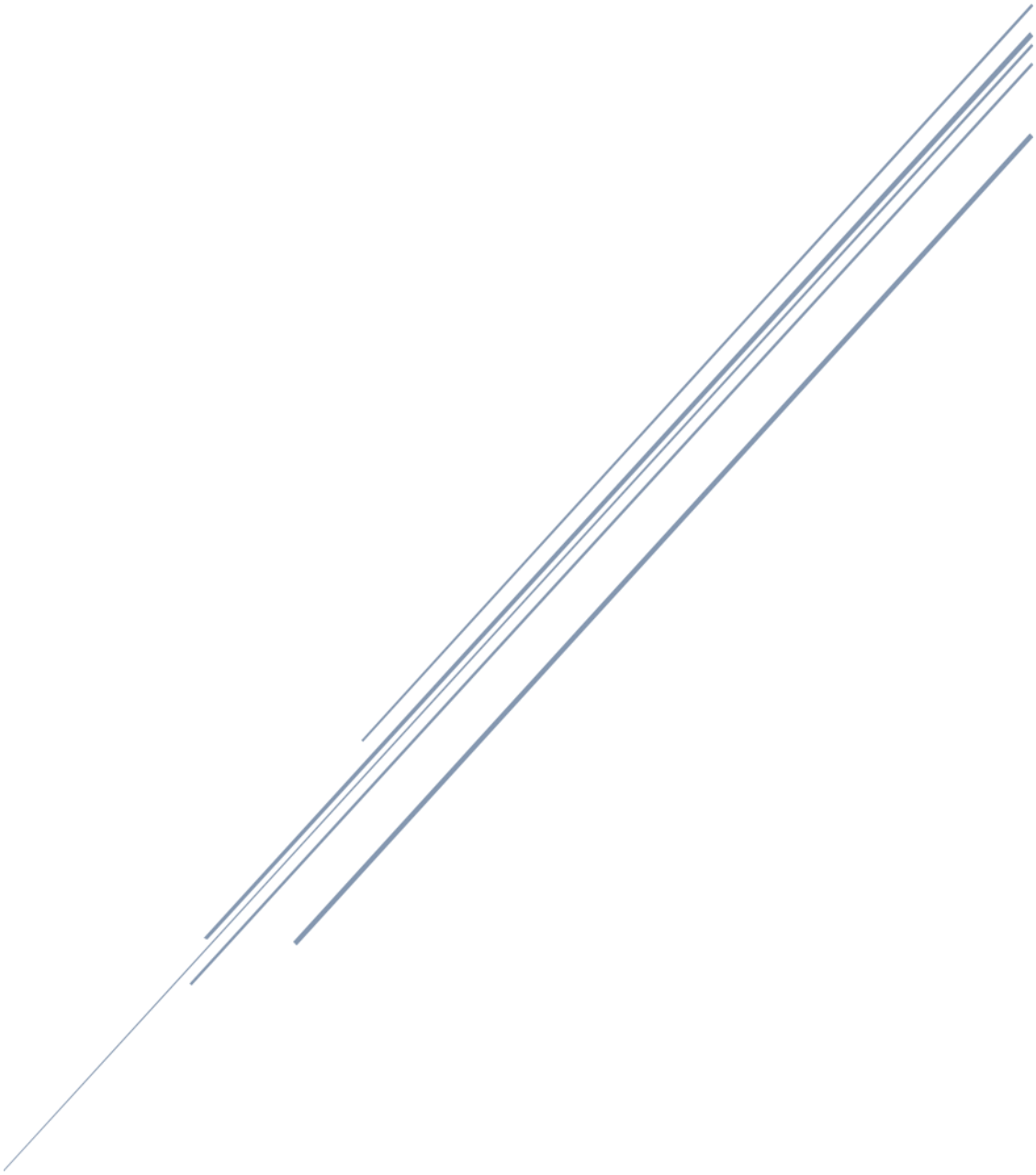
ASSESSMENT WITH DECISION MAKERS ON USE OF STILLBIRTH DATA FOR DECISION MAKING

Qualitative Study Report of SPEED Project



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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
DHIS2	District Health Information System
DPRS	Department of Planning Research and Statistics
FGD	Focus Group Discussion
FHD	Family Health Department
FMoH	Federal Ministry of Health
GASHE	Gender Adolescent School of Health
IHVN	Institute of Human Virology Nigeria
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MPDSR	Maternal and Perinatal Death Surveillance and Response
SMB	Safe Motherhood Branch
SPEED	Improving Nigeria's Capacity To Use Data of Registered Stillbirth

EXECUTIVE SUMMARY

Despite the collection and upload of stillbirths' data on the Federal Ministry of Health DHIS2 Data Management Platform, the usage of this information for relevant policy impact to achieve necessary systems/process change towards a reduction of preventable stillbirths in Nigeria has been limited. Beyond the ongoing quantitative analysis of stillbirths' data by the SPEED Project, the need to gain an in-dept understanding of other factors (outside the scope of available indicators used for quantitative stillbirths' data on FMoH DHIS 2) limiting the use of stillbirths' data by policymakers in Nigeria is imperative. As such, the SPEED Project conducted a qualitative assessment to gain extensive data insight from the actors and decision-makers on factors that affect the use of Nigeria's stillbirths' data for policy impact in Nigeria.

