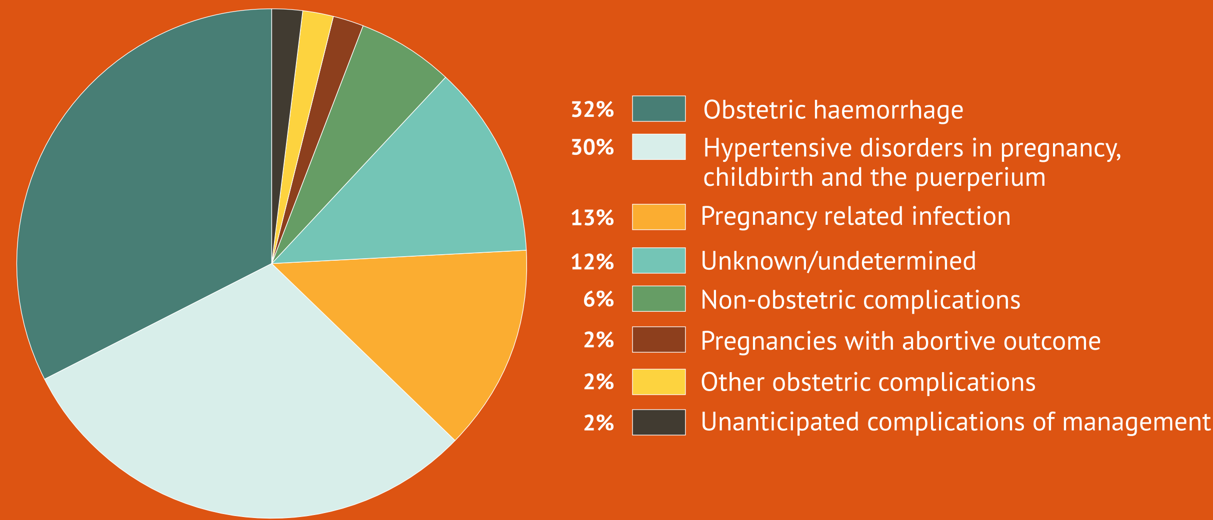
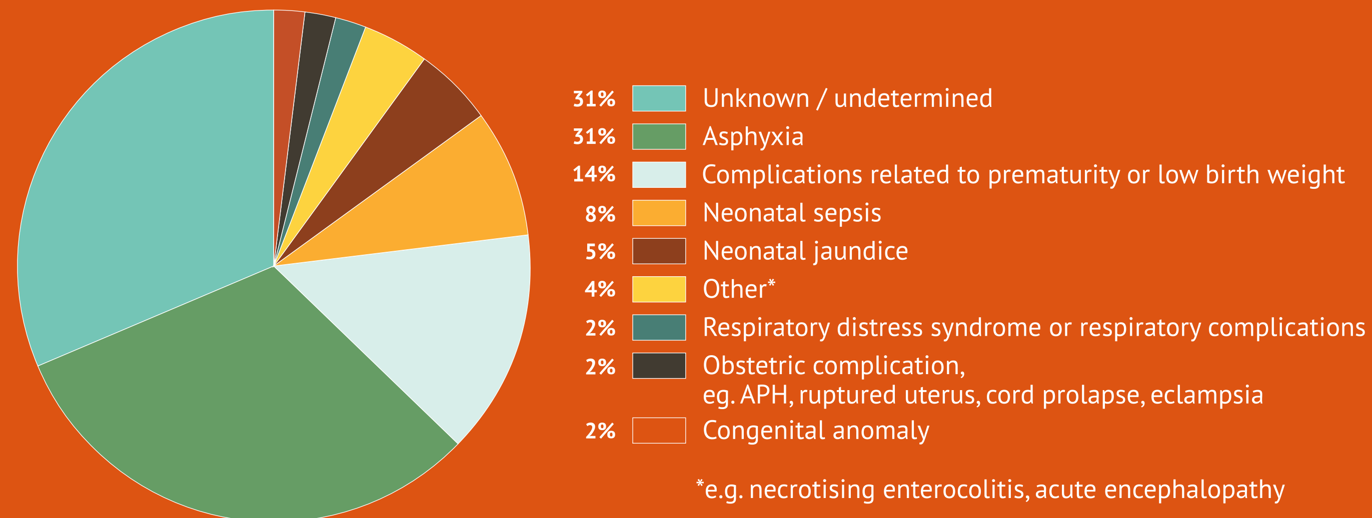
The Lagos State Ministry of Health is doing tremendously well to reduce maternal and perinatal deaths. **We ask the Ministry of Health to ensure that all facility MPDSR committees develop and implement action plans based on review findings to improve maternal and perinatal survival.**

