REFERENCE SHEET. BAUCHI MNH SCORECARD. JULY-DECEMBER 2017

This reference sheet has been developed to assist interpretation of the data displayed in the scorecard and to support debate between stakeholders in the state.

General note regarding data in this scorecard: General note regarding data in this scorecard: There are some limitations to the available data, specifically, some facilitiies submit poor quality data or incomplete data. Further indicator specific problems are detailed below. We are requesting that the SMoH attends to this problem so as to improve the quality and usefulness of the data we present.

S/N	INDICATORS	WHO GUIDELINE	NIGERIA	BAUCHI STANDARD	CALCULATIONS	DENOMINATOR	DATA SOURCE	ANY OTHER INFORMATION
1	**% of pregnant women receiving antenatal care in the first 20 weeks**	2016 recommendations state "E.7: Antenatal care models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care." www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/ Accessed January 2018	Federal MoH guidellines: focused ANC recommends at least 4 visits spread at specific times across the pregnancy with specified actions in each appointment	Bauchi State used the Nigeria guidelines of at least 4 visits	Total 1st ANC <20wks/Total 1st ANC X100	Women attending ANC for the first time in that pregancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	2015 data cannot be verified for this indicator
2	**% of pregnant women who attended at least 4 antenatal visits**	2016 recommendations state "E.7: Antenatal care models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care." www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/ Accessed January 2018	Federal MoH guidellines: focused ANC recommends at least 4 visits spread at specific times across the pregnancy with specified actions in each appointment	Bauchi State uses the Nigeria guidelines of at least 4 visits	Total 4th ANC/ Total 1st ANC X 100	Women attending ANC for the first time in that pregancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	
3	**% of pregnant women who received two doses of malaria internittent preventive treatment (IPT2)**	To ensure that pregnant women in endemic areas start IPTp-SP as early as possible in the second trimester, policy-makers should ensure health system contact (ANC) with women at 13 weeks of gestation. WHO recommendations at least for 3 doses of IPT in pregnancy. http://www.who.int/malaria/areas/preventive_therapies/pregnancy/en/ http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/ (2015, accessed January 2018)	Federal Ministry of Health, National Malaria Control Programme, Abuja, Nigeria. Strategic Plan 2009 - 2013 page 27 states that all pregnant women attending ANC services should be provided at least two doses of SP (three for women with known HIV infection) http://www.nationalplanningcycles.org/sites/default/files/country_docs/Nigeria/nigeria_draft_malaria_strategic_plan_2009-2013.pdf	Bauchi State uses the National Malaria Control Programme Strategic Plan 2009-2013	Total IPT2/Total 1st ANC X100	Women attending 4th ANC in that pregancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	
4	**Percentage of HIV-positive pregnant women who received ARV prophylaxis**	The available data show that maternal ART during pregnancy and continued during breastfeeding is the most effective intervention for maternal health and is also efficacious in reducing the risk of HIV transmission and infant death in this group of women with the highest risk of MTCT. Therefore, HIV-infected pregnant women in need of treatment for their own health should start ART irrespective of gestational age and should continue with it throughout pregnancy, delivery, during breastfeeding (if breastfeeding) and thereafter. The timing of ART initiation for HIV-infected pregnant women is the same as for non-pregnant women, i.e. as soon as the eligibility criteria are met http://www.who.int/entity/hiv/pub/mtct/antiretroviral2010/en/index.html	Chapter 3 of Nigeria National Guideline for HIV Prevention Treatment and Care stated that ART should be initiated in all adults, all including pregnant and breastfeeding women, adolescents and children living with HIV, regardless of WHO clinical stage and at any CD4+ cell count. http://apps.who.int/medicinedocs/documents/s23252en/s23252en.pdf	Bauchi State uses the national guideline	Numerator: Number of HIV+ pregnant women who received ARV prophylaxis Denominator: Number of HIV+ pregnant women	Denominator: Number of HIV+ pregnant women	DHIS2	This indicator has another source of data, which is not fed into the DHIS2 FHI 360 supports this other platform called eNNRIMS
5	**% of deliveries attended by a skilled birth attendant in health facilities**	2004, WHO/FIGO/ICM issued a joint statement that defined SBA. Actual practice at country level, however, is challenged by a lack of clear guidelines, standardization of names and functions, and task shifting. In addition, many countries have found that there is a large gap between the defined standards and the skill set/competence of existing birth attendants who are able to correctly manage common obstetric and neonatal complications. In 2018 a revised definition was proposed in order to measure SDG indicator 3.2.1 Defining competent maternal and newborn health professionals http://www.who.int/reproductivehealth/SBA-background-report.pdf?ua=1 Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to: (i) provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and their newborns; (ii) facilitate physiological processes during labour to ensure clean and safe birth; and (iii) identify and manage or refer women and/or newborns with complications. In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthesiologists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of mothers and newborns. Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards* can provide almost all of the essential care needed for women and newborns. In different countries, these competencies are held by varying occupational titles.	Nigeria Task-Shifting and Task-Sharing Policy for Essential Health Care Services in Nigeria (Page 15 of the Task-Shifting and and Task-Sharing Policy for Essential Health Care Services in Nigeria recogniseds CHEWs as skilled birth attendant)	Bauchi State Task Shifting/Sharing Policy for Essential Services has included CHEWs to those who already handle labour and delivery tasks (page 6 of Bauchi State Task Shifting/Sharing Policy for Essential Services)	No of deliveries by SBA/Total deliveries X 100	Total deliveries include normal/ assisted/caesarean section	DHIS2	Following the approval of Tasj Shifting / Saring Policy, CHEWs have been trained and equipped to handle deliveries and when there are danger signs they are to refer to the next level of care.

