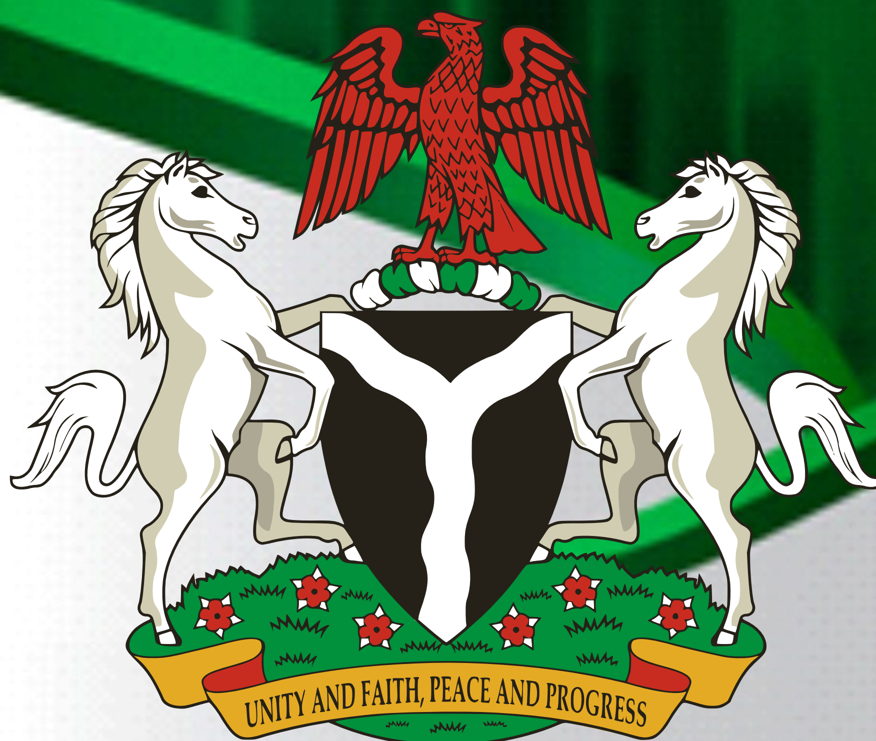
NATIONAL GUIDELINES AND TOOLS ON MATERNAL, PERINATAL AND CHILD DEATHS SURVEILLANCE AND RESPONSE (MPCDSR) IN NIGERIA



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FOREWORD

Reporting and tracking maternal, perinatal and child deaths and government initiatives to reduce preventable deaths remain a major challenge in Nigeria. The first 28 days of life – the neonatal period is a critical period for survival of the child. Every day in Nigeria, over 700 babies die, the highest number of new-born deaths in Africa, and second highest in the world. Over 40,000 Nigerian women die each year during child birth. For every maternal death, at least seven newborn die and a further four babies are stillborn. Nigeria was unable to meet MDG 4 & 5 goals and going by the 2018 NDHS report, current maternal mortality ratio of 512/100,000 live births is still far from SDG 3 target of 70/100,000 live births. Under-5 mortality rate is also high at 132 per 1000 live births.

It is commonly accepted that the causes of maternal, neonatal, infants and under-five mortality are preventable through systematic public health education and strengthening of the health system blocks, which deal with the three delays: **delay in seeking care, delay in access to health care and delay in receiving quality care.** Achieving the latter is pivoted in maternal, newborn and child death audits and response to recommendations from the audits.

In view of this, the Federal Ministry of Health, in collaboration with the professional Associations (Society of Obstetrics and Gynaecology of Nigeria (SOGON), the Paediatric Association of Nigeria (PAN), and Nigerian Society of Neonatal Medicine (NISONM)), Development Partners and other stakeholders in reproductive, maternal and child health, provided technical support for the review of this guideline and tools to routinely track maternal, perinatal and child deaths in Nigeria. Effective conduct of these audits will identify capacity gaps, which, when addressed, should improve the knowledge and skills of health care providers in providing quality maternal, newborn and child care during birth and in childhood. The guideline and tools provide direction and instructions required for the establishment of Maternal, Perinatal and Child Death Surveillance Response in Nigeria. Prompt response to the recommendations made from the audits will improve quality of care and reduce maternal, newborn and child deaths significantly in Nigeria. The success of the MPDSR and the need to improve the quality of child health services along the continuum of care by incorporating child Death Audit into MPDSR for better outcomes, informed the need for this review.

I recommend this document to all stakeholders: Health Institutions at all levels, Government Agencies, Development Partners, Non-Governmental Organisations, Private and Faith-based Health Institutions.

I hope it will be put to practical use throughout the country.

Dr Osagie Ehanire. *MD, FWACS*
Hon. Minister of Health, Federal Republic of Nigeria

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The Federal Ministry of Health, in collaboration with Development Partners, has developed the National guidelines for the conduct of Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) in Nigeria as recommended by World Health Organization in 2004. The Review of this document is a major breakthrough for reduction of preventable maternal, newborn and child 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 review of this National guideline to include Child death audit. Special thanks go to the Society for Obstetrics and Gynaecologists of Nigeria (SOGON), Paediatric Association of Nigeria (PAN) and Nigeria Society of Neonatal Medicine (NISONM) for their hard work, technical input and leading the process for the institutionalization of Maternal, Perinatal and Child Death Surveillance and Response in Nigeria. The unprecedented success of the development and review process was made possible by the contributions from a number of individuals and organisations. I wish to acknowledge the National MPCDSR Desk Officer, Dr Samuel Oyeniyi, Deputy Director directly supervised by me and his team, technical expertise of the Lead Consultant, Prof. Oladapo Shittu and his team, members of the National Reproductive Health Technical Working Group and Child Health Technical Working Group under the leadership of Prof A.O Otolorin and Prof R.D Wammanda respectively.

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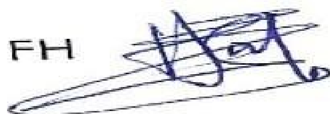
My gratitude also goes to the leadership of MPCDSR team, Dr. Oyeniyi Samuel. O, Deputy Director, Head Safe motherhood & Planning Monitoring and Evaluation & National MPCDSR Desk officer RHD and other staff of the Department of Family Health for their commitment and concerted efforts in ensuring that this Policy document becomes a reality.



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July, 2022

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1. ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
APN	Association of Pathologists of Nigeria
APHPN	Association of Public Health Physicians of Nigeria
CBCA	Criterion-Based Clinical Audits
CBMPCDSR	Community-Based Maternal, Perinatal and Child Death Surveillance and Response
CDA	Child Death Audit
CEMD	Confidential Enquiries on Maternal Death
CHEW	Community Health Extension Worker
CHIPS	Community Health Influencers, Promoters and Services
CHO	Community Health Officer
CMD	Chief Medical Director
CR/VS	Civil Registration / Vital Statistics
CSO	Civil Society Organization
DSNO	Disease Surveillance Notification Officer
DPHC	Department of Primary Health Care
FBMPCDSR	Facility-Based Maternal, Perinatal and Child Death Surveillance and Response
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
ICD	International Classification of Disease
IDSR	Integrated Disease Surveillance and Response
JCHEW	Junior Community Health Extension Worker
LEMCHIC	Local Government Emergency Maternal and Child Health Intervention Centre
LGA	Local Government Area/Authority
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
MPCDR	Maternal, Perinatal and Child Death Review
MPCDSR	Maternal, Perinatal and Child Death Surveillance and Response
MPCM	Maternal, Perinatal and Child Mortality
MRO	Medical Records Officer
NCWS	National Council of Women Societies
NEMCHIC	National Emergency Maternal and Child Health Intervention Centre
NDHS	National Demographic Health Survey
NISONM	Nigerian Society of Neonatal Medicine
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NoQA	Nigerian Obstetrics Quality Assurance

NPC National Population Commission
NPHCDA National Primary Health Care Development Agency
NMCN Nursing and Midwifery Council of Nigeria
OQA Obstetrics Quality Assurance
P4R Performance for Result
PAN Paediatric Association of Nigeria
PHC Primary Health Care
PHCC Primary Health Care Centre
PDR Perinatal Death Review
PDSR Perinatal Death Surveillance Response
PMR Perinatal Mortality Rate
PNA Paediatric Nurses Association
QED Quality, Equity and Dignity
QoC Quality of Care
RH Reproductive Health
R-RMCH Rotary-Reproductive Maternal and Child Health
SA Social Autopsy
SDG Sustainable Development Goals
SEMCHIC State Emergency Maternal and Child Health Intervention Centre
SMOH State Ministry of Health
SOGON Society of Gynaecology and Obstetrics of Nigeria
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

2. DEFINITION OF TERMS

Maternal Death

This is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".

Pregnancy-Related Death

This is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death".

Late Maternal Death

"The death of a woman from direct or indirect obstetric causes, occurring more than 42 days, but less than one year after termination of pregnancy". For example, a woman who dies from renal failure three months after delivery that was complicated by eclampsia.

