



MATERNAL DEATH REVIEW

ONDO STATE SCORECARD

October - December 2015



Mamaye!
evidence for action
mothers · babies · alive



Ondo STATE
IṢẸ LOÒGÙN IṢẸ
Ministry of Health

INDICATORS	DATA TYPE	GH IGBARA-OKE	SSH OKITIPUPA	GH OWO	GH ODE-IRELE	GH IWARO-OKA	GH IPE AKOKO	GH IDANRE	GH ORE	SSH IKARE AKOKO	SSH ONDO	GH IGBOKODA	GH IRUN	GH BOLORUNDURO	GH IGBOTAKO	MOTHER & CHILD ONDO	MOTHER & CHILD AKURE	GH IJU-ITAOGBOLU	GH IDO-ANI	SSH AKURE	GH IGBEKEBO
Review of Maternal Deaths																					
Number of maternal deaths in the last 3 months	Number	0	5	0	0	0	1	0	0	2	2	0	0	0	0	7	1	0	No Data	1	No Data
Number of maternal deaths reviewed in the last 3 months	Number	N/A	3	N/A	N/A	N/A	1	N/A	N/A	2	0	N/A	N/A	N/A	N/A	7	1	N/A	No Data	0	No Data
% of maternal deaths reviewed	%	N/A	60%	N/A	N/A	N/A	100%	N/A	N/A	100%	0%	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	0%	N/A
Review of Preinatal Deaths																					
Number of perinatal deaths in the last 3 months	Number	0	5	0	0	0	0	0	0	4	0	0	0	0	0	14	13	0	No Data	18	No Data
Number of perinatal deaths reviewed in the last 3 months	Number	0	5	N/A	N/A	N/A	N/A	N/A	N/A	4	N/A	N/A	N/A	N/A	N/A	14	13	N/A	No Data	0	No Data
% of peri-natal deaths reviewed	%	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	0%	N/A
Use of MDR Evidence																					
MPDSR Committee has an action plan for current quarter	Yes/No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Action plan contains clearly defined activities	Yes/No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Number of activities in this quarters' action plan	No	10	3	4	5	2	3	5	5	5	5	7	5	0	4	6	5	7	4	4	N/A
Number of activities in action plan implemented during this quarter	No	0	3	1	0	1	3	5	5	5	5	5	5	0	0	0	5	7	No Data	0	N/A
% of actions implemented	%	0	100%	25%	N/A	50%	100%	0	0	0	0	0	0	N/A	0	0	100	100%	N/A	0	N/A
MPDSR Meetings and Reporting																					
MPDSR Committee hold monthly meetings with minutes of meeting	Yes/No	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
MPDSR focal person is notified of all maternal deaths within 12 hours	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	No	No	No	No	No	Yes	Yes	No	No	No	No
All maternal deaths are reviewed within 48 hours	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	No	No	No	No	No	Yes	Yes	No	No	No	No
MPDSR focal person is notified of all perinatal deaths within 12 hours	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	No	No	No	No	No	Yes	Yes	No	No	No	No
All perinatal deaths are reviewed within 48 hours	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	No	No	No	No	No	Yes	Yes	No	No	No	No
MPDSR forms are completed	Yes/No	No	Yes	No	No	No	Yes	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	Yes	No	No	No	Yes	No	No	Yes	Yes	No	No	No	No	Yes	Yes	No	No	No	No
Causes of each perinatal death are clearly defined	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	Yes	No	No	No	No	Yes	Yes	No	No	No	No
Health staff are using evidence from MDR to improve quality of care	Yes/No	No	Yes	No	No	No	Yes	No	No	Yes	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	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No