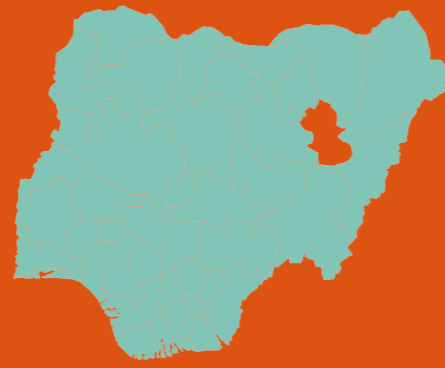


We ask Gombe State Ministry of Health to:



- ✓ Provision of accommodation to the medical personnel in some facilities without accommodation
- ✓ Provide refresher training for maternal health providers in management of labour and delivery, including routine partograph use to prevent prolonged labour
- ✓ Ensure delivery beds are fully functional in all hospital delivery rooms
- ✓ Provision of more man power to Kaltungo General Hospital
- ✓ Training of Medical Officers who have not be trained on MPDSR guidelines
- ✓ Distribution of date capturing tools to all the facilities



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Produced by the Gombe State Accountability Mechanism for Maternal and Newborn Health (GOSAM) in December 2017, with support from MamaYe-Evidence for Action

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

GOMBE STATE, NIGERIA

October – December 2017





FACILITIES NAMES

INDICATORS	DATA TYPE	FACILITIES NAMES																					
		State Specialist Hospital	Billiri General Hospital	Bambam Cottage Hospital	Bajoga General Hospital	Biri Cottage Hospital	Bajude Cottage Hospital	Deba General Hospital	Dukku General Hospital	Hinna Cottage Hospital	Kuri cottage Hospital	Kaltungo General Hospital	Kumo General Hospital	Kashere General Hospital	Mallam Sidi Cottage Hospital	Nafada General Hospital	Potuki Cottage Hospital	Pindiga Cottage Hospital	Talase General Hospital	Tula Cottage Hospital	Tumu Cottage Hospital	Women & Children Hospital ¹	Zambuk General Hospital
Total Number of Deliveries	Number	880	124	73	151	88	75	93	291	101	130	141	115	64	55	54	34	129	5	149		106	
REVIEW OF MATERNAL DEATHS																							
Number of maternal deaths in the last 3 months	Number	33	1	1	5	1	1	3	5	1	0	2	0	0	1	0	0	0	2	0	0	3	
Number of maternal deaths reviewed in the last 3 months	Number	34	1	0	5	1	1	3	2	1	0	2	0	0	1	0	0	0	1	0	0	3	
% of maternal deaths reviewed	%	103%	100%	0%	100%	100%	100%	100%	40%	100%	0%	0%	0%	0%	0%	0%	0%	0%	50%	0%	0%	100%	
REVIEW OF PERI-NATAL DEATHS																							
Number of peri-natal deaths in the last 3 months	Number	228	7	2	24	7	15	18	36	5	0	2	0	0	1	0	0	0	2	0	0	3	
Number of peri-natal deaths reviewed in the last 3 months	Number	228	7	0	21	7	15	18	12	5	0	2	0	0	1	0	0	0	1	0	0	3	
% of peri-natal deaths reviewed	%	100%	100%	0%	88%	100%	100%	100%	100%	0%	100%	0%	100%	0%	17%	0%	100%	100%	100%	0%	13%	100%	
USE OF MDR EVIDENCE																							
MPDSR committee has an action plan for current quarter	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Action plan contains clearly defined activities	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Number of activities in this quarters action plan	Number	11	11	6	3	6	3	6	6	4	0	4	4	10	3	0	4	3	1	0	9	11	
Number of activities in action plan implemented during this quarter	Number	11	3	2	0	5	1	6	5	0	0	4	3	8	1	0	4	3	1	0	6	10	
% of actions implemented	%	100%	27%	33%	0%	83%	33%	100%	83%	0%	NA	100%	75%	80%	33%	NA	100%	100%	100%	NA	67%	91%	
MPDSR MEETINGS AND REPORTING																							
MPDSR committee hold monthly meetings with minutes of meeting	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MPDSR focal person is notified of all maternal deaths within 12 hours	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
All maternal deaths are reviewed within 48 hours	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MPDSR focal person is notified of all perinatal deaths within 12 hours	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
All perinatal deaths are reviewed within 48 hours	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MPDSR forms are completed	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Causes of each maternal death clearly defined	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Causes of each perinatal death are clearly defined	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Health staff are using evidence from MDR to improve quality of care	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Completed MDR forms are submitted monthly to the state M&E officer	Yes/No	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	