Severe Acute Maternal Morbidity (SAMM or "Near-miss")

"Any pregnant or recently delivered woman (within six weeks after termination of pregnancy or delivery), in whom immediate survival is threatened and who survives by chance or because of the hospital care she receives". Examples are: women with VVF or ruptured uterus from prolonged obstructed labour;

Maternal Mortality Cause Specific Case Fatality Rate

The proportion of women with major obstetric complications who die within a specified reference period (usually one year).

It is calculated as follows;

$$\frac{\text{Number of deaths from specified obstetric complication}}{\text{Total number of women with the specified complication}} \times 100$$

Perinatal Death

A death that occurred around the time of birth; it includes both still births and early neonatal deaths.

Perinatal Mortality Rate

Perinatal Mortality Rate is calculated as;

$$\frac{\text{Number of perinatal deaths (Still birth + Early Neonatal Death)}}{\text{Total number of births (stillbirth + Livebirths)}} \times 1000$$

The perinatal period

This commences at 28 completed weeks of gestation and ends seven completed days after birth.

Stillbirth

This is death prior to the complete expulsion or extraction from its mother of a foetus/baby of 28 weeks‟ gestation or more; the death is indicated when the foetus/baby does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. However, where gestational age cannot be determined, birth weight of 1000grams or more should be used.

Undelivered Foetal Death

This involves the death of a foetus inside its dead mother, whose pregnancy is of gestational age of 28 weeks or more, and remains neither delivered nor expelled.

Live Birth

This is the complete expulsion or extraction from its mother of a foetus/baby of 28 weeks‟ gestation which after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each foetus/ baby of such a birth is considered live birth. However, where gestational age cannot be determined, birth weight of 1000grams or more could be used.

Early Neonatal Deaths

These are deaths of newborn babies occurring during their first seven days of life.

Late Neonatal Deaths

These are deaths of newborn babies occurring after the seventh day but not later than the 28th day of life.

Life Table

A life table (also called a mortality table or actuarial table) is a table which shows, for each age, what the probability is that a person of that age will die before their next birthday ("probability of death"). In other words, it represents the survivorship of people from a certain population. They can also be explained as a long-term mathematical way to measure a population's longevity.

Infant Deaths

These are the deaths of young children occurring within one year of birth.

Under-5 Deaths

These are the deaths of young children between birth and the age of five years.

Child Deaths

These are deaths occurring between age 0 and 14 years (which includes neonatal, infant, under-5, and early adolescent). For the purpose of this document, the focus will be on under-5.

Medical Audits (MA)

"It is a systematic and critical analysis of quality of care which includes procedures for diagnosis, treatment, care and outcomes for patients". Its purpose is to appraise the extent to which individual patients were served with specific standards of care. The process consequently reveals any substandard practices within the facility (and before arriving the facility) which when remedied, lead to improvement in quality of care and services and preserves the lives of patients and the people.

Before MA can be established in a facility, it is necessary that the service providers be trained and acquainted with the standard protocols and guidelines for service provision. These protocols must be evidence-based and current, to ensure quality care and efficient maternal, perinatal and child auditing. To achieve these, good record keeping is essential.

The principles of MA include;

- A constant quest for service improvement.
- Upholding of evidence-based practices.
- Non-punitive approaches; (no name, no blame).
- Respecting human rights and confidentiality.

MA takes the form of a process that involves cycle of events as shown in figure 1.

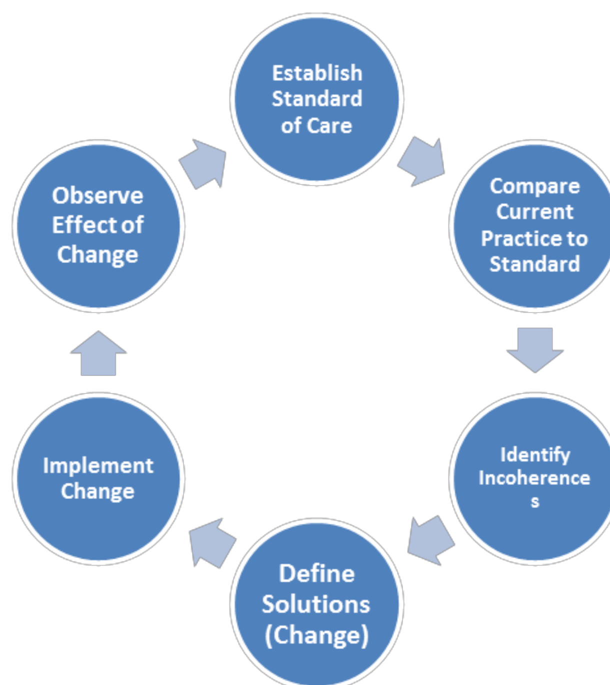

Figure 3.1: Showing the Cycle of Events in Medical Audit and how it Improves Quality of Care

This MA process has been used to study routine clinical practice, severe morbidities or maternal deaths; its adaptation for these purposes includes the following:

Verbal Autopsy (VA) – conducted at the community level to audit maternal deaths;
Maternal Death Review (MDR), Perinatal Death Review (PDR), Severe Acute Maternal Morbidity Review ("Near miss") and Criterion-based Clinical Audits (CBCA) at health care facility level;
Confidential Enquiries into Maternal Deaths (CEMD) at state, zonal or national levels;

and this process is now being extended to Child Deaths

.

The Maternal, Perinatal and Child Death Reviews (MPCDR)

"This is a qualitative, in-depth investigation into the causes of, and circumstances surrounding maternal, perinatal and child deaths which occur in health care facilities." Recorded information and interviews that are conducted to "re-create" and understand the series of events that lead to a maternal, perinatal or child death are confidentially discussed under non-threatening conditions. This is with a view to identifying avoidable and remediable factors that will prevent recurrences of such maternal, perinatal and child deaths, and improve maternal, perinatal and child health in future.

Its primary purpose is to characterize the causes and circumstances of each maternal, perinatal or child death in health facilities, with a view to determining strategies for preventing future recurrence, in other words, to improve the quality of care of the facilities.

The principles of the MPCDR are as follows:

Identify and document every maternal, perinatal and child death
Review all the maternal, perinatal and child deaths that occur in each health facility;
Involve the people who were directly concerned with management of the deceased;
Institutionalize the multi-disciplinary approach to care, the reviews and the remedies;
Identification of modifiable (preventable) factors that are rectified to improve quality of care.

Principles of MPCDR Process

i. Facility practices and services should be based on current evidence-based guidelines and protocols.
ii. Clinicians must be cooperative and willing to routinely participate in medical audits and quality improvement efforts.
iii. Prompt documentation and production of accurate reports.
iv. Ensuring confidentiality and objectivity all the time.
v. Ensuring non-punitive processes.
vi. Ensuring anonymity in the conduct of the entire process.
vii. Safeguarding “No name, no blame” processes.

The Advantages of institutionalizing MPCDR includes:

i. Improvement of professional performances of clinical staff;
ii. Improvement of resource allocation
iii. Improvement of maternal, perinatal and child health services
iv. Ability to monitor and implement recommendations
v. Improved cost-effectiveness and efficiency of services
vi. Valuable advocacy tool for stakeholder engagement in maternal, perinatal and child health care (MPCHC); and
vii. Extension of quality improvement to other healthcare services.

Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR)

This is a form of continuous surveillance, that links the health information system and quality improvement processes from local to national levels, which includes the routine identification, notification, quantification and determination of causes and avoidability of all maternal, perinatal and child deaths, as well as the use of this information to respond with actions that will prevent future deaths, and guide public health actions that are monitored for impact.

Facility-based Maternal, Perinatal and Child Death Surveillance and Response (F-MPCDSR)

This is the mainstream MPCDSR that is carried out within healthcare facilities, at Primary, Secondary or Tertiary levels, in both public and private sectors. It is implemented by trained medical personnel who process documented or interview-sourced medical information on the deceased woman/perinate/child to implement the scheme.

Community-based Maternal, Perinatal and Child Death Surveillance and Response (C-MPCDSR)

This is the segment of MPCDSR that is carried out outside health facilities, at the community level. It is purposed to account for and capture every maternal/perinatal/child death that occur within each community, as well as identify their probable medical and non-medical causes, with a view to identifying modifiable factors that can be addressed to prevent recurrences of the deaths. Its implementation is conducted by trained Verbal and Social Autopsy (VASA) providers who might not necessarily be health workers, but use standardized national MPCDSR Form 11-Verbal Autopsy tool. The language of communication at the interview is simple, non-medical but allows inferences of probable medical causes of death to be made. Unlike its facility-based counterpart, C-MPCDSR has the advantage of allowing the calculation of population-based Maternal Mortality Ratio, and Perinatal, Infant and U-5 Child Mortality Rates.