Objective

The following objectives were taken into consideration when engagement with the actors was made.

- To establish the frequency of, and highlight approaches adopted for stillbirths' data analysis.
- To inquire about past or existing interventions/programs/policy/changes implemented because of findings from stillbirths' data.
- To discover operational/administrative/technical factors limiting the analysis and use of Nigeria's stillbirths' data for decision-making.
- To receive information on factors that impede the ability to share data insight from stillbirth data analysis to decision-makers.
- To identify possible systemic gaps that could be limiting the ability of key stakeholders to communicate stillbirths' data insights to the Nigerian legislature.

Methods/Methodology adopted.

Overall, we conducted four (4) interviews in FCT. The breakdown goes as follows:

- One FGD with Representatives from Ministry of Health (NHMIS, Department of Health Planning, Research & Statistics, Department of Family Health)
- Three KIIs with Policymakers and Key custodian of the stillbirth data (Deputy Director, Safe-motherhood Family Health Dept, Head of M&E Officer, and Head of NHMIS FMoH Department of Planning, Research and Statistics)

Outputs

- Verified documented information on frequency and approach of stillbirths' data analysis (Policy implementing level)
- Documented responses on factors limiting the use of stillbirth's data for decision-making (policy level)
- Documented responses on impediments to policy application (policy implementing level)
- Documented suggestions on how to address these limitations at both levels.

Anticipated Outcomes

- Ideation processes to address identified operational/structural/administrative factors limiting the use of Nigeria's stillbirths' data.

- A strategy document- output of a strategy development workshop to discuss and document strategies (data analysis plan, sharing plan, modalities for follow-up on usage, implementation tracker) to be implemented for the improved use of Nigeria's stillbirths' data.
- Increase in interventions/partnerships/collaborations towards a reduction of preventable stillbirth in Nigeria.

Participants

Table 1: Number of Interview Conducted by category.

Group	Category	Number
Decision-making level	KII	3
Policy implementing level	FGD	1
	Total	**4**

FINDINGS

Overall, we found mixed results, with varying responses across and within the policy making level and policy implementing level of stillbirth data in Nigeria. Though the respondents were satisfied with the focus of the project in the sense that it will help in reducing the maternal mortality, and how quality data on stillbirth can be used for decision making processes, they identified several gaps and barriers to accessing quality data of stillbirth as well.

1. Department and duration of work in his/her position.

This section focuses on respondent's department and the number of years spent in their current roles. This tries to give full description of the nature of the participants engaged during discussion of stillbirth data in Nigeria.

Most of the participants who engaged in FGD discussions worked in Family Health Department and Reproductive Health Division , Gender Adolescent School of Health Family Branch, Family Health Division Children with Special Needs Unit in Child Health Division, M& E Division of Health DPRS, Planning, Research and Statistics NHMIS Branch. Most of them have been working in this department for over a minimum of 2 years.

R1: Family Health Department Reproductive Health Division (SIGMA) Branch
R2: GASHE Division (Gender Adolescent School of Health Family Branch, Gender, Family Health Department)
R3: Family Health Division Children with Special Needs Unit in Child Health Division
R4: M& E Division DPRS
R5: Federal Ministry of Health DPRS
R6: FMoH M&E Branch
R7: Planning, Research and Statistics NHMIS Branch
R8: M&E Division DPRS FMoH

# of years participant working in her position:
R1: 4-5 years in FHD, 2 years in his current working unit, Save Motherhood Branch
R2: Working in Gender branch for 4-5 years.
R3: Worked in FHD for over 6 years.
R4: Worked in M&E Division for 3 to 4 years.
R5: Worked over 5 years in the DPRS Department
R6: NHMIS Branch of M&E
R7: Working in Health Information Officer for 25 years, but joined headquarters 5 years ago, Department of Planning, Research and Statistics
R8: 5 years

For the KII, the participants engaged in the discussions were M&E Officers in the Department of Planning, Research and Statistics who has been functioning in that role for at most a year, Deputy Director of Family Health and has been working for less than a year and lastly, the Head of National Health management Information System who has been working in this department for the duration of over one year.

KII-01: My name is Dr. xxxx, the Head of Monitoring and Evaluation in the Department of Planning, Research and Statistics at FMOH, Federal Ministry of Health. I've been in the ministry for the past 16 years and I've been in this position for the past five months.

KII-02.. Okay. Deputy Director, Department of Family Health. I am a Deputy Director for almost a year.

KII-03: Ok, I work in the Department of Health Planning, Research and Statistics, M&E Division, and National Health Management Information System but I am the head of the branch, National Health Management Information System. One year plus

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2. Motivation/Passionate of Stillbirths in Nigeria

Here, the participants both FGD and KII participants were engaged on what motivated them about stillbirth data in Nigeria. The essence of this question was to familiarize the participants with the concept of stillbirth and how knowledgeable they were about stillbirth in the country.

