NATIONAL TOOLS FOR MATERNAL AND PERINATAL DEATHS SURVEILLANCE AND RESPONSE IN NIGERIA

MARCH, 2015

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Table of Contents

List of Tables

FOREWORD

Reporting and tracking maternal and perinatal deaths and response to reduce preventable deaths remain major challenge in Nigeria. The first 28 days of life – the neonatal period – is a critical time for survival of the child. Every day in Nigeria, about 700 babies die (around 30 every hour). This is the highest number of newborn deaths in Africa, and the second highest in the world. A staggering 33,000 Nigerian women die each year giving birth, and for every maternal death, at least seven newborns die and a further four babies are stillborn. Going by the report of the 2013 DHS report, Nigeria is unable to meet MDGs 4 & 5 as maternal mortality ratio remains 576 per 100,000 live births and neonatal mortality 37 per 1000 live births despite plans to reduce maternal mortality to 250 per 100,000 live births and neonatal mortality to 27 per 1000 by 2015.

It is generally agreed that the causes of maternal , neonatal, infants and Underfive mortality are preventable through systematic public health education and strengthening of the health system blocks which deal with the three delays: delay to seek care, delay to access health care and delay in receiving quality care. Achieving the latter is pivoted on MNH death audits and response to the recommendations made from the audits.

In view of this, the Federal Ministry of Heath in collaboration with the professional Associations; (Society of Obstetricians and Gyneacologists of Nigeria (SOGON) and Paediatric Association of Nigeria (PAN), as well as Nigerian Society of Neonatal Medicine (NISONM), Development partners and other stakeholders in reproductive, maternal and child health in Nigeria, provided technical support to the development of this guideline and tools to routinely track all maternal and perinatal deaths in Nigeria. Effective conduct of these audits will result in improved care for women and their babies. This will improve the knowledge and skills of health care provider in quality providing maternal and newborn care during birth and immediately after. The guideline and the tools provide direction, and instructions required for the establishment of Maternal Perinatal Deaths Surveillance Response in Nigeria. The prompt response to the recommendations made during the audits of the maternal and perinatal deaths will improve quality of care reduce maternal and Newborn deaths significantly in Nigeria.

The unprecedented success of the development process was made possible by the contributions from a number of individuals and organisations. I wish to acknowledge the technical expertise of the Lead Consultant, Dr. Oladipo Shittu and his team, members of the National Reproductive and Child Health Technical Working Groups under the leadership of Prof A.O Ladipo and Prof Okolo respectively, and our development partners namely World Health Organisation(WHO), United Nations Population Fund (UNFPA) , United Nation Children Fund (UNICEF), Evidence for Action, Partnership for Transforming Health System (PATHS2/DFID) Action Network in Nigeria, Jhpiego, Save the Children in Nigeria Safe-Motherhood branch of the Reproductive Health Division and New Born branch of the Child Health Division of Department of Family Health, Federal Ministry of Health.

I highly recommend this document for all stakeholders: Federal Health Institutions, State Governments, Government Agencies, Development Partners, Non-Governmental Organisations and Faith-based Health Institutions. I hope that it will be put to practical use at all levels across the country.

Dr Khaliru Al-hassan
Hon. Minister of Health, Federal Republic of Nigeria
March,2015

ACKNOWLEDGEMENT

The Federal Ministry of Health, in collaboration with Development partners, has developed the National guidelines for the conduct of Maternal and Perinatal Death Surveillance and Response (MPDSR) in Nigeria as recommended by World Health Organization in 2004. The development of this document is a major breakthrough for reduction of preventable maternal and newborn deaths in Nigeria.

The Ministry would like to extend its sincere thanks and gratitude to organizations and persons who contributed considerable time and effort in ensuring the development of this National guideline. Special thanks go to the Society for Obstetrics and Gynecologists of Nigeria (SOGON) and Nigeria Society of Neonatal Medicine (NISONM) for their hard work, technical input and leading the process for the institutionalization of Maternal and Perinatal Death Surveillance and Response in Nigeria.

I commend the support of our Development partners; notably WHO, UNICEF,UNFPA, , E4A, Save the Children for the time and resources committed to the development of this policy document. My appreciation goes to all other partners for their technical inputs during the process for the development of this National guideline for the conduct of MPDR in Nigeria.

My gratitude also goes to the staff of Safe Motherhood branch of Reproductive Health Division and Newborn branch of Child Health Division of the Department of Family Health, under the able leadership of Dr. Kayode Afolabi and Dr Bose Adeniran respectively for their commitment and concerted efforts in ensuring that this Policy document which is long overdue becomes a reality.