S/N	INDICATORS	WHO GUIDELINE	NIGERIA	BAUCHI STANDARD	CALCULATIONS	DENOMINATOR	DATA SOURCE	ANY OTHER INFORMATION
6	**% of pregnant women attending a postnatal clinic visit within 3 days of delivery**	Key points of WHO guidelines: PNC in the first 24 hours to all mothers and babies - women and mothers stay in health facility for at least 24 hrs after delivery and home births are visited within 24 hours. Provide every mother and baby a total of four postnatal visits on: - Day 1, between days 7–14 and at 6 weeks Offer home visits by midwives, other skilled providers or well-trained and supervised community health workers (CHWs). Use chlorhexidine after home deliveries in high newborn mortality settings. Re-emphasize and support elements of quality postnatal care for mother and newborn, including identification of issues and referrals. At each of the four postnatal care check-ups, assess for key clinical signs of severe illness and referred as needed. www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf 2015 guidelines accessed January 2018	Discharge within 48 hours,then PNC at 3 and 7 days and 6 weeks. This is from DHIS2	Bauchi state practices 3 days after delivery from the DHIS2	Total PNC/Total Deliveries X 100	Total deliveries include normal/ assisted/caesarean section	DHIS2	Due to fund and cultural practices women hardly adhere to PNC
7	**% of children less than 1 year fully immunised**	Routine immunization standards vary across countries according to prevailing conditions. Full recommended immunization tables are shown at http://www.who.int/immunization/policy/Immunization_routine_table2.pdf?ua=1	Routine Immunization basic Guide for Service Providers in Nigeria states all children 0-11 months must be fully immunized. The recommended vaccine includes BCG, OPV3, HepB2, Penta3, PCV3, IPV, Measles and Yellow Fever. http://healthfolk.net/documents/1/8/basic-guide-for-routine-immunization-service-providers	Bauchi state uses the routine immunisation basic guide for service providers in Nigeria	Total No of fully Immunized under 12 months /Total population of Children less than I year X 100	Total population of children less than 12 months	Addition of fixed post and out reached data in the DHIS2	
8	**% of new diarrhoea cases in under five year olds who are given ORS/zinc supplementation**	Diarrhoea is defined as the passage of three or more loose or liquid stools per day (or more frequent passage than is normal for the individual.) http://www.who.int/mediacentre/factsheets/fs330/en/updated 29/01/2018	Nigeria uses the WHO standard	Bauchi State uses the WHO standard	Total No. of new cases of children<5yrs with Diarrhoea given ORS & Zinc/Total No. of children <5yrs with new cases of Diarrhoea x 100	Total new cases of diarrhoea in children < 5 years reported in in private and public facilities (primary, secondary and tertiary).	DHIS2	
9	**% of females ages 15-49 using any method of modern contraceptives**	Modern contraception listed by WHO as: oral contraceptive pills (various), implants, injectables (various), combined patch and vaginal ring, IUD (various), male/female condoms, male/femaile sterilisation, lactational amenorrhea, emergency contraception, standard days/basal body temp/ sympto-thermal/2days methods. www.who.int/mediacentre/factsheets/fs351/en/ accessed January 2018	The Nigeria Family Planning Guide listed oral pills/satchets, injectables, IUCDs, Implants, and male/female condoms. (Family Planning Guide for Service Providers in Nigeria). http://www.health.gov.ng/doc/FPRHProtocols.pdf	Bauchi State uses the national Family Planning Guide for Service Providers in Nigeria	Total no of Women 15-49 using Modern Contraceptives/ Total population of Women aged 15-49years X 100	Total population of women aged 15-49 years	DHIS2	DHIS2 data cannot capture total number of women using modern contraception (eg. when purchased through the informal / private sector).
10	**% of all births that are caesarean deliveries**	WHO Statement on Caesarean Section Rates: Caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. At population level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates. Currently, there is no standard classification system for caesarean section that would allow the comparison of caesarean section rates across different facilities, cities, countries or regions in a useful and action-oriented manner. www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/ accessed January 2018. WHO proposes the Robson classification system as a global standard for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities (follow link above for Robson classification).			Total Caesarian Deliveries/Total Deliveries X 100	Total births in private and public facilities (primary, secondary and tertiary)	DHIS2	This indicator is not colour coded because there is no relevant international standard. The data for this indicator are incomplete
11	**% of all deliveries that are stillbirths**	Stillbirths are defined as third trimester fetal deaths (⩾ 1000 g or ⩾28 weeks). WHO method of measurement of still births using data from health facilities: "the number of stillbirths divided by the number of total births documented in the facility." (2015 Global Reference List of 100 Core Health Indicators: http://apps.who.int/iris/bitstream/10665/173589/1/WHO_HIS_HSI_2015.3_eng.pdf?ua=1 - accessed January 2018)	NO GUIDELINE	NO GUIDELINE	No of Still Births/ Total births X 100	Total births in private and public facilities (primary, secondary and tertiary)	DHIS2	This indicator is not colour coded because there is no relevant international standard.