REFERENCE SHEET. GOMBE 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: There are some limitations to the available data, specifically, some facilities submit poor quality data or incomplete data, this problem is generally worse in the private sector. 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	GOMBE STANDARD	CALCULATIONS	DENOMINATOR	DATA SOURCE	ANY OTHER INFORMATION
1	**% of pregnant women who reported for antenatal care before 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.		Total 1st ANC <20wks/Total 1st ANC X100	Pregnant women attending ANC before and after 20 weeks in both the public and primary (PHCs, secondary and tertiary levels)	DHIS2	None
2	**% of Pregnant women that attended at least 4 antenatal visits**			Gombe State uses the national guideline	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	None
3	**% of Pregnant women who received malaria 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	Gombe State uses the National Malaria Control Programme Strategic Plan 2009-2013	Total IPT2/Total 1st ANC X100	Pregnant women that attended 1st ANC both in public and private clinics (primary, secondary and tertiary levels)	DHIS2	The supply of vaccines by the donor organisation resulted to increase
4	**% Post Natal Clinic visit within 3 days 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. 2015 guidelines accessed January 2018 http://www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf	Discharge within 48 hours,then PNC at 3 and 7 days and 6 weeks. This is from NHMIS monthly summary form for health facilities version 2013	Gombe state practices 3 days after delivery based on the training provided by JHPIEGO and 6 weeks which follows the WHO's standard practice	Total PNC visit within 3days/Total livebirth X 100	Women who delivered (normal, CS, assisted) in private and public facilities (primary, secondary and tertiary)	DHIS2	
5	**Percentage of HIV-positive pregnant women who received ARV prophylaxis**	The available data show that maternal ARTduring 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	Strategic Plan 2009-2013	Gombe State uses the national guideline	Number of HIV+ pregnant women who received ARV prophylaxis / Number of HIV+ pregnant women x 100	Number of HIV+ pregnant women	DHIS2	This indicator is added to ascertain progress of HIV+ve pregnant women on ARV in order to reduce new infection between a mother and child.
6	**% of Deliveries monitored with partograph**	WHO management of obstructed labour. 2008. Details of WHO modified partograph use from page 55 http://apps.who.int/iris/bitstream/10665/44145/4/9789241546669_4_eng.pdf	Module 11 of the Manual on Life Saving Skills for Nurses/Midwives states management of normal labour including use of partograph in page 146	Gombe State uses the Maunal on life Saving Skills for Nurses/ Midwives	Total deliveries monitored by partograph/Total deliveries x 100	Total deliveries (normal, CS, assisted) in private and public facilities (primary, secondary and tertiary)	DHIS2	Development partners supported with training 57 PHCs in the state on the use of partograph while the director hospital services directed the distribution of partograph to the clinics
7	**% of Deliveries taken by a skilled birth attendant**	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.	Every birth should be attended by a skilled birth attendant. It is defined as a doctor, nurse, midwife, and in those states where the task shifting policy is in place includes community health extension workers (CHEW). (confirm source?)	Gombe State uses the National Task-Shifting and Task-Sharing Polcy for Essential Health Care Services in Nigeria	No of deliveries by SBA/Total deliveries x 100	Total deliveries (normal, CS, assisted) in private and public facilities (primary, secondary and tertiary)	DHIS2	These data include deliveries assisted by CHEWs at PHCs but do not include deliveries in the community (unassisted/assisted by TBAs), or those deliveries assisted by auxilliary nurses in private facilities. In Gombe CHEWS/ JCHEWS were trained and equipped to handle normal deliveries in 57 wards last year. However there are limitations to what these CHEWs are able/permitted to do and they are mandated to refer up to higher skilled personel when there are danger signs

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8	**% of Fully immunized children < 1 year**	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	Gombe 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	DHIS2 (immunisation data) and census data (2006) + 3.2% annual growth rate is used for the population data.	Low data reporting and indaquate data tools accounted for the poor percentage of the routine immiunisation
9	**% of Children 0-6 months exclusively breastfed**	WHO and UNICEF recommend: early initiation of breastfeeding within 1 hour of birth; exclusive breastfeeding for the first 6 months of life; and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond. Recommendations have been refined to also address the needs for infants born to HIV-infected mothers. Antiretroviral drugs now allow these children to exclusively breastfeed until they are 6 months old and continue breastfeeding until at least 12 months of age with a significantly reduced risk of HIV transmission.(2017). http://www.who.int/mediacentre/factsheets/fs342/en/ accessed January 2018.	The National Policy on Infant and Young Child Feeding in Nigeria	Gombe State uses the National Policy on Infant and Young Child Fedding in Nigeria (page 8 Exclusive Breastfeeding subheading 2.1.1 of the National Policy on Infant and Young Child Feeding in Nigeria)	Total No of children EBF/ Total population 0-6months x 100	Total population of children 0-6 months	DHIS2 (immunisation data) and census data (2006) + 3.2% annual growth rate is used for the population data.	
10	**% of children with Diarrhoea <5yrs - new cases given ORS & Zinc**	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	Same as who standard	Same as who standard	Total No. of new cases children<5yrs with Diarrhoea given ORS & Zinc/Total No. of children <5yrs with new cases of Diarrhoea x 100	Total new cases diarrhoea in children < 5 years reported in in private and public facilities (primary, secondary and tertiary).	DHIS2	
11	**% New family planning acceptors**	Recommendations on ensuring human rights in the provision of contraceptives http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf?ua=1	N/A	N/A	Total No. of new FP acceptors/Total No. of women counseled x 100	Total female clients counselled for Family Planning uptake	DHIS2	No standard or guideline to show what is an accpetable target for new family planning acceptors
12	**% of females aged 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	Gombe 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		
13	**% of all births which are stillborn**	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)	N/A	N/A	No of Still Birth/ 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. Note: the denominator is total births not total deliveries.
14	**% of Caesarian 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).	N/A	N/A	Total Caesarian Deliveries/Total Deliveries X 100	Total births in private and public facilities (primary, secondary and tertiary)	DHIS2	There is a reversal in the traffic colour , though the indicis are low, it's assumed to be positive indicator but with high still birth it means CS deliveries are not well utilized
15	**% of Assisted Vaginal Delivery**	N/A			Total Assisted Vaginal deliveries/ 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.
16	**% of Deliveries – Preterm**	Preterm delivery is defined as delivery prior to 37 completed weeks of gestation. The shorter the gestational age of an infant, the more likely it is for that infant to suffer adverse effects. Preterm birth, along with low birthweight, is the second leading cause of infant death (see the Infant Mortality indicator), and preterm infants are at higher risk for health and developmental problems Source: http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf Preterm incidence in developed countries is somewhat lower, the preterm birthrate in more developed countries =7.5%; less developed=8.8; least developed= 12.5; source: "The worldwide incidence of preterm birth: a systematic review of maternal mortality and morbidity" www.who.int/bulletin/volumes/88/1/08-062554/en/ accessed January 2018.	N/A	N/A	Total preterm deliveries/Total deliveries x 100	Total deliveries in private and public facilities (primary, secondary and tertiary)	DHIS2	This indicator is not colour coded because there is no relevant international standard. The indicator has been selected because of the association of preterm delivery with adverse events.