Progress on Country Accountability Framework for Women's and Children's Health in Nigeria

Based on Demographic & Health Survey (DHS) 2013 estimates, it estimated that Nigeria has approximately 576 maternal deaths per 100,000 live births and contributes about 14% of the global burden of maternal deaths.[1, 2] The mortality rate of 69 per 1,000 live births are steadily declining, but remain unacceptably high, with the Millennium Development Goals unlikely to be met.[2]

Nigeria's average population health outcomes are relatively low compared to other countries with similar levels of resources and endowments. Despite significant financial and technical investments in the health sector in Nigeria, progress to improving health has been slow. Many key stakeholders including government officials are beginning to acknowledge accountability as the catalyst for change.

In September 2010, in an effort to accelerate progress, the Secretary-General of the United Nations launched the Global Strategy for Women's and Children's Health. The strategy aims to save 16 million lives by 2015 in the world's 49 poorest countries. The Commission on Information and Accountability for Women's and Children's Health (CoIA) was established to ensure that every woman and child receive the highest attainable standard of health and to achieve equity in health. All accountability mechanisms should be effective, transparent and inclusive of all stakeholders, it begins with national sovereignty and the responsibility of a government to its people and the global community.

The accountability framework covers national and global levels and comprises three interconnected processes aimed at learning and continuous improvement: monitor, review and act. It links accountability for resources to results.

To support African countries with skills and information in tracking progress in achieving the 11 CoIA indicators, WHO convened a multi-country workshop to strengthen results and accountability for women and children's health and the health sector, in Harare, Zimbabwe October, 2012. Nine African countries including Botswana, Eritrea, The Gambia, Lesotho, Nigeria, Liberia, South Africa, Swaziland and Zimbabwe attended. Among CoIA's ten recommendations, three notable areas included: better use of information to improve results, tracking of resources and oversight of results and resources globally and nationally. Included within this was a recommendation to establish transparent national accountability mechanisms, inclusive of all stakeholders, addressing maternal, newborn and child health (MNCH).

1. World Health Organization, UNICEF, UNFPA, The World Bank & the United Nations Population Division. (2014). Trends in Maternal Mortality: 1990 – 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: WHO.

2. National Population Commission [Nigeria], & ICF International. (2013). Nigeria Demographic and Health Survey 2013. Abuja & Rockville: NPC & ICF International.

Following the Harare workshop, a national workshop, was convened in April 2013, resulting in the development of a Country Accountability Framework (CAF). The meeting focused on the review and finalisation of Nigeria's CAF and priority actions in line with seven thematic areas:

1. **Advocacy and Outreach**
2. **Review Processes**
3. **Monitoring of Resources**
4. **E-Health and Inovation**
5. **Maternal Death Surveillance and Response**
6. **Monitoring of Results**
7. **Civil Registration and Vital Statistics**

In order to facilitate transparency and accountability for implementing, tracking progress and planning on the national MNCH roadmap, civil society organizations (CSOs) present at the workshop proposed the establishment of an independent expert review group through an existing umbrella coalition which brings together CSOs, healthcare professional bodies and the media.[3] Accountability for MNCH in Nigeria (AMHiN). AMHiN in collaboration with key development partners and stakeholders will support the implementation and accountability towards meeting the 2014 CAF recommendations.

The independent expert review group, known as the Nigeria Independent Accountability Mechanism (NIAM), operates within the platform of AMHiM. NIAM is a hybrid accountability mechanism, led by citizens with national approval to act as the independent group, tracking implementation of the MNCH roadmap. Membership of NIAM includes media, civil society, and health professional associations across Nigeria's six geopolitical zones. Diverse membership aims to ensure wide range of knowledge and expertise across the thematic areas. NIAM specific aims to review progress against health plans and budgets (particularly the roadmap on MNCH), assess equity of investments and improvements in health, review and analyse barriers in access to health services, ensure political will and commitment from national and state level governments and to promote success stories relating to MNCH.[4]

This report developed by NIAM outlines the scope of work, methodology and critical review of the progress made in implementing CAF in line with the baseline scorecard developed in April 2013. It also delineates the agreed prioritised areas in which AMHiN will be focusing its advocacy going forward.

3. World Health Organization, Nigeria Report of the National Workshop on Strengthening Results and Accountability for Women's and Children's Health and the Entire Health Sector in 2013: Abuja.

4. Garba, A.M. & Bandali, S. The Nigeria Independent Accountability Mechanism for maternal, newborn and child health. International Journal of Gynecology & Obstetrics, (early online publication).

METHODOLOGY

Key documents reviewed include:

- 2013 Country Accountability Framework Road Map
- National accountability roadmap workshop report 2013
- Country implementation plan for United Nations Commission on Life-Saving Commodities for Women and Children, August 2013
- Progress reports on United Nations Commission on Life-Saving Commodities for Women and Children 2013-2014
- WHO 2013 maternal mortality estimates
- 2013 independent Expert Review Group (iERG) Report
- Accountability for women and children's health - 2013 report
- Countdown to 2015, maternal, mewborn and child Survival: Nigeria – 2013
- Achieving measurable results for health through the National Strategic Health Development Plan 2010-2015
- Country compact between Federal Government of Nigeria and Development Partners (Dec 2010)
- Integrated Maternal, Newborn and Child Health strategy (2013 Revision)
- Reproductive Health Commodities Security Strategy 2011-2015
- Health Care Financing in Nigeria-National Health Accounts Perspective: Lawanson AO, 2013
- WHO Global expenditure database - Health System Financing Profile: Nigeria 2012
- National Essential Childhood Medicines Scale-up Plan 2011
- National Child Health Policy 2006
- Saving One Million Lives Initiative
- WHO Methods and Data Sources for Global Burden Disease Estimates - (Health system & policy indicators)
- 2010 Revised Integrated Disease Surveillance and Response policy
- Nigeria Demographic and Health Survey 2013

KEY INFORMANT INTERVIEWS

Purposively sampled key stakeholders with substantial knowledge of the issues under review were interviewed. Dr Nkem Ene conducted the interviews and produced a draft scoring of the 2014 CAF document.

COUNTRY ACCOUNTABILITY FRAMEWORK (CAF) COMPLETION (2014)

After data collection the CAF for 2014 was completed for identified indicators. Some indicators were investigated in-depth to assess individual processes, during the development of the 2014 CAF. These changes do not affect comparison with 2013 scores as each thematic area has sub-thematic scores. The sub-thematic scoring mechanism remained the same. Entries included a summary of the current status of the indicator, the source of the information and a performance score assigned. The 2014 scores were aggregated for each thematic area for comparison with scores from the baseline review in 2013.

A half-day review and validation workshop was hosted by AMHiN in June 2014. Attendees included AMHiN representatives and members of the media.The objectives of the workshop included:

- **To review 2013 baseline CAF**
- **To address information gaps in CAF 2014**
- **To obtain, review and validate on 2014 findings**
- **To develop draft corrective action recommendations**
- **To identify advocacy priorities and key messages**
- **To articulate next steps**

REVIEW OF 2013 CAF BASELINE SCORECARD

The participants were presented with the 2013 CAF scorecard with a detailed explanation of the baseline indicators, scoring criteria and overall scores per thematic area in order to set the tone for the 2014 scorecard results.

2014 CAF SCORECARD

After introducing the 2013 baseline scorecard, the results of the 2014 scorecard were presented with description of the indicators, current status of each thematic area and the mode of verifying the information on each indicator. This review was driven by civil society, with inputs from a variety of key stakeholders to incorporate unbiased and diverse views to assess the progress in implementing the CAF.

