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

QUARTERS 3 AND 4, 2015

Indicators	Data type	SHB Q3	SHB Q4	GH TORO Q3	GH TORO Q4	GH SHIRA Q3	GH SHIRA Q4	GH GADE Q3	GH GADE Q4	GH ZAKI Q3	GH ZAKI Q4	GH GAMAWA Q3	GH GAMAWA Q4	GH TYG GADAU Q3	GH TYG GADAU Q4	GH JAMA ARE Q3	GH JAMA ARE Q4
Review of Maternal Deaths																	
Number of maternal deaths in the last 3 months	Number	2	3	12	9	1	0	1	1	0	0	1	3	1	0	0	1
Number of maternal deaths reviewed in the last 3 months	Number	0	0	1	0	0	0	0	0	0	0	1	2	0	0	0	0
% of maternal deaths reviewed	%	0	0	8	0	0	N/A	0	0	N/A	N/A	100	67	0	N/A	N/A	0
Review of Peri-natal Deaths																	
Number of peri-natal deaths in the last 3 months	Number	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% of peri-natal deaths reviewed	%	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	N/A	N/A
Use of MDR evidence																	
MPDSR Committee has an action plan for current quarter	Yes/No	No	No	Yes	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No
Action plan contains clearly defined activities	Yes/No	No	No	Yes	No	No	N/A	No	No	N/A	N/A	Yes	Yes	No	N/A	N/A	No
Number of activities in this quarters action plan	Number	0	0	2	0	0	N/A	0	0	N/A	N/A	2	2	0	N/A	N/A	0
Number of actives in action plan implemented during this quarter	Number	0	0	1	0	0	N/A	0	0	N/A	N/A	1	1	0	N/A	N/A	0
% of actions implemented	%	N/A	N/A	50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50	50	N/A	N/A	N/A	N/A
MPDSR meetings and reporting																	
MPDSR Committee hold monthly meetings with minutes of meeting	Yes/No	No	No	Yes	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No
MPDSR focal person is notified of all maternal deaths within 12 hours	Yes/No	No	No	Yes	No	No	N/A	No	No	N/A	N/A	No	No	No	N/A	N/A	No
All maternal deaths are reviewed within 48 hours	Yes/No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
MPDSR focal person is notified of all perinatal deaths within 12 hours	Yes/No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
All perinatal deaths are reviewed within 48 hours	Yes/No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
MPDSR forms are completed	Yes/No	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No
Causes of each maternal death are clearly defined	Yes/No	No	No	Yes	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No
Causes of each perinatal death are clearly defined	Yes/No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Health staff are using evidence from MDR to improve quality of care	Yes/No	No	No	Yes	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No
Completed MDR forms are submitted monthly to the State M&E officer	Yes/No	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No

Indicators	GH AZARE Q3	GH AZARE Q4	GH BURA Q3	GH BURA Q4	GH NINGI Q3	GH NINGI Q4	GH K. MADAKI Q3	GH K. MADAKI Q4	GH T. BALEWA Q3	GH T. BALEWA Q4	GH BOGORO Q3	GH BOGORO Q4	GH BAKARA Q3	GH BAKARA Q4	GH DAS Q3	GH DAS Q4
Review of Maternal Deaths																
Number of maternal deaths in the last 3 months	2	1	0	1	6	6	1	1	0	1	0	0	0	0	3	0
Number of maternal deaths reviewed in the last 3 months	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
% of maternal deaths reviewed	0	0	N/A	0	0	0	100	0	N/A	0	N/A	N/A	N/A	N/A	33	N/A
Review of Peri-natal Deaths																
Number of peri-natal deaths in the last 3 months	5	1	0	0	7	1	0	0	0	0	0	0	0	0	0	2
Number of peri-natal deaths reviewed in the last 3 months	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% of peri-natal deaths reviewed	0	0	N/A	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Use of MDR evidence																
MPDSR Committee has an action plan for current quarter	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No
Action plan contains clearly defined activities	No	No	No	No	No	No	No	No	N/A	No	N/A	N/A	N/A	N/A	Yes	N/A
Number of activities in this quarters action plan	0	0	N/A	0	0	0	0	0	N/A	0	N/A	N/A	N/A	N/A	2	N/A
Number of actives in action plan implemented during this quarter	0	0	N/A	0	0	0	0	0	N/A	0	N/A	N/A	N/A	N/A	2	N/A
% of actions implemented	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	100	N/A
MPDSR meetings and reporting																
MPDSR Committee hold monthly meetings with minutes of meeting	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No
MPDSR focal person is notified of all maternal deaths within 12 hours	No	No	No	No	No	No	No	No	N/A	No	N/A	N/A	N/A	N/A	Yes	N/A
All maternal deaths are reviewed within 48 hours	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	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No
All perinatal deaths are reviewed within 48 hours	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
MPDSR forms are completed	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No
Causes of each maternal death are clearly defined	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No
Causes of each perinatal death are clearly defined	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Health staff are using evidence from MDR to improve quality of care	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No
Completed MDR forms are submitted monthly to the State M&E officer	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No

Indicators	GH WC HOSPITAL KU BAUCHI Q3	GH WC HOSPITAL KU BAUCHI Q4	GH KIRFI Q3	GH KIRFI Q4	GH ALKALERI Q3	GH ALKALERI Q4	GH DAMBAM Q3	GH DAMBAM Q4	GH MISAU Q3	GH MISAU Q4	GH DARAZO Q3	GH DARAZO Q4	GH BUNUNU Q3	GH BUNUNU Q4	GH BOTO Q3	GH BOTO Q4	GH K. WABI Q3	GH K. WABI Q4
Review of Maternal Deaths																		
Number of maternal deaths in the last 3 months	0	0	0	5	5	6	0	0	16	10	0	0	0	0	0	0	0	0
Number of maternal deaths reviewed in the last 3 months	0	0	0	0	5	5	0	0	0	0	0	0	0	0	0	0	0	0
% of maternal deaths reviewed	N/A	N/A	N/A	0	100	83	N/A	N/A	0	0	N/A	N/A	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	0	0	0	0	16	10	0	0	0	0	0	0	0	0	0	0	0	0
Number of peri-natal deaths reviewed in the last 3 months	0	0	0	0	14	8	0	0	0	0	0	0	0	0	0	0	0	0
% of peri-natal deaths reviewed	N/A	N/A	N/A	N/A	88	80	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Use of MDR evidence																		
MPDSR Committee has an action plan for current quarter	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes
Action plan contains clearly defined activities	N/A	N/A	N/A	N/A	Yes	Yes	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Number of activities in this quarters action plan	N/A	N/A	N/A	0	6	4	N/A	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	1	2
Number of actives in action plan implemented during this quarter	N/A	N/A	N/A	0	6	4	N/A	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	1	2
% of actions implemented	N/A	N/A	N/A	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100	100
MPDSR meetings and reporting																		
MPDSR Committee hold monthly meetings with minutes of meeting	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes
MPDSR focal person is notified of all maternal deaths within 12 hours	N/A	N/A	N/A	N/A	Yes	Yes	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A	No	No
All maternal deaths are reviewed within 48 hours	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
MPDSR focal person is notified of all perinatal deaths within 12 hours	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
All perinatal deaths are reviewed within 48 hours	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
MPDSR forms are completed	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Causes of each maternal death are clearly defined	N/A	N/A	N/A	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Causes of each perinatal death are clearly defined	N/A	N/A	N/A	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Health staff are using evidence from MDR to improve quality of care	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes
Completed MDR forms are submitted monthly to the State M&E officer	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No