Quality of Care

This is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes.

3. INTRODUCTION

3.1. BACKGROUND

Nigeria is reputed as the most populous nation in Africa and the seventh in the World, with an estimated population of 211.4 million in 2021 [1]. It is also acclaimed as the largest economy in Africa. On the other hand, its healthcare system and indices manifest with contrasting features: receiving global accolades for impressive emergency responses to Ebola and Covid-19 epidemics, but disappointing on routines like maternal and child health indices.

By the current UN estimates, Nigeria contributed the highest number of 67,000 maternal mortalities (23%) to the global burden in 2017 [2]; ranks among countries with the highest Infant and Under-5 mortality rates [3]; with a health system ranked 144 th of 167 countries [1]. Although successive NDHS suggest that Nigeria‟s Maternal Mortality Ratio is less than internationally perceived, there has been no statistical decline in the Ratio since 2008 [4]. Similarly, the trends in Neonatal, Infant and Under-5 Mortality Rates between 1990 and 2018 indicate a paltry decline.

Although Under-5 mortality declined from 157 deaths per 1,000 live births in 2008 to 132 deaths per 1,000 live births in 2018, and Infant mortality rate from 75 deaths per 1,000 live births to 67 deaths per 1,000 live births over the same period, there was no improvement in the Neonatal mortality during the interval (40 deaths per 1,000 live births in 2008 versus 39 deaths per 1,000 live births in 2018)[4].

The persistence of these substantial burdens of morbidity and mortality are obvious threats to the attainment of "health for all" by 2030, as envisaged in the SDG-3. Incidentally, the contributory factors to these burdens are well known and documented as ranging from behavioral, socio-cultural, to health systems factors, all of which require well-known interventions that should be electively designed and routinely implemented as remedies. It is pertinent to acknowledge some of these factors in this discuss: shortage and uneven distribution of manpower; emphasis on cure of disease at the expense of prevention; limited physical infrastructures and inequities in healthcare delivery; inadequate funding of healthcare; high cost of medical equipment and pharmaceutical products; delay in the implementation of the national healthcare insurance scheme; endemic corruption within the system; incessant

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[1] CEOWORLD Health Care Index, 2021 https://worldpopulationreview.com/country-rankings/best-healthca in-the-world. Accessed on November 8, 2021

[2] WHO 2019. Trends in maternal mortality: 2000 TO 2017. Estimates by WHO, UNICEF, UNFPA, WORLD B group and the UNITED NATIONS population division

[3] UN Inter-Agency Group for Child Mortality Estimation.

[4] National Population Commission. National Demographic and Health Survey. 2018.

labor strikes, inter-professional conflicts and poorly developed emergency response system. Others are: poor health-seeking behaviour; harmful traditional practices; and poverty.

Nigeria is well suited for “emergency health responses” compared to electives, which has been further substantiated by the emerging responses to the evolution of MDR, MDSR and MPDSR across Nigeria. These death audit strategies have been adopted since 2015, with the aim of improving quality of care in health facilities and strengthening CRVS. MPDSR has received acceptance and institutionalization across all cultural, political and economic divide in the country with implementation in all 36+1 States across all secondary and tertiary health facilities and the implementation of PHC MPDSR has also commenced in many states across the country. In addition, audit findings and remedies are uploaded unto the national e-platform. Likewise, annual MPDSR reports (Confidential Enquiry Reports on Maternal and Perinatal Deaths) are already published by seven states and enactment of enabling laws have reached various stages of completion at the national and in eight states.

In line with the WHO recommendation, the introduction of Child Death Audit (CDA) into MPDSR to become MPCDSR[5] offers a wider life-cycle coverage that will potentially leverage more pace for facility quality of care improvement, more reliable CRVS, and accelerated reduction of maternal, perinatal and child mortalities towards attaining the SDG-3 targets.

3.2. RATIONALE FOR MPCDSR IN NIGERIA

The leading global healthcare systems manifest with outcomes and indices of low morbidities and mortalities, and client satisfaction because they routinely invest in the following: facilities with minimum complements and standards of resources; up-to-date pre- and in-service training programs; development, deployment, continuous use of service guidelines, treatment protocols & job-tools; in-facility & external supportive supervision; and HMIS that inform quality improvement. The gaps in these essentials, inevitably account for the fragility of Nigeria‟s system, its current low rating, and is a major contributor to the persistence of high burden of maternal, perinatal and child mortalities and morbidities in the country.

Although MPCDSR is by no means a replacement for these routine measures, it provides a stop-gap means of using the reflections on maternal, perinatal or child mortality to identify locally prevalent quality of care issues (the modifiable factors) and remedy them. Published

[5] WHO 2021. Child Death Audits.

annual reports on MPDSR from six States and the FCT since 2017[6,7,8,9, 10] already attest to improvements in the quality of care in facilities and States that are attributable to this strategy. The national MPDSR e-platform, to which relevant officials of Nigeria‟s IDSR and CRVS (NPC) are linked, also confirmed improved timeliness and access to these mortality data and their causal factors.

3.2.1. Quality of Care

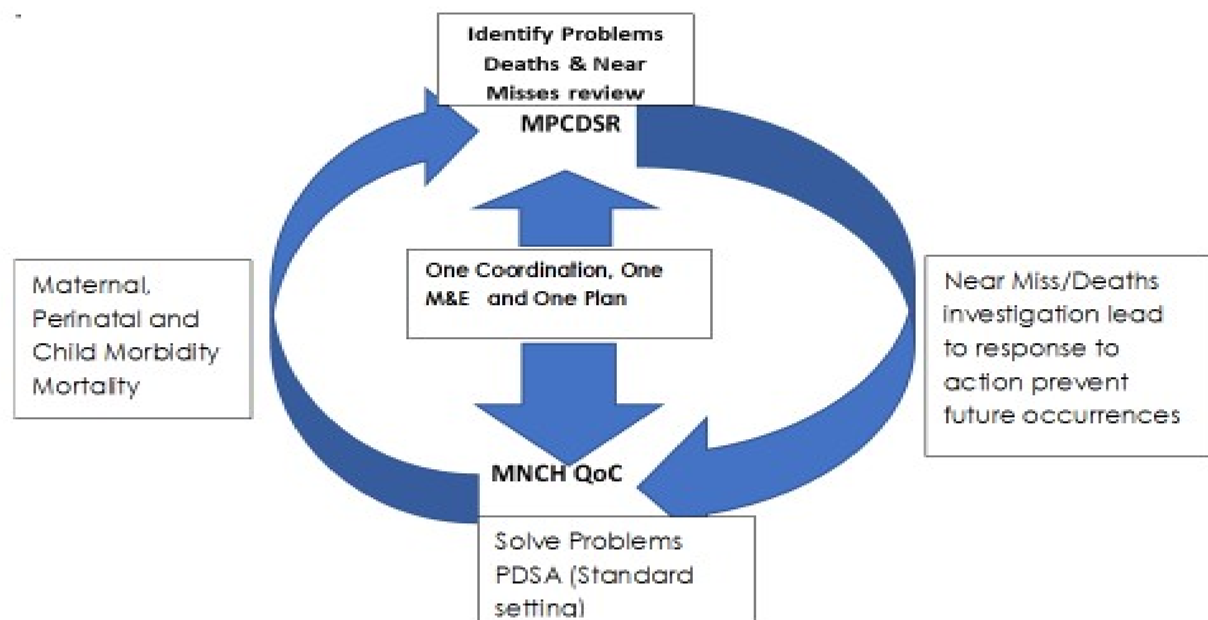

Figure 4.1: Showing the way MPCDSR is implemented to achieve improved quality of care within health facilities

3.2.2. Quality, Equity and Dignity

The World Health Organization describes quality in the health care system as comprising of six dimensions, which are

1. **Effectiveness** in delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
2. **Efficiency** in delivering health care in a manner which maximizes resource use and avoids waste;

[6] Delta State Maternal and Perinatal Death Surveillance Annual Report.2017-2018.
[7] Lagos State Maternal and Perinatal Death Surveillance and Response. Annual Report, 2018.
[8] Annual Report. Maternal and Perinatal Death Surveillance and Response. Kaduna State. 2018.
[9] Maternal and Perinatal Death Surveillance and Response in Ogun State, Southwest Nigeria. 2017.
[10] Maternal and Perinatal Death Surveillance and Response Steering Committee. 2018 Annual Report.

3. **Accessibility** in delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
4. **Acceptability**/patient-centeredness in delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
5. **Equity** in delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
6. **Safety** at delivering health care which minimizes risks and harm to service users.

3.2.3. Surveillance

As a result of the institutionalization of MPDSR in Nigeria, Maternal and Perinatal deaths were included in the IDSR list in 2019 (and now, Child deaths). The system is alerted through the completion of the respective Death Notification Forms for the three types of deaths and the data uploaded by the MRO unto the National e-platform, as illustrated below in Figures 4.2.