ACRONYMS

C4MNH	Champions for Maternal and Newborn Health
CHAI	Clinton Health Access Initiative
CIDA	Canadian International Development Agency
CoIA	Commission on Information and Accountability
CRVS	Civil Registration and Vital Statistics
CTC	Core Technical Committee
DPRS	Department of Planning, Research and Statistics
DevComs	Development Communications Network
E4A	Evidence for Action
EmONC	Emergency Obstetric and Newborn Care
FCT	Federal Capital Territory
FIGO	International Federation of Gynaecology and Obstetrics
FMOH	Federal Ministry of Health
HDSS	Health and Demographic Surveillance System
HERFON	Health Reform Foundation of Nigeria
HSRC	Health Sector Reform Coalition
ICC	Interagency Committee on Civic Registration and Vital Statistics
ICD	International Classification of Diseases
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IMNCH	Integrated Maternal, Newborn and Child Health
INGO	International Non-Governmental Organization
IPAS	Global Non Profit Organization
LGA	Local Government Area
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MSS	Midwives Service Scheme
NAFDAC	National Agency for Food and Drug Administration and Control
NASS	National Assembly
NDHS	Nigeria Demographic and Health Survey
NHIS	National Health Insurance Scheme
NHMIS	Nigeria Health Management Information System
NHSDP	National Health Sector Development Plan
NPHCDA	National Primary Health Care Development Agency
NPoPC	National Population Commission
PHC	Primary Health Care
PRRINN-MNCH	Partnership for Reviving Routine Immunisation in Northern Nigeria–Maternal, Newborn and Child Health
QoC	Quality of Care
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCI	Save the Children International
SHA	System of Health Accounts
SMOH	State Ministry of Health
SMS	Short Message Service
SOP	Standard Operating Procedure
ToR	Terms of Reference
UN	United Nations
UNCoLSC	The United Nations Commission on Life-Saving Commodities
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

SUMMARY OF PROGRESS

AREA	2013 SCORE (%)	2014 SCORE (%)
ADVOCACY AND OUTREACH	44	40
REVIEW PROCESSES	49	76
MONITORING OF RESOURCES	30	51
E-HEALTH AND INNOVATION	25	59
MATERNAL DEATH SURVEILLANCE AND RESPONSE	4	35
MONITORING OF RESULTS	33	64
CIVIL REGISTRATION AND VITAL STATISTICS	8	53

ADVOCACY AND OUTREACH

2013 OVERALL SCORE:	44%
2014 OVERALL SCORE:	40%

SCORE KEY:

1 Not present, needs to be developed

2 Needs a lot of strengthening

3 Needs some strengthening

4 Already present, no action needed

ADVOCACY AND OUTREACH

1. PARLIAMENT ACTIVE ON RMNCH ISSUES

Parliament has established transparent accountability mechanism for RMNCH, such as a multi-stakeholder commission or committee that reports to parliament.

A

2013 SITUATIONAL ANALYSIS

Parliament has not established a specific committee on transparent accountability for RMNCH, however there exists a Standing Committee on Health and Standing Committee on MDGs that meet regularly to discuss health issues including RMNCH . There is multistakeholder commission and committee that reports to the parliament on RMNCH issues. Parliament does not organize public fora. These are usually initiated by ministries, agencies, NGOs and CSOs working directly with parliamentarians.

SCORE 2

1. PARLIAMENT ACTIVE ON RMNCH ISSUES

Parliament organises public forums for information sharing and discussions on RMNCH issues.

B

2013 SITUATIONAL ANALYSIS

Parliament has not established a specific committee on transparent accountability for RMNCH, however there exists a Standing Committee on Health and Standing Committee on MDGs that meet regularly to discuss health issues including RMNCH . There is multistakeholder commission and committee that reports to the parliament on RMNCH issues. Parliament does not organize public fora. These are usually initiated by ministries, agencies, NGOs and CSOs working directly with parliamentarians.

SCORE 2

2014 STATUS

Parliament has not established a transparent and multi-stakeholder accountability mechanism for RMNCH. Most interaction with Parliament has been driven by MNCH advocates on an "as needed" basis. However there is a committee on health and another on MDGs. MNCH issues are discussed here and at the Inter-Parliamentary Union.

RECOMMENDATIONS

Support the legislature to establish accountability mechanism on RMNCH especially on financing and availability of quality data.

SCORE 2

2014 STATUS

Proceedings are captured by the committee clerks, but whether these minutes are shared with the wider House is unclear.There have been stand alone engagements such as public hearings on the National Health Bill, parliamentarian advocates for vaccine financing and respectful maternity care.

RECOMMENDATIONS

CSOs to work with the NASS to facilitate the organization of public hearings/forums for sharing of information on RMNCH periodically.

SCORE 2

ADVOCACY AND OUTREACH

2. CIVIL SOCIETY COALITION

Civil society coalitions exist, are funded, and meet regularly with key stakeholders, including government, parliamentarians, multi-sectorial policy/decision-making body, and media.

A

2013 SITUATIONAL ANALYSIS

Yes, there are some examples of CSO coalitions in some states and national level coalitions with broad health sector focus, e.g. Health Sector Reform Coalition and Family Planning Action group and White Ribbon Alliance for Safe Motherhood (WRA) which have a MNCH and national focus. However, there is still a good degree of fragmentation among CSOs, particularly at state level. There are some good examples of evidence-based advocacy (mainly by INGOs and CSOs), however, coverage and sustainability has been a challenge. Fragmented efforts result in duplication and gaps.

SCORE 2

2. CIVIL SOCIETY COALITION

Civil Society coalition(s) produce evidence-based advocacy messages and materials with effective dissemination strategy.

B

2013 SITUATIONAL ANALYSIS

Yes, there are some examples of CSO coalitions in some states and national level coalitions with broad health sector focus, e.g. Health Sector Reform Coalition and Family Planning Action group and White Ribbon Alliance for Safe Motherhood (WRA) which have a MNCH and national focus. However, there is still a good degree of fragmentation among CSOs, particularly at state level. There are some good examples of evidence-based advocacy (mainly by INGOs and CSOs), however, coverage and sustainability has been a challenge. Fragmented efforts result in duplication and gaps.

SCORE 2

2014 STATUS

Civil society coalitions exist. They are very active at national level e.g. AMHiN and Health Sector Reform Coalition, but even more so at state level in Kano, Jigawa, Lagos, Enugu, Kaduna. State level accountability mechanisms on MNCH exist specifically to track progress on MNCH indicators and outcomes. Other coalitions are demanding for improved accountability and increased MNCH funding. Most coalitions are supported by individual members and foreign donors including E4A, SCI, PATHS 2. They have all contributed to press conferences, stakeholder panel discussions, advocacy visits, among other activities in furthering the cause of the National Health Bill. Some coalitions do not currently obtain donor support, but this may change as organisations like the former Family Planning Action Group (FPAG), re-configure themselves to become eligible for donor support.

SCORE

RECOMMENDATIONS

Continue monitoring and documenting efforts.

2014 STATUS

State level Coalitions are not financed as well as those at national level. Most receive support from programmes such as E4A, PATHS 2, SAVI and White Ribbon Alliance, etc. Several have contemplated approaching government for support as provided for under the Strategic Health Development Plans (Community Participation and Partnerships). This move, however, may compromise their objectivity and thereby their “Voice”.

There are several MNCH factsheets, advocacy and press briefs in circulation

SCORE

RECOMMENDATIONS

Support the legislature to strengthen accountability mechanism on RMNCH (AMHIN, HSRC) especially on financing and availability of quality data.

Continue monitoring (no capital) and documenting efforts.

ADVOCACY AND OUTREACH

3. MEDIA ROLE

There is frequent and robust media reporting on a wide range of RMNCH-related topics, including policy and budget action.

