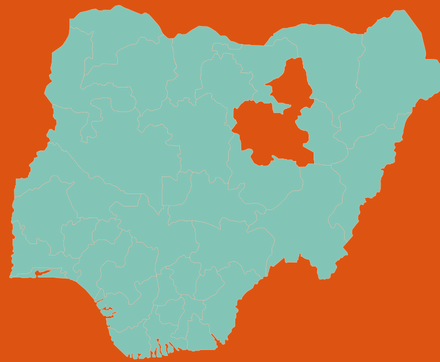
We ask
Bauchi State Ministry of Health to:



- ✓ Strengthen weak capacity of facility MPDSR staff by conduct training on MPDSR
- ✓ Solve high staff attrition of secondary facilities
- ✓ Print data capturing and reporting tools and forms and distribute to all facilities
- ✓ Strengthen the weak monitoring and supervision of MPDSR facilities

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Produced by the Bauchi State Accountability Mechanism for Maternal and Newborn Health (BaSAM) 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

BAUCHI STATE, NIGERIA

July – December 2017

FACILITIES 3RD & 4TH QUARTER 2017

INDICATORS	DATA TYPE	ALKALERI	AZARE	BAYARA	BOGORO	BOTO	BUNUNU	BURA	DAMBAM	DARAZO	DASS	GAMAWA	GIADE	ITAS GADAU	JAMA ARE	K. MADAKI	K.WARJI	KIRFI	MISAU	NINGI	SHIRA	SPECIALIST HOSPITAL BAUCHI	T.BALEWA	TORO	WOMEN & CHILDREN HOSPITAL	YIGUDA	ZAKI
REVIEW OF MATERNAL DEATHS																											
Number of maternal deaths in the last 3 months	Number	11	3	0	0	0	0	1	0	0	3	4	2	1	1	2	0	5	26	12	1	5	1	21	0	1	0
Number of maternal deaths reviewed in the last 3 months	Number	10	0	0	0	0	0	0	0	0	1	3	0	0	0	1	0	0	0	0	0	0	0	1	0		0
% of maternal deaths reviewed	%	91%	0%	0%	0%	0%	0%	0%	0%	0%	33%	75%	75%	0%	0%	0%	50%	0%	0%	0%	0%	0%	0%	5%	0%	0%	0%
REVIEW OF PERI-NATAL DEATHS																											
Number of peri-natal deaths in the last 3 months	Number	26	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Number of peri-natal deaths reviewed in the last 3 months	Number	22	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
% of peri-natal deaths re-viewed	%	85%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
USE OF MDR EVIDENCE																											
MPDSR committee has an action plan for current quarter	Yes/ No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	Yes	No	No	No	No	No	No	Yes	No	No	No
Action plan contains clearly defined activities	Yes/No	Yes	No	NA	NA	NA	NA	NA	NA	NA	Yes	Yes	No	No	NA	No	Yes	NA	No	No	No	No	NA	Yes	NA	No	NA
Number of activities in this quarters action plan	Number	10	0	NA	NA	NA	NA	NA	NA	NA	2	4	0	0	NA	0	3	NA	0	0	0	0	NA	2	NA	0	NA
Number of activities in action plan implemented during this quarter	Number	10	0	NA	NA	NA	NA	NA	NA	NA	2	2	0	0	NA	0	3	NA	0	0	0	0	NA	1	NA	0	NA
% of actions implemented	%	100%	NA	NA	NA	NA	NA	NA	NA	NA	100%	50%	NA	NA	NA	NA	100%	NA	NA	NA	NA	NA	NA	50%	NA	NA	NA
MPDSR MEETINGS AND REPORTING																											
MPDSR committee hold monthly meetings with minutes of meeting	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No
MPDSR focal person is notified of all maternal deaths within 12 hours	Yes/No	Yes	No	NA	NA	NA	NA	NA	NA	NA	Yes	No	No	No	NA	No	No	NA	No	No	No	No	NA	Yes	NA	Yes	NA
All maternal deaths are reviewed within 48 hours	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No
MPDSR focal person is notified of all perinatal deaths within 12 hours	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	Yes	No
All perinatal deaths are reviewed within 48 hours	Yes/No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No
MPDSR forms are completed	Yes/No	Yes	No	No	No	No	No	No	No	No	No	Yes	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No
Causes of each maternal death clearly defined	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	NA	No	No	No	No	No	Yes	NA	No	No
Causes of each perinatal death are clearly defined	Yes/No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	NA	No	No	No	No	No	No	NA	No	No
Health staff are using evidence from MDR to improve quality of care	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	Yes	No	No	No	No	No	No	Yes	No	Yes	No
Completed MDR forms are submitted monthly to the state M&E officer	Yes/No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No

NA Not applicable · 75% - 100% All criteria met · 50% - 75% Some criteria met · <50% No criteria met · Yes · No