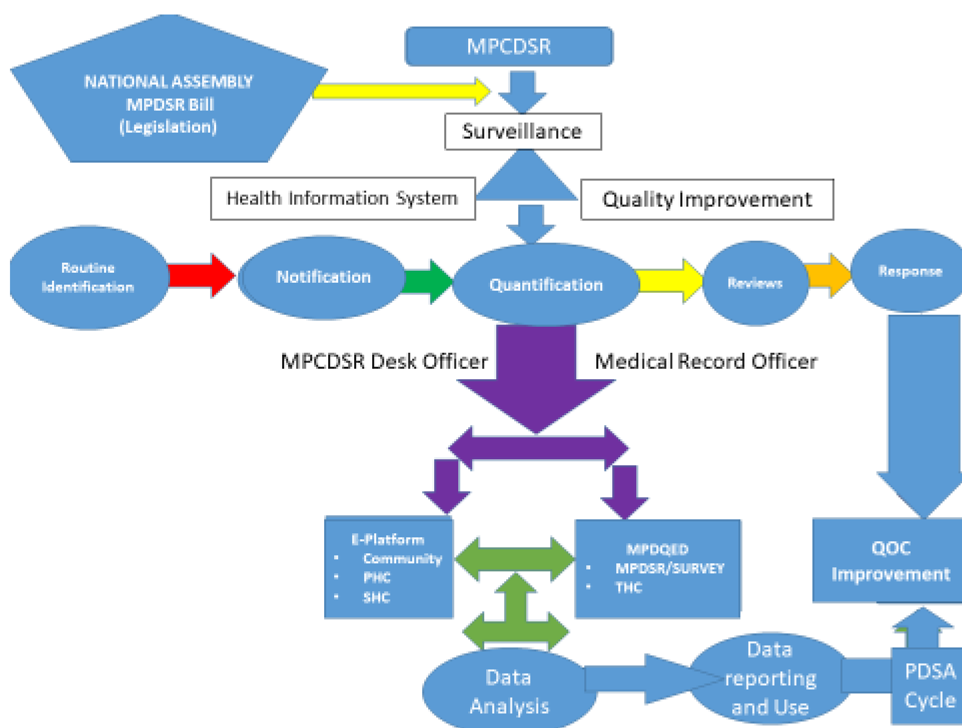

Figure 4.2: Showing the Pathway of Data Flow from Sites of the Deaths to Surveillance

3.2.4. Civil Registration and Vital Statistics

The fragility of the routine national CRVS is one of the major reasons for introducing MPCDSR, for the purpose of strengthening it. In this regard, relevant NPC officials and the operators of national CRVS, are configured to access the uploaded death notification data from the MPCDSR e-platform, for inclusion and triangulation with the data sourced from other routine means.

4.3.HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS)

The Nigeria Health Information policy posits that, accurate, reliable and timely health information is the foundation of decision-making across all the health system building blocks, based on WHO‟s recognition of it being essential for the development of health system policy and its implementation for improved health outcomes. Routine health information and CRVS ordinarily should provide the maternal, perinatal and child health information needed for MPCDSR. Therefore, its integration with HMIS and CRVS systems is essential for data reliability, as well as the scalability and sustainability of MPCDSR, which depends on it. However, a weak HMIS system at sub-national level and poor CRVS; including incomplete registration of deaths, poor certification of the underlying cause of death, poor timeliness and use of data, and poor understanding of the importance of data on *cause of death* have made it difficult to access and use these data for making any meaningful policy decision. Hence, the need for a more robust and accurate data capturing on maternal, perinatal and child health, which has received considerable enhancement from the nation-wide establishment of the e-Platform (formerly NOQA platform), which ensures real-time MPCDSR data upload and management across the country.

4. GOAL, OBJECTIVES AND TARGET AUDIENCE

4.1. GOAL

The primary goal of MPCDSR is to eliminate preventable maternal, perinatal and child mortality by obtaining and using information on each maternal, perinatal and child death to improve quality of care in health facilities, community health interventions and guide public health actions. MPCDSR expands on ongoing efforts to provide information that can be used to develop programmes and interventions for reducing maternal, perinatal, child morbidity and mortality and improve access to quality care that women, neonates and children receive during pregnancy, delivery, puerperium and childhood. MPCDSR aims to provide information and data that will inform specific recommendations, actions and transformative changes.

4.2. OBJECTIVES

4.2.1. To notify and collect accurate data on all maternal, perinatal and child deaths in the country, including:

Identification of all maternal, perinatal and child deaths.

Notification and reporting of all maternal, perinatal and child deaths.

Determine the causes of death and contributing factors and review all maternal, perinatal and child deaths (using facility records and/or verbal and social autopsies);

4.2.2. To analyse and interpret data collected for public health use, in respect of:

Trends in maternal, perinatal and child mortality

Causes of death (medical) and contributing factors (human, health system and socio-economic factors) using the three delay model, (quality of care, barriers to care, non-medical factors e.g., socio-cultural, religious, health seeking behaviour, etc.);

4.2.3. To identify and collate factors that can be remedied;

Risk factors, groups at increased risk of maternal, perinatal and child deaths;

Demographic, socio-economic, political and religious factors

4.2.4. To use the data to make evidence-based recommendations for action to decrease maternal, perinatal and child mortality, and morbidity. These recommendations could be related to: -

community education and involvement;

timeliness of referrals;

access to and delivery of services;

quality of care;

training needs of healthcare personnel or protocols use;

deployment of resources where they are likely to have impact;

regulations and policy;

billing and cost of care, emergency services; and

advocacy for MNCH interventions.

4.2.5. To disseminate findings and recommendations to policy makers, civil society, health personnel and other stakeholders.

4.2.6. To ensure timely and impactful actions take place, by monitoring the implementation of recommendations.

4.2.7. To inform programmes on the effectiveness of interventions and their impact on maternal, perinatal and child mortality, including feedback.

4.2.8. To allocate resources more effectively, efficiently and equitably to address identified needs.

4.2.9. To promote informed community actions for maternal and perinatal mortality reduction through community dialogue and social autopsy

4.2.10. To enhance accountability for maternal, perinatal and child health.

4.2.11. To improve maternal, perinatal and child mortality statistics and move towards attaining complete civil registration and vital statistic records.

4.2.12. To guide and prioritize research related to maternal, perinatal and child health.

4.2.13. To strengthen referrals and linkages across the levels of care.

4.2.14. To provide opportunity for gathering information and allow for its strategic use in guiding public health actions and monitoring the impact of those actions. Effective implementation of MPCDSR can directly impact the quality of care and improve maternal, perinatal and child health outcomes (Figure 6.1).

4.2.15. To enhance Government‟s accountability for maternal, perinatal and child health, which requires periodic and transparent dissemination of key results, particularly on maternal, perinatal and child mortality, and its discussion with stakeholders, including civil society. The findings generated from the MPCDSR process can be used to increase awareness on women and children healthcare needs. The evidence and stories behind the maternal, perinatal and child deaths are ingredients for powerful and effective advocacy for saving the lives of mothers, newborn and children.

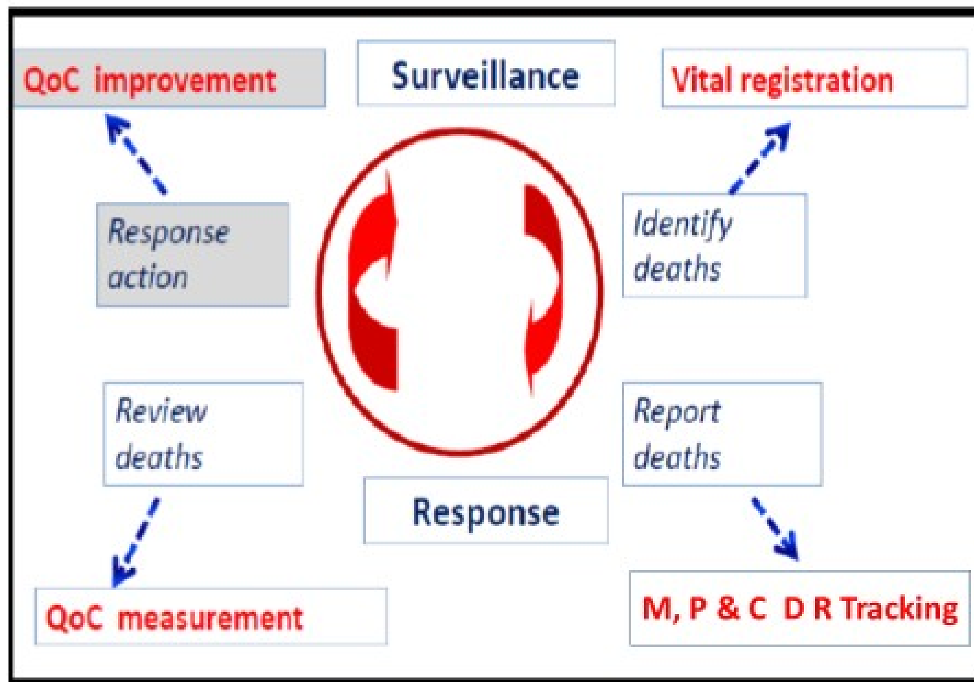

Figure 5.1: Showing the Relationship between Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) and Quality of Care

4.3. TARGET AUDIENCE

These guidelines are intended for use by all stakeholders of maternal, newborn and child health (MNCH) across the country, including:

Policy makers in all the three arms of government and at the three tiers of political administration;

Health systems and facility administrators and managers;

MNCH service managers and providers (Doctors, Midwives & Nurses, Laboratory Officers, CHEWS and Pharmacists);

Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs)

Lawyers;

Women"s Groups;

Community leaders; and

Media professionals.