A

2013 SITUATIONAL ANALYSIS

There are good examples of electronic and print media reporting on RMNCH. Development Communications Network (DevComs) has trained media on improved reporting on RMNCH . There are many privately-owned media operations, which can also be of advantage.

SCORE 3

3. MEDIA ROLE

Media are actively engaged in the accountability process, reporting on progress towards implementation of the national commitments towards the Global Strategy.

B

2013 SITUATIONAL ANALYSIS

There are good examples of electronic and print media reporting on RMNCH. Development Communications Network (DevComs) has trained media on improved reporting on RMNCH . There are many privately-owned media operations, which can also be of advantage.

SCORE 2

3. MEDIA ROLE

Media receive information and briefings from key national bodies (e.g. annual reviews) to generate reports and engage in public discussion/debate.

C

2013 SITUATIONAL ANALYSIS

There are good examples of electronic and print media reporting on RMNCH. Development Communications Network (DevComs) has trained media on improved reporting on RMNCH . There are many privately-owned media operations, which can also be of advantage.

SCORE 2

2014 STATUS

Though there has been some regular engagement of journalists on MNCH issues by organizations such as UNICEF, C4MNH, IPAS, HERFON and E4A, reporting is not as robust as it needs to be. Currently, MNCH articles do not make front page news.

SCORE 2

RECOMMENDATIONS

Build on existing initiatives to strengthen media capacity to report on RMNCH related issues. Strategic engagement of media on RMNCH. Employ the use of social media platforms to expand reach on evidence-based data.

2014 STATUS

Media has engaged in reporting on progress towards implementation of national commitments, but not actively engaged.

SCORE 2

RECOMMENDATIONS

Improve information flows to media. Document efforts of media to identify capacity and training gaps on MNCH reporting.

2014 STATUS

AMHiN consistently hosts quarterly media interactive sessions. Media fellowship awards have been funded to facilitate more investigative and impactful reporting of MNCH issues. Devcom, IPAS provide feedback regular sessions for journalists, but is unclear if such exchange of information happens with Federal Gov. structures, beyond the coverage of programme launches.

SCORE 2

RECOMMENDATIONS

Improve information flows to media. Document efforts of media to identify capacity and training gaps on MNCH reporting.

ADVOCACY AND OUTREACH

4. COUNTDOWN EVENT FOR RMNCH

At least one national Countdown event for RMNCH is held during 2012-2014, presenting available information on RMNCH and involving high-level decision makers (e.g. parliamentarians), government, civil society, media and other stakeholders.

A

2013 SITUATIONAL ANALYSIS

Nigeria has actively participated in Countdowns. A country Countdown report/profile is produced.

SCORE 3

4. COUNTDOWN EVENT FOR RMNCH

A country CountDown report or profile is produced and is of high quality.

B

2013 SITUATIONAL ANALYSIS

Nigeria has actively participated in Countdowns. A country Countdown report/profile is produced.

SCORE 3

2014 STATUS

One national Countdown event has been held since 2012.

SCORE 4

RECOMMENDATIONS

Dissemination of RMNCH evidence should be regular and continue to involve key decision-makers.

2014 STATUS

The 2012 Countdown event presented available information on RMNCH and involved high-level decision-makers. A high quality country Countdown report was produced.

SCORE 3.5

RECOMMENDATIONS

Ensure up to date and timely collection, analysis and use of RMNCH data for planning and decision-making.

REVIEW PROCESSES

2013 OVERALL SCORE:	49%
2014 OVERALL SCORE:	76%

SCORE KEY:

1 Not present, needs to be developed

2 Needs a lot of strengthening

3 Needs some strengthening

4 Already present, no action needed

REVIEW PROCESSES

1. REVIEWS

Multi-stakeholder review meetings are conducted every year to review health sector performance against annual and long term goals and targets.

A

2013 SITUATIONAL ANALYSIS

There is a joint annual review (JAR) every year and key stakeholders are actively involved in the preparation and execution of these reviews. RMNCH programmes are reviewed during the JAR process. CSOs, Parliamentarians, the media and organized private sector are not adequately represented and involved.

SCORE 3

1. REVIEWS

Key stakeholders are actively involved in the preparation and execution of the reviews (MOH, other sectors, academia, development partners, UN, private sector and civil society including women's organizations).

B

2013 SITUATIONAL ANALYSIS

There is a joint annual review (JAR) every year and key stakeholders are actively involved in the preparation and execution of these reviews. RMNCH programmes are reviewed during the JAR process. CSOs, parliamentarians, the media and organized private sector are not adequately represented and involved.

SCORE 3

1. REVIEWS

RMNCH programme reviews are held annually and aligned with the national health sector review.

C

2013 SITUATIONAL ANALYSIS

There is a joint annual review (JAR) every year and key stakeholders are actively involved in the preparation and execution of these reviews. RMNCH programmes are reviewed during JAR. CSOs, parliamentarians, the media and organized private sector are not adequately represented and involved.

SCORE 3

2014 STATUS

Stakeholder reviews of health sector performance were conducted over the last year on RMNCH life-saving commodities and to develop Nigeria's implementation plan. Existing policies, strategies and programmes were considered to learn lessons and apply best practices. This is a key aspect of Nigeria's accelerated strategy towards achieving MDGs. national & state health sector JARs occur annually, however dissemination of performance against goals and targets are inconsistent.

SCORE 3

RECOMMENDATIONS

Strengthen inclusion of diverse stakeholders including CSOs, professional bodies, media in the JAR process at national and state levels. Ensure public dissemination of progress towards goals and targets.

Ensure alignment of the RMNCH lifesaving commodities, with the National and State Health Sector Strategic plans. Increase transparency of performance against implementation of plans.

2014 STATUS

Key stakeholders such as FMOH, NPHCDA, NAFDAC, UNFPA,UNICEF, WHO, USAID, SCI, CIDA, PRINN-MCH, CHAI etc. were actively involved in the preparation and review of this plan. Involvement of CSOs and women's groups was limited.

SCORE 3

RECOMMENDATIONS

Strengthen inclusion of diverse stakeholders including CSOs, professional bodies, women's groups and media in the JAR process at national and state levels.

2014 STATUS

The Country Implementation plan for UNCoLSC was done in August 2013. National and state health sector planning and meetings occur annually, however challenges with the use of data persist.

SCORE 3

RECOMMENDATIONS

Strengthen inclusion of diverse stakeholders including CSOs, professional bodies, media etc in the JAR process at national and state levels.

REVIEW PROCESSES

2. SYNTHESIS OF INFORMATION AND POLICY CONTEXT

The health sector performance reviews are informed by a good synthesis of all relevant health data, including RMNCH, with sub national analyses.

A

2013 SITUATIONAL ANALYSIS

The health sector performance reviews are informed by some synthesis of relevant health data; however, lack of sub-national data impacts completeness. Some states have good subnational data but others rely on national data. There is weak use of qualitative data during reviews and the use of service provider and public opinions for these reviews is limited. There is no annual assessment of data quality at national and sub-national level.

SCORE 2

2. SYNTHESIS OF INFORMATION AND POLICY CONTEXT

The reviews are informed by a systematic analysis of qualitative data , e.g. policy changes, public opinion, service provider opinions.

B

2013 SITUATIONAL ANALYSIS

The health sector performance reviews are informed by some synthesis of relevant health data; however, lack of sub-national data impacts completeness. Some states have good subnational data but others rely on national data. There is weak use of qualitative data during reviews and the use of service provider and public opinions for these reviews is limited. There is no annual assessment of data quality at national and sub-national level.

