This could be attributed to the perception of inadequate capacity of primary health care facilities to deliver quality healthcare services which may have influenced the choice of health facilities by enrollees at the point of enrolment.

Owing to the feedback on the quality of care provided at health care facilities, the Commission is currently conducting a re-accreditation exercise of facilities that were automatically empanelled. The exercise is being led by the Health Services, Standards and Quality Control (HSS&QC) department. The results of the exercise will be used to inform the re-issuance of accreditation licenses to successful health care facilities. The Commission can use this as an opportunity to review its contracting process to enable the linkage of financial incentives to payments to influence provider behaviour for the delivery of quality healthcare services. This is because contracting is a key

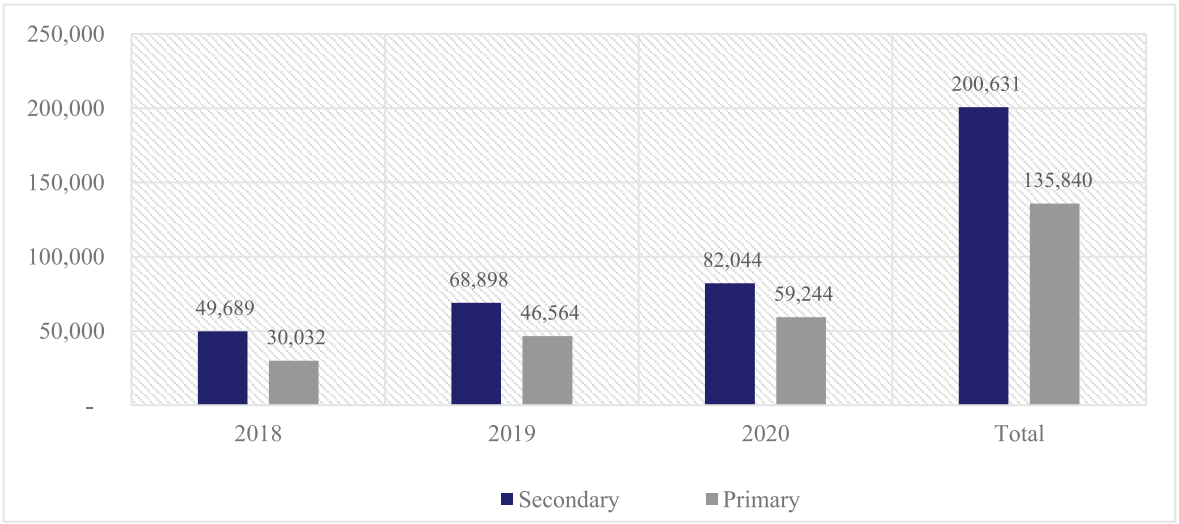


Figure 11: Total assigned lives per level of care

policy instrument for strategic purchasing and effective payment systems by putting greater focus on the achievement of measurable results[23].

Claims Management

The responsibility for managing claims lies with the BDM department. A defined process for claims management exists however, this was not backed up by any documented evidence such as an SOP. The Commission has developed tariffs for services and drugs which has been reviewed upward once. The upward review has led to a reduction in the number of complaints from the facilities regarding the tariff as stated by a respondent. However, this conflicts with feedback provided by facilities as most of them did complain about the low tariffs and called for a further upward review.

The claims management process has been digitized and health care facilities have been provided with requisite tools to facilitate the transition to the IT-based system. Claims are to be submitted by facilities on the 14th of every new month following which a review is conducted by the Commission to ensure adherence to treatment protocol and set tariffs. Approved claims are then submitted to the DG for approval before they are transferred to the F&I department for processing. The Commission also recently commenced the process of inviting providers that have issues with submitted claims for discussions. The claims process usually takes an average of 6 months based on data provided by the Commission. These delays are largely due to wrong entries made during claims filing by the providers, these errors lead to iterations that take up time. Respondents mentioned that roles are clearly delineated, and each staff understands their duties as regards to claims processing.

Over the last four years of operationalisation, a total of *1,277,188* number of claims that have been submitted by health facilities. Facilities in Delta Central and Delta North senatorial zones had the highest number of submitted claims, while Delta South has the lowest over the four-year period as shown in figure 12 below:

[23] Mathauer I, Dale E, Jowe M, Kutzin J. Purchasing of health services for universal health coverage: How to make it more strategic? Policy Brief, Department of Health Systems Governance and Financing, Geneva: World Health Organization; 2019 (WHO/UHC/HGF/Policy Brief/19.6). Licence: CC BY-NCSA 3.0 IGO.