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March , 2015

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ABBREVIATIONS

ANC	Antenatal Care
APN	Association of Pathologists of Nigeria
APHPN	Association of Public Health Physicians of Nigeria
CBCA	Criterion-Based Clinical Audits
CBMDSR	Community-Based Maternal and Perinatal Death Surveillance and Response
CBMPDR	Community-Based Maternal and Perinatal Death Review
CEMD	Confidential Enquiries on Maternal Death
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CMD	Chief Medical Director
CSO	Civil Society Organization
DPHC	Department of Primary Health Care
FCT	Federal Capital Territory
FIGO	International Federation of Gynaecology and Obstetrics
FMOH	Federal Ministry of Health
HOD	Head of Department
HMIS	Health Management Information System
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
LOGIC	Leadership in Obstetrics & Gynaecology for Impact and Change
MA	Medical Audits
M & E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MNCH	Maternal, Newborn and Child Health
MMR	Maternal Mortality Ratio
MPDR	Maternal and Perinatal Death Review
MPDSR	Maternal and Perinatal Death Surveillance and Response
NDHS	National Demographic Health Survey
NCWS	National Council of Women Societies
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NPopC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NMCN	Nursing and Midwifery Council of Nigeria
PAN	Paediatric Association of Nigeria
PHC	Primary Health Center
PDR	Perinatal Death Review
PMR	Perinatal Mortality Rate
PNA	Paediatric Nurses Association
RH	Reproductive Health
SMOH	State Ministry of Health
SOGON	Society of Gynaecology and Obstetrics of Nigeria
SONM	Society of Neonatal Medicine
SPHCDA	State Primary Health Care Development Agency
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UN	United Nations
VA	Verbal Autopsy
VVF	Vesico-Vaginal Fistula
WHO	World Health Organization
WRA	Women of Reproductive Age

GRID ANALYSIS OF MATERNAL AND PERINATAL DEATH CASES PRESENTED TO THE FACILITY MPDSR COMMITTEE

In the chain of events described below, note which one dysfunctions appeared and explain why it is a dysfunction (by comparing with standards of good practices):

1. ITINERARY BEFORE ADMISSION

1. If referred patient:
   - Were conditions of transfer adequate regarding mode of transport (ambulance), qualified escort, and first treatment (e.g.: intravenous line in place) and time to reach the hospital. Was there a referral letter? Understandable? Useful? Applying clinical standards of best practices?
2. If not referred but having complication:
   - Was decision to seek for hospital care taken in time?
   - Was itinerary followed by the patient adequate regarding mode of transport and time to reach the hospital?

2. ADMISSION

1. Reception:
   - Was admission process given to the patient adequate, regarding the timing and the first aid provided regarding the patient's condition (e.g. if necessary: rapid call for qualified assistance, supportive first cares)?

3. DIAGNOSIS

1. If complication was already present at admission, were the following adequately performed?
   - First examination of the patient in terms of reactivity and in terms of standards.
   - Diagnosis at admission regarding the available information.
   - Time to make diagnosis regarding the standards.
   - Management given on admission regarding the diagnosis and the standards of care.
2. If the complication occurred after admission:
   - Was time to make diagnosis acceptable regarding the standards?
   - Was the management correct regarding the patient's condition and the standards of care?
   - Was the management correct regarding the patient's condition and the timing between the diagnosis and the treatment?
3. In both cases:
   - Were the necessary investigations for diagnosis done (all, none or some of them) regarding the standards?
   - Was the time to carry out the investigations acceptable according to the patient condition?
   - If applicable, were the results from investigations utilized accordingly?
   - Were unnecessary investigations requested/performed?

4. TREATMENT

1. Was adequate treatment (full) given for the complication regarding the diagnosis and the standards of care?
2. If applicable, was the time interval between the diagnosis and the surgical treatment acceptable according to standards?
3. Was the medical treatment given made without delay, after the diagnosis was made?
4. Was clear and daily instructions on how the treatment should be administered given and noted?

5. PATIENT MONITORING

1. Were clear instructions to monitor vital signs and other parameters given and noted?
2. If applicable, were adequate instructions given regarding the standards of care (what to be monitored, frequency and duration)?
3. Were monitoring of vital signs and other parameters performed according to instructions given or according to standards of care?
4. How complete or incomplete were the records found regarding the diagnosis and the standard of care on the deceased?

6. INFORMATION IN PATIENT FILE

1. Were all necessary information expected by the standard of care present in the patient's file?

7. Case Summary:

1. The main problems identified in the case management.
2. The positive and strong observations in the case management.
3. The main causes of dysfunctions/mismanagement identified.
4. The medical cause of death and the contributing factors.

FEDERAL MINISTRY OF HEALTH

MATERNAL DEATH REVIEW FORM 1 - NOTIFICATION

(MPDSR FORM 1)

GENERAL INSTRUCTIONS:

- This form must be completed by the attending officer in the health facility or community based informer for all maternal deaths including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy
- This form must be completed immediately after death by the last person who attended to the patient, and submit to the head of the health Facility or person responsible for maternal health in the LGA for onward transmission to the appropriate health authorities – in the State and/or the Federal Ministry of Health within 24 hours.