SCORE 2

2014 STATUS

National and state JAR occur annually, however use of sub-national data challenges persist. UN Commodities country Implementation Plan synthesizes multiple sources of health data (demographics, supply chain, human resources for health, health information system, logistics, financing, governance structures, social mobilization and service uptake).

SCORE

4

RECOMMENDATIONS

Greater use of sub-national RMNCH evidence in health sector performance reviews to accurately ascertain progress.

Scoring and and recommendation may change pending wider review of national and state level processes on performance of RMNCH.

2014 STATUS

While it acknowledges documented service uptake trends, it does not indicate solicitation of end user opinion or feedback.

SCORE

2

RECOMMENDATIONS

Involve community/public and service provider opinions to enrich data.

3. FROM REVIEW TO PLANNING

There are mechanisms in place to translate results of the review meeting into planning processes and resource allocation decisions at all levels.

A

2013 SITUATIONAL ANALYSIS

There is a mechanism in place to translate results of reviews into planning processes but the review process and meeting results are hardly used in resource allocation. Annual operational planning meetings have active participation of only a few stakeholders, including MNCH annual operational planning meetings.

SCORE

2

3. FROM REVIEW TO PLANNING

Annual operational planning meetings have active participation of all key stakeholders.

B

2013 SITUATIONAL ANALYSIS

There is a mechanism in place to translate results of reviews into planning processes but the review process and meeting results are hardly used in resource allocation. Annual operational planning meetings have active participation of only a few stakeholders, including MNCH annual operational planning meetings.

SCORE

3

2014 STATUS

There are mechanisms for translation of review meeting results into planning processes and resource allocation decisions at all levels. However, subsequent budget approvals rarely match recommendations made at review meetings.

RECOMMENDATIONS

Strengthen the use of review results for planning purposes, resource allocation and release in the review process.

SCORE 2

2014 STATUS

Key stakeholders participated in annual operational planning meetings. There is a trend towards the development of multi-year operational plans with mid-term review intervals. This reduces lost lag time at the beginning of each year. Partners are actively involved.

RECOMMENDATIONS

Continue monitoring.

SCORE 3

4. COMPACTS OR SIMILAR MECHANISMS

There is a country compact or similar mechanism (a government-led process of planning, coordination and facilitation of all development partners, including funding flows) and adherence is good.

A

2013 SITUATIONAL ANALYSIS

There is a country compact but there are challenges as the funding arrangements that should support the compact are not explicit. Major development partners are not committed to the compact. Some partners have not signed the compact and some partners have also not adjusted their budget allocation accordingly.

SCORE 2

4. COMPACTS OR SIMILAR MECHANISMS

All major development partners are committed to the country "compact", aim to align their resource allocations and adjust their budget allocation according to country review & planning outcomes.

B

2013 SITUATIONAL ANALYSIS

There is a country compact but there are challenges as the funding arrangements that should support the compact are not explicit. Major development partners are not committed to the compact. Some partners have not signed the compact and some partners have also not adjusted their budget allocation accordingly.

SCORE 2

2014 STATUS

A country compact is in place. Though chaired by the Federal Ministry of Health, sustainability in the absence of partner support is questionable.

RECOMMENDATIONS

Continue Monitoring.

SCORE

4

2014 STATUS

Adherence and partner commitment is good.

RECOMMENDATIONS

No action needed.

SCORE

3.5

MONITORING OF RESOURCES

2013 OVERALL SCORE:	**30%**
2014 OVERALL SCORE:	**51%**

SCORE KEY:

1 Not present, needs to be developed

2 Needs a lot of strengthening

3 Needs some strengthening

4 Already present, no action needed

MONITORING OF RESOURCES

1. NATIONAL HEALTH ACCOUNTS (NHA) FRAMEWORK AND GOVERNANCE

There is an officially approved NHA framework built upon international guidelines (SHA 2011 key + beneficiaries classifications for tracking RMNCH flows).

A

2013 SITUATIONAL ANALYSIS

There is an officially approved NHA framework but it is not for SHA 2011 (Implementation Manual and Training Guide, Oct 2010). There is a formal governance mechanism and coordinated by FMOH via Nigeria NHA team. However, the committee functions in an ad hoc manner. There is no clear system and budget line to support tracking of expenditure at all levels. No sub accounts exist for MNCH.

SCORE

3

1. NATIONAL HEALTH ACCOUNTS (NHA) FRAMEWORK AND GOVERNANCE

There is a formal governance mechanism that specifies coordination, management, national indicators and budget for implementing health accounts and tracking resources on key policy issues such as financial flows for RMNCH.

B

2013 SITUATIONAL ANALYSIS

There is an officially approved NHA framework but it is not for SHA 2011 (Implementation Manual and Training Guide, Oct 2010). There is a formal governance mechanism and coordinated by FMOH via Nigeria NHA Team. However, the committee functions in an ad hoc manner. There is no clear system and budget line to support tracking of expenditure at all levels. No sub accounts for MNCH.

SCORE

2

2014 STATUS

Historically the NHA framework has been driven and approved by the FMOH and supported by partners.

RECOMMENDATIONS

Continue monitoring.

SCORE 3

2014 STATUS

There are terms of reference (ToR) for the governing committee, but they are poorly adhered to and have not been as active since 2010. There is a system to support tracking of expenditure at national level, though not really used at sub-national levels. Most of the support came from Partners such as WHO, World Bank and USAID. Sustained ownership of the system by the government has been threatened by lack of funding. There are no sub-accounts for MNCH.

RECOMMENDATIONS

Implement the ToRs for the formal governance mechanism and ensure that it is a more inclusive process. Ensure health budget tracking at all levels, include civil society into the process and make information public. Discuss effectiveness of developing sub-accounts or analysis of NHA to determine funding for MNCH.

SCORE 2

MONITORING OF RESOURCES

2. COMPACT

There is a formal agreement (or compact) between government and partners that requires reporting on partner commitments and disbursements, and donor funded expenditures on health (including on flows for RMNCH).

A

2013 SITUATIONAL ANALYSIS

There is a compact between government and partners but it does not require reporting using standard formats. Commitments to these has not been encouraging.

SCORE 2

3. COORDINATION

There is an NHA steering committee that provides technical oversight on data needs, methods of production and data use.

A

2013 SITUATIONAL ANALYSIS

There is no effective data sharing between systems. The Nigeria NHA team serves as the steering committee for NHA. Key stakeholders are involved but the committee will benefit from further involvement of local and national NGOs and CSOs.

SCORE 3

3. COORDINATION

Key stakeholders are actively involved in the production of NHA (including government stakeholders at national and subnational level, CSOs, NGOS, partners, health insurance companies).

B

2013 SITUATIONAL ANALYSIS

There is no effective data sharing between systems Nigeria NHA team serves as the steering committee for NHA. Key stakeholders are involved but the committee will benefit from further involvement of local and national NGOs and CSOs.

SCORE 2

2014 STATUS

There is a formal agreement between government and partners that requires reporting on partner commitments, disbursements and expenditure on health.

The international standard format for NHA is used to allow comparability with other countries.

SCORE

RECOMMENDATIONS

Continue monitoring.

2014 STATUS

There is an NHA Steering Committee but, the current governance structure for NHAs is weak.

SCORE

RECOMMENDATIONS

CSO engagement can help to ensure that NHA is functional and active.

2014 STATUS

Oversight on data needs, methods of production and data use are not robust. There is no CSO or NGO involvement at this time. However, NHIS and stakeholders have been involved in the past.

SCORE

RECOMMENDATIONS

Advocate for civil society inclusion into resource tracking efforts and to NHA oversight body.

MONITORING OF RESOURCES

4. PRODUCTION

There is adequate human capacity at national and subnational levels to produce NHA tables and core indicators, including on expenditure by beneficiaries for tracking flows on RMNCH.

