Maternal and Perinatal Death Surveillance and Response Scorecard

The MPDSR scorecard shows how facility MPDSR committees are faring from the notification and investigation of a maternal and perinatal (stillbirth or a baby during the first 7 days of life) death to using death review findings to develop and act on appropriate solutions to prevent similar events from happening in the future. The scorecard ends with a state call to action.

Indicator	Data type	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8	Facility 9	Facility 10	Facility 11	Facility 12	Facility 13	Facility 14	Facility 15	Facility 16	Facility 17	Facility 18	Facility 19	Facility 20
MDR NOTIFICATION AND REPORTING																					
Number of maternal deaths in the last 3 months	Number	35	0	1	8	0		0	0	1	2	2	5	1	2	8	1	1	0	0	2
Number of perinatal deaths in the last 3 months	Number	16	12	9	32	19		2	23	35	3	17	1	13	14	35	21	47	0	0	49
MDR focal person is promptly notified of all maternal deaths	Yes / No	YES	YES	YES	YES	YES		YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	N/A	YES
MDR forms are completed	Yes / No	YES	YES	YES	YES	NO		NO	NO	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	NO	YES
Completed MDR forms are submitted monthly to the State M&E officer	Yes / No	NO	YES	YES	YES	NO		NO	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	N/A	YES
REVIEW OF MATERNAL DEATHS																					
MDR Committee hold monthly meetings with minutes of meeting	Yes / No	YES	YES	YES	YES	YES		YES	NO	YES	YES	YES	YES	YES	YES	NO	YES	N/A	N/A	YES	YES
Number of maternal deaths reviewed in the last 3 months	Number	35	0	1	8	0		0	0	1	2	2	5	1	2	8	1	1	0	0	2
Number of perinatal deaths reviewed in the last 3 months	Number	16	2	9	32	19		0	0	35	3	17	1	0	14	35	21	0	0	0	49
% of maternal deaths reviewed in the last 3 months	%	100%	N/A	100%	100%	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	100%
All maternal deaths are reviewed within 48 hours	Yes / No	YES	N/A	YES	YES	N/A		NO	NO	YES	YES	YES	NO	NO	YES	YES	YES	YES	N/A	N/A	YES
Causes of each maternal death are clearly defined	Yes / No	YES	N/A	YES	YES	N/A		NO	N/A	YES	NO	YES	N/A	YES	YES	YES	YES	YES	N/A	N/A	YES
Causes of each perinatal death are clearly defined	Yes / No	NO	YES	YES	YES	NO		NO	NO	YES	NO	YES	NO	NO	YES	YES	YES	NO	N/A	N/A	YES
MDR USE AND RESPONSE																					
MDR Committee has an action plan for current quarter	Yes / No	YES	YES	YES	YES	YES		YES	NO	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Action plan contains clearly defined activities	Yes / No	YES	YES	YES	YES	YES		YES	N/A	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Number of activities in this quarter's action plan	Number	13	11	5	5	8		10	1	11	6	7	8	5	6	7	8	5	7	5	5
Number of activities in action plan implemented during this quarter	Number	8	9	4	5	5		5	1	6	5	6	7	4	6	5	8	3	5	3	5
% of actions implemented	%	62%	82%	80%	100%	63%	N/A	50%	100%	55%	83%	86%	88%	80%	100%	71%	100%	60%	71%	60%	100%
Action plan implemented?	Yes / No	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Health staff are using evidence from MDR to improve quality of care	Yes / No	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Examples of of how health staff have used evidence from MDR to improve quality of care	2-3 examples																				

KEY: 100% 50-99% 0-49%

CASE STUDY

Gambo Sawaba General Hospital in Zaria, Kaduna State, is a referral hospital attending to over a hundred patients daily. It has an MNCH2-trained MPDSR committee to create and implement action plans in relation to maternal deaths. Despite training, the committee was always reported as weak. It was not conducting monthly meetings even when there was a maternal death. Deaths were not properly documented and there was no action plan. The hospital operated with an unsteady power source and had an inadequate blood stock.

Based on the negative reports, MNCH2 intensified coaching and mentoring of the facility MPDSR committee. This specifically focused on how to engage hospital management through strategic internal advocacy. The mentors went to the facility monthly, instead of quarterly, and coached the committee on action plans. One of the mentors accompanied the committee on an advocacy visit to the management of the hospital.

The MPDSR committee became more active and started a dialogue with hospital management on the need for steady power supply to properly operate the blood bank. The Hospital Matron stated "this MPDSR committee engaged the management of the hospital on the issues of power supply and functionality of blood bank for emergency purposes. As a result of their persistent dialogue with the hospital management, the hospital had to put requests to the State Ministry of Health, which eventually led to the installation of solar panels […] now we have 24 hours power supply not only in the Lab where the blood bank is located but even in maternity and other wards."

The MPDSR focal person in Gambo Sawaba added: "We also solicited for constant availability of blood to be used exclusively for emergency cases at the labour ward. I am happy to say that at any given time, there are three pints of blood ready for emergency for pregnant women. Between January and June 2018, three maternal deaths occurred and they were all reviewed and none of them was as a result of bleeding."

The committee also advocated for an increase in the number of skilled workers and recently, 60 nurses were deployed.