1. Date of Death being reported (dd/mm/yy):.....
2. Time of Death being reported.....
3. Date of Admission to Facility (if on admission) (dd/mm/yy): .....
4. Name of Facility where death occurred: .....
5. Local Government Area: .....
6. State: .....
7. Place where death occurred: (Tick √ one box)
   a. [ ] Tertiary Health Institution
   b. [ ] General Hospital
   c. [ ] Primary Health Care Centre
   d. [ ] Faith based Institution
   e. [ ] Private for profit
   f. [ ] TBA's place
   g. [ ] On the way/ before arrival to health facility
   h. [ ] Home
   i. [ ] Other (specify) .....
8. Ownership of Facility: (Tick √ one box)
   a. [ ] Federal Government
   b. [ ] State Government
   c. [ ] Local Government Council
   d. [ ] Faith –based
   e. [ ] Private
   f. [ ] others (specify) .....
9. Patient Identity: .....
10. Case Note No.(if hospitalized):.....
11. Age (years): .....
12. Gravidity(Total numbers of previous pregnancies): .....
13. Parity(Total numbers of previous deliveries): .....
14. Suspected cause of death: (Tick √ one box)
   a. [ ] Haemorrhage
   b. [ ] Pre-eclampsia / eclampsia
   c. [ ] Puerperal sepsis
   d. [ ] Prolonged/Obstructed labour
   e. [ ] Ruptured uterus
   f. [ ] Complications of abortions
   g. [ ] Ectopic pregnancy
   h. [ ] Others (specify) .....
15. At the time of death, was the baby delivered? (Tick √ one box)
   a. [ ] Yes
   b. [ ] No
16. Condition of the baby at the time of delivery (Tick √ one box)
   a. [ ] Alive
   b. [ ] Fresh Still birth
   c. [ ] Macerated still birth
   d. [ ] Not applicable

Name of Person reporting: .....: Designation: .....
Telephone numbers.....
Emails.....
Address: .....
Signature: ..... Date: .....

FEDERAL MINISTRY OF HEALTH
HEALTH -FACILITY BASED MATERNAL DEATH REVIEW
(MPDSR FORM 2)

GENERAL INSTRUCTIONS:

- This form must be completed by MDR Officer at health facility level for all maternal deaths including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy

SECTION 1: HEALTH INSTITUTION/FACILITY WHERE DEATH OCCURRED.

1. Name and location of Facility where death occured: .....
2. Local Government Area: .....
3. State .....
4. Type of facility: (Tick √ one box)
   a. [ ] Tertiary Health Institution
   b. [ ] General Hospital
   c. [ ] Primary Health Care Centre
   d. [ ] Faith based health facility
   e. [ ] Private Health facility
   f. [ ] TBA's place
   g. [ ] Others (specify) .....
5. Ownership of Facility: (Tick √ one box)
   a. [ ] Federal Government
   b. [ ] State Government
   c. [ ] Local Government Council
   d. [ ] Faith –based
   e. [ ] Private
   f. [ ] Others (specify) .....

SECTION 2. SOCIO-DEMOGRAPHIC DETAILS OF DECEASED.

6. Patient Identity: (State/LGA/Town/ Hospital/Year/Serial No.) .....
7. Hospital No. /Case Note No.(if hospitalized): .....
8. Age (years): .....
9. Residence: (Tick √ one box)
   a. [ ] Rural b. [ ] Urban
10. Marital Status: (Tick √ one box)
    a. [ ] Married b. [ ] Not married c. [ ] Divorced
    d. [ ] Separated e. [ ] Widowed
11. Educational level (Completed): (Tick √ one box)
    a. [ ] None b. [ ] Primary c. [ ] Secondary
    d. [ ] Higher e. [ ] Don't Know
12. Occupation: .....
13. Occupation of spouse/partner: .....
14. Religion: (Tick √ one box)
    a. [ ] Christianity b. [ ] Islam c. [ ] Traditional African Religion
    d. [ ] Others (specify) .....
15. Ethnic Group: (Tick √ one box)
    a. [ ] Hausa / Fulani b. [ ] Yoruba c. [ ] Igbo
    d. [ ] Others (specify) .....

SECTION 3: PAST MEDICAL, SURGICAL AND OBSTETRICS/GYNAECOLOGICAL HISTORY

16. Any existing medical condition(s) (Tick √ one or more boxes)
    a. [ ] Hypertension b. [ ] Diabetes c. [ ] Anaemia d. [ ] HIV/AIDS
    e. [ ] Hepatitis f. [ ] Sickle cell disease g. [ ] Tuberculosis h. [ ] Heart condition
    i. [ ] Others (specify) .....

17. Past Surgical Operations/cervical tear repairs: (Tick √ one or more boxes)

a. [ ] Cesarean Section b. [ ] Myomectomy c. [ ] MVA
d. [ ] D and C e. [ ] Laparatomy f. [ ] Diagnostic Laparoscopy
g. [ ] Hysterotomy h. [ ] Hysteroscopy i. [ ] Cervical tear repair
j. [ ] Other (specify) .....

18. No. of previous life births .....
19. No. of previous Still births .....
20. No. of previous miscarriages/ abortions .....
21. No. of previous ectopic pregnancies .....

SECTION 4: ADMISSION AT FACILITY WHERE DEATH OCCURRED OR FROM WHERE IT WAS REPORTED

22. Date of Admission to Facility (if on admission) (dd/mm/yy): .....
23. Time of Admission (- -/-- am/pm) : .....
24. Admitted from: (Tick √ one box)

a. [ ] Another facility b. [ ] Home c. [ ] Other (specify) .....

