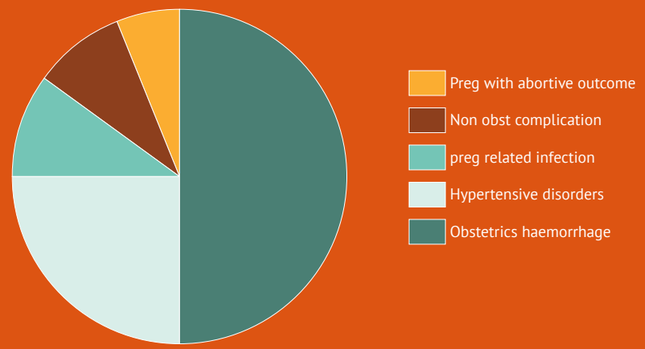
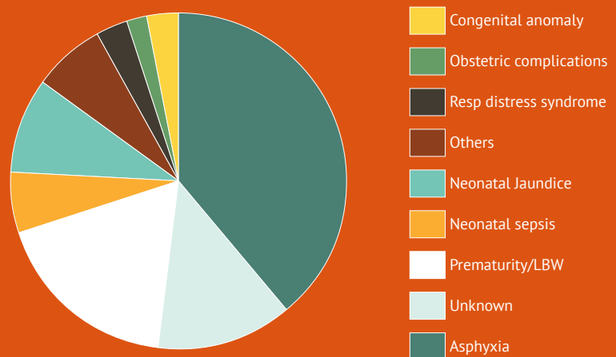
We ask
Lagos State Ministry of Health to:

- ✓ employ more Medical/Health Personnels (all cadres) for the General Hospitals in Lagos State
- ✓ request that the Primary Health Care (PHC) Board ensure that its officers adhere strictly to the referral Policy of the State vis a vis early referral of cases
- ✓ supply the Service Delivery Protocols (SDPs) to all the facilities that do not have SDPs

Causes of maternal deaths



Causes of perinatal deaths



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Produced by the Lagos State Accountability Mechanism for Maternal and Newborn Health (LASAM) in October 2018, with support from MamaYe-Evidence for Action

@MamaYeNigeria MamaYeNigeria

HEALTH FACILITY MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE (MPDSR) SCORECARD

LAGOS STATE, NIGERIA

October – December 2017

FACILITY

INDICATORS	GENERAL HOSPITAL ALIMOSHO	ISLAND MATERNITY	GENERAL HOSPITAL BADAGRY	RANDLE GENERAL HOSPITAL	HARVEY GENERAL HOSPITAL	SOMOLU GERAL HOSPITAL	IFAKO-IJAIYE GENERAL HOSPITAL	AJEROMI GENERAL HOSPITAL	ORILE AGEGE GENERAL HOSPITAL	AGBOWA GENERAL HOSPITAL	APAPA GENERAL HOSPITAL	IJEDE GENERAL HOSPITAL	KETU EJIRIN GENERAL HOSPITAL	IKORODU GENERAL HOSPITAL	ISOLO GENERAL HOSPITAL	GBAGADA GENERAL HOSPITAL	AMUWO-ODOFIN MCC	EPE GENERAL HOSPITAL	IBEJU-LEKKI GENERAL HOSPITAL	MASSEY CHILDREN HOSPITAL	MUSHIN GENERAL HOSPITAL	ONIKAN HEALTH CENTRE	LASUTH	SUMMARY
NO OF DELIVERIES IN THE FACILITY	599	909	232	484	160	147	751	205	384	24	17	193	5	643	468	451	569	151	199	0	109	113	0	6813
REVIEW OF MATERNAL DEATHS																								
Number of maternal deaths in the last 3 months	9	13	3	2	0	0	5	6	2	0	0	2	0	3	1	6	0	1	1	NA	1	0	NA	55
Number of maternal deaths reviewed in the last 3 months	9	3	3	2	0	0	5	6	2	0	0	2	0	3	1	6	0	0	1	NA	0	0	NA	34
% of maternal deaths reviewed	100%	23%	100%	100%	NA	NA	100%	100%	100%	NA	NA	100%	NA	100%	100%	100%	NA	0%	100%	NA	0%	NA	NA	62%
REVIEW OF PERI-NATAL DEATHS																								
Number of peri-natal deaths in the last 3 months	48	0	5	11	6	2	6	22	13	0	0	5	0	31	1	3	5	5	4	15	1	2	7	192
Number of peri-natal deaths reviewed in the last 3 months	6	0	4	6	6	2	6	22	13	0	0	5	0	12	1	3	5	5	4	13	1	2	5	121
% of peri-natal deaths reviewed	13%	NA	80%	55%	100%	100%	100%	100%	100%	NA	NA	100%	NA	39%	100%	100%	100%	100%	100%	87%	100%	100%	71%	63%
USE OF MDR EVIDENCE																								
MPDSR Committee has an action plan for current quarter	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Action plan contains clearly defined activities	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Number of activities in this quarters action plan	17	8	7	7	4	6	7	6	15	2	0	17	1	3	5	9	9	0	11	8	5	4	0	151
Number of activies in action plan implemented during this quarter	12	5	3	3	2	6	7	4	14	2	0	17	0	2	5	8	7	0	7	3	2	3	0	112
% of actions implemented	71%	63%	43%	43%	50%	100%	100%	67%	93%	100%	NA	100%	0%	67%	100%	89%	78%	NA	64%	38%	40%	75%	0%	74%
MPDSR MEETINGS AND REPORTING																								
MPDSR Committee hold monthly meetings with minutes of meeting	●	●	●	●	●	●	●	●	●	●	●	●	NA	●	●	●	●	●	●	●	●	●	●	
MPDSR focal person is notified of all maternal deaths within 24 hours	●	●	●	●	NA	NA	●	●	●	NA	NA	●	NA	●	●	●	NA	●	●	NA	●	NA	NA	
MPDSR focal person is notified of all perinatal deaths within 24 hours	●	●	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	
LGA District Surveillance Notification Officers (DSNOs) are notified of all Maternal Deaths within 48hrs	●	●	●	●	NA	NA	●	●	●	NA	NA	●	NA	●	●	●	NA	●	●	NA	●	NA	NA	
LGA DSNOs are notified of all Perinatal Deaths within 48hrs	●	NA	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	
All maternal deaths are reviewed within 7 days	●	●	●	●	NA	NA	●	●	●	NA	NA	●	NA	●	●	●	NA	●	●	NA	●	NA	NA	
All perinatal deaths are reviewed within 7 days	●	NA	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	
MPDSR forms are completed	●	●	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	
Causes of each maternal death are clearly defined	●	●	●	●	NA	NA	●	●	●	NA	NA	●	NA	●	●	●	NA	●	●	NA	●	NA	NA	
Causes of each perinatal death are clearly defined	●	NA	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	
Health staff are using evidence from MPDSR to improve quality of care	●	●	●	●	●	●	●	●	●	●	●	●	NA	●	●	●	●	●	●	●	●	●	●	
Completed MDR forms are submitted monthly to the State M&E officer	●	●	●	●	●	●	●	●	●	NA	NA	●	NA	●	●	●	●	●	●	●	●	●	●	

NA Not applicable ● Yes ● No

100% of deaths reviewed

75% - 99% All criteria met

50% - 75% Some criteria met

<50% No criteria met