A case study of Nigeria Evidence-based Health System Initiative (NEHSI) In Bauchi State

Presentation made to the Joint Planning Board (JPB) Meeting

By

Aminu Hammayo,
Secretary to the State Government

At Zarandah Hotel, Bauchi

23 April 2014

Introduction

- The objective of this presentation is to share with participants the achievements of the NEHSI project in Bauchi State and its impact in Planning and Resource Allocation. This is particularly in relation to the need to address the unacceptable levels of maternal & child mortalities.

Background

- Information is the cornerstone to plan and deliver better services and improve development outcomes
- This requires a major improvement in the Information systems, especially the capacity to generate, analyse and use evidence for planning and resource allocation

Background (Cont'd)

- Since 2009, the Federal Government working with the Canadian Government had initiated a model of evidence based planning in the health sector in Bauchi and Cross River States
- The five year project which started in 2008 was funded by CIDA through IDRC and ended in December 2013

Scope of the Initiative

- Social Audits: Population based benchmarks for evidence based planning
- Modelling Strategies to socialise evidence for participatory action (SEPA)
- Community Surveillance System: Strengthening community based HMIS
- Human Capital development for Institutionalisation and sustainability

Multi Stakeholder Information System (MSS) Social Audit

- Since 2009, under the auspices of the SMOH and with the support of the SPHCDA, the MSS component of NEHSI has established and implemented three rounds of social audit
- The State Government had decided the priorities for the social audits
- The first (2009-10) focused on maternal health outcomes

Multi Stakeholder Information System (MSS) Social Audit (Cont'd)

- The second covered child healthcare within the context of the Integrated Management of childhood illnesses (IMCI)
- The third was on primary healthcare Millennium development goals which consolidated the two priority areas
- The social audits had initially used paper based data collection system but later shifted to a geo-referenced electronic data gathering and transmission system

Modelling Strategies to socialise evidence for participatory action (SEPA)

- Under this initiative, the evidence generated from the surveys were shared with all major stakeholders at the state and local government levels using scorecards
- At the community and household levels, a documentary drama was used to share the evidence to help generate community and individual action plans to improve the situation

Findings from the first social audit

A woman was more likely to suffer from complications during pregnancy or child birth if she:

- had four or more pregnancies
- was exposed to physical Intimate Partner violence (IPV)
- was not discussing pregnancy with the husband
- had insufficient food during the week prior to survey
- had female genital mutilation (FGM)
- had less than four Antenatal checkups
- was delivered by an un-skilled birth attendant

Follow-up evidence based actions

Need to Implement a structured strategy for social mobilisation to:

- Increase awareness on danger signs during pregnancy/child birth
- Reduce heavy workload during pregnancy
- Encourage women and their husbands to discuss about pregnancy
- Ensure at least four home visits to pregnant women by a trained worker
- Prevent intimate partner and domestic violence during pregnancy
- Improving availability of skilled health workers

Health seeking for illness/experience at health facility

- *Health seeking behaviour (children 0-36 months)*
  - 3% had mothers involved in deciding where to go
  - 49% taken to a qualified health facility for treatment
  - 46% taken to a government health facility (map)

- *Experience at government health facility*
  - 56% waited less than 30 minutes to be seen
  - 45% received full explanation about child's condition
  - 66% paid for treatment at the health facility
  - 27% paid for medicines or tests outside the facility

Social Audit on PHC MDGs -Scope of data collection

Units	*2009*	*2011*	*2013*
Households (all LGAs)	5709	5535	6230
Women 14-49 years	11486	-	8881
Mothers/caregivers	-	6933	7775
Children 0-59 months*	-	11277	12331
Children 6-59 months (MUAC)	-	7183	9355
Focus groups	180	180	TBD**

Maternal health

Indicator	2009	2013
Knowledge on danger signs		
during pregnancy	50%	88%
during childbirth	50%	80%
ANC coverage (4 visits)	40%	47%
BP checked on every visit	35%	44%
Urine tested on every visit	8%	4%

Maternal health

Indicator	2009	2013
Delivery at a health facility	19%	21%
By a skilled heath worker	20%	22%
Post natal checkup within 6 weeks	14%	28%
Paid unofficial charges for ANC	50%	57%

Child health

Nutrition and immunisation*	2011	2013
Exclusively breastfed into 6 months	9%	6%
Malnourished (MUAC)	12%	9%
Received measles vaccine	42%	29%
Received all vaccines	12%	7%
Received polio vaccine	85%	92%
Had measles like symptoms	30%	23%