25. If referred from another facility, please indicate name of facility: .....
26. If referred from another facility, please indicate distance (Km) : .....
27. Condition on Admission: (Tick √ one box)

a. [ ] Stable b. [ ] Critically ill c. [ ] Dead on Arrival (DOA)

28. Reason for admission: (Tick √ one box)

a. [ ] Ante partum haemorrhage b. [ ] Post partum Haemorrhage
c. [ ] Obstructed/prolonged labour d. [ ] Ruptured Uterus
e. [ ] Puerperal Sepsis f. [ ] Pre-eclampsia/eclampsia
g. [ ] Complications of abortion h. [ ] Ectopic pregnancy
i. [ ] Others (specify) .....

29. Pregnancy Status at Admission: (Tick √ one box)

a. [ ] Before 28 weeks gestation b. [ ] After 28 weeks gestation c. [ ] Intrapartum
d. [ ] Postpartum

SECTION 5: ANTENATAL CARE (ANC) - (If early pregnancy death move to Section 6)

30. Was index pregnancy planned? (Tick √ one box) a. [ ] Yes b. [ ] No c. [ ] Don't know
31. Did she receive ANC? a. [ ] Yes b. [ ] No c. [ ] Don't know
32. Place where Antenatal Care (ANC) was provided: (Tick √ one box)

a. [ ] Tertiary Health Institution b. [ ] General Hospital
c. [ ] Primary Health Care Centre d. [ ] Faith based health facility
e. [ ] Private Health facility f. [ ] Health Centre
g. [ ] TBA's place h. [ ] Church
i. [ ] No ANC

33. Gestational Age at commencing ANC .....
34. Total No. of ANC visits: .....
35. Who was the main ANC provider? (Tick √ one box)

a. [ ] Obstetrician/Gynaecologist – Consultant b. [ ] Obstetrician/Gynaecologist – Resident
c. [ ] Medical Officer d. [ ] Midwife
e. [ ] Nurse f. [ ] CHEW
g. [ ] TBAs h. [ ] Others (specify) .....

36. Did she have the following ANC risks or complications? (Tick √ one or more boxes)

a. [ ] Hypertension b. [ ] Diabetes c. [ ] Anaemia d. [ ] HIV/AIDS
e. [ ] Proteinuria f. [ ] Sickle cell disease g. [ ] Malaria h. [ ] APH
i. [ ] Previous uterine scar j. [ ] Multiple gestation k. [ ] Abnormal lie l. [ ] UTI.
m. [ ] Premature Rupture Of Membrane n. [ ] Others (specify) .....

37. Other Comments on ANC period including complications:

.....
.....
.....
.....
.....
.....
.....
.....

SECTION 6: LABORATORY/RADIOLOGICAL INVESTIGATIONS DONE – Please attach the results

38. Haematology – PCV, Hb, -	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
39. Haematology – Genotype, Blood group	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
40. Urinalysis	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
41. Syphylis screening and confirmation	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
42. HIV test	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
43. Electrolyte and Urea	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
44. Hepatitis B screening and confirmation	a. [ ] Yes	b. [ ] No	c. [ ] Don't know
45. Abdominal/Pelvic Ultrasound Scan	a. [ ] Yes	b. [ ] No	c. [ ] Don't know

SECTION 7: LABOUR AND DELIVERY

46. Pregnancy outcome: (Tick √ one box)

a. [ ] Undelivered b. [ ] delivered –live birth c. [ ] delivered- still birth
d. [ ] Miscarriage e. [ ] Induced abortion f. [ ] ectopic pregnancy

47. Where did she deliver? (Tick √ one box)

a. [ ] Tertiary Health Institution b. [ ] General Hospital
c. [ ] Primary Health Care Centre d. [ ] Faith based health facility
e. [ ] Private Health facility f. [ ] Health Centre
g. [ ] TBA's place h. [ ] On her way to hospital
i. [ ] At home i. [ ] Not applicable

48. How was she delivered? (Tick √ one box)

a. [ ] Undelivered b. [ ] Normal Vaginal c. [ ] Forceps delivery
d. [ ] Vacuum delivery e. [ ] Caesarean Section f. [ ] Destructive Operation
g. [ ] Laparatomy

49. If laboured, was Parthograph used? (Tick √ one box) a. [ ] Yes b. [ ] No c. [ ] Don't know

50. If laboured, what was the length of the 1st stage? .....

51. If laboured, what was the length of the 2nd stage? .....

52. If laboured, what was the length of the 3rd stage? .....

53. Main attendant at delivery: (Tick √ one box)

a. [ ] Obstetrician/Gynaecologist – Consultant b. [ ] Obstetrician/Gynaecologist – Resident
c. [ ] Medical Officer d. [ ] Midwife
e. [ ] Nurse f. [ ] CHEW
g. [ ] TBAs h. [ ] Self
i. [ ] Others (specify) .....

54. Gestational Age at delivery: .....

55. Complications in labour and delivery? (Tick √ one or more boxes)

a. [ ] Haemorrhage b. [ ] Infections c. [ ] Pre-eclampsia/Eclampsia

d. [ ] Prolonged labour e. [ ] Obstructed labour f. [ ] Others (specify) .....

56. Other Comments on labour and Delivery:

.....

.....

.....

.....

.....