A

2013 SITUATIONAL ANALYSIS

There is capacity to produce NHA tables but it is not adequate and the capacity only exists at the national level. Capacity to produce NHA tables is not available at state level. Government expenditure data conversion into NHA format is not automated. There is no central database for automated production but the development of the database is in process.

SCORE 2

4. PRODUCTION

Government expenditure data conversion into NHA format is automated, including for expenditure by beneficiaries.

B

2013 SITUATIONAL ANALYSIS

There is capacity to produce NHA tables but it is not adequate and the capacity only exists at the national level. Capacity to produce NHA tables is not available at state level. Government expenditure data conversion into NHA format is not automated. There is no central database for automated production but the development of the database is in process.

SCORE 1

4. PRODUCTION

There is a central database for automated production of standard NHA tables, including tables by beneficiaries; automated production of key indicators (including COIA indicators); methods and sources are well documented and accessible.

C

2013 SITUATIONAL ANALYSIS

There is capacity to produce NHA tables but it is not adequate and the capacity only exists at the national level. Capacity to produce NHA tables is not available at state level. Government expenditure data conversion into NHA format is not automated. There is no central database for automated production but the development of the database is in process.

SCORE 1

2014 STATUS

Ttraining was done at national Level on collecting data for the NHA across the country, completed in 2014.

SCORE 3

RECOMMENDATIONS

Continue monitoring.

2014 STATUS

Extensive training was done at state Level in 17 of the 36 states. LGA coverage was sparse.

SCORE 2

RECOMMENDATIONS

Train FMOH and SMOH staff on NHA and system of health accounts.

2014 STATUS

Unable to verify.

SCORE 1

RECOMMENDATIONS

Develop and/or strengthen database for NHA and create/ strengthen dedicated desk at FMOH and SMOHs.

MONITORING OF RESOURCES

5. ANALYSIS

Analytical summaries are produced annually on SHA 2011 health accounts (including beneficiaries).

A

2013 SITUATIONAL ANALYSIS

Analytical summaries are not produced annually on SHA 2011 but there is a plan to produce them annually. The SHA 2011 NHA, indicators and analysis are not publicly available in Nigeria but they are available on the website of the World Health Organization.

SCORE 1

5. ANALYSIS

SHA 2011 NHA (including beneficiaries for tracking RMNCH) and indicators and analyses are publicly accessible.

B

2013 SITUATIONAL ANALYSIS

Analytical summaries are not produced annually on SHA 2011 but there is a plan to produce them annually. The SHA 2011 NHA, indicators and analysis are not publicly available in Nigeria but they are available on the website of the World Health Organization.

SCORE 1

6. DATA USAGE

SHA 2011 NHA (including beneficiaries for tracking RMNCH) are an essential element of annual reviews and are used in the development of national policies, including RMNCH-specific policies.

A

2013 SITUATIONAL ANALYSIS

Nigeria is not yet using SHA 2011; however, the NHA data that is available is being used for policy making.

SCORE 2

2014 STATUS

Unable to verify whether analytical summaries for SHA 2011 were produced.

SCORE

RECOMMENDATIONS

Strengthen analytical capacity on the use of the SHA tool in government at all levels and other institutions. Include civil society in the process of using the tools. Ensure up-to-data analysis of SHA and NHA.

2014 STATUS

Unable to verify whether analytical summaries for SHA 2011 were produced, and therefore cannot verify whether they are publically accessible.

SCORE

RECOMMENDATIONS

Disseminate report and analyses on public website in Nigeria to facilitate transparency and accessibility to this important information.

2014 STATUS

NHA data only to some extent, as many states are no longer compliant. In a limited measure NHA data is used in policy making.

SCORE

RECOMMENDATIONS

Advocate for /promote use of NHA data in policy making process. Involve CSO and media in this process. Produce budget tracking scorecards to determine progress on allocation, release and use of funds. Promote the use of NHA data as an advocacy tool to address gaps in health care financing and budget process.

E-HEALTH AND INNOVATION

2013 OVERALL SCORE:	**25%**
2014 OVERALL SCORE:	**59%**

SCORE KEY:

1 Not present, needs to be developed

2 Needs a lot of strengthening

3 Needs some strengthening

4 Already present, no action needed

E-HEALTH AND INNOVATION

1. POLICY

A national eHealth strategy or policy has been developed, including the use of ICT for MNCH.

A

2013 SITUATIONAL ANALYSIS

The national ICT policy is in place. Stakeholders have been invited to attend a meeting on eHealth policy development for the National eHealth Strategy under NPHCDA use during MNCH week.

SCORE 2

2. INFRASTRUCTURE

There is connectivity (internet, broadband, and mobile) and infrastructure (computers) available for health reporting in urban areas, district capitals and rural areas.

A

2013 SITUATIONAL ANALYSIS

There is connectivity for mobiles. Efforts to improve internet and broadband connectivity are in place.

SCORE 2

2014 STATUS

A National eHealth Strategy and policy has been developed but not yet rolled out. The National eHealth Strategy is all encompassing.

SCORE 2.5

RECOMMENDATIONS

Ensure roll-out of national ehealth strategy.

2014 STATUS

There is the use of phones and computers in all levels of health facilities including rural health facilities.

Connectivity for internet and broadband is non-existent in most rural areas.

There is connectivity for mobile phones for health reporting in district and urban facilities.

There is connectivity for mobile phones for health reporting in rural facilities, but network signals are poor and/or intermittent.

Computers are available for use in health reporting in urban health facilities and district capitals.

Computers are available for use in health reporting in rural areas but penetration is still low. There is a coverage of about 52% and in 16,000 health centres on e health overall.

SCORE 2.5

RECOMMENDATIONS

Ensure investment in appropriate infrastructure and scale-up of ehealth infrastructure and technology in rural health facilities.

E-HEALTH AND INNOVATION

3. SERVICES

eHealth services and applications are used to improve recording, reporting and performance of information systems (e.g., reporting on maternal death or immunization).

A

2013 SITUATIONAL ANALYSIS

eHealth services and applications are not used to improve recording and reporting, however, rapid SMS is being used to improve recording and reporting during IMNCH weeks.
There are some adhoc efforts to record and report.
There is no effective data sharing between systems.

SCORE 2

3. SERVICES

There is effective data sharing between systems (e.g. facility data on child health workload with health worker information).

B

2013 SITUATIONAL ANALYSIS

eHealth services and applications are not used to improve recording and reporting, however, rapid SMS is being used to improve recording and reporting during IMNCH weeks .
There are some adhoc efforts to record and report.
There is no effective data sharing between systems.

SCORE 1

4. STANDARDS

There are commonly agreed interoperability requirements or standards for eHealth services and application, e.g. for data storing, transfer and compilation.

A

2013 SITUATIONAL ANALYSIS

There are commonly agreed interoperability requirements or standards for eHealth. DHIS 2.0 database exists for data exchange and analysis. The Nigeria Health Management Information System (NHMIS) unit of the FMOH is leading the process.

SCORE 3

2014 STATUS

e-Health services have been used to improve reporting and recording rates. We are now at 52% overall. (Links to data availability for specific health programmes is not provided).

SCORE

RECOMMENDATIONS

Determine the eHealth services required to support the country's priority programmes and goals, particularly with respect to information flows.

2014 STATUS

There is effective data sharing between systems, but examples of data sharing were unavailable.

SCORE

RECOMMENDATIONS

Establish effective data sharing system at all levels. Success stories of effective data sharing should be documented and shared.

2014 STATUS

There are jointly agreed standards for ehealth services and applications. Other partners, such as WHO have also been actively involved.

SCORE

RECOMMENDATIONS

Continue to monitor.