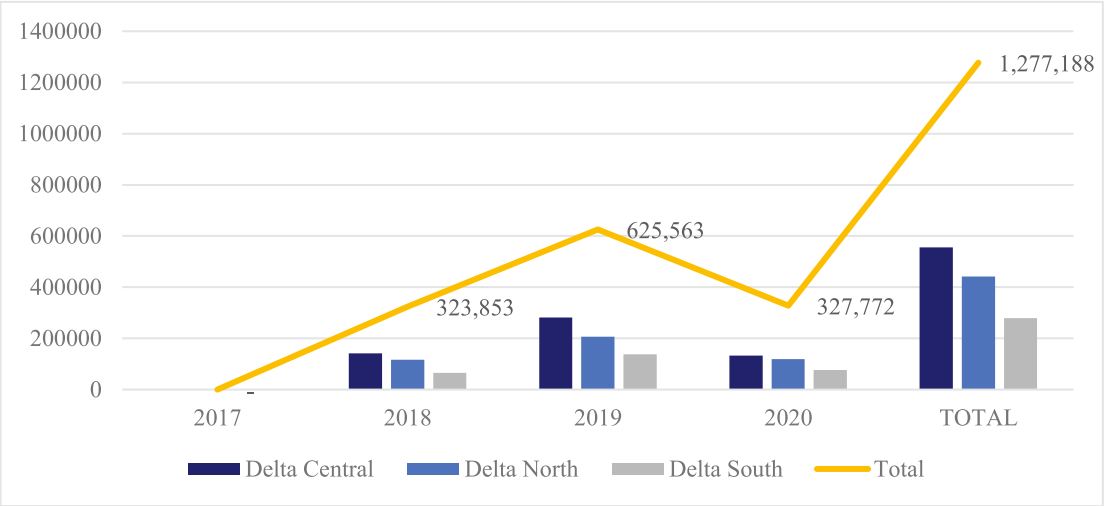


Figure 12: Number of Claims procured in 3-senatorial zones

There was however a general decline in the total number of claims submitted in 2020 which could be attributed to the impact of the COVID-19 pandemic on the use of essential services. This was however not further investigated because it was not within the scope of assignment for the evaluation.

Challenges identified with claims management include lack of adherence to treatment guidelines by the providers, inability of the providers to meet up with the deadlines for claims submission, poor data quality and low capacity of the providers to navigate the IT software. Majority of respondents also mentioned the delay in the payment of claims and the absence of a functional feedback mechanism to providers on issues with submitted claims as major challenges.

> *Documentation is very important in everything,... some of them are interested in the electronic process…. Most of their claim forms lacks the vital details, sometimes you have to cancel all their bills, not because they didn't answer those questions but because they did not keep it straight. When you didn't take your time to process your bills and you realize oh, I was shortpaid or ….they will come back and ... some will come back and some will not back..*
>
> *- Regulator 3*

A key requirement for providers to function appropriately, is the availability of sufficient capacity, else the quality of care will suffer eventually[24]. Also, to enable efficient strategic purchasing, it is critical to include the right incentives by instituting a functional system to enhance the provider payments and this can be done through the provision of an active response feedback mechanism and capacity strengthening. Therefore, to address challenges with claims management, the Commission should consider the institutionalisation of a feedback mechanism that enables the provision of feedback to the providers on the issues with submitted claims in a timely manner. Other recommendations as proffered by respondents included –

[24] Barroy, H., E. Dale, and S. Sparkes, Budget matters for health: key formulation and classification on issues, in WHO Policy brief. 2018: Geneva.

continuous capacity building on the claims management process and use of the IT software to address issues with data quality and the review of timelines for the claims cycle to enable timely payments and avoid disruptions to service provision.

Quality Assurance

To achieve strategic purchasing, appropriate measures for performance monitoring should be established to ensure provision of quality services. Provider performance monitoring is a routine process of ensuring that the standard of care is maintained in service delivery.