Causes of maternal deaths January - April 2017 (total = 142)



Causes of perinatal deaths January - April 2017 (total = 500)



*e.g. necrotising enterocolitis, acute encephalopathy

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Produced by the Lagos State Accountability Mechanism for Maternal and Newborn Health (LASAM) in October 2017, with support from MamaYe-Evidence for Action

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

LAGOS STATE, NIGERIA

January – June 2017

FACILITY

INDICATORS	GENERAL HOSPITAL ALIMOSHO		ISLAND MATERNITY		GENERAL HOSPITAL BADAGRY		RANDLE GBAJA GENERAL HOSPITAL		HARVEY GENERAL HOSPITAL		SHOMOLU GENERAL HOSPITAL		IFAKO-IJAIYE GENERAL HOSPITAL		AJEROMI GENERAL HOSPITAL	
QUARTER	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
TOTAL NUMBER OF DELIVERIES	578	747	751	1139	353	340	432	674	155	330	161	254	664	852	386	305
MATERNAL DEATH REVIEWS																
% of maternal deaths reviewed	100%	100%	83%	94%	100%	100%	100%	100%	100%	NA	100%	100%	100%	67%	100%	100%
Number of maternal deaths reviewed in the last 3 months	4	5	15	15	8	6	3	5	2	0	1	5	4	8	5	3
Number of maternal deaths in the last 3 months	4	5	18	16	8	6	3	5	2	0	1	5	4	12	5	3
PERINATAL DEATHS REVIEWS																
% of perimatal deaths reviewed	100%	100%	NA[1]	22%	60%	25%	100%	100%	100%	100%	100%	100%	100%	22%	100%	76%
Number of perinatal deaths reviewed in the last 3 months	22	21	NA[1]	18	3	10	6	14	4	7	4	2	10	2	13	22
Number of perinatal deaths in the last 3 months	22	21	NA[1]	83	5	40	6	14	4	7	4	2	10	9	13	29
USE OF MPDSR EVIDENCE																
MPDSR committee has an action plan for current quarter	Red	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Green	Green	Green
Action plan contains clearly defined activities	Red	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Green	Green	Green
Number of activities implemented out of the total number of activities in this quarter's action plan	Red 0/0	Yellow 2/4	Green 6/6	Yellow 3/5	Red 6/14	Green 7/7	Yellow 2/3	Red 0/0	Green 6/8	Green 9/10	Green 4/4	Green 3/3	Red 0/0	Yellow 4/6	Green 6/6	Yellow 10/16
MPDSR MEETINGS AND REPORTING																
MPDSR committee holds monthly meetings with meeting minutes	Green	Green	Green	Green	Red	Red	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green
MPDSR focal person is notified of all maternal deaths within 24 hours	Green	Green	Green	Green	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
MPDSR focal person is notified of all perinatal deaths within 24 hours	Green	Green	Green	Green	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
LGA District Surveillance Notification Officers (DSNOs) are notified of all maternal deaths within 48hrs	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Green	Green	Green
LGA DSNOs are notified of all perinatal deaths within 48hrs	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Red	Green	Green	Green
At least 2 maternal deaths are reviewed within 7-14 days of occurrence	Green	Green	Green	Green	Green	Green	Green	Green	Red	NA	Green	Green	Green	Green	Green	Green
At least 2 perinatal deaths are reviewed within 7-14 days of occurrence	Green	Green	Green	Green	Green	Red	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green
MPDSR forms are completed	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Causes of each maternal death are clearly defined	Green	Green	Green	Green	Green	Green	Green	Green	Green	NA	Green	Green	Green	Green	Green	Green
Causes of each perinatal death are clearly defined	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Health staff are using evidence from MPDSR to improve quality of care	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green
Completed MPDSR forms are submitted monthly to the State M&E officer	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green

