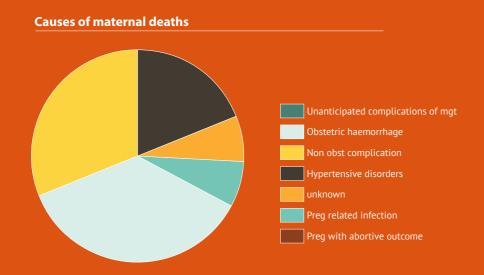
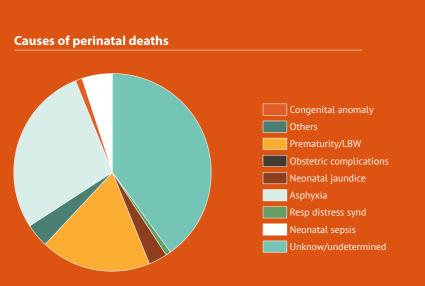
We ask Lagos State Ministry of Health to:

- encourage facilities to increase the number of maternal and perinatal death reviews
- ✓ ensure that facilities regularly give notification of all maternal and perinatal deaths to the DSNOs
- ensure that facilities emphasize the use of standardized protocols for patient management of obstetric heamorrhage, hypertensive disorder in pregnancy and birth asphyxia
- encourage the development of a wholistic behavioral communication change program for timely reporting of patients to the health facilities









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









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

LAGOS STATE, NIGERIA

July - December 2018



INDICATORS		ISLAND MATERNITY	GENERAL HOSPITAL BADAGRY	RANDLE GBAJA GENERAL HOSPITAL	HARVEY GENERAL HOSPITAL	SHOMOLU 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 GENERAL HOSPITAL	EPE GENERAL HOSPITAL	IBEJU-LEKKI GENERAL HOSPITAL	MASSEY CHILDREN HOSPITAL	MUSHIN GENERAL HOSPITAL	LASUTH	ONIKAN HEALTH CENTRE	SUMARRY
NO OF DELIVERIES IN THE FACILITY	GENERAL HOSPITAL ALIMOSHO	1804	465	957	321	279	1874	344	755	96	59	399	10	890	991	853	1129	468	471	NA	252	NA	268	1391
REVIEW OF MATERNAL DEATHS																								
Number of maternal deaths in the last 6 months	15	33	3	4	0	0	14	6	0	0	0	3	0	15	4	5	3	6	1	NA	3	NA	0	115
Number of maternal deaths reviewed in the last 6 months	6	19	3	4	NA	NA	14	5	NA	NA	NA	3	NA	9	3	5	3	6	1	NA	3	NA	NA	84
% of maternal deaths reviewed	40%	37%	100%	100%			100%	83%		_	_	100%		60%	75%	100%	100%	100%	100%		100%			73%
REVIEW OF PERINATAL DEATHS																								
Number of perinatal deaths in the last 6 months	73	65	24	21	11	5	36	40	16	0	3	8	0	64	16	21	48	18	7	27	4	6	7	520
Number of perinatal deaths reviewed in the last 6 months	1	11	6	7	6	5	27	18	6	NA	3	8	NA	14	16	21	31	12	7	21	3	6	7	236
% of perinatal deaths reviewed	1%	17%	25%	18%	66%	100%	75%	45%	38%		100%	100%		22%	100%	100%	65%	100%	100%	78%	75%	100%	100%	45%
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	19	17	9	19	5	5	23	11	12	11	18	10	1	20	18	18	29	10	14	23	7	9	10	169
Number of activies in action plan implemented during this quarter	15	15	8	15	3	3	23	8	8	11	8	10	1	14	18	18	23	8	11	21	6	1	10	141
% of actions implemented	79%	88%	89%	100%	100%	100%	100%	73%	67%	100%	44%	100%	100%	70%	100%	100%	79%	80%	79%	91%	86%	11%	100%	83%
MPDSR MEETINGS AND REPORTING																								
MPDSR Committee hold monthly meetings with minutes of meeting																								
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											
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											
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											
MPDSR forms are completed										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											
Health staff are using evidence from MPDSR to improve quality of care																								
Completed MPDR forms are submitted monthly to the state M&E officer																								