A key responsibility of accredited health care facilities (HCFs) is to ensure the provision of quality healthcare services to enrolees of the Scheme. One way of ensuring adherence to quality standards of the DSCHC, is the conduct of regular unscheduled monitoring visit to HCFs which should be led by the HSS&QC department. This layer of quality assurance should be accompanied by sanctions as stipulated in the law for HCFs that operate below expected quality service standards. Findings from the evaluation, showed that the Commission has no articulated procedures for monitoring and applying sanctions to erring HCFs. In addition, while infrequent monitoring visits were conducted mostly on a need basis, sanctions were not levied and there is no mechanism for follow-up to ensure implementation of feedback to erring HCFs. Some of the providers expressed their satisfaction with the current monitoring process and this may be due to the irregularity of monitoring visits and non-application of sanctions by the Commission.

> *Unless when they come for re-accreditation of the facilities, but also sometimes they come on their own. But there is no regular visitations. They have suggestion box but people hardly use suggestion now our days.*
>
> *- Provider 1*

The evaluation also assessed the HCF's adherence to treatment protocol which is a crucial parameter in ascertaining the delivery of quality health services. Findings show that the Commission is yet to develop a treatment protocol and as such, the claims vetting process is leveraged to review adherence to protocol for treatment. Based on this, majority of accredited empanelled health care facilities were deemed to adhere to the treatment protocol according to some respondents. This however contradicts with statements from a few respondents on significant issues with non-adherence to treatment which often leads to adjustments of submitted claims.

To further review quality standards, the trend in request for facility change was assessed. Findings show that the percentage of enrollees requesting for a change of healthcare provider during the evaluation period was not significant averaging 1.5% over the evaluation period as shown in figure 13. This could be attributed to a possible improvement in the quality of care resulting in fewer enrolees requesting for change in provider or low knowledge on how such requests can be made since service quality was a significant issue raised by respondents.

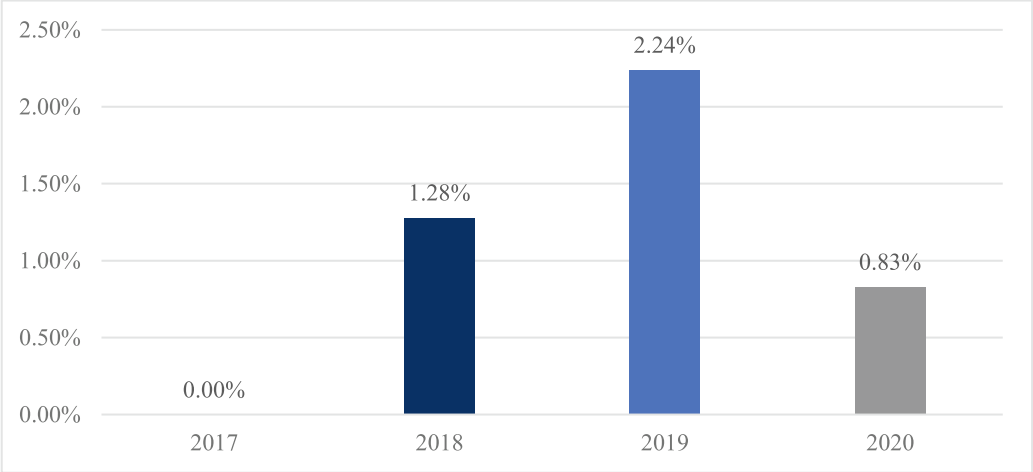


Figure 13: Percentage of enrollees requesting for a facility change

To improve performance monitoring mechanisms and adherence to quality standards by providers, the commission should institute effective mechanisms for performance monitoring. Communication channels with providers should also be established for the effective resolution of complaints and efforts should be made for continuous capacity building measures for DSCHC staff and healthcare providers on service quality and operational requirements.

Stakeholder Satisfaction with Service Quality

Satisfaction of stakeholders with service delivery was also assessed for the performance evaluation. Enrollee satisfaction was assessed in terms of quality of drugs received, waiting time and availability of services that met their health needs. Findings showed that some of the respondents expressed satisfaction with the quality of service received across these parameters. However, challenges mentioned by majority of the respondents include - unavailability of some services not covered in the health benefit package (HBP), cases of external purchase of drugs based on instructions by healthcare providers and poor attitude of health workers. On the side of the healthcare providers, common challenges mentioned included delays in the provision of monthly enrollee lists which often causes disruption in the provision of services to enrollees and absence of channels for complaint resolution.

