

BAUCHI STATE MATERNAL AND PERI-NATAL DEATHS SURVEILLANCE AND RESPONSE SCORECARD



evidence for action mothers · babies · alive										JANU	JARY -	MAR	CH 20	16													
Indicators	Data type	SHB	GH TORO	GH SHIRA	GH GIADE	GH ZAKI	GH GAMAWA	GH ITAS GADAU	GH JAMA ARE	GH AZARE	GH BURA	GH NINGI	GH K. MADAKI	GH T. BALEWA	GH BOGORO	GH BAYARA	GH DAS	W/C HOSPITAL K/ WASE	GH KIRFI	GH ALKALERI	GH DAMBAM	GH MISAU	GH DARAZO	GH BUNUNU	GH BOTO	GH K. WARJI	
Review of Maternal Deaths																											
Number of maternal deaths in the last 3 months	Number	N/A	5	1	1	4	6	0	1	3	N/A	6	2	N/A	N/A	N/A	N/A	N/A	1	6	N/A	N/A	N/A	N/A	0	N/A	
Number of maternal deaths reviewed in the last 3 months	Number	N/A	1	1	0	4	1	0	1	0	N/A	6	1	N/A	N/A	N/A	N/A	N/A	0	0	N/A	N/A	N/A	N/A	0	N/A	
% of maternal deaths reviewed	%	N/A	20	100	0	100	17	N/A	100	0	N/A	100	50	N/A	N/A	N/A	N/A	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	
Review of Peri-natal Deaths																											
Number of peri-natal deaths in the last 3 months	Number	0	37	2	0	1	0	2	4	0	0	3	0	0	0	N/A	N/A	N/A	27	0	N/A	N/A	N/A	N/A	2	N/A	
Number of peri-natal deaths reviewed in the last 3 months	Number	0	0	1	0	1	0	2	3	0	0	3	0	0	0	N/A	N/A	N/A	0	0	N/A	N/A	N/A	N/A	0	N/A	
% of peri-natal deaths reviewed	%	N/A	0	50	N/A	100	N/A	100	75	N/A	N/A	100	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	N/A	
Use of MDR evidence																											
MPDSR Committee has an action plan for current quarter	Yes/No	N/A	Yes	Yes	No	Yes	No	No	Yes	No	N/A	Yes	No	N/A	N/A	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
Action plan contains clearly defined activities	Yes/No	N/A	Yes	Yes	No	Yes	N/A	No	Yes	No	N/A	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	
Number of activities in this quarters action plan	Number	0	2	5	0	1	N/A	0	7	0	N/A	2	0	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	
Number of activies in action plan implemented during this quarter	Number	0	0	5	0	1	N/A	0	5	0	N/A	2	0	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	
% of actions implemented	%	N/A	0	100	N/A	100	N/A	N/A	71	N/A	N/A	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
MPDSR meetings and reporting																											
MPDSR Committee hold monthly meetings with minutes of meeting	Yes/No	N/A	Yes	Yes	No	Yes	Yes	No	Yes	Yes	N/A	Yes	Yes	N/A	N/A	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
MPDSR focal person is notified of all maternal deaths within 12 hours	Yes/No	N/A	Yes	No	No	N/A	No	No	No	No	N/A	No	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	
All maternal deaths are reviewed within 48 hours	Yes/No	N/A	No	No	No	Yes	N/A	No	No	No	N/A	No	No	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
MPDSR focal person is notified of all perinatal deaths within 12 hours	Yes/No	N/A	No	Yes	No	N/A	N/A	No	Yes	No	N/A	Yes	N/A	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
All perinatal deaths are reviewed within 48 hours	Yes/No	N/A	No	Yes	No	N/A	No	No	Yes	No	N/A	Yes	N/A	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
MPDSR forms are completed	Yes/No	N/A	Yes	Yes	No	Yes	Yes	No	Yes	No	N/A	Yes	Yes	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
Causes of each maternal death are clearly defined	Yes/No	N/A	Yes	Yes	No	Yes	Yes	No	Yes	Yes	N/A	Yes	Yes	N/A	No	N/A	N/A	N/A	Yes	No	N/A	N/A	N/A	N/A	No	N/A	
Causes of each perinatal death are clearly defined	Yes/No	N/A	No	Yes	No	N/A	N/A	Yes	Yes	No	N/A	Yes	N/A	N/A	No	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	No	N/A	
Health staff are using evidence from MDR to improve quality of care	Yes/No	N/A	Yes	Yes	No	Yes	Yes	No	Yes	No	N/A	Yes	Yes	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	
Completed MDR forms are submitted monthly to the State M&E officer	Yes/No	N/A	Yes	Yes	No	No	Yes	No	Yes	No	N/A	Yes	Yes	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	N/A	N/A	No	N/A	