INDICATORS	ORILE AGEGE GENERAL HOSPITAL		AGBOWA GENERAL HOSPITAL		APAPA GENERAL HOSPITAL[2]		IJEDE GENERAL HOSPITAL		KETU EJIRIN GENERAL HOSPITAL		IKORODU GENERAL HOSPITAL		ISOLO GENERAL HOSPITAL		GBAGADA GENERAL HOSPITAL	
QUARTER	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
TOTAL NUMBER OF DELIVERIES	352	493	21	32			161	223	2	9	624	838	386	540	447	471
MATERNAL DEATH REVIEWS																
% of maternal deaths reviewed	100%	100%	NA	NA			100%	100%	NA	NA	100%	60%	100%	100%	100%	100%
Number of maternal deaths reviewed in the last 3 months	5	4	0	0			1	2	0	0	1	3	1	5	2	6
Number of maternal deaths in the last 3 months	5	4	0	0			1	2	0	0	1	5	1	5	2	6
PERINATAL DEATHS REVIEWS																
% of perimatal deaths reviewed	50%	100%	NA	0%			100%	100%	NA	NA	100%	12%	100%	100%	53%	100%
Number of perinatal deaths reviewed in the last 3 months	7	8	0	0			3	8	0	0	9	5	12	7	9	17
Number of perinatal deaths in the last 3 months	14	8	0	1			3	8	0	0	9	43	12	7	17	17
USE OF MPDSR EVIDENCE																
MPDSR committee has an action plan for current quarter	Green	Green	Red	Green			Green	Green	Red	Red	Green	Green	Red	Green	Red	Red
Action plan contains clearly defined activities	Green	Green	Red	Green			Green	Green	Red	Red	Green	Green	Red	Green	Red	Red
Number of activities implemented out of the total number of activities in this quarter's action plan	Yellow 2/3	Red 2/5	Red 0/0	Red 0/1			Green 10/10	Green 6/6	Red 0/0	Red 0/0	Green 3/4	Green 3/4	Red 0/0	Green 7/7	Red 0/0	Red 0/0
MPDSR MEETINGS AND REPORTING																
MPDSR committee holds monthly meetings with meeting minutes	Green	Green	Red	Red			Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
MPDSR focal person is notified of all maternal deaths within 24 hours	Green	Green	NA	NA			Green	Green	NA	NA	Green	Green	Green	Green	Green	Green
MPDSR focal person is notified of all perinatal deaths within 24 hours	Green	Green	NA	Green			Green	Green	NA	NA	Green	Green	Green	Green	Green	Green
LGA District Surveillance Notification Officers (DSNOs) are notified of all maternal deaths within 48hrs	Green	Green	NA	Red			Green	Green	NA	NA	Red	Green	Green	Green	Red	Green
LGA DSNOs are notified of all perinatal deaths within 48hrs	Green	Green	NA	Red			Green	Green	NA	NA	Red	Green	Green	Green	Red	Green
At least 2 maternal deaths are reviewed within 7-14 days of occurrence	Green	Green	NA	NA			Green	Green	NA	NA	Green	Red	Red	Green	Green	Green
At least 2 perinatal deaths are reviewed within 7-14 days of occurrence	Green	Green	NA	Red			Green	Green	NA	NA	Green	Red	Red	Green	Green	Green
MPDSR forms are completed	Green	Green	NA	Green			Green	Green	NA	NA	Green	Green	Green	Green	Red	Green
Causes of each maternal death are clearly defined	Green	Green	NA	NA			Green	Green	NA	NA	Green	Green	Green	Green	Red	Green
Causes of each perinatal death are clearly defined	Green	Green	NA	Green			Green	Green	NA	NA	Green	Green	Green	Green	Red	Green
Health staff are using evidence from MPDSR to improve quality of care	Green	Green	NA	Red			Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Completed MPDSR forms are submitted monthly to the State M&E officer	Green	Green	NA	Green			Green	Green	NA	NA	Green	Green	Green	Green	Green	Green