The participants who engaged in focus group discussions were asked to share their views on what motivation do they have when talking about stillbirth in the country. The essence of what motivated them about stillbirth was to establish whether they have similar reasons or divergent views.

According to most of the participants who took part in FGD, what motivated them is having a safe delivery, where both mother and the child are alive. They also further explained that the collation, analyzing and disseminating the stillbirth data really gives them joy. In contrast, few participants believed understanding the trend and the causes of stillbirth and what remedy to proffer in reducing stillbirth are the major motivators of stillbirth to them.

So, collation of the data and then analysis and dissemination of the data is one thing that really motivates me in seeing how stillbirth is or will be addressed in Nigeria.
(R8, spent 5 years)

… me to really understand the trend, what is really the causes of stillbirth in women and to also proffer solutions on how those stillbirths can be minimized if not stopped completely.
(R6, years spent not stated)

One of the FGD participants said seeing stillbirth as a clarion call really motivates him. That initially people are not boarded about stillbirth data but now seeing one of the stakeholders having interest in stillbirth data for the first time really gives him joy. Another participant said having concern about stillbirth data will lead to early identification of what could be the contributing factors of stillbirth gives him joy.

Nobody's calling or making requests for the data for studies or for research until IHVN now show an interest and what we discovered at the facility level, even some of the facility level, they don't even want to record anything like stillbirth. I don't know why, but we encourage them to do that. But what motivates me is that, okay, ouch. Now it's like a wake-up call. We are now, people are now getting interest. They don't want to, in that aspect, they want to know what is really happening. What is causing the stillbirth in the women? That's what is really motivating me.
(R5, 5 years)

... it will help to come up with early identification that leads to stillbirth and from the facility they'll be able to record whenever there is any stillbirth that happens. (R2, 4-5 years)

When comparing the view of key informant participants on the focus topic, what motivate them about stillbirth in Nigeria, all the three Key Informant participants also emphasized the health outcome of the mother and that of the child. They are particular about the survival of mothers and the children during child labour as the key motivators driving their passion about stillbirth in the country. One of them also perceived this from the quality of care and services mothers received at facility during child labour and stillbirth is seen as the proxy indicator in accessing the quality of care received during child delivery. More so, they are more concerned in reducing maternal mortality during child labor by ensuring that adequate care is channelled towards mother and child during delivery.

... I think it's based on the popular saying about the health of a nation, the health of a woman and the children, I realize that one of the key areas of intervention is to ensure that every wanted pregnancy has a positive outcome. That is the delivery of a live baby. So, stillbirth is one of those gaps that is still a big concern and it's something that the current administration has identified as one key area to ensure that we improve the indices around stillbirth maternal mortality. (KII-01, 16years)

Stillbirth is a living life. It's not a disease process so, of course, we want everything to go seamless without harm to the mother or the baby. So, unfortunately, that's not always the case. A lot of pregnancies are complicated and it's an outcome that is adverse to the mother or the newborn and to a large extent these are problems that can be prevented. So, easily prevented for that matter. Okay. So, that's why we are all concerned about it. Pregnancy is not a disease condition so it shouldn't result in serious morbidity or death. (KII-02, 1 year)

So, if I could get it right, sir. So, what you are saying that motivates you is trying to save life not just the life of the mother and the baby

R: The issue of stillbirths also is related to quality of care and quality of services at the facility. So, a stillbirth is a clear proxy indicator for also assessing the quality of care at the facility. That is critical. (KII-03, 1 year plus)

In conclusion, both FGD and KII participants were more particularly in saving the life of mother and the unborn child as the driving factor that motivate on stillbirth situation in Nigeria.

3. Frequency and Approaches adopted for Stillbirths' Data Analysis

This section focuses on the frequency of and highlighted the approaches the FMoH adopted for stillbirths' data analysis. The participants were fully engaged to share their thoughts on the number of and strategies/approaches adopted in analyzing stillbirth data. Some of the key informant stakeholders were thoroughly engaged to share their views and thoughts on the thematic area.

For the FGD participants, almost all of them had similar view on the frequency of stillbirth data reporting and analysis. They said the stillbirth data should be reported **monthly or quarterly basis** for decision making. They also reported that government of Nigeria has made an initiative on the frequency of reporting stillbirths' data on DHIS2. Below are some of their responses.

