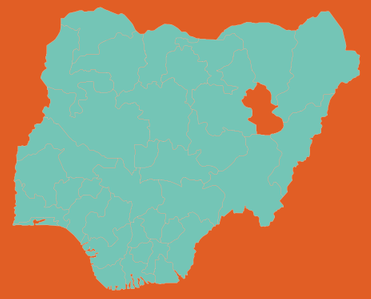
We ask
Gombe State Ministry of Health to:



- ✓ Ensure regular and adequate supply of MPDSR reporting forms in all secondary facilities to enable reporting of all maternal and perinatal deaths
- ✓ Ensure at least one functional blood bank with a constant electricity source in each senatorial district
- ✓ Sustain the provision of life-saving commodities such as magnesium sulphate and misoprostol in all facilities
- ✓ Ensure adequate ambulance services for early and prompt referral from primary to secondary health facilities
- ✓ Provide refresher training for maternal health providers in management of labour and delivery, including routine partograph use to prevent prolonged labour
- ✓ Ensure availability of functional antenatal care (ANC) services and comprehensive emergency obstetric care in all hospitals in the state
- ✓ Ensure delivery beds are fully functional in all hospital delivery rooms

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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

July – September 2017

FACILITY NAMES

INDICATORS	State Specialist Hospital	Bajoga General Hospital	Bajude Cottage Hospital	BamBam Cottage Hospital	Billiri General Hospital	Biri Cottage Hospital	Deba General Hospital	Dukku General Hospital	Hinna Cottage Hospital	Kaltungo General Hospital	Kashere General Hospital	Kumo General Hospital	Kuri Cottage Hospital	Mallam Sidi Cottage Hospital	Nafada General Hospital	Pindiga Cottage Hospital	Potuki Cottage Hospital	Talase General Hospital	Tula Cottage Hospital	Tumu Cottage Hospital	Women & Children Hospital[1]	Zambuk General Hospital
REVIEW OF MATERNAL DEATHS																						
% of maternal deaths reviewed	44%	100%	NA	NA	33%	NA	100%	0%	NA	100%	100%	40%	NA	NA	0%	100%	NA	100%	NA	100%		100%
Number of maternal deaths in the last 3 months	25	6	0	0	3	0	1	3	0	6	2	5	0	0	1	1	0	3	0	2		3
Number of maternal deaths reviewed in the last 3 months	11	6	0	0	1	0	1	0	0	6	2	2	0	0	0	1	0	3	0	2		3
REVIEW OF PERINATAL DEATHS																						
% of perinatal deaths reviewed	65%	62%	100%	67%	17%	100%	100%	100%	93%	62%	100%	61%	NA	0%	0%	100%	NA	92%	0%	100%		100%
Number of perinatal deaths in the last 3 months	222	50	11	6	6	3	11	3	14	21	11	31	0	4	19	4	0	13	1	13		8
Number of perinatal deaths reviewed in the last 3 months	144	31	11	4	1	3	11	3	13	13	11	19	0	0	0	4	0	12	0	13		8
USE OF MDR EVIDENCE																						
MPDSR committee has an action plan for current quarter													NA				NA					
Action plan contains clearly defined activities													NA				NA					
Number of activities implemented out of the total number of activities in this quarter's action plan	13/33	4/6	6/11	2/6	0/0	1/4	16/17	4/7	7/8	4/4	2/2	3/4	NA	0/0	0/0	2/4	NA	4/9	0/0	6/9		7/11
MPDSR MEETINGS AND REPORTING																						
MPDSR committee hold monthly meetings with minutes of meeting													NA				NA					
MPDSR focal person is notified of all maternal deaths within 12 hours			NA	NA		NA							NA	NA			NA		NA			
All maternal deaths are reviewed within 48 hours			NA	NA		NA			NA				NA	NA			NA		NA			
MPDSR focal person is notified of all perinatal deaths within 12 hours													NA				NA					
All perinatal deaths are reviewed within 48 hours													NA				NA					
MPDSR forms are completed				NA									NA	NA			NA					
Cause of each maternal death clearly defined			NA	NA		NA			NA				NA	NA			NA		NA			
Cause of each perinatal death clearly defined													NA	NA			NA					
Health staff are using evidence from MPDSR to improve quality of care													NA	NA			NA					
Completed MPDSR forms are submitted monthly to the State M&E officer													NA	NA			NA					

[1] Women and Children Hospital is yet to be commissioned

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