5. FRAMEWORK FOR MPCDSR IN NIGERIA

5.1. *OVERVIEW OF STRUCTURE*

The MPCDSR Scheme shall be facilitated by the Federal Ministry of Health and is comprised of a network of committees that exist across the country at the three levels of governance and at each level of the healthcare system; from the Community and Primary Health Facility through to the Tertiary Facility levels, and covers both the public and private sectors (Figure 7.1).

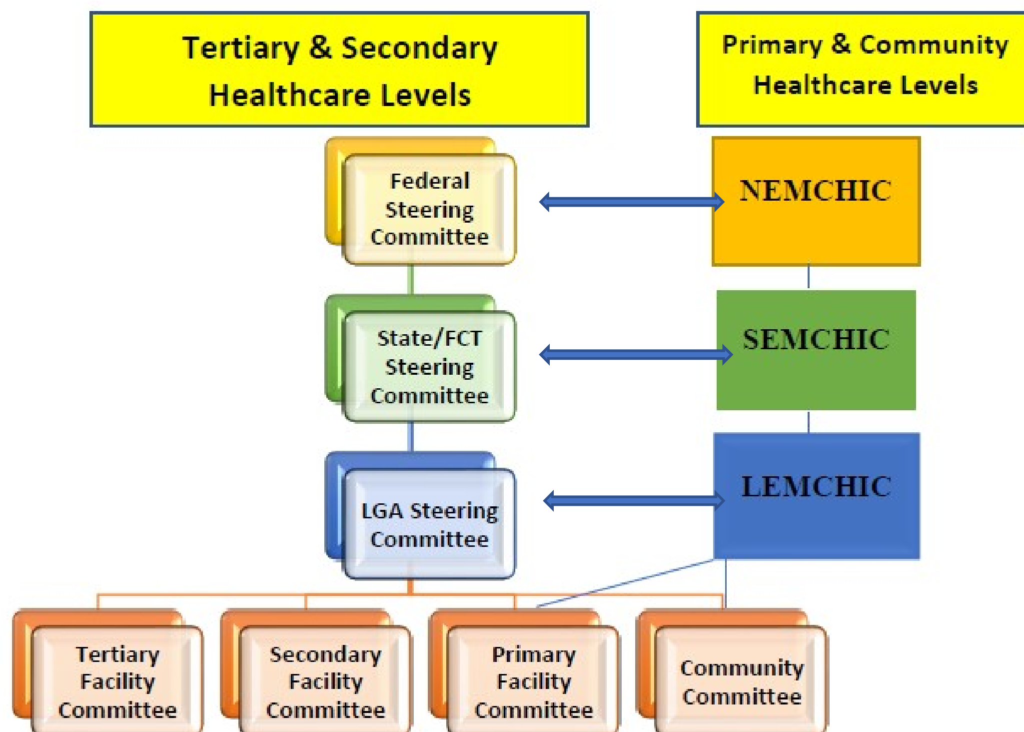

Figure 6.1: Showing the Network of Committees that Implement and directly relate to MPCDSR across Nigeria (NEMCHIC - National Emergency Maternal and Child Health Intervention Centre; SEMCHIC - State Emergency Maternal and Child Intervention Centre; LEMCHIC – Local Government Emergency Maternal and Child Intervention Centre).

In each health facility (tertiary, secondary and primary) and community, an MPCDSR Committee shall be established to perform the primary functions of conducting notification and audits on maternal, perinatal and child death that occur in their respective domain. During the latter, modifiable (preventable) factors to the deaths will be identified for which preventive action plans will be drawn and pursued for implementation. These committee outputs will be simultaneously communicated by electronic uploads to the National e-database that is accessible to MPCDSR Steering Committees at the three levels of government (Local, State and National). The respective Steering Committees perform the secondary function of accessing and utilizing uploaded MPCDSR data from facilities and

communities within their jurisdiction to understand the magnitude and pattern of these deaths, their modifiable factors and identify appropriate remedies and responses for preventing recurrences, including quality improvement in health services. Since these Steering Committees are located within government circles, they are expected to use their data to leverage policies and resources controlling these deaths and improving maternal, perinatal and child health. The two primary healthcare level MPCDSR committees (PHC and Community) shall simultaneously serve as sub-committees of Local Government Emergency Maternal and Child Intervention Centre (LEMCHIC), which has a direct relationship with its State (SEMCHIC) and National (NEMCHIC) counterparts, all of which refer to the NPHCDA.

The National, State, LGA and Facilities MPCDSR Committee operates with three sub-committees: Technical sub-committee that collates and analyses their data, presenting them in understandable form to the larger committee; Advocacy/Fund-raising sub-committee that develops and undertakes advocacy activities for resources to implement action plans; and M & E sub-committee that relates MPCDSR data to other data, including surveys and HMIS data, for enhanced public health benefits.

5.2. *OVERVIEW OF FUNCTIONS*

The primary functions of relating with deceased mothers, newborns, children and their bereaved relatives is to source MPCDSR data when deaths occur at facility and community levels. This process starts with trained persons, MPCDSR officers in facilities and verbal autopsy interviewers in communities, who should identify every relevant death in their domain and enter their information into two categories of Forms: a Death Notification Form; and a Death Review Form (Verbal Autopsy Form at community level) for the respective category of death involved.

5.2.1. Death Notification

Whenever maternal, perinatal or child death occurs in a facility, a Death Notification Form (MPCDSR Form 1, 6 or 7) should be completed and its contents uploaded by the Medical Record Officer (MRO) to the National e-database within 24 hours. At the community level, it starts by reporting the suspected deaths by key informants. The reporting is to a Secretary and the Chairman, CMPDSR Committee. The focal person, secretary and chairman confirms the event. Then followed by the completed notification form that is dispatched within 48 hours to

LGA medical officer for the assignment of "cause of death" prior to its uploading by the LGA M&E officer.

The notified death is accessed from the National e-platform by the: *Integrated Disease Surveillance Response* (IDSR) officer; and the National Population Commission (NPC) officer for *Civil Registration and Vital Statistics* purposes. Information on the notified death is also accessible to the technical committees of the MPCDSR Steering committees, for their analytic functions.

5.2.2. Facility Death Reviews (Maternal, Perinatal and Child)

Facility death review is a special meeting conducted by trained multidisciplinary group of persons established in each facility to: ensure all deaths (maternal, perinatal and child) are identified and discussed with confidentiality; assign a cause (s) to each death; determine whether care provided was consistent with evidence-based guidelines; determine social, environmental and nutritional risk factors for any death; determine possible modifiable factors; and develop action plans for preventing recurrence of the deaths. These meetings are conducted in non-threatening atmosphere and are followed by implementation of recommendations and changes at health facility (Figure 7.2). The monitoring and evaluation of the changes introduced, in patient care and outcomes, including case fatality rates, are key elements in the reports that are sent to the LGA, State and National MPCDSR committees. The primary objective of the entire process is a steady improvement of the quality of care in each facility.

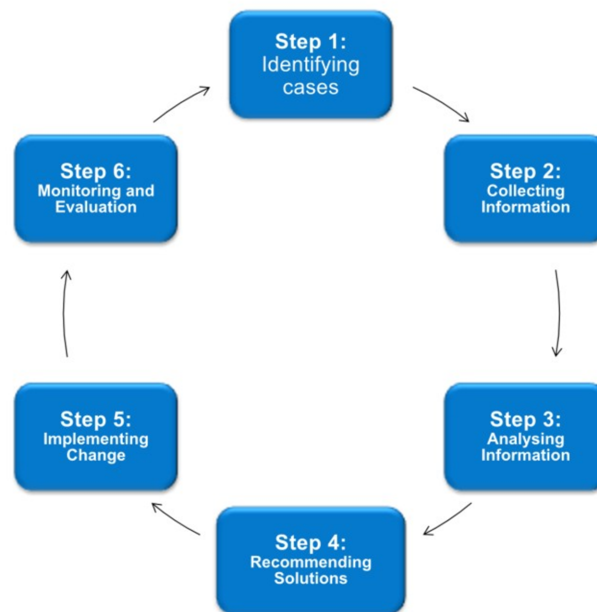

Figure 6.2: Showing the six steps of Maternal, Perinatal or Child Death Audit and Review.