…it is expected that this data should be you know regularly reviewed and shared with the decision makers and all of that. But for the states that are very active, and they have an active committee, at

least quarterly and its quarterly that data is usually analyzed. But for us at the national, that's what is also expected for us. At least quarterly we should have a review of that data. (R1, 4-5 years)

... I think on NHIS, we deal with a routine monthly data reporting on every important prioritized indicator for the country and at the program level. So, the data from all the programs come in from the facility every month after the validation meeting including the stillbirth data and once, they come in you know there is an activity we call DQA. It's a quarterly activity that we will go and check the quality of the data there from there stillbirth is part of the data element or indicator that will be downloaded and reviewed before going to the field so that when you get to the field you'll be able to ask the question on the quality issue or how the data is been reporting or why some most of the facilities are not reporting on the data. So that's how we gather the data, and the platform is DHIS2 platform where the data comes in every month. (R5, 5 years)

On the aspect of the approaches or modalities adopted for stillbirth data to be reconned with, some of the approaches mentioned were as follows: setting up Core Team by the FMoH which includes representatives from all departments, agencies, and parastatals, setting up MPDSR electronic platform which generates automatic reports. The Core Teams were trained on how to use the DHIS2 Tool to analyse monthly report and feedback are given to their directors. Those at the program department coordinate the stillbirth data reporting and monitor all the indicators related to Maternal and Newborn Health issues. See some of their responses below.

Currently, about two months ago the Federal Ministry of Health put together what we call the Core Teams, and the core team includes representatives from all the departments, agencies, and parastatals under the Ministry of Health. They were trained on how to use the DHIS2 Tool to analyse monthly. So what is expected of them is that once they analyses their program or departmental data, they are to feed --- give feedbacks to their directors so as for them to know what is going on as it relates to their departments and then from my--- our end we are supposed to be looking as the national data, their timeliness, their accuracy, if there are outliers, if there are other challenges that might be discovered during the monthly analysis…. They will monthly review what has been uploaded, give feedback to their departmental heads, and then copy us, so that if there are needs to make corrections, if there are needs for improvements, we will get all that from the analysis that will be submitted. And apart from that, monthly the states do what we call newsletters. These newsletters contain their own analysis, monthly analysis, which are submitted to their department, department of planning, research, and statistics for them to know what is happening, why is it happening, and what are they expected to do. So, the state level has their own regular analysis for those who are regular. Not all of them are regular anyway, but some are doing it monthly. Once it is demanded, it will be done. But there is need for us to improve demand and use of analytics from the DHIS2. So, this is the current status of analysis in health information management (R7, HIO 25 years, 5yrs DPRS).

We at the program level, our activities are just to coordinate the data reporting of the thing…. So, at the DPRS, NHIS, we don't have any indicator of interest. All the programs in the indicator, that's our own indicator of interest. (R5, 5 years DPRS)

...which is the MPDSR electronic platform. ..., the platform generates reports automatically. Yes. So, what's expected is that for either at all levels, at the national we have, we have our window--- national window, we also have a zonal window as well. So we have a zonal statistician, who's

responsible for analysing data for the zone. Then we have the state statistician who's also responsible for the state's data. So usually, at the end of the month (R1, 4-5 years, FHD, SMB)

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4. Past or existing interventions/programs/policy/changes implemented from stillbirths' data.

This section examines the past or existing interventions/programs or policy as well as changes that has occurred from the stillbirth's data. The essence of this objective is to understand whether stillbirth's data has brought about any changes or not in any policies or interventions with regards to the available data. Findings from the key informant participants showed that there hasn't been any stillbirth data collected within the country except the one sourced from Nigeria Demographic Health Survey (NDHS) and Multiple Indicator Cluster Survey (MICS). Looking at the NDHS 2018, the data was collected in 2018 about 6 years ago and yet relying on the dataset to track mortality whether maternal or child which is not supposed to be. Data on stillbirth should be done either monthly or quarterly but this is not so. Although there has been a slight improvement on some of the indices/indicators measured in NDHS to track the changes around maternal mortality, **stillbirth** is one of them. Perinatal death, neonatal, child mortality and adult mortality were the indicators NDHS captured in its final report. More so, they are planning to conduct a survey around pregnancy-related issue to tackle some of the causes of maternal mortality. See the quote from the participant of KII.

...the country over the five years, the country has been conducting research with the help of the Nigeria Demographic and Heath Survey. I would say that if we talk about the indices, I will say there has been a very slight improvement, but not what we expected. Also, I know that every two years we also have the MIC Survey also to give us an insight into what we need to do in terms of the health for women and children in Nigeria and so far, so good the country has really been benefiting from the use of the data from those surveys over the years. Currently, we are conducting another one and this time around, it's with a difference because we really want to dive into the key indicators surrounding maternal mortality, morbidity, and under-fives, and also some issues that are around pregnancy so that once and for all, we can be able to provide that particular direction... (KII-01, 16 years)

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5. Operational/Administrative/Technical factors limiting the analysis and use of Nigeria's stillbirths' data for decision-making.

In this section, operational, administrative, or technical factors limiting the analysis and use of stillbirth's data for decision-making in Nigeria is examined. The participants who have operational, administrative, and technical knowledge of factors that could hinder or limit analysis and use of stillbirth's data for decision making were fully engaged to share their views. One of the key informant participants that transitioning to the use of digital tools to support data collection has been a major factor impeding the analysis and the use of stillbirth. The participant further explained that for decision on stillbirth issues to make, there should be a real-time data, routine data, and prompt analysis of this data for decision making, which is not available, but effort has been provided to make sure that data on stillbirth is routinely provided and analysis is done for decision making. The participant also emphasized the need for technical capacity of staff at the health facility in detecting or performing technical diagnosis on the causes of stillbirth as well as documenting the findings which is not available also impede the use and analysing the stillbirth data for decision making in Nigeria. Another participant was of the opinion of over reliance of reporting certain indicators such as stillbirth, neonatal, perinatal etc. using NDHS that is conducted every five years and has long overdue, and this has limit using such data to performance analysis of some indicators related to stillbirth for decision to made.