E-HEALTH AND INNOVATION

5. GOVERNANCE

There is a national coordination mechanism for eHealth, with stakeholder involvement (health and non-health) in planning and implementation.

A

2013 SITUATIONAL ANALYSIS

A national coordination mechanism for eHealth has not yet been established but early discussions are underway.

SCORE 1

6. PROTECTION

Data protection, legislation and regulatory frameworks exist for sharing health information.

A

2013 SITUATIONAL ANALYSIS

There are no legislation and regulatory frameworks for data protection. There is lack of clarity over data protection. Data protection policies are not enforced.

SCORE 1

6. PROTECTION

Data protection policies are enforced and adhered to.

B

2013 SITUATIONAL ANALYSIS

There are no legislation and regulatory frameworks for data protection. There is lack of clarity over data protection. Data protection policies are not enforced.

SCORE 1

2014 STATUS

We have a national data bank that generates data, then shares with the other levels. There is a coordination mechanism or governance system for ehealth, which is driving the formulation of the national policy. The governance structure includes CSOs, media and development partners. The development partners are more active and the CSOs are not very participatory because they do not know what they should be doing.

SCORE

RECOMMENDATIONS

Support a strong and effective coordination /governance mechanism (including CSOs, media and development partners) . Provide CSOs with necessary information on progress to enhance watchdog role.

2014 STATUS

There is a regulatory/legislative framework for data projection when sharing health information. It is part of the policy that has recently been developed on ehealth education.

SCORE

RECOMMENDATIONS

Enforce compliance to data protection policies, guidelines, procedures and SoP.

2014 STATUS

Data projection and policies are enforced at the national level where there is data security . In this stage, no individual ID is required at the health facility level, apart from email access. Data is shared by personal information.

SCORE

RECOMMENDATIONS

Enforce compliance to data protection policies, guidelines, procedures and SoP.

MATERNAL DEATH SURVEILLANCE AND RESPONSE

2013 OVERALL SCORE:	**4%**
2014 OVERALL SCORE:	**35%**

SCORE KEY:

1. Not present, needs to be developed
2. Needs a lot of strengthening
3. Needs some strengthening
4. Already present, no action needed

MATERNAL DEATH SURVEILLANCE AND RESPONSE

1. NOTIFICATION

There is a national policy requiring notification of all maternal deaths (maternal death is a notifiable event within 24 hours).

A

2013 SITUATIONAL ANALYSIS

Maternal Death Notification does not exist within the National policy.

SCORE 1

2. CAPACITY TO REVIEW AND ACT

There is national capacity to review and act as part of a system of maternal death surveillance and response.

A

2013 SITUATIONAL ANALYSIS

There is a national capacity but not properly coordinated (FIGO has trained a critical mass of obstetricians and gynaecologists).

SCORE 2

2. CAPACITY TO REVIEW AND ACT

There is district capacity to review and act as part of a system of maternal death surveillance and response.

B

2013 SITUATIONAL ANALYSIS

No State/LGA/facility capacity to review and act

SCORE 1

2014 STATUS

The national policy does not have provision for notification of maternal deaths within 24hrs. Notification of maternal deaths varies by state. Maternal Death Surveillance and Response (MDSR) reporting has not been included in the revised IMNCH strategy. The 2010 revised IDSR policy does not include MDSR.

SCORE

RECOMMENDATIONS

Implement recommendations in national guidelines and tools to ensure maternal death is a notifiable event. Include MDSR in the on-going IDSR strategy review. Include MDSR in the on-going IMNCH review.

2014 STATUS

Training on MDSR was given to government, academia and NGOs at national level to improve coordination.

SCORE

RECOMMENDATIONS

Continue to monitor.

2014 STATUS

Limited training has been offered at sub-national levels. Training was conducted for 5 state ministries of health namely Jigawa, Kano, FCT, Ondo and Delta states.

SCORE

RECOMMENDATIONS

Establish State/LGA/facility MDSR teams to review and act on findings. Develop perinatal death review policy, guidelines and tools.

MATERNAL DEATH SURVEILLANCE AND RESPONSE

3. HOSPITALS/FACILITIES

Hospital reporting of maternal deaths is nearly complete (over 90%) and timely (within 24 hours) and provides reliable cause of death using ICD.

A

2013 SITUATIONAL ANALYSIS

No (Some hospitals do MDR - All facilities in Lagos and Ebonyi States and the majority of federal tertiary institutions are conducting MDRs).Effort by partners to support NPHCDA to improve quality of care at PHC.

SCORE 1

3. HOSPITALS/FACILITIES

All maternal deaths occurring in hospitals (public and private) are reviewed

B

2013 SITUATIONAL ANALYSIS

No (Some hospitals do MDR - All facilities in Lagos and Ebonyi States and the majority of federal tertiary institutions are conducting MDRs).Effort by partners to support NPHCDA to improve quality of care at PHC.

SCORE 1

4. QUALITY OF CARE ASSESSMENTS

Quality of care assessments are conducted in a sample of maternity facilities on a regular basis (at least once every two years).

A

2013 SITUATIONAL ANALYSIS

No; an integrated maternal , newborn and child health quality of care tool has been developed by FMOH but not piloted yet. However NPHCDA has tools for PHCs. There are some existing quality of care assessments done partners in a range of geographic areas with minimal coordination at national level.

The last EmONC survey was done 10 years ago.

SCORE 1

2014 STATUS

Hospital reporting within 24hrs is not being achieved. Hospitals are not currently required to do this.

RECOMMENDATIONS

Fast track implementation of the approved national MDR guidelines and tools by Honourable Minister of Health.

SCORE

2014 STATUS

Maternal Death Reviews occur in public hospitals but not for all maternal deaths. Neither public nor private hospitals are required.

RECOMMENDATIONS

Improve reporting by hospitals and training on MDR at facility levels. Learning from examples elsewhere in the country through 'action network' virtual and physical meetings.

SCORE

2014 STATUS

We are not aware of any quality of care assessment being conducted unless it is being done by individual hospitals. If a quality of care assessment has been conducted the results have not been disseminated to national and state levels.

RECOMMENDATIONS

Establish a regular system of QoC assessments, with good dissemination of results for policy and planning. Conduct an EmONC survey every 5 years. Improve coordination and disseminate findings to wider stakeholders at national and state levels. Establish process of confidential enquiry or use the national MDR steering committee to review MDR findings and produce national recommendations. Instate similar institutional process at state level.

SCORE

MATERNAL DEATH SURVEILLANCE AND RESPONSE

5. COMMUNITY REPORTING AND FEEDBACK

All community maternal deaths are reported to districts within 24 hours.

A

2013 SITUATIONAL ANALYSIS

Some maternal deaths are recorded at village level, but data is poorly transmitted to LGA, state and federal level.

SCORE 1

5. COMMUNITY REPORTING AND FEEDBACK

Electronic devices are used to get faster and more complete reporting from communities and to initiate response.

B

2013 SITUATIONAL ANALYSIS

The electronic data reporting (DHIS 2.0) will commence soon through Global Fund and relevant partner resources. UNICEF will support NPoPC with dashboards to improve death reporting. Birth reporting is already in existence.

SCORE 1

5. COMMUNITY REPORTING AND FEEDBACK

Verbal autopsies are done for community maternal deaths.

C

2013 SITUATIONAL ANALYSIS

No

SCORE 2

5. COMMUNITY REPORTING AND FEEDBACK

Communities receive feedback and are involved in the review.

D

2013 SITUATIONAL ANALYSIS

No

SCORE 1

2014 STATUS

Community links with LGA and state structures are weak, therefore, not all community maternal deaths are report to LGAs.

SCORE 1

RECOMMENDATIONS

Develop/strengthen a community system of maternal death reporting and response within 24hrs using ICT.