Facility death reviews are conducted using the following steps:

Whenever a maternal, perinatal or child death occurs, the MPCDSR Officers should be informed immediately, by the clinical staff who were involved in managing the deceased. She/he collects the deceased‟s case-folder and performs the following within 24 hours:

- o Retrieve necessary information and casefiles on the deceased
- o Informs the Head of Obstetrics & Gynaecology Department and head of Paediatric/Neonatal unit or Officer in Charge as applicable.
- o Completes a maternal/perinatal/child death notification form and gives it to the medical records officer (MRO), who uploads the information unto the National MPCDSR e-platform; and
- o Completes a maternal/perinatal/child death review form simultaneously.

The content of the completed maternal/perinatal/child death review form and other relevant details on the deceased are presented by the MPCDSR Officer at the next 2-4 weekly MPCDSR Committee meeting of the facility

During the review, it is important that bedside causes as well as the underlying contributing factors be identified and analyzed in order to understand why the mother/perinate//child died. This will also give an ample opportunity to discover modifiable factors, especially sub-standard care and weaknesses in the health system. The discussion should include an in-depth analysis of the root causes of the identified shortcomings and problems (issues identified), which are listed on the first column of the MPCDSR Form 3-Recommendations and Action Plan Form. The next step involves the Committee Chairman using the MPCDSR Grid-Analysis Guide to engage members in critical thinking on each of the "issues identified", to make recommendations and action plans for remedying the modifiable factors, which are directly entered on the MPCDSR Form-3. Implementation of each recommendation is very critical to the success of MPCDSR, therefore details stated on the Form-3 should be Specific, Measurable, Attainable and Time-bound (SMART). The meeting closes with the Committee Secretary: writing the session report on the meeting (minutes); completing the MPCDSR proforma (in triplicates) and Action Plan Form, copies of which are shared with the LGA/State/Federal through the office of the head of facility.

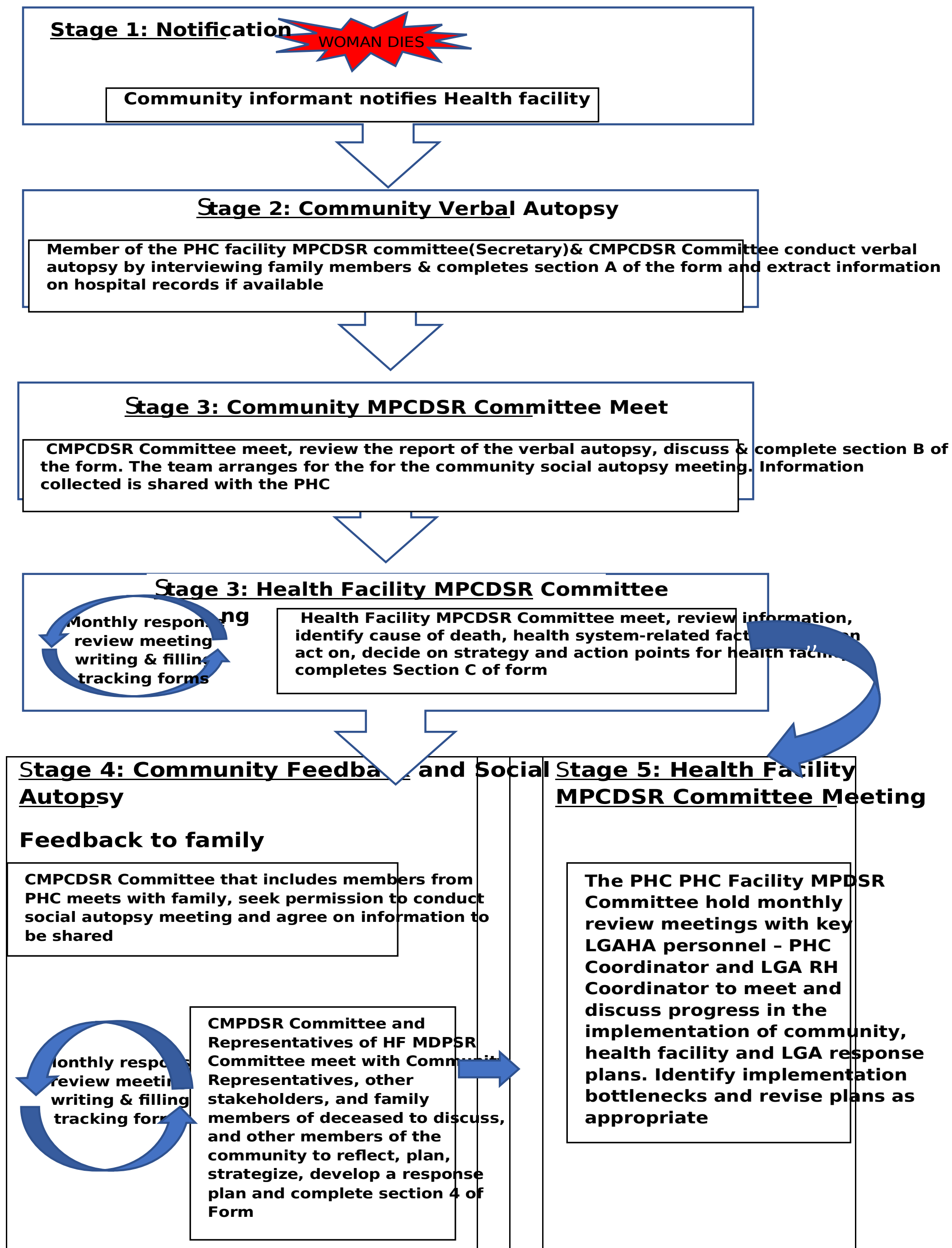

Fig 6.4 Steps involved in conducting Community MPCDSR

5.2.3. <u>Verbal Autopsy (VA)</u>

Verbal Autopsy is a method of gathering information about symptoms and signs for a deceased individual to determine their cause of death, using a questionnaire. Health information about the illness are acquired from conversations or interviews with a person or persons familiar with the deceased and analyzed by health professionals or computer algorithms to assign likely cause(s) of death. It attempts to establish causes of death for otherwise undocumented subjects, allowing scientists to analyze disease patterns and direct public health policy decisions. It is also a major contributor to the national CRVS

Verbal Autopsy is implemented through the following steps:

Identification of maternal, perinatal and child deaths: To ensure that all maternal, perinatal and child deaths are identified in a defined population. This is intended to serve entire communities and on a continuous basis, irrespective of the place of death of the deceased; for those who died in facilities and whose data were also captured by Facility MPCDSR, a process of triangulation is used by the Steering Committees and NPC to prevent double counting. It is important to conduct verbal autopsies on all reported deaths of women of reproductive age, rather than on only those deaths of women with obvious pregnancies, because it may be difficult for community members to identify women that die during early pregnancy or from cases such as ectopic pregnancy or abortion complications. Failure to include all such maternal deaths can result in misleading results. Similarly, stillbirths and deaths of newborns (before their seventh day of life when they are named), and children are identified using the same approach.

The Verbal Autopsy (VA) interview: Verbal autopsy interviews usually consist of a combination of structured, semi-structured and in-depth interviews. A question-answer format is often used to reconstruct the medical circumstances leading to death, while a more open respondent-led or semi-structured approach is used to arrive at the contributing factors. The data collection process and personnel should be carefully selected and well-trained to: identify the appropriate respondents; to use the VA tools effectively in collecting the required information; and be skilled in community-entry processes, including demonstration of appropriate culturally accepted behaviour and empathy in the context of the bereavement and qualitative interviewing skills. The interviewer, may not necessarily be people with medical backgrounds but should be trained in some basic notions of the

medical conditions and their associated symptoms that may lead to locally prevalent maternal, perinatal or child deaths.

Assignment of the causes of death: Diagnosis of pregnancy-related, perinatal and child deaths should preferably not be made at the time of interview, but by the Medical Officer of health of the LGA who is entrusted with review of the completed verbal autopsy tools. Where this is not feasible a panel of health workers (a three-person team) with background professional training and experience (Doctors, Nurses/Midwives etc) should review the questionnaires at a later stage and give independent opinions on the maternal/perinatal/child cause of death. Among all deaths reviewed, the diagnosis is considered final if at least two of the three experts agree on the Primary (Underlying) Cause of Death. To aid the process, flowcharts for causes of maternal, perinatal and child deaths should be made available to such experts.