More so, another participant mentioned lack of technical know-how on how data can be pull as a factor affecting or limiting the analysis and use of stillbirth's data for decision making. Limited capacity in data analytics is also seen as a factor influencing or limiting the analysis and use of Nigeria's stillbirths' data for decision making. See the quotes from the KIIs below.

... it's true that... Yes. I think now that we are really transitioning to the use of digital tools to support data collection, I think, yes, that has always been our issue in the past. It's real-time data, analysis of data, routine data needs to be more available and the use of data tool is very key to ensure that that is done and then another part that we also want to look at is also where we can improve from the diagnosis and reporting at the level of the service delivery so that we can get the technical diagnosis, the technical decision taking at that level and we'll be able to use that one to do a lot of deep dive into the cause and the cause of stillbirth and then also provide solution to prevent further occurrence of stillbirth.(KII-03, 16 years)

Of course, any data you get as quick as possible is vital for you to change direction even in the middle of a project. Majorly what the country uses now is the NDHS, which comes every five years. So, things can be going wrong and it's after five years you know that things are going on. If you have something that can provide you with that immediate analysis of data, you've seen the direction of how you're going, even in six months you can halt what you're doing and say, no, it's not the right way to go. Of course, like I told you about the MPDSR earlier, we currently run it with an e-platform, on an e-platform and it's something that you can generate instant reports, and the deaths of mothers and babies are reported real time and this can be seen. So, analysis of this can also provide immediate insight. Of course, a lot of states, a lot of facilities have not keyed into it. So, we can't have it. The data that we have can't say it's the representative of the whole of the country. (KII-02, 1 year)

Okay, yes. So, when you come to data use now even the service providers, even people documenting is also supposed to have some level of training on data analytics. So, if you cannot pull the data rightly and then you don't even have that capacity to understand data analytics. So, it's also a challenge. One, the end users or the front-end line workers also have some limited capacity in data analytics. So that also affects the quality of analysis they do or interpretation. So that's a challenge. (KII-03, 1 years plus)

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6. Factors that impede the ability to share data insight from stillbirth data analysis to decision-makers.

Sharing data insight from stillbirth data analysis would have informed quality decision making processes but this is not the case. For this reason, key stakeholders at FMoH and FGD for some of the different actors were engaged on the factors that impede the ability to share data insight from stillbirth to decision makers and the factors mentioned were lack of technical-know-how of the staff on how to visualize the stillbirth data for decision making, and as well having challenges performing data analytics, non-feeding of stillbirth data from the community into DHIS2 because healthcare workers don't have the skills required to document any records relating to maternal mortality, child mortality into the Health Management Information System (HMIS), and lastly the use of outdated infrastructure due to high cost of procuring software for data visualization and none feeding of Secondary and Tertiary data from facilities into DHIS2 data capturing platform impeded the ability to share data insight from stillbirth data analysis to

the decision maker. They also mentioned that because they only focus on data from PHC with taking into cognizance of secondary and tertiary facilities have contributed to the reason for not sharing data insight from stillbirth data analysis to the decision-maker.

In this wise, most of the participants of FGD then recommended capacity building of staff in training staff on data visualization, training on data analytics and collaboration of stakeholders with the FMoH to improve the quality of data reporting at the grassroot and community level to the federal level, and to procure software for data visualization for them. More so, data from secondary and tertiary even private hospitals on stillbirth should be fed into DHIS2 or HMIS to be able to capture all the data issues related not only to stillbirths but other maternal and health indicators. See some of the quotes from FGD with the stakeholders at FMoH.

Yes, okay training, training of those record officers in facilities yes in all the 36 states including FCT. Just to retrain have moved, some are new and all of that.
(R6, M&E, year not specified)

Please train us how to discover some data quality issues at Federal level and that is that analytics, training on data analytics. (R5, 5 years)