2014 STATUS

Not all community maternal deaths are reported to LGAs, therefore we cannot determine whether they are reported within 24 hours.

SCORE 1

RECOMMENDATIONS

Develop/strengthen a community system of maternal death reporting and response within 24hrs using ICT.

2014 STATUS

Though there may be pilots in parts of the country, the proportion of reports made by electronic devices is unknown.

SCORE 1

RECOMMENDATIONS

Strengthen a system of maternal death reporting and response initiation by electronic devices.

2014 STATUS

NPHCDA introduced verbal autopsies to MSS sites in 2011; implementation achieved to date is unclear. A far as we are aware, community feedback from or contribution to MDRs is minimal.

SCORE 1.5

RECOMMENDATIONS

Develop national guidelines and tools for conducting verbal autopsy in communities. Develop system of involving communities in review and response.

MATERNAL DEATH SURVEILLANCE AND RESPONSE

6. REVIEW OF THE SYSTEM

The maternal death surveillance and response system is reviewed annually in terms of completeness of surveillance and quality of the response, including actions to improve quality of care.

2013 SITUATIONAL ANALYSIS

No.

A

SCORE

1

2014 STATUS

The first guidelines for MDRs were written for a small pilot that would be implemented on two levels. The first was to be done in all federal government facilities, while the second would be expanded on what the MSS had started in PHCs.The observations made during the pilot were to inform the future scale up. Five states have implemented MDRs and there will be lessons to learn after 12 months of implementation. Results are not yet ready to be disseminated, they are being finalised. Recommendations have not yet been made as results are currently being finalised.

RECOMMENDATIONS

Continue to monitor. Identify platform through which MDR findings can be systematically reviewed and recommendations made/acted upon at all levels. Publish and disseminate annual MDR results and recommendations. Publish MDR results at national and state level and track progress of implementation.

SCORE

MONITORING OF RESULTS

2013 OVERALL SCORE:	**33%**
2014 OVERALL SCORE:	**64%**

SCORE KEY:

1. Not present, needs to be developed
2. Needs a lot of strengthening
3. Needs some strengthening
4. Already present, no action needed

MONITORING OF RESULTS

1. M&E PLAN

There is a comprehensive M&E plan for the National Health Strategy that specifies indicators, data sources, analysis, dissemination and roles and responsibilities.

A

2013 SITUATIONAL ANALYSIS

There is a comprehensive M&E plan for the National Health Strategy and all partners have bought into it. The RMNCH M&E plan is fully aligned with the overall health sector M&E plan and all the 11 core RMNCH indicators are included.

SCORE 3

1. M&E PLAN

The RMNCH M&E plan is fully aligned with the overall health sector M&E plan and includes the 11 core RMNCH indicators

B

2013 SITUATIONAL ANALYSIS

There is a comprehensive M&E plan for the National Health Strategy and all partners have bought into it. The RMNCH M&E plan is fully aligned with the overall health sector M&E plan and all the 11 core RMNCH indicators are included

SCORE 2

2. M&E COORDINATION

There is a well-functioning national M&E coordination committee, with representation of the key constituencies (MOH, statistics, academia, civil society, development partners, UN)

A

2013 SITUATIONAL ANALYSIS

There is an M&E coordination committee at national level with some key constituencies, but several constituents are missing such as CSOs and academia. A broader range of constituents are represented in the RMNCH committee, but the M&E sub-committee of the RMNCH committee is not functional. Many states do not have the committees and it is not functional where it exists.

SCORE 2

2014 STATUS

There is a comprehensive health plan strategy with buy-in of all stakeholders. The NHSDP M&E plan is the overarching strategy document for all health interventions, while the IMNCH strategy operationalizes the MNCH component of the NHSDP. Based on this both are in alignment.

SCORE 4

RECOMMENDATIONS

Continue to monitor.

2014 STATUS

The NHSDP M&E plan is fully aligned with the overall health sector M&E plan. Most of the CoIA indicators are included, if not all.

SCORE 3.5

RECOMMENDATIONS

Continue to monitor.

2014 STATUS

There is an M&E Coordination Committee at national level anchored by the DPRS.

There is not sufficient representation by CSOs and academia within the M&E Coordination Committee.

Compliance with RMNCH Core Technical Committee (CTC) at state level is low.

SCORE 2

RECOMMENDATIONS

Continue to monitor

Reactivate/establish RMNCH CTC in all states and include other constituents such as civil society, academia and statisticians in the M&E committees. HMIS/M&E officers to coordinate M&E issues.

Ensure regular meetings of the RMNCH CTCs and M&E committees.

MONITORING OF RESULTS

3. HEALTH SURVEY

There is a national health survey plan

A

2013 SITUATIONAL ANALYSIS

There is a national health survey plan but implementation is weak. Important gaps in coverage and content exist. There is a DHS planned for 2013 and the MNCH indicators are included

SCORE

2

3. HEALTH SURVEY

An MNCH Intervention Survey is planned for 2012-2013

B

2013 SITUATIONAL ANALYSIS

There is a national health survey plan but implementation is weak. Important gaps in coverage and content exist. There is a DHS planned for 2013 and the MNCH indicators are included.

SCORE

3

2014 STATUS

Yes, but adherence can not be verified at this time. However the NDHS 2013 covers MNCH indices nationwide and with most indicators disaggregated by state.

SCORE

RECOMMENDATIONS

Continue to monitor

2014 STATUS

Unable to verify

SCORE

RECOMMENDATIONS

Not applicable .

MONITORING OF RESULTS

4. FACILITY DATA (HMIS)

There is a well functioning facility reporting system (HMIS) that provides subnational statistics for core indicators with a data quality report.

A

2013 SITUATIONAL ANALYSIS

There is a facility reporting system in place but it is weak. Facility survey for data verification and service readiness is not carried out annually. There is limited transmission of information from the community level (ward development committees) to health facility.

SCORE 2

4. FACILITY DATA (HMIS)

A facility survey for data verification and service readiness (SARA) is carried out annually.

B

2013 SITUATIONAL ANALYSIS

There is a facility reporting system in place but it is weak. Facility survey for data verification and service readiness is not carried out annually. There is limited transmission of information from the community level (ward development committees) to health facility.

SCORE 2

2014 STATUS

There is a well-functioning facility reporting system, the DHIS 2.0 is also being rolled out and covers more indicators. Accuracy and completeness of reporting, however, is still challenging in many states. HMIS officers have been trained on the use of DHIS 2.0.

SCORE

3

RECOMMENDATIONS

Continue to monitor

2014 STATUS

Community data tools have been developed to facilitate the collection of community health data but unable to verify if in use.

Unable to verify whether facility survey for data verification and service readiness carried out in the last year.

HMIS coverage has not yet been expended to include private facilities.

SCORE

2

RECOMMENDATIONS

Continue to monitor

Conduct annual facility survey for data verification and service readiness.

Initiate discussion with government about inclusion of private sector health data in DHIS 2.0

MONITORING OF RESULTS

5. ANALYTICAL CAPACITY

Good quality analytical reports of progress and performance are produced to inform reviews (annual, mid term, final).

A

2013 SITUATIONAL ANALYSIS

Analytic reports of progress and performance are available but they need to be improved.

SCORE 2

6. EQUITY

Disaggregated health data on key indicators (sex, income, minority and location) are used extensively in reviews.

A

2013 SITUATIONAL ANALYSIS

Only DHS captures and disaggregates health data on sex, wealth, age and location.

SCORE 2

7. DATA SHARING

There is an up-to-date country health data repository, including subnational data, for public access to all relevant reports and data on key health indicators.