Majority of respondents also stated that the low quality of services provided by health facilities was a major challenge that impacted on willingness of state residents to enrol on the scheme. Key contributing factors that affect the general service quality within the state as noted by respondents include – inadequate personnel, poor infrastructure, and poor attitude of health workers. The government has made efforts to address some of these challenges through the recruitment of over 200 community midwives and approval of funds for renovation of 166 primary health care centres. This is in a bid to enable the PHCs meet the quality standards of the DSCHC. The Commission is also collaborating with the private sector to improve the functionality of primary health care

> *"some of the Health Facilities (HFs) may not have the requisite number of health workers and some of them the infrastructure may not be as we really want it to be to deliver the quality services we are planning"*
>
> *- Policy maker 1*

centres through the Access to Finance Scheme in a bid to increase the spread and quality of service delivery.

3.2.4.4 Service Utilization (MNCH)

Maternal, new-born and child health (MNCH) indices for Delta have been marginally low but better than national averages. Survey data show a coverage rate of 57% for ante-natal care visits and 43% proportion of births were assisted by skilled birth attendants (SBAs) as at 2018[25]. To increase access to basic health services for women and children, the Delta state government established the Free Maternal and Free Under-Five Programmes. Both programmes were integrated into the DSCHS as a means of institutionalizing and enabling effectiveness of the implementation of the programmes. Thus, to gain insight on the utilisation of maternal, new-born and child health (MNCH) services and the impact of the integration on utilisation, the four-year trend in administrative data on ANC coverage (completion of 4 focused visits) and deliveries by skilled birth attendants (SBAs) across the senatorial zones were assessed.

Findings of the evaluation showed that majority of the LGAs had good ANC coverage. However, some LGAs including Sapele, and Isoko South had low ANC uptake. There was a decline in utilization of ANC services across all LGAs due to challenges from the Covid-19 pandemic and consequent lockdown which restricted the movement of individuals and a closure of most healthcare facilities. Ascertaining the reason for the decline was not within the scope of the evaluation thus, there may be a need for further investigation. Figure 15 below illustrates this finding:

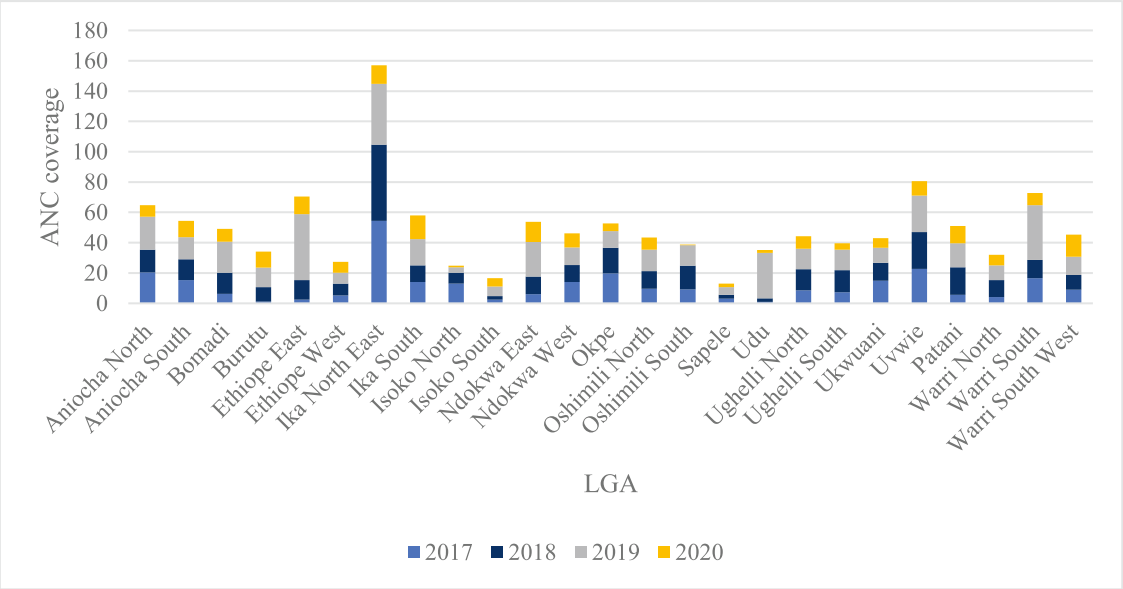


Figure 14:ANC Coverage per LGA

Deliveries attended by SBAs contributed to improved pregnancy and childbirth outcomes. Therefore, skilled attendance during pregnancy, childbirth, and postpartum is among the most critical interventions for improving maternal and neonatal survival.[26] Generally, findings showed