So apart from that apart from that currently and I'm sure IHVN will be a partial witness that's with the commencement of the power BI training many of us are using outdated system because that is what we can afford. So, if you don't have what it takes to do the work well, definitely you'll be limited. Even while we were looking for our staff to join us here, I was considering the capacity of who to invite. Not that we don't have many staff, but do they have that capacity to understand what we are talking? Can they easily I mean get what we want to discuss, and can they contribute positively to what the discussions? Because there are some people there, I couldn't call them. One, if you ask them to do something on the system, they wouldn't be able to do because they don't have. Secondly, what is mostly important concerning our own branch is the FMoH has decided that the whole NHMIS should be a one house NHMIS. All that we've been gathering for the past 5 to 10 years or more are just primary health care data. We are losing data from the community. We are losing data from the secondary and tertiary facilities which are if we add those two together, they are more than 70% of what we are supposed to have on the DHIS2. What we have on the DHIS-2 is like 25% of what is going on in the country. So, if we can perfect the secondary and tertiary data, and then make them flow into the DHIS2, and then add the community, make them flow into the DHIS2, that is when we can say we have a National Health Management Information System. So until ---and luckily for us, we have been pulling here, pulling there to perfect. We already have the tools for the community health management information system, all we need is to expand it to other states. That's an operational challenge. Then for the secondary and tertiary, we have started developing the tools. We only have just one more meeting to go. If we are able to bring the consultants from the needed about---I listed about 20 fields at the secondary and tertiary area so that once we are able to bring these consultants to a table, let them develop their data elements according to their thematic area, we'll put it together with what we have gathered then we have a perfect or a near perfect secondary and tertiary health information management system. So, I would say we are 80% done to having a National Health Management Information System that has the community, primary, secondary, and tertiary all-inclusive in one goal. So, by the time we have all this together, even the stillbirths, It happens mostly in the secondary and tertiary but the data we have are just primary. Stillbirth do happen in the primary and it happens in the community but most of them, once the primary sees complications, they refer them. So where are that information of the referred still births, we don't have them. We are losing them. These are operational challenges that even no

matter how small, if the SPEED project can say, this is what I have, it's small, I can cover two consultants out of 20, we are good to go. We'll look for another person; I mean another partner that can cover 5 consultants. We'll look for another one that can cover 10 consultants. Even if it is one consultant you can cover, we know we have removed 1 out of 20. So, these are the areas where the SPEED project can help us bring a one-house health information management which will expose more of the stillbirths that are occurring that are not being recorded or captured. (R7, HIO 25 years, 5yrs DPRS).

When trying to examine the views and opinions of key informant stakeholders on the factors that impeded the ability to share data insight from stillbirth data analysis to decision makers, they mentioned those areas that need to be improved or enhanced for data on stillbirth to be available for decision making to be possible. Some of the factors mentioned include non-availability of quality data, use of outdated tools, poor management of data, wrong statistics/figure of stillbirth recorded or documented (that is poor documentation of stillbirth data, non-collaboration of stakeholders and government agencies in discussing the key indicators to monitor and examine the implication of these findings and non-effective communication of findings from the data. One of the stakeholders who took part in KII also mentioned that some people did not understand the concept of stillbirth (that is limited understanding of stillbirth), poor reporting and documentation, under or over reporting of stillbirth are the factors responsible for not sharing data insight from stillbirth data analysis to the law makers for them to make a policy that will informed changes and reduced maternal mortality, stillbirth etc.

Yes. To an extent, I will say yes because the issue of stillbirth is also an issue that is sensitive for one, you know, when you talk of stillbirth and then reporting along the line for the end users or the front-end workers that are documenting the stillbirth, at times what is even the understanding of stillbirth is also limited. Issues around even reporting stillbirth to some facilities even when it occurs is like it's not properly documented. As such, we have very low level of reporting in the first instance and then also issues of understanding as to what constitutes stillbirth. So as such, the number of what we are picking is not, is not, is not the true picture of what is happening at the facility. So that is one challenge. Okay. So, the other challenge is also that if you don't have accurate numbers, you're also making decisions that are not evidence-based that would be wrong because you're not getting the accurate data to make such a intervention. (KII-03, 1 years plus)

R: Yes. I just ask you now, if you send the DHIS2 there is gap and I work with this. So of course, so imagine people out there and some will tell you that for every maternal death there could be up to eight to ten stillbirths. It could be that bad. So, I think there's a lot of gaps in the sharing of data and this is at the federal level. I'm seeing this at the federal level talk less of what we have at the sub-national level, especially going to the community. So, I'm sure if data is presented, data presented to – in the community level to tell them how people are dying in terms of words that they can understand. For instance, you say, 'do you know that I spent two minutes with you, do you know that a child has died in those two minutes. Things like that make sense to people. When you are putting out plans or strategies, it's easy for them to buy into. So, for sure I think there is a gap in data sharing. We are stakeholders in this data, maybe they are doing NDHS, they invite a focal person to be there and all of that. But do we really sit down together and discuss this data and look at all of the implications of the data so that we can all take unified action based on the data? I'm not sure it's done very effectively. (KII-02, 1 year)

... the country has the Federal Ministry of Health; has a mandatory task to ensure that data is available to decision makers especially the Secretary to the Government, to the Presidency, and to the State House of Assembly. Okay, all right, so, what we need to do is to see how we can improve on this because as part of our Universal Health Coverage goal and the Sustainable Development Goal, it's expected that we'll meet up with...there's a reduction in the current status as far as under-fives, maternity, mortality, and stillbirth is concerned in Nigeria. So, we know that there's still need for improvement especially in areas of feasibility of the data, the use of various tools to ensure that those data are available presenting them clearly to the lawmakers, to the decision makers in terms of making decisions and ensure we also use it as a way of resource mobilization for further funding for health. (KII-01, 16 years)

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7. Systemic Gaps limiting the ability of key stakeholders to communicate stillbirths' data insights to the Nigerian legislature.