A

2013 SITUATIONAL ANALYSIS

There is no health data repository in Nigeria that is available for public access.

SCORE 1

2014 STATUS

Quality reports on progress and performance are currently being produced. Despite this, access and transparency is inconsistent across states.

At national and state levels, analytical reports of progress are used, primarily by State Ministry of Health, with limited utilization by other stakeholders and at the LGA level.

SCORE 3

2014 RECOMMENDATIONS

Increase transparency and accessibility of progress reports to diverse stakeholders including media, professional bodies and CSOs to promote advocacy and accountability.

2014 STATUS

HMIS - To a limited degree DHIS 2.0 - captures and disaggregates more but not for all indicators.

To a large extent the health data is used extensively in reviews.

Equity analysis is not included in reviews.

SCORE 2

2014 RECOMMENDATIONS

Continue to monitor.

Promote extensive use of health data for reviews.

Include equity analyses in reviews.

2014 STATUS

HMIS and DHIS 2.0 include subnational data.

The DHIS 2.0 is supposed to be accessible to the public but this fact may not have been disseminated widely by the DPRS yet.

SCORE 2.5

2014 RECOMMENDATIONS

Continue to monitor.

Relevant reports to be made available to the public on key health indicators.

CIVIL REGISTRATION AND VITAL STATISTICS

2013 OVERALL SCORE:	**8%**
2014 OVERALL SCORE:	**53%**

SCORE KEY:

1. Not present, needs to be developed
2. Needs a lot of strengthening
3. Needs some strengthening
4. Already present, no action needed

CIVIL REGISTRATION AND VITAL STATISTICS

1. ASSESSMENT & PLAN

A rapid assessment of the status and practices of CRVS has been conducted in the last 5 years

A

2013 SITUATIONAL ANALYSIS

No rapid assessment has been conducted in the last 5 years. 30% of birth registrations, however, were covered (2008 NDHS), Statistical Commission of Africa 2011 In-depth Assessment, Routine Data Collection in the LGAs on Birth Registration. Also partnership with FMOH on MNCH strategy.

SCORE 1

1. ASSESSMENT & PLAN

A full assessment of the status and practices of CRVS has been conducted and a improvement plan has been developed

B

2013 SITUATIONAL ANALYSIS

There was an assessment done by NPoPC covering the period from 1994 – 2007, but only assessed births, deaths and still births. Currently an operational plan covering years 2012 – 2016 has been developed.

SCORE 1

2014 STATUS

There is no published record of Rapid CRVS on National Population Commission. A review of the CRVS system was completed in 2014.

30% of de jure (recognised by law) children under five have their births registered.

No Health Statistics Report given by Nigeria in 2013

13% of birth registration was done at the LGA level

A partnership exists with the FMOH concerning MNCH strategy but it is not strong. A strengthened partnership requires better collaboration and information sharing between government and partners.

SCORE

2

RECOMMENDATIONS

Conduct rapid CRVS assessment and use results for advocacy/mobilization of key stakeholders. Explore ways of improving birth and death registration such as using rapid SMS.

2014 STATUS

The last report for vital registration was done in November 2008. It was a report for vital statistics between 1994-2007. A full CRVS assessment has not been carried out by NPoPC.

No improved plan has been developed as no assessment has taken place.

SCORE

2.5

RECOMMENDATIONS

Conduct rapid CRVS assessment and use results for advocacy/mobilization of key stakeholders. Explore ways of improving birth and death registration such as using rapid SMS.

CIVIL REGISTRATION AND VITAL STATISTICS

2. COORDINATING MECHANISM

There is an interagency coordinating committee that involves key stakeholders from civil registrar's office, national statistics office and ministry of health.

A

2013 SITUATIONAL ANALYSIS

The National Population Commission is the coordinating agency on all population matters but no specific committee is coordinating vital registration. The process of establishing a coordinating committee is already on-going.

SCORE 1

3. HOSPITAL REPORTING

Hospital reporting of deaths is complete and accurate

A

2013 SITUATIONAL ANALYSIS

Not complete and not accurate.

SCORE 1

3. HOSPITAL REPORTING

Hospital reporting of deaths includes a cause of death, using the ICD-10, with regular quality control

B

2013 SITUATIONAL ANALYSIS

Causes are recorded but not ICD 10 compliant, except at tertiary facilities and little regular quality control.

SCORE 2

2014 STATUS

A multi sectorial committee was established called ICC-CRVS. They meet quarterly (have met twice since last year) and it is chaired by NPoPC.

The committee is chaired by the NPoPC.

SCORE

RECOMMENDATIONS

Continue to monitor

2014 STATUS

Hospital death reporting rate for public institutions is fair. For private institutions, however, it is poor.

SCORE

RECOMMENDATIONS

Improve hospital reporting, particularly among private facilities and use electronic reporting system

2014 STATUS

Most hospitals are still implementing classification that is not the latest version of ICD coding. Training updates will still be needed.

In various parts of the nation, medical record officers and doctors have been trained and certified to improve coding practices. This, however, is still not comprehensive.

SCORE

RECOMMENDATIONS

Training of doctors in ICD 10, regular quality control of certification and improve coding practices.

Training of medical records officers and others on reporting on deaths and linkages with NPoPC established for registrations of the deaths.

CIVIL REGISTRATION AND VITAL STATISTICS

4. COMMUNITY REPORTING

Community births and deaths are reported, using ICT where appropriate, covering the whole country.

A

2013 SITUATIONAL ANALYSIS

Is being done in very few communities but not ICT compliant.

SCORE 2

4. COMMUNITY REPORTING

Verbal autopsy (VA) is done for deaths without medical certification in the community

B

2013 SITUATIONAL ANALYSIS

Yes, NPoPC registrars are trained on verbal autopsy reporting.

SCORE 2

5. VITAL STATISTICS

Vital statistics (fertility and mortality) are published every year, for national and subnational level, with data quality assessment.

A

2013 SITUATIONAL ANALYSIS

Vital statistics (fertility and mortality) are not published every year, for national and subnational level, with data quality assessment.

SCORE 1

2014 STATUS

Community deaths are reported nationwide, but not systematically.

SCORE 2

RECOMMENDATIONS

Community mobilization/advocacy

2014 STATUS

The reports are not ICT compliant.

Verbal Autopsy reporting is at rudimentary stages, however, there may be a few small pilot projects across the country that have started to focus on this.

SCORE 1.5

RECOMMENDATIONS

Strengthen community reporting of births and deaths by implementing innovative approaches including ICT techniques (direct data capture, use of mobile phones).

Improve community reporting through use of VA by training of more NPoPC registrars and other community workers. Increase the number of community registration centres.

2014 STATUS

There is a vital statistics report at national level, but not at sub-national levels.

The data quality is assured before publication.

SCORE 2.5

RECOMMENDATIONS

Increase capacity to process more vital statistics data by state and district data entry clerks. ICT equipment and funds should be provided by NPoPC.

Continue to monitor

6. LOCAL STUDIES FOR MORTALITY STATISTICS (HDSS)

There are local health and demographic surveillance sites (HDSS) that provide regular and timely (less than 3 years old) vital statistics including cause of death that are used in annual health reviews.

2013 SITUATIONAL ANALYSIS

There are no local health and demographic surveillance system sites (HDSS) that provide regular and timely (less than 3 years old) vital statistics including cause of death that are used in annual health reviews.

A

SCORE

1

2014 STATUS

A National Health and Demographic Surveillance System has not been established in Nigeria yet and therefore cannot be used for annual health reviews.

RECOMMENDATIONS

Establish HDSS system to report regularly on deaths and still births, including annual health reviews.

SCORE

AMHiN acknowledges and appreciates the generous technical and financial support of the following organisations towards the development of this scorecard.