* Vaccine coverage reported among children aged 12-23 months

Child health

Personal hygiene	2011	2013
Households with		
access to improved water source	42%	47%
a formal toilet within	-	62%
no garbage, sewage or excrete	24%	15%
water container clean/covered/raised	31%	17%

Child health

Bed nets and Malaria	2011	2013
Households with treated bed nets	87%	78%
Children 0-59 sleeping under a net	52%	49%
Had high fever*	28%	37%
Taken to a qualified facility	40%	44%
Received anti-malarial medicines	16%	40%

* Last two weeks prior to survey as a proxy to malaria

Child health

Quality of care at health facilities*	2011	2013
waited for 30 minutes or less	57%	53%
given full explanation about illness	45%	62%
received all prescribed medicine	63%	69%
paid unofficial charges for treatment	66%	79%

* For children taken to a govt. facility for treatment during last one year

CSS: Implementation framework

- Initiated as a pilot in Oct 2010 in Giade LGA, Bauchi
- Involved training of health workers to visit 400-600 households
- Identify pregnant women; screen all women of child bearing age. The pregnant woman is visited every two months to identify her risk status
- Based on her situation, a plan for managing the risk as identified is made. A male worker discusses with the husband of the pregnant woman for a plan to address the risk

CSS: Implementation framework

- Work divided into three distinct phases
  - Phase 1: paper instruments, Bhopal books, 10 communities
  - Phase 2: e-data gathering with NDG, Nokia handsets, universal coverage
  - Phase 3: e-data gathering with ODK, android tablets, universal coverage

Coverage so far…..

- 39,426 households registered
- 22,745 pregnancies registered and followed
- 3,264 new born registered and followed

during the period Jun-Dec 2013……

- 7,176 home visits
- 23,646 visits to pregnant women
- 13,379 visits to husbands

Preliminary trends in maternal mortality

Contrast among three phases

	Mat deaths	Live births	MMR
Phase 1	12	1359	883
Phase 2	28	4488	624
Phase 3	29	5126	566

Planning Concerns

Improvements in maternal health indicators but…

- Quality of care still a concern
- More people paying unofficial charges at facilities
- Low indices on hygiene and child care practices

Most importantly…..

- Polio coverage improves but routine goes down

Action Implications

- **SMOH**
- review free treatment policy/quality of care
- improve upon governance and system checks
- bring in community for local accountability
- **SPHCDA**
- advocates donors allocate more on routine immunisation
- use home visits as a means to reach non-adopters of PHC services

Action Implications

BACATMA

- implements awareness package on use of bed nets

SOCIAL AUDIT TEAM

- helps SPHCDA & BACATMA to produce video clips on key messages
- uses third cycle focus groups to identity contents for knowledge translation

Human Capital development

- Information can only become useful evidence if capacities are present to analyse, interpret and use the information
- With NEHSI, there has been capacity building/training of a pool of human resources with specific set of skills to carry out different components of social audit
- These include those at policy level within MDAs, institutions & LGA Councils

Human Capital development

- Continuous involvement of State/LGA stakeholders
- 18 state officials trained in basic data analysis
- 13 trainers/supervisors/128 workers trained in home visit methods
- 9 participants to the eight week course completed the draft publication – under review for submission

Sustainability strategies

Skill transfer

- training and supervision
- field data collection including electronic
- basic analysis and interpretation – scorecards
- come from state as well as LGAs
- both from government as well as NGOs

Domestication - CSS unit in SPHCDA

Expansion – Beyond the Health Sector (Multi sectoral)

Sustainability strategies

Financial sustainability

- Estimate minimum costs - SMOH
- Line-up existing resources – SMOH/SPHCDA (human, space, vehicles)
- Establish permanent budget lines – MOB&P

Benefits of social audit

- Information has provided useful context to the MOB&EP to evaluate progress against key indicators not just in health but other sectors
- SMOH and its agencies as well as LGAs have leveraged on social audit evidence to develop their strategic plans
- The social audit evidence has also been used as a justification for budget allocations
- It also provided a basis to source for resources and support from donor agencies
- Having access to the same evidence, the SPC has found it easy to evaluate justifications for proposed allocations from other MDAs

Benefits of social audit

Though health sector driven, the evidences have been used beyond the Health related MDAs. It has provided useful guide for some other MDAs, for example:

- Drawing up plans for portable water accessibility (MWR);
- Addressing socio-cultural practices that are inimical to gender rights (MOWA);
- Making plans for Promotion and Protection of Child Rights (MOWA);
- Designing strategies for Mass mobilisation, Sensitisation and Public Enlightenment (MOI) etc.

THANK YOU & GOD BLESS