Classification of contributing factors to maternal, perinatal and child death: The focus is to identify the "modifiable" factors, which should provide the basis for recommendations and actions to reduce the burden of maternal, perinatal and child death. The three-delay model, which examines maternal deaths for factors contributing to three different delays, (1) delays in the decision to seek care; (2) delays in arrival at a health facility; and (3) delays in the provision of adequate care within the facility, is a useful guide in initiating discussion regarding possible factors relating to each maternal/perinatal/child death. The C-MPCDSR is also purposed and designed for identifying "modifiable" factors.

Use the findings for action: The ultimate purpose of verbal autopsy and the C-MPCDSR is to develop action plans, which when implemented will lead to reduced maternal/perinatal/child death within each community. It is therefore necessary to establish mechanisms for monitoring the implementation of recommendations and action plans that are made.

5.2.4. Social Autopsy

Whereas verbal autopsy is used to attribute a clinical cause to a maternal, perinatal or child death, it is also a first step towards the conduct of a social autopsy. The purpose of a social autopsy is to empower communities address the socio-cultural determinants of maternal, perinatal and child mortality. A social autopsy of a maternal death involves interaction with the family of the deceased woman and the deceased‟s wider local community, where facilitators explore the social causes of the death and identify improvements needed to curb recurrences.

Although still relatively new, the process has proved useful to capture data for policymakers on the social determinants of maternal deaths. A social autopsy facilitates “community self-diagnosis” and identification of modifiable social and cultural factors that are attributable to the death. Social autopsy therefore has the potential not only for increasing awareness among community members, but also for promoting behavioural change at the individual and community level. It also promotes accountability and provides population level data. There has been little formal assessment of social autopsy use on perinatal and child deaths. The integration of community dialogue with social autopsy in CMPCDSR will enhance its use as a tool for health promotion.

Following a verbal autopsy, the report is presented to the CMPDSR Committee, who analyze the factors contributing to the deaths along the three delays pathway and discuss possible preventive actions. At the meeting, Secretary CBMPCDSR Committee present their own analysis and proposed actions. The purpose of this meeting is to have a more informed engagement, community dialogue, with the community members during the social autopsy sessions. Members of the CMPDSR Committee arrange the community dialogue/social autopsy sessions. Participants to the meeting include the immediate family of the deceased, neighbours, representatives of women groups, traditional and religious leaders, heads of households, representatives of maternity care providers in the community, and representatives of the local government health authority. At the meeting, anonymized summaries of the deaths, including contributory factors are presented. Through guided discussions, the community members reflect on the mortalities identify community-level factors, factors relating to difficulty in reaching health facilities, and facility-related factors that contribute to the mortalities. The discussions are based on the principle of no name no blame‟ Based on the analysis, the participants develop a community action plan of interventions they propose to carry out by themselves to prevent future deaths, including an accountability framework. A copy of the plan is submitted to the LGA for monitoring of implementation. At the end of each session a health talk on key topics on maternal and child mortality reduction is given to raise their awareness. Social autopsy should be conducted at least once in a quarter.

5.2.5. Community Dialogue

Community dialogue is a forum that draws participants from different sections of a community and creates the opportunity for exchanging information and perspectives clarifying viewpoints and developing solutions to issues of interest to the community. This forum is employed by

Community Based MPCDSR Committee for feedbacks, outreaches, actions from mortality reviews, communication, health promotion etc.

Participants Expected During Community dialogues are Patent Drugs Vendors, PHC In charge, LGA RH/FP Coordinators, Ward Head, Health Educators (State and LGAs), TBA Leaders, CHIPs, Community Health workforce/ community health workers, Women Leaders, Market women, house wives, WDCs, DSNOs, MROs and LGA M&E Officers, e.t.c **Note:**
The LGA M&E Officers are responsible for taking data during each dialogue and uploading on the e-platform.

Health Commodities that are displayed and/or distributed as outreaches during Community Dialogues are Male and Female Condoms, Injectables (norristerat, depo provera), Oral pills (excluton, microglynon), IUDs, LNG-IUS, LLIN-Long lasting Insecticide Net, birth kits e.t.c
The community dialogue is carried out quarterly at a convenience time for all stakeholders that is determined by WDC Chairman in collaboration with MPCDSR focal person and secretary

During community dialogues the LGA M&E officers present the data analysis from the previous community dialogues to the respective stakeholders (WDCs, LGA workers, partners etc.) for their consideration and feedback.

5.2.5.1 Steps in Conducting Community Dialogue

- Selection of the most deficient LGA in each state according to the maternal, child health data guide within the state
- Advocacy visit to the selected LGA by state and LGA officials
- Community mobilization by the community mobilizer of the selected LGA to create awareness and inform the community members of the upcoming dialogue within their LGA and community.
- Arrangement of the venue of the dialogue by the state Rotary representatives and the LGA officials and procurement of refreshment and snacks for the dialogue according to the fund released for this purpose
- Discussions/Teaching/Lectures/Video/Brainstorming on topics for the day
- Questions raised are answered.

- Refreshment is served to participants
- Closing/Vote of thanks

5.2.5.2 Topics to consider during Community Dialogue

The following topics are treated by health officials

- Identification of at risk pregnancies
- 3 delay model emphasis to early health seeking behavior and transport to the Hospital/Facility and
- Labor/Delivery
- Family Planning& Contraceptives
- Nutrition
- Hygiene
- Adolescent Sexual Reproductive Health
- Male Involvement
- Maternal, Newborn, Child deaths reporting and review

5.2.5.3 Curriculum in Conducting Community Dialouque

- Risk of Home Delivery
- Limitations of TBAs
- Attendance Antenatal Clinics
- 3 Delays (At home, Bad Roads & Long Distance to Hospital, Condition at Maternity. Wards and Attitude of Midwives
- Risky Pregnancies (Too Early, Too Late, Too Close &
- Too Many)
    - h. Hygiene
    - i. Nutrition

- j. Immunizations
- k. Family Planning (Types of contraceptives, Counseling, Natural Methods, Referrals).
- l. Post-Partum Family Planning
- Reports and Retirement of Advance
- Community Health Data Management
- Death Reviews

Social Autopsy will be integrated into Community Dialogue agenda to be conducted at least once in a quarter.

5.2.6. Data Management

MPCDSR is entirely based on data generated from the occurrence of maternal, perinatal or child mortality, and its success is dependent on how well the data is created and managed. In health facilities, as soon as one of these deaths occur, the *Certificate of Cause of Death* is completed by last physician to manage the patient. The MPCDSR Officer is notified to collect the deceased‟s casefile and complete both the *Death Notification Form* and the *Death Review Form*. The former is immediately delivered to the MRO who uploads the data to the **National MPCDSR e-Platform** (www.noqanetwork.ng) within 24 hours of the death. By this upload, the information alerts the IDSR system through the LGA IDSR Officer, while the NPC officer also receives it for CRVS triangulation and documentation.

The completed *Death Review Form* is handed over to the Facility MPCDSR Committee Secretary (Obstetrics & Gynaecology or Paediatrics), in advance of its presentation and discussion at the next Committee meeting. At the end of each meeting, a *Recommendation and Action Plan Form* is completed and further documentation performed towards aggregating data on the *Quarterly Response Tracking MPCDSR Form,* and the *Annual Maternal, perinatal and child Death Summary Report*.

Although Facility MPCDSR data best serves the facility for quality-of-care improvement, its aggregation with those of other facilities and community by the LGA, State and National Steering Committees provide additional information on CRVS, healthcare needs, gaps in

services and should inform objectivity and equity in budgetary and resource allocation to the health and social system.

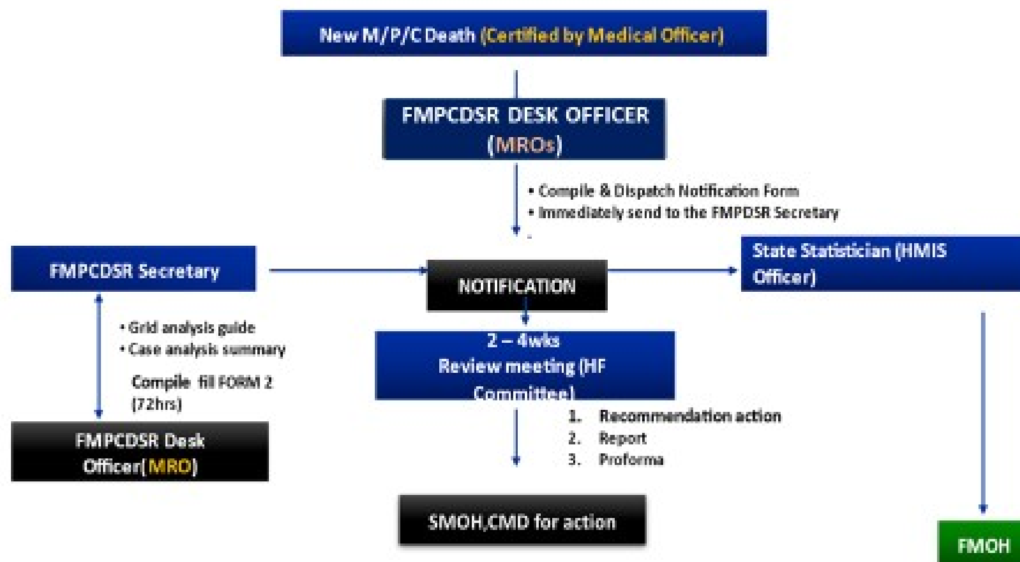

Figure 6.4: Showing the flow of data within and beyond the MPCDSR system

6.3.*EVOLUTION OF MPCDSR IN NIGERIA*

The evolution of MPCDSR in Nigeria has been remarkable, undergoing two major transformations since its inception less than a decade ago, and receiving acceptance and institutionalization across the country.

