

REFERENCE SHEET. LAGOS 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.

INDICATORS	INTERNATIONAL STANDARD	NIGERIAN STANDARD	LAGOS STANDARD	CALCULATION	DENOMINATOR	DATA SOURCE	ANY OTHER INFORMATION
% of pregnant women reporting for 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 guidelines: focused ANC recommends at least 4 visits spread at specific times across the pregnancy with specified actions in each appointment.	As national standard	Total 1st ANC <20wks/Total 1st ANC x 100	Women attending ANC for the first time in that pregnancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	None
% of pregnant women who attended 4 antenatal care visits, according to standard				Total 4th ANC/ Total 1st ANC x 100	Women attending ANC for the first time in that pregnancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	There is an aberration in the way these data have been collected: specifically, there has been double counting particularly of women who attend more than 4 ANC visits (meaning it is possible to have a result >100%) and some anomalies with patients who transfer to different facilities. These are being investigated and solutions sought. Use of a more accurate denominator is also being considered.
% of pregnant women who received two doses of malaria IPT	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)	3 doses are recommended	As national standard	Total IPT2/Total 1st ANC x 100	Women attending ANC for the first time in that pregnancy at private and public facilities (primary, secondary and tertiary levels)	DHIS2	In Lagos the policy for at least 3 doses of IPT during pregnancy has been adopted. Current HMIS data does not capture three doses so IPT2 is used as the indicator. National malaria survey (2015) indicated a drop in malaria prevalence in Lagos. Federal and donor support has been withdrawn and the state MoH has taken over provision of antimalarials in Lagos.
% of women who attended postnatal clinic visits	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 at 3, and 7 days and 6 weeks.	As national standard	Total PNC/Total deliveries x 100	Women who delivered (normal, CS, assisted) in private and public facilities (primary, secondary and tertiary)	DHIS2	The figures for this indicator reported in Lagos are usually >100%, mainly because: 1. The denominator is not accurate: many women do not deliver in facility but do come for postnatal visits; 2. Training of data recorders (definition of PNC and post-partum care is not widely understood). A need has been identified for M&E officers to be trained on how to use the HMIS indicator guide.
% of births attended by 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 worker (CHEW).	As national standard, except in Lagos CHEWs are not considered SBAs.	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 do not include deliveries in the community (unassisted/assisted by TBAs and community health extension workers (CHEWs), or those deliveries assisted by auxiliary nurses in private facilities. In some states where there are CHEWs taking deliveries there are limitations to what they are able/permitted to do and they are mandated to refer up to higher skilled personnel in some circumstances.

INDICATORS	INTERNATIONAL STANDARD	NIGERIAN STANDARD	LAGOS STANDARD	CALCULATION	DENOMINATOR	DATA SOURCE	ANY OTHER INFORMATION
% of fully immunised children less than 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	Children between 12 and 23 months that have received measles and yellow fever vaccine happens at 9 months. (Proxy measure) Routine immunization in Nigeria is: HEPB2; BCG, OPV 3, Penta3, PCV3, DPT3, CSM, Measles2, yellow fever, (source HMIS Instruction Manual, 2013)	Children below 12 months that have received 1 measles vaccine (this proxy measure for routine vaccination happens at 9 months.	Total number of 'fully immunized' children / Total population of children less than 12 months x 100	Total population of children less than 12 months	District vaccination data management tool (DVTMT), and population data from Lagos Bureau of Statistics (BoS)	For the denominator, the population is based on formula for estimating total population of infants <1yr (Source: Lagos State Bureau of Statistics). Measles vaccination in children under 12 months is used as a proxy for full immunization in Lagos State as this vaccination is the last routine vaccine to be administered in children under 12 months. These data should be interpreted with caution because the state population of Lagos is disputed. This scorecard uses the population of 24,821,418million (for 2017) from the Lagos State BoS (not the federal population data), because it is believed to be a more accurate representation of the population. There are several sources of immunization coverage data which report different figures. In addition to the data we report (38% average across the state), the NICS reported coverage of 65.1.% (2017 survey data children 12-23 months) and the SPHCDA/NBS reported 80% (children 12-23 months using federal population data).
% of females aged 15 - 49 years using any method of modern contraception	Modern contraception listed by WHO as: oral contraceptive pills (various), implants, injectables (various), combined patch and vaginal ring, IUD (various), male/female condoms, male/female sterilisation, lactational amenorrhoea, emergency contraception, standard days/basal body temp/ sympto-thermal/2days methods. www.who.int/mediacentre/factsheets/fs351/en/ accessed January 2018	HMIS lists the following: oral pills/sachets, injectables, IUCD, implants, sterilization, male/female condoms.	As national standard	Total number of women aged 15-49 using any method of modern contraceptive /Total population of women aged 15-49 x 100	Total population of women aged 15-49	Lagos MoH Family Planning Unit for numerator and LBS for population data	This calculation has been made using different data from the previous scorecard and therefore should not be used for comparison purposes. The scorecard for January-July 2017 used MICS survey data, but this it is not collected sufficiently frequently to track change within a year or LGA specific information. This scorecard uses routine (DHIS), which we will continue to use in future. The estimated proportion in the population of women of reproductive age is 22%. (Source: Lagos State Bureau of Statistics) The data for this indicator should also be interpreted with some caution due to the difficulty of identifying an adequate denominator. Our denominator captures those women who seek FP services from public facilities, in Lagos approximately 50% of people use public health facilities for family planning purposes (source: Lagos State Government Household Survey Indicators page 342) . This indicator is therefore only an adequate reflection for those 50% who use the public sector FP services. The routine data from the Lagos Family Planning Unit do not adequately capture the coverage for the many women who seek FP services for the private or informal sector.
% 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	Same as WHO standard	As WHO/national standard	Total no. of Diarrhoea new cases < 5 years given ORS and zinc supplementation/ Total Diarrhoea new cases < 5years X 100	Total new cases diarrhoea in children < 5 years reported in private and public facilities (primary, secondary and tertiary).	DHIS2	The State gives seed stock of ORS and Zinc to the health facilities (primary and secondary) and they are then meant to re-stock through their Drug Revolving Fund.
Caesarian section rate	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	No of CS/Total deliveries x 100	Total deliveries (normal, CS, assisted) in private and public facilities (primary, secondary and tertiary)	DHIS2	This indicator is not colour coded because there is no relevant international standard. Maternal and child care centres (MCCs) in Lagos are likely to have highest levels of c-section deliveries as complicated deliveries are frequently referred to this level of care. The average for the state should be interpreted with caution due to the variation in figures according to the level (primary/secondary/tertiary) of facilities. One reason for relatively high rates of c-section in Nigeria may be due to late skilled intervention in mis-managed labour as a large proportion of deliveries take place in the community (unassisted/assisted by TBAs and community health extension workers).
Percentage of all births which 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)	N/A	N/A	No of stillbirths/ 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.