[25] National Population Commission (NPC) [Nigeria] and ICF. 2019. *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF

[26] WHO.Making pregnancy safer: the critical role of the skilled attendant. Geneva: WHO; 2004

that the number of deliveries by SBAs across most LGAs are still low with Ughelli North in Delta Central having the highest number of deliveries by SBAs while LGAs within Delta South had the lowest.. The study did not investigate the existence of any relationship between the availability of skilled birth attendants and utilization of ANC services at the health facilities. It is therefore important to conduct further investigation to ascertain the factors that are possibly influencing the use of skilled birth attendants within respective LGAs despite the availability of subsidized health services.

The figure 16 below shows the number of deliveries by Skilled Birth Attendants per reporting period year 2017-2020:

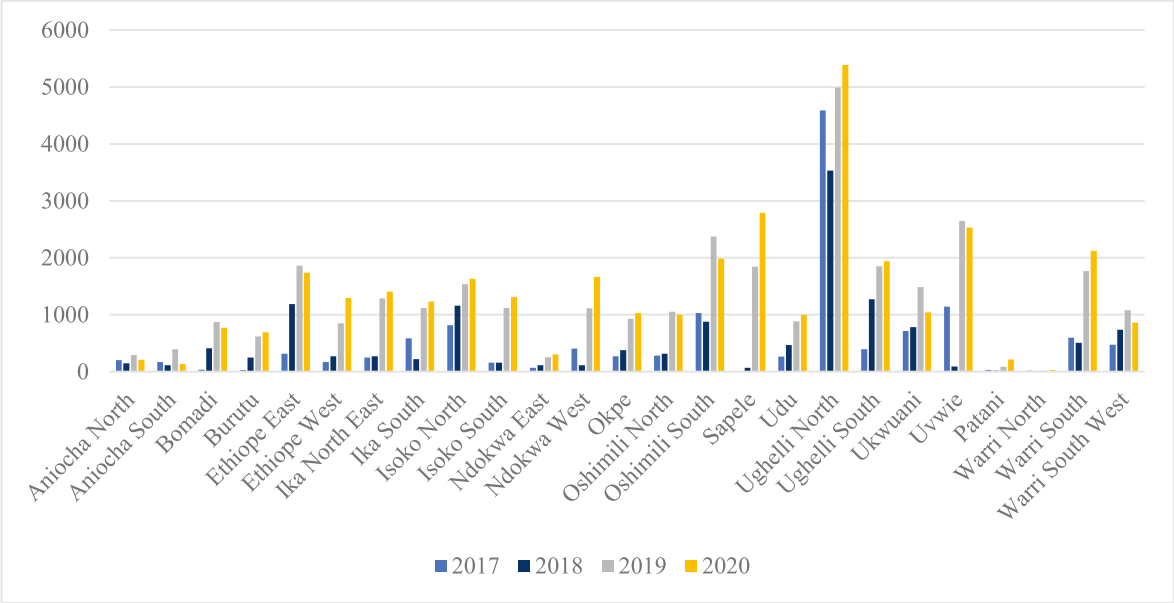


Figure 15: Number of deliveries by SBAs

Majority of the respondents expressed satisfaction with the quality of MNCH services received under the scheme due to ease of access. However, a few respondents mentioned challenges with poor health workers attitude and cases of non-provision of expected services such as scans for pregnant women.

MNCH services were the most sought-after services on the scheme as reported by respondents. It is therefore important for the Commission to improve the quality of MNCH service available and by relation, increase service utilisation. Prior studies show that maternal educational status, place of residence, travel time from home to the nearest health facility, decision maker on place of delivery, frequency of ANC visit, birth preparedness and complication readiness status ahead of child birth and knowledge on key obstetric danger signs after delivery/during post-partum are factors that are significantly associated with utilization of skilled birth attendants during child

> *"recently they gave approval for us to more community midwives to improve access to maternal care and reduce maternal deaths and improve number of pregnant women access antenatal services and increasing the number of skilled birth attendance".*
>
> *- Policy maker 3*

birth.[27] To improve utilisation of MNCH services & reduce maternal deaths, the state government recently approved the recruitment of community midwives. Further efforts can be made by the DSCHC through the implementation of strategies that are developed based on contextual information. Implementation of DG strategies should be targeted at LGAs with low ANC and SBA indices as shown in figure 15 and 16. This should be collaboratively implemented with the supply side stakeholders such as the State Primary Health Care Development Agency (SPHCDA) because addressing the demand side barriers in addition to ensuring supply-side readiness prior to introducing a service or expanding benefits is of fundamental importance[28].