This section examines the systematic gaps limiting the ability of key stakeholders to communicate stillbirths' data insights to the policy maker. When having these conversations with key informant participants, the systemic gaps mentioned were as follows: limited or no understanding of stillbirths' data at all levels of the country, delayed in data reporting at the service delivery point due to lack of capacity to do so, issue around data sharing, non-effectiveness coordination and review of data among the stakeholders, poor documentation of stillbirths' data, infrequent high-level meeting of the stakeholders with the policy maker, lack of access to data visualization dashboard at the National Assembly to track some of the indicators

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So, one of the things that has been a big issue is the more understanding of data use at the level of data collection. At the level of the service delivery points, all they know is about the fact that they need to report data but we're trying to see how we can improve capacity, especially in that area to see how people can generate the data and use the data, okay as the first contact for that. So, this is um this is what we are looking at to see how we can improve capacity for data use. (KII-01, 16 years)

For the identified gaps to be closed, participants were asked to suggest a more effective feedback mechanism for reporting significant data insights to high-level decision makers in Nigeria and some of their suggestions were as follows: regular sharing of fact sheets to the legislators and other stakeholders during their meetings, advocacy packages to some states who do not understand the stillbirths' concept, creating enabling access to the dashboard to the policy-makers for them to understand the prevalence, rates or incidence of this indicators and the need to make a policy that will improve quality of care mothers and child receive at health facility.

If you say high-level, I think...This data when obtained it should be a kind of whether it is yearly or so. There should be this high-level meeting between ministers and state chief executives where all this data are shared with all of them and then different states see where they are and that may even kind of prompt them to do better because you see state A doing better than you are doing and we are telling you this how your people dying because the honest truth is the state governments are fully in charge of the states and sometimes if decisions don't go through them it's difficult to implement some of their intervention. So, for high-level, I think that's one. And what I would like to say is that... We also have committees in the National Assembly for Health, Senate Committee, House Committee, and all of that. I think this. If you have a dashboard that we can see as a technical

people, those decision-makers should also have access to this dashboard so that they wake up in the morning and they see that, oh, this one month, you know, so number of women have died, not because they are sick but because they are pregnant and so number of women delivered but unfortunately they are also bearing their babies. So those kinds of things, I think regular sharing of this data or making access to the data easier I think will make it...If you are seeing something every day, you are more likely to effect change but if it's something we are analysing every five years five years maybe the person there might not be the person there in the next five years. Talking about political class, so this I think is part of the issues. (KII-02, 1 yeas)

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8. Recommendations to address operational, administrative, and technical issues for improved decision-making on stillbirth data.

Stakeholders/participants were asked what could be done to address operational, administrative, and technical issues for improved decision-making on stillbirth's data, and some of the recommendations proffered were as follows:

FGD participants: Policy Implementing Level

- Increase the bandwidth of the DHIS2 that is the front-end of National reporting database which houses data elements of stillbirths, to enable the officer to have ease of accessibility to download the dataset on time.
- Printing of data tools. This is because they usually go out of stock and since no financial dedicated for this, there is need for stakeholders to come into play to make the tools available for use by printing them.
- Constant holding of meetings with all actors involved in stillbirth to have a discussion around data and some other indicators of maternal mortality.
- Procurement of Laptops and other equipment for the division will also go along way in solving delayed in stillbirth data reporting.
- Housing/harmonizing all the dataset in one platform will also help interoperability.
- Financial support for MPDSR yearly subscription.
- Advocacy expansion to include stillbirth data of women with disability.
- Establishment of data visualization dashboard for the policymakers to have access to some of the maternal and child mortality indicators for proper tracking and policy formulation.

…So, one of the recommendations I would want SPEED project to help is one, to see how we can increase the bandwidth of the DHIS2 which is the front end of the national reporting database which of course houses this data element; stillbirths. We need to increase the bandwidth because oftentimes maybe during peak hour you discover that when facility M&E are trying to upload their information, the system tends to slow down or even at the point, (software issues?) that's part of it. So, another one is these data tools, most times they always have stock outs at the respective health facilities. So, if you guys can help us to see how you can print more of these data tools across the health facilities, that would be a wonderful one. And again, see how we can convene a meeting that will also house all these gatekeepers at the respective arms of government, both from the local government, state and then we'll discuss some issues pertaining to stillbirths. That would be great. That's just a few from my own end. (R8, 5 years)

R6: If you can consider assisting the division with some laptops, we don't mind. Equipment. Specifically, laptops no matter how little, we appreciate that. That's one of our operational issues. (R6, years spent not stated)