SECTION 8: POSTPARTUM AND POST ABORTAL PERIOD

57. Postpartum /Postabortal complications: (Tick √ one or more boxes)

a. [ ] Haemorrhage b. [ ] Infections c. [ ] Pre-eclampsia/Eclampsia

d. [ ] Depression e. [ ] Others (specify) .....

58. Other Comments on Postpartum / postabortal care including complications:

.....

.....

.....

.....

.....

.....

.....

SECTION 9: NEONATAL INFORMATION

59. Birth Weight (kg) .....

60. Apgar Score at 1 minute .....

61. Apgar Score at 5 minutes .....

62. Outcome for newborn: (Tick √ one box)

a. [ ] Alive b. [ ] Fresh Still birth c. [ ] macerated- still birth

d. [ ] Neonatal death

SECTION 10: PROCEDURES/INTERVENTIONS

63. Interventions in early pregnancy: (Tick √ one or more boxes)

a. [ ] Evacuation b. [ ] Laparotomy c. [ ] Hysterectomy

d. [ ] Blood transfusion e. [ ] Nil f. [ ] Others (specify) .....

64. Interventions in the Antenatal period: (Tick √ one or more boxes)

a. [ ] Blood Transfusion b. [ ] External Cephalic version c. [ ] Induction of labour

d. [ ] Magnesium Sulphate e. [ ] Antibiotics f. [ ] Nil

g. [ ] Others (specify) .....

65. Interventions in Intrapartum period: (Tick √ one or more boxes)

a. [ ] Instrumental delivery b. [ ] Symphysiotomy c. [ ] Caesarean section

d. [ ] Blood transfusion e. [ ] Hysterectomy f. [ ] Magnesium Sulphate

g. [ ] Antibiotics h. [ ] Nil i. [ ] Others (specify) .....

66. Interventions in Postpartum period: (Tick √ one or more boxes)

a. [ ] Evacuation b. [ ] Laparotomy c. [ ] Hysterectomy

d. [ ] Blood transfusion e. [ ] Manual removal of placenta f. [ ] Magnesium Sulphate

g. [ ] Antibiotics h. [ ] Misoprostol i. [ ] Nil

j. [ ] Others (specify) .....

67. Anaesthetics and Intensive care management (Tick √ one or more boxes)

a. [ ] Nil b. [ ] Local c. [ ] Spinal

d. [ ] Epidural e. [ ] General f. [ ] Intensive Care

g. [ ] Invasive monitoring h. [ ] Others (specify) .....

SECTION 11. TIME AND CAUSES OF DEATH

68. Date of death (dd/mm/yy): .....

69. Time of death (--/--am/pm): .....

70. Period : (Tick √ one box)

a. [ ] First trimester b. [ ] Second trimester c. [ ] Third trimester

d. [ ] Labour/delivery e. [ ] Post partum

71. Place where death occurred: (Tick √ one box)

a. [ ] Health Institution/facility b. [ ] On the way to Hospital c. [ ] Home

d. [ ] Others (specify) .....

72. Primary underlying cause of death (indicate ICD 10 code):- see WHO classification

.....

73. Final cause of death (indicate ICD 10 code):- see WHO classification

.....

74. Contributory (or antecedent) causes: specify – (indicate ICD 10 codes)

.....

.....

75. Autopsy performed? (Tick √ one box) a. [ ] Yes b. [ ] No

If yes, please attach a copy of the report.

SECTION 12. CASE SUMMARY

76. Please supply a short summary of the events surrounding the death.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

SECTION 13. IN YOUR OPINION, WERE ANY OF THESE FACTORS PRESENT?

(Tick √ one box)

77. Delay in woman seeking help?	a. [ ] Yes	b. [ ] No
78. Refusal of treatment or Admission?	a. [ ] Yes	b. [ ] No
79. Lack of transport from home to health care facility?	a. [ ] Yes	b. [ ] No
80. Lack of transport between health care facilities?	a. [ ] Yes	b. [ ] No
81. Health services communication breakdown?	a. [ ] Yes	b. [ ] No
82. Lack of facilities, equipment or consumables?	a. [ ] Yes	b. [ ] No
83. Lack of human resources?	a. [ ] Yes	b. [ ] No
84. Lack of expertise, training or education?	a. [ ] Yes	b. [ ] No
85. Delays in giving care?	a. [ ] Yes	b. [ ] No

86. Comments on other potential avoidable factors, missed opportunities and substandard care:

.....

.....

.....

.....

.....

.....

.....

SECTION 14: THIS FORM IS COMPLETED BY-

NAME: .....

ADDRESS: .....

.....

.....

RANK: .....

TELEPHONE: .....

E-MAIL: .....

SIGNATURE: .....

FEDERAL MINISTRY OF HEALTH

MATERNAL AND PERINATAL DEATHS REVIEW: RECOMMENDATIONS & ACTION PLAN FORM (MPDSR FORM 3)

GENERAL INSTRUCTIONS:

- This form must be completed by MPDSR Committee Secretary at all levels following every maternal death reviewed. Information includes recommendations and mapped out implementation plan and actions.

1. Facility reporting.....
2. LGA.....
3. State.....
4. Identification number.....
5. Hospital number.....
6. Date of Death.....
7. Medical cause of Death.....