[27] Ayele, G.S., Melku, A.T. & Belda, S.S. Utilization of skilled birth attendant at birth and associated factors among women who gave birth in the last 24 months preceding the survey in Gura Dhamole Woreda, Bale zone, southeast Ethiopia. *BMC Public Health* **19,** 1501 (2019). https://doi.org/10.1186/s12889-019-7818-6

[28] O'Donnell, O., *Access to health care in developing countries: breaking down demand side barriers.* Cadernos De Saude Publica, 2007. **23**(12): p. 2820-2834.

4.0 RECOMMEDATIONS

Based on findings from the performance evaluation, the following recommendation have been proffered to enable the DSCHC transition scale-up effectively into its consolidation and sustainability phase:

Organisational Capacity

1. The organisational structure of the Commission should be reviewed to ensure alignment with scale-up plans and agility in its operations
2. Standard process manuals (flowcharts) for technical and administrative functions within the Commission should also be developed to facilitate the implementation of key processes as well as strengthen staff capacity in the implementation of processes. Provision should be made for periodic reviews of the processes to enable the reflection of implementation realities.
3. An in-depth assessment of staff capacity should be conducted to ascertain gaps in knowledge and capacity in carrying out their respective responsibilities – particularly in respect to the scale-up plans of the Commission. The results of the capacity assessment should inform the development of a capacity building plan and an action plan for implementation.
4. Capacity of relevant staff should be continuously strengthened to manage the Commission's IT software.
5. Although not mentioned in the report, it is important that the Commission develop a strategic plan articulating the strategic objectives and initiatives that will guide the Commission's transition to its consolidation and sustainability phase.
6. A data management system (data collection, collation, analysis, use and storage) should be developed by the Commission as the provision of adequate quantitative data for the evaluation was a major challenge.
7. The Commission should also develop a performance management framework and an implementation plan to enable the tracking and measurement of results as it scales up its operations.

Resource Mobilisation

1. Strategies that enable the Commission to diversify and grow its revenue base through sources provided in the law and other innovative mechanisms should be developed and implemented. These could include mechanisms for enforcing enrolment of employees of the organised private sector (such as oil & gas companies and banks) and investing pooled resources in investment instruments approved by the law. The development and implementation of strategies can be done in collaboration with relevant regulatory agencies such as the Board of Internal Revenue and Ministry of Oil and Gas.
2. A review of the current informal sector enrolment strategy to ensure it articulates multiple contextual approaches that address factors affecting enrolment by the informal sector should be conducted. This should be targeted at enabling ease of enrolment and expanding the revenue base of the Commission. Short term strategies could include – (i) expanding awareness about the self-enrolment application (ii) fully deploying the enrolment agents'

monitoring application. Mid to long term strategies could include – (i) introducing a government subsidy for the informal sector to encourage premium payments. The subsidy can be funded through an earmarked revenue source and (iii) generating data on the informal sector to improve PFM systems (tax administration) and enable effective targeting of the informal sector.

3. A communications and demand generation strategy articulating contextual approaches for targeting the various population groups should also be developed to improve uptake of the scheme. The development & implementation of the strategy should be a collaborative effort involving relevant departments, community structures and ministries, departments and agencies within the state.
4. As a part of the DG strategy, the development of sensitisation messages should be guided by contextual information (knowledge of behaviour, cultural/religious norms and perspectives on available health care etc) per population group.
5. Consider conducting a workload analysis to address the mismatch between the available human resource, and what is required to deliver service. The analysis will enable an optimized workforce planning & management strategies including ensuring availability of a dedicated person for the call-centre in the case of a scale up.
6. In addition, the Commission should consider organising periodic stakeholder sessions to engage with enrollees. These sessions will provide an opportunity to further sensitise enrollees on the scheme and receive feedback that can be leveraged to improve stakeholder trust and uptake of the scheme.