Yeah, so for me, I'll say that one of the things we've been discussing is seeing how we can have comprehensive data in one place. You know, for MPDSR, MPDSR as I mentioned, it's another data platform and then, so we've been discussing on how to you know to merge yes, interoperability of these platforms so that we don't have discrete data, you know, here and there. So that's one thing we've been discussing. So, if the SPEED project can help us, you know, to pursue this cost, support, yeah, provide support to actualize this, this would be great. And then, secondly, again, so for the MPDSR e-platform one of the challenges, you know, the platform is being hosted by Galaxy Backbone. Currently, it was in Germany, but currently it was transferred to Nigeria and currently being hosted by Galaxy Backbone. So, what do you call it, subscription or what? We must pay for subscription, yearly subscription, so sometimes that becomes a challenge. So, if support could come in that way to take care of that, it would be highly appreciated.
(R1, 4-5 years in FHD, 2 years in SMB)

Sorry, yes, you can also include women with disabilities. They also have stillbirth. So, you can expand your advocacy too. Okay. Women with disabilities. (R2, 4-5 years)

KII participants: Decision-making level

The KII participants gave the following recommendations:

- Continuous training and re-training of healthcare workers and the end-users on the data elements
- Capacity building on proper documentation of stillbirth data

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Well, we have also strongly recommended that those health facility workers or end users should continually be trained and retrained so that one you build your understanding about what constitutes that data element and then secondly, they can also document properly and then we will not have any challenge documenting. (KII-03, 1 years)

Retraining, retraining is what you are also proposing. (KII-03, 1 years)

Yes, retraining and retraining (KII-03, 1 years)

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9. Summary and Conclusion of Findings

Below is the summary of all the objectives raised in this report.

The driving motivators of stillbirth data to the policy implementing level were as follows:

- Safe delivery of mothers
- Collation, analyzing and dissemination of stillbirth data.
- Understanding the trend, causes, and remedy to stillbirths.
- Seeing stillbirth as the Clarion call because in the past, people are not concern about it, but now, they are showing concern about stillbirth data in the country.

To the policy making level, the following points were the driving motivators of stillbirth mentioned:

- Health outcomes mothers and children during child labour that is survival of mothers and their children.
- Quality of care mothers and children received during child labour where stillbirth is seen as the proxy indicator.

For the frequency of and approaches adopted for stillbirths' data analysis:

- Monthly/quarterly report of stillbirth's data

The approaches were as follows:

- Setting up Core Team by FMoH to oversee the stillbirth data.
- Setting up MPDSR electronic platform to generate automatic reports.
- Feedback mechanism on stillbirth data to their directors
- Coordination of stillbirth data among the program department.

On the past or existing interventions/programs/policy/changes implemented from stillbirths' data, findings revealed that the actors have been solely relying on the secondary data either from NDHS or MICS to track the mortality indicators and these have not been helpful since they would have to wait for another 4 to 5 years before having to see whether there have been changes in mortality ratio or not. They believed for progress to be monitored, stillbirths' data needed to be collected and programmatically, findings must be reported on monthly or quarterly basis.

Some of the operational, administrative, and technical factors limiting the analysis and use of stillbirths' data for decision making were as follows transitioning to the use of digital tools to support data collection, stillbirth data is not reported on a real-time, non-routinely reported and non-availability of data that hindered prompt analysis for decision making process. They further explained the need for technical capacity of staff health care workers in detecting or performing technical diagnosis of the causes of stillbirth and lack of proper documentation of this stillbirth. The over-reliance of secondary data which is not routinely collected and limited capacity around data analytics were the factors impeded the analysis of stillbirth data.

Lack of technical know-how of staff to visualize the stillbirth data for decision, performing data analytics, non-feeding of stillbirth data from the community into DHIS2 platform because healthcare workers have no capacity to document maternal and child mortality indices into the HIMS, and the use of outdated infrastructure due to high cost of procuring software for data visualization and none feeding of secondary and tertiary facility data into DHIS2 data capturing platform impeded the ability to share data insight from stillbirth data analysis to the decision-maker. Among the participants of KII, some of the factors mentioned were as follows: non-availability of quality data, use of outdated tools, poor data management, poor documentation of stillbirth records, non-collaboration of stakeholders and government agencies in discussing the key indicators to monitor and to examine the implications of these findings, and non-effective communication of findings and lack of understanding of the concept of stillbirth, under and over-reporting of stillbirth are the factors responsible for not sharing data insight from stillbirth data analysis to the policy-makers.

For the systemic gaps limiting the ability of key stakeholders to communicate stillbirths' data insight to the Nigeria legislature were as follows: limited or no understanding of stillbirths' data at al level of the country, delayed in data reporting at the service delivery point due to lack of capacity to do so, issue around data sharing, non-effective coordination and review of data among stakeholders, poor documentation of stillbirths' data, infrequent high-level of meeting of the stakeholders with the policy-makers, lack of access to data visualization dashboard at the National Assembly to track some of the maternal and child health indicators. In order to close the identified gaps, some of the recommendations mentioned were as follows: regular sharing of fact sheets to the policy-makers and other stakeholders during meetings, advocacy packages to some states who do not understand the stillbirth concept, creating enabling access to dashboard to the policy-makers and the need to formulate a policy that will improve the quality of care mothers and children will receive at the health facility.