S/N	ISSUES IDENTIFIED	LEVEL (HF,LGA,ST,FED)	ACTION REQUIRED	BY WHOM	TIMELINE

FEDERAL MINISTRY OF HEALTH

MPDSR quarterly summary report form: RESPONSE TRACKING (MPDSR FORM 4)

GENERAL INSTRUCTIONS:

- This form must be completed by MPDSR Officer at Federal , State or Health facility level to track response to recommendations made for all maternal deaths including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy.

S/No.	Date of Death	Facility	Town	LGA	State	Hospital No	ID No	Cause of Death	Recommen-dation	Response	Remark

FEDERAL MINISTRY OF HEALTH

MDR FORM IDENTIFICATION NUMBER CODING INSTRUCTION

(MPDSR FORM 5)

STATE = Have first 3 letters

Follow by

LGAs= Have first 3 letters

Followed by

Town/ Village= Have first 3 letters

Followed by

Facility or Community= Have first 3 letters

Followed by

Month= In two digits

Followed by

Year= Last two figures

Followed by serial numbers for the year= Three decimal figure

For example

A maternal death occurred in Dutse PHC in Abuja, FCT on 6th of June 2014. This was the fifth death that year.

The patient identification number is MDR/FCT/BWA/DUT/PHC/06/14/005

FEDERAL MINISTRY OF HEALTH

PERINATAL DEATHS NOTIFICATION FORM (MPDSR Form 6)

GENERAL INSTRUCTIONS:

- This form must be completed for all perinatal/Newborn deaths (including stillbirths and neonatal deaths).
- This form must be completed immediately after death by the last person who attended to the patient.
- A copy should be submitted to the LGADSNO Officer , who will report to the LGA M&E officer and the MCH coordinator of the State Ministry of Health (SMOH).
- Coding must be done at hospital level with code of HF (first 4 letters), LGA and state and MD individual code number for each deceased.

DETAILS OF THE DECEASED AND MOTHER

1. PND Case Number: ☐☐☐☐ /☐☐/☐☐/☐☐☐
2. File Number (health facility): ☐☐☐☐☐☐☐☐☐☐
3. Physical Address or locality where mother lived: (LGA, Name of village, Code)
4. Family Contact No:
5. Age of mother (years): ☐☐ (estimate if age is unknown)
6. Locality where death occurred: LGA:_____State:_____
7. Place where death occurred: (√ one box)

a. ☐ Tertiary Teaching Hospital
b. ☐ Federal Medical Centre
c. ☐ General Hospital
d. ☐ Primary Health Care Centre
e. ☐ Stand alone Maternity Unit
f. ☐ TBA
g. ☐ Home
h. ☐ On the way/before arrival at H/F
i. ☐ Others (specify)

8. Ownership of health facility: (√ one box)

a. ☐ Federal MOH
b. ☐ State MOH
c. ☐ Private
d. ☐ LGA
e. ☐ Faith-based
f. ☐ Other

9. Name of Health Facility: _____
10. Primary cause of death: _____
11. Final cause of death: _____
12. Modifiable Contributing factors:
13. Classification of perinatal/Newborn death (√ one box)
14. Birth weight: ☐☐☐☐ grams
15. Gestation at birth: ☐☐ weeks
16. Date of Birth
17. Date of Admission: ☐☐ /☐☐/☐☐
18. Date of Death ☐☐ /☐☐/☐☐
19. Name of Reporting Officer:_____
20. Designation:_____
21. Date: ☐☐ /☐☐/☐☐
22. Signature: _____

FEDERAL /STATE MINISTRY OF HEALTH

HEALTH FACILITY BASED PERINATAL /NEONATAL DEATH REVIEW FORM (MPDSR FORM 7)

GENERAL INSTRUCTIONS:

- This form must be completed for all perinatal deaths (including stillbirths and neonatal deaths within first 28 days after birth).
- The MPDSR Officer should complete the MPDSR form 7 within 48 hours.
- The Health Facility Maternal and Perinatal/Neonatal Death Review Committee must complete the form within 1 month and/follow up on the implementation of the action plan within 3 months.
- The original form should stay at health facility level and a copy submitted to the LGA DSNO who will report to the LGA M&E officer and submit to the MCH coordinator of the State Ministry of Health (SMOH).
- Federal and State hospitals should submit copies of the form to the MCH coordinator of the SMOH.
- The code must be the same as on the notification form, PNDR 1,

PND Case Number: ☐☐☐☐/☐☐/☐☐ /☐☐☐ (First 4 characters of name of HF / Month / Year / Case no.)