Purchasing

1. As the Commission plans to scale-up its operations, consideration should be given for the update of the health benefit package. In doing this however, decisions should be guided by an updated actuarial study, fiscal space and realistic potentials for expanding the fiscal space and supply-side readiness.
2. A clearly defined mechanism that enforces accountability by providers in delivering services to enrolees as per agreements should be developed and implemented. This is important as it contributes to improving the efficiency of the PPMs utilised by the DSCHC as well as improving quality-of-service delivery.
3. Providers' capacity on the business of health insurance should be strengthened to address the perception of their inability to provide quality health services due to low capitation and tariff rates. In addition, financial management systems at the provider level should be strengthened to improve financial management, transparency and accountability.
4. The contracting process of the Commission should be strengthened through the inclusion of a performance management framework that enables incentivising positive provider behaviour and improving quality service provision by empaneled health facilities.
5. To avoid disruptions in service provision to enrollees, the claims management cycle should be reviewed and revised with a view to reducing the timelines for validating and processing payments. In addition, the knowledge and capacity of providers on the operational modalities of the claims cycle and use of the IT software should be continuously strengthened to address poor capacity issues.

6. A treatment protocol guideline should be developed and use of the document should be institutionalised for quality assurance at the facility level.
7. To improve the quality assurance mechanisms, a framework that enables the effective tracking of providers adherence to the operational modalities of the scheme should be developed & implemented in collaboration with relevant supply-side stakeholders.
8. Communication channels with providers should be strengthened for the effective resolution of complaints. The Commission should consider organising periodic sessions with the providers. These sessions will serve as an opportunity to further educate/engage providers on the scheme and receive feedback that can be leveraged to improve stakeholder trust and adherence to designed processes.
9. A study should be conducted to ascertain the factors that are responsible for the low ANC service uptake and facility deliveries. The results of the study can be used to inform the development of contextual strategies across LGAs to drive uptake of MNCH services.

ANNEXES

Photo Gallery

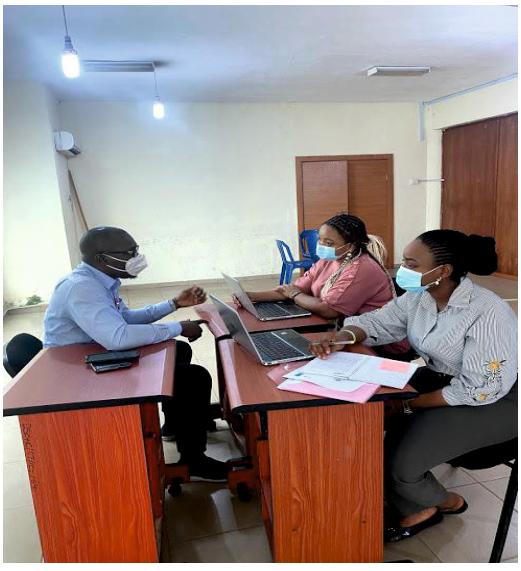
Group Photograph with the DG/CEO DSCHC and the HSCL Team

Interview with the DG/CEO DSCHC

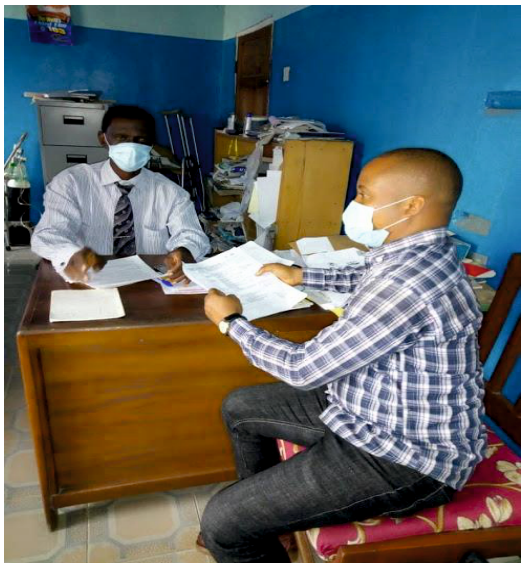
Inception Meeting with the Commission's Staff

Interview with Commission's Staff

Group Photograph with the Facility Management's Team



Interview with DSCHC staff



Interview with Provider