INDICATORS	AMUWO-ODOFIN GENERAL HOSPITAL		EPE GENERAL HOSPITAL		IBEJU-LEKKI GENERAL HOSPITAL		MASSEY CHILDREN HOSPITAL		MUSHIN GENERAL HOSPITAL		ONIKAN GENERAL HOSPITAL		LASUTH[3]	
QUARTER	1	2	1	2	1	2	1	2	1	2	1	2	1	2
TOTAL NUMBER OF DELIVERIES	463	648	128	164	224	299	0	0	94	160	75	79		
MATERNAL DEATH REVIEWS														
% of maternal deaths reviewed	NA	100%	100%	100%	100%	100%	NA	NA	100%	NA	100%	NA		
Number of maternal deaths reviewed in the last 3 months	0	1	3	1	5	2	0	0	1	0	1	0		
Number of maternal deaths in the last 3 months	0	1	3	1	5	2	0	0	1	0	1	0		
PERINATAL DEATHS REVIEWS														
% of perimatal deaths reviewed	75%	0%	100%	100%	100%	NA	100%	100%	100%	NA	100%	100%		
Number of perinatal deaths reviewed in the last 3 months	9	0	19	19	5	0	42	24	5	0	2	2		
Number of perinatal deaths in the last 3 months	12	17	19	19	5	0	42	24	5	0	2	2		
USE OF MPDSR EVIDENCE														
MPDSR committee has an action plan for current quarter	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green		
Action plan contains clearly defined activities	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green		
Number of activities implemented out of the total number of activities in this quarter's action plan	Green 3/4	Red 0/0	Red 1/9	Yellow 5/7	Green 4/4	Green 9/9	Green 10/10	Green 4/4	Green 4/4	Green 6/7	Red 0/0	Green 3/4		
MPDSR MEETINGS AND REPORTING														
MPDSR committee holds monthly meetings with meeting minutes	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
MPDSR focal person is notified of all maternal deaths within 24 hours	NA	Green	Green	Green	Green	Green	NA	NA	Green	NA	Green	Green		
MPDSR focal person is notified of all perinatal deaths within 24 hours	Green	Green	Green	Green	Green	NA	Green	Green	Green	NA	Green	Green		
LGA District Surveillance Notification Officers (DSNOs) are notified of all maternal deaths within 48hrs	NA	Green	Red	Red	Green	Green	NA	NA	Green	NA	Red	Red		
LGA DSNOs are notified of all perinatal deaths within 48hrs	Red	Green	Red	Red	Green	NA	Green	Red	Green	NA	Red	Red		
At least 2 maternal deaths are reviewed within 7-14 days of occurrence	NA	Red	Green	Green	Green	Green	NA	NA	Green	NA	Green	NA		
At least 2 perinatal deaths are reviewed within 7-14 days of occurrence	Red	Red	Green	Green	Green	NA	Green	Green	Green	NA	Green	Green		
MPDSR forms are completed	Green	Red	Red	Green	Green	Green	Red	Green	Green	Green	Green	Green		
Causes of each maternal death are clearly defined	NA	Red	Red	Green	Green	Green	NA	NA	Green	NA	Green	Green		
Causes of each perinatal death are clearly defined	Green	Red	Red	Green	Green	NA	Green	Green	Green	NA	Green	Green		
Health staff are using evidence from MPDSR to improve quality of care	Green	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green		
Completed MPDSR forms are submitted monthly to the State M&E officer	Green	Red	Green	Green	Green	Green	Green	Green	Green	NA	Green	Green		

1 These perinatal deaths are captured by Massey Children Hospital
2 Data not retrievable from facility
3 No data available as facility MPDSR committee yet to be fully functional

QUARTER
1 = Jan - March
2 = April - July