1. DETAILS OF MOTHER

1.2 File No.: ☐☐☐☐☐☐☐☐☐☐☐☐ (Hospital file of mother)
1.3 Age of mother (years): ☐☐ (if unknown: estimate)
1.4 Physical Address or locality where mother lives: (LGA, Name of village/town/ area)

1.5 Telephone No.:
1.6 Marital status of mother:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
1.7 Educational level (completed):
☐ None ☐ Primary ☐ Secondary ☐ Higher ☐ Others (specify): .....
1.8 Ethnic group
☐ Hausa ☐ Yoruba ☐ Igbo ☐ Others (specify): .....
1.9 Pregnancy condition at time of death:
Gravida☐☐ Para☐☐ Gestation at delivery (weeks) ☐☐

2. ADMISSION AT FACILITY WHERE DEATH OCCURRED

2.1 Date of admission of mother to facility: ☐☐/☐☐/☐☐ (dd/mm/yy)
2.2 Time: ☐☐:☐☐ am/pm
2.3 Date of admission of newborn from home: ☐☐/☐☐/☐☐ (dd/mm/yy)
2.4 Time: ☐☐:☐☐ am/pm
2.5 Admitted from:
☐ Health Facility ☐ TBA ☐ Home ☐ Others (specify): .....
Name of referring facility (if applicable): .....
2.6 Foetal Heart Rate on admission: ☐ Absent ☐ Normal ☐ Abnormal (>180 or < 100)
2.7 Condition of mother on admission:
☐ Stable ☐ Critically ill ☐ Dead on arrival (DOA)
2.8 Date of death: ☐☐/☐☐/☐☐ (dd/mm/yr)
2.9 Time of death: ☐☐:☐☐ AM/PM
2.10 Pregnancy stage at time of death:
☐ Before onset of labour ☐ Intra partum ☐ Postpartum

3. ANTENATAL CARE

3.1 Did she receive antenatal care? ☐ Yes ☐ No (skip to section 4)
3.2 If "Yes," total number of visits: ☐
3.3 Any complication (s) identified: ☐ Yes ☐ No
3.4 If "Yes" specify: .....
3.5 Any action taken on identified danger signs? ☐ Yes ☐ No
3.6 If "Yes", tick all that apply:

☐ Referred ☐ Anaemia treatment ☐ Treatment of hypertension
☐ Malaria treatment ☐ Treatment of PROM ☐ Treatment of syphilis (VDRL +)
☐ PMTC of HIV ☐ Treatment of infection ☐ Tetanus vaccination of mother …
☐ Others (specify): .....

4. DELIVERY AND PUERPERIUM

4.1 Time of rupture of membranes to delivery: ☐ (hrs/days)
4.2 condition of liquor: ☐ Clear fresh meconium, ☐ foul Meconium-stained ☐ Blood-stained
4.3 Date of delivery: ☐☐/☐☐/☐☐ (dd/mm/yy)
4.4 Time of delivery: ☐☐:☐☐ AM/PM
1. Duration of labour: Less than 12 hours[ ]; 12 to 24 hours [ ]; More than 24 hours [

4.5 Was a partograph used during labour? ☐ Yes ☐ No
2. Duration of labour: Less than 12 hours[ ]; 12 to 24 hours [ ]; More than 24 hours [ ]
Did she have problems during labour or delivery of this baby? Yes [ ] No
If yes, what was/ were the problems?

4.6 Locality where patient delivered (level of facility): (√ one box)

☐ Home ☐ MCH ☐ PHC / CHC ☐ General Hospital ☐ FMC/Teaching Hospital
☐ On the way before arrival at facility ☐ Others (specify): .....

4.7 Mode of Delivery: (√ appropriate boxes)

☐ SVD ☐ Vacuum ☐ Forceps ☐ Caesarean section
☐ Breech ☐ Destructive delivery ☐ Others (specify):

4.8 Delivered by: (√ one box)

☐ Specialist (Obs&Gyn) ☐ Medical officer ☐ Midwife
☐ Nurse ☐ S CHEW ☐ J CHEW ☐ CHO
☐ . ☐ TBA ☐ Other (specify): .....

4.9 Was the baby weighed after delivery? ☐ Yes ☐ No
4.10 If "Yes", Birth weight: ☐☐☐☐ grams

4.11 Was the Apgar score determined at delivery? ☐ Yes ☐ No
If no, did the baby cry at birth
4.12 If "yes": 1 min Apgar score: ☐☐ 5 min Apgar score: ☐☐
4.13 Newborn resuscitation done with bag and mask? ☐ Yes ☐ No

4.14 Did baby cry immediately after birth? Yes [ ] No [ ]
4.15 Did the baby have any bruise or marks of injury at birth? Yes [ ] No [ ]
4.16 Was the baby able to suck breast well after delivery? Yes [ ] No [ ]
4.17 Did the baby have any problem before baby died? Yes [ ] No [ ]
What was/ were the problem(s)?

a. Convulsion Yes [ ] No [ ]

b. Unconscious Yes [ ] No [ ]

c. Neck retraction Yes [ ] No [ ]

d. Bulging fontanelle Yes [ ] No [ ]

e. Inability to open the mouth Yes [ ] No [ ]

f. Jaundice Yes [ ] No [ ]

g. Bleeding Yes [ ] No [ ]

h. Skin rashes containing pus Yes [ ] No [ ]

i. Fever Yes [ ] No [ ]

j. Cough Yes [ ] No [ ]

k. Difficult breathing Yes [ ] No [ ]

l. Fast breathing Yes [ ] No [ ]

m. Stop breathing Yes [ ] No [ ]

n. Cold to touch Yes [ ] No [ ]

o. Discharge from cord Yes [ ] No [ ]

p. Others(Specify):.....

.....

4.18 Was care sought during the illness? Yes [ ] No [ ]
If yes, list Facilities Home [ ]; Traditional birth attendant [ ]; Herbal home [ ]; Church [ ]; Health [ ]; facility [ ]; Others [ ](specify)
.....:.....
.....

4.19 Where did this child die?
Home [ ]; Traditional birth attendant [ ]; Herbal home [ ]; Church [ ]; Health [ ]; facility [ ]; Others [ ](specify)
.....

4.20 Outcome for new-born: (√ one box):
☐ Fresh SB ☐ Macerated SB ☐ Early Neonatal Death (ENND) Neonatal Death.
If NND:
4.21 Time of death: ☐☐:☐☐ am/pm
4.22 Date of death: ☐☐/☐☐/☐☐(dd/mm/yy)

Reported cause of Death

5. CAUSE OF DEATH (Identified by the Reviewers)

5.1 Final Cause of Death (√ appropriate boxes):

☐ Birth asphyxia
☐ Birth trauma
☐ Sepsis
☐ Neonatal tetanus
☐ Dehydration due to diarrhoea
☐ Congenital abnormality
☐ Intra-uterine death with unknown reason

- ☐ Respiratory Distress Syndrom
- ☐ Neonatal aspiration
- ☐ Hemolytic disease of the newborn
- ☐ Neonatal Jaundice
- ☐ Necrotizing Enterocolitis.
- ☐ Other (specify): ……..

5.2 Primary Cause of Death (√ appropriate boxes):

- ☐ Spontaneous premature birth
- ☐ Intrapartum asphyxia
- ☐ Congenital abnormality
- ☐ Maternal infection
- ☐ Shoulder dystocia
- ☐ Prolonged or obstructed labour
- ☐ Hypertensive disorders / (pre)-eclampsia
- ☐ Antepartum haemorrhage
- ☐ Pre-existing maternal disease
- ☐ Breech delivery
- ☐ Cord problems (prolapse, knot, entanglement)
- ☐ Other (specify); ……

6. ASSOCIATED FACTORS THAT CONTRIBUTED TO DEATH

(√ appropriate boxes, to be extracted as far as possible from records)

Factors	Causes	Yes	No	**Remarks** (use back of page if necessary)
6.1 Health worker factors	Lack of necessary midwifery/obstetric/NC skills			
	Delay in deciding to refer / consult senior staff			
	Partograph not used during labour			
	Prolonged labour with no/ delayed intervention			
	Inadequate monitoring of FHR during labour			
	Inadequate newborn resuscitation			
	Multiple referrals without stabilization			
	Inadequate monitoring of newborn after birth			
	Prolonged abnormal observations without action			
	Inadequate response to maternal disease/complic			
	No response to positive syphilis test during ANC			
	No or inadequate response to PROM			
	Inadequate management of premature labour			
	Wrong or missed diagnosis			
	No or inadequate treatment			
	Delay in starting treatment			
	Others (specify)			

6.2 Admin. Factors	Communication problem between health facilities			
	Transport problem between health facilities			
	Lack of qualified staff			
	Absence of skilled staff on duty			
	Lack of essential drugs			
	Lack of essential equipment, incl. resuscitation			
	Lack of laboratory facilities			
	Non availability of blood			
6.3 Patient/ Family Factors	No antenatal care (ANC)			
	Late booking of ANC or infrequent visits			
	Failure to recognise danger signs			
	Delay in decision making or getting permission			
	Preference for care at home or by TBA			
	Unsafe traditional/cultural practice			
	Use of traditional medicine			
	Unsafe medical treatment			
	Refusal of treatment – non-compliance to advice			
	Inappropriate response to rupture of membranes			
	Inappropriate response to poor foetal movements			
	Transport problem from home to health facility			
	Financial constraints			
6.4 Community factors	Failure to recognise danger signs			
	Failure to accept limitations			
	Use of traditional medicine			
	Transport problems			
	Delay in deciding to refer			
6.5 Other factors (specify)				

7. CASE SUMMARY AFTER ASSESSMENT OF PERINATAL DEATH BY REVIEW COMMITTEE

(Provide a detailed and short summary of the events surrounding the death including quality of care at all levels of care and at different times (antenatal care, intra-partum care, newborn care). Use back of page if necessary.

8. FACILITY MATERNAL & PERINATAL DEATH REVIEW COMMITTEE ACTION PLAN TO IMPROVE FUTURE CARE

(use back of form if more space is needed)

Level of Care	Proposed Activities	Proposed Time Frame	Responsible Person
Hospital			
Health Centre			
TBA			
Family/ Community			

9. FORM COMPLETED BY:

10.1 Name:_____10.2 Designation: _____
10.3 Telephone: ☐☐☐☐☐☐☐☐☐☐
10.4 E-mail: _____
10.5 Date: ☐☐/☐☐/☐☐ (dd/mm/yy)

10.6 Signature: _____

10.7 Name Chair Person Review Committee:_____
10.8 Designation: _____
10.9 Date: ☐☐/☐☐/☐☐ (dd/mm/yy)

10.11 Signature: _____(Chairperson of Review Committee)


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