In 2004, the WHO, in a landmark publication titled “Beyond the Numbers”, recommended that all countries should establish medical auditing systems for the reduction of maternal deaths.

FMOH partnered with SOGON & FIGO in their “LOGIC” initiative to organize two sensitization/training workshops on MDR in Abuja, on March 13th-15th, 2012 and April 12th, 2012.

Follow-up workshop was held on July 4-5, 2012 to articulate a National Guidelines, Protocol and tools for MDR.

A National Stakeholders meeting on MDR was held in 2013 to validate zero draft guidelines

The roll-out plan was for a pilot implementation at all Federal Tertiary Health Institutions, and in selected states like Lagos, Ogun, Delta and FCT that were already conducting MDR pilots with SOGON, for a period of one year after which lessons learnt would be reviewed towards scaling up to other health facilities.

In 2014, Nigeria‟s endorsement of the 67th World Health Assembly‟s resolution on *Every Newborn Action Plan*, to eliminate preventable deaths by 2030, necessitated the transformation of MDR into MPDSR.

Inauguration of the National MPDSR Steering Committee was performed by HMH in March 2015

Inaugural meeting of the committee held on 15th September,2015 and MPDSR Sub committees were formed.

A National MPDSR implementation plan was developed and presented to PSH for approval.

Final edited copy of the 1st MPDSR guideline was developed in 2015

Trainings on MPDSR were held in the six geopolitical zones for core members of State Steering Committees of all 36+1 States across the country in October-November, 2015, and mandate given to them to use partnerships to establish the program in their States.

A published national baseline survey on MPDSR was conducted in September-October, 2016.

Between 2017-18, the maiden editions of MPDSR Annual Reports were published by individual States.

In 2019, Rotary International partnered with FMOH to introduce the National Obstetric Quality Assurance (NOQA) electronic platform for uploading and managing MPDSR data across the country

The need to scale-up MPDSR to private health facilities, PHCs and the community levels prompted a revision of the National Guidelines on MPDSR and its Training Toolkits (2nd edition of National MPDSR Guidelines) in 2019.

In 2020, FMOH, partnered with the Chairman, Senate Committee on Health, SOGON and Rotary International, to develop an MPDSR Bill that is awaiting the President‟s assent.

On September 9, 2021, WHO-Afro Office held a Pan-Africa virtual meeting to train member-Countries on the new *Child Death Audit*, for adoption and integration into existing death audit mechanisms. This MPCDSR Guidelines is Nigeria‟s effort at integrating the CDA into its existing MPDSR program.

6.4. *CAPACITY BUILDING FOR MPCDSR*

Since MDR was first adopted in 2013, centralised trainings were held by FMOH and SOGON, were subsequently cascaded down to individual States, this assisted States like Lagos, Delta and Ogun to introduce the scheme. The 2015 MPDSR trainings held in the six geopolitical zones for all States and the FCT invested capacity in the States to build their own capacities towards institutionalizing the programme in their health systems. These capacity building efforts were supported by a wide array of partners that included UN Agencies such as UNFPA, WHO and UNICEF, bilateral agencies such as DFID and Implementing Partners (Save-the-Children, Evidence-for-Action and Rotary International). The 2015 and 2019 MPDSR National Guidelines and Training Toolkits were used for these trainings, which resulted in the establishment of MPDSR State Steering Committees in all States and facility MPDSR in most secondary health facilities across the country.

There has been a long history of capacity building on MDR at the community level in Nigeria[11]:

NPHCDA had used its Midwives Service Scheme to establish VA and MDR in 19+1 northern States in 2011-2013;

SOGON established VA and MDR and later MPDSR in three communities of the FCT in 2014-2018; and

MNCH2 established VA and MDR in six northern States in 2014-2018.Recently, NPHCDA commenced a national MPCDSR capacity building at the PHC (health facility and community) level, through the NEMCHIC/SEMCHIC/LEMCHIC programme. Most Tertiary Health Facilities in Nigeria were not conducting MPDSR until 2019 when WHO introduced the MPD4QED and medical death audit in49 tertiary and five secondary health facilitiess. This initiative combined quality improvement strategies with continuous capture

[11]Oladapo Shittu and Mary Kinney. Assessment of Maternal and Perinatal Death Surveillance and Response Implementation in Nigeria (Baseline Survey). August 2017.

and review of routine maternal and perinatal health data for the purpose of halving the burden of maternal mortality in the country.

The implementation of MPCDSR by FMoH and NPHCDA is now integrated by the *National Maternal and Perinatal Death Surveillance and Response Bill* (SB.581) under the FMOH Department of Family Health. The recent introduction of the Child Death Audit by WHO has widened the life-cycle dimensions of the program to MPCDSR.

7. NATIONAL LEVEL MPCDSR

7.1. MEMBERSHIP

The National Maternal, Perinatal and Child Death Surveillance and Response Steering Committee shall be chaired by the Hon. Minister of Health.

The membership of the National MPCDSR Committee shall include the following:

7.1.1. A Vice Chairman 1 who shall be President Society of Gynaecology and Obstetrics in Nigeria a Consultant Obstetrician and Gynaecologist, as approved by the Minister.

7.1.2. A Vice Chairman 2 who shall be President Paediatrics Association of Nigeria a Consultant Paediatrician /Neonatologist, as approved by the Minister.

7.1.3. Secretariat to the committee shall be domiciled in the Office of Director, Department of Family Health, FMOH.

7.1.4. One representative from Ministries, Departments and Agencies (MDAs) are to be nominated by the Heads and Authorities of Government MDAs and Development Partners of:

- Department of Family Health, FMOH.
- Department of Health Planning Research and Statistics, FMOH
- Department of Hospital Services, FMOH
- Department of Information Communication Technology (ICT), FMOH
- Department of Public Health, FMOH
- National Primary Health Care Development Agency (NPHCDA);
- National Centre for Disease Control
- National Health Insurance Scheme
- Civil Registration/Vital Statistics National Population Commission
- Ministry of Women Affairs
- National Bureau of Statistics;
- Chairman QoC TWG
- Chairman RMNACAEH+N Coordination & Partnership subcommittee
- Chairman RMNACAEH+N Advocacy & Resource Mobilisation subcommittee.
- Chairman RMNACAEH+N Accountability, Data and Knowledge Management, subcommittee.
- Chairman RMNACAEH+N Quality and Technical subcommittee.
- National Coordinator MPD4QED
- States Commissioners of Health
- Development Partners on Health

7.1.5. One representative each of the National Professional Associations to be nominated by the Associations;

- Nigeria Medical Association
- Association of General and Private Medical Practitioners of Nigeria
- Pathologists Association of Nigeria
- Association of Haematologists of Nigeria
- National Association of Nigeria Nurses and Midwives
- Association of Anaesthetists of Nigeria
- Society of Family Physicians of Nigeria (SOFPON)
- Association of Public Health Physicians of Nigeria.
- Society of Gynaecology and Obstetrics of Nigeria (SOGON)

President Paediatrics Association of Nigeria
National Association of Community Health Practitioners

7.1.6. One representative of a CSO that is active in Maternal, Perinatal and Child health

7.2. TENURE

The tenure of the committee shall be as below:

7.2.1. The Chairman shall hold office for the period as Honourable Minister of Health

7.2.2. Vice Chairman 1 and Vice chairman 2 of the Committee shall hold office for the period as President of Society of Gynaecology and Obstetrics in Nigeria and Paediatrics Association of Nigeria respectively renewable once.

7.2.3 Other members of the committee will serve a term of four years" renewable only for a term.

7.3. FUNCTIONS

The National MPCDSR Steering Committee shall perform the following functions;

Make appropriate recommendations to the Minister for prompt implementation;

Be responsible for giving effect to the MPCDSR Scheme across the federation, including regular review and publications;

Track accumulated data on notifications on Maternal, Perinatal and Child deaths;

Appoint Sub-Committees including Technical Sub-Committee, M & E Sub-Committee and Advocacy Sub-Committees with specific TORs. The Sub-Committees will analyse the reports in clinical depth and make recommendations to the Federal Committee;

Collate reports on all maternal, perinatal and child deaths; ensure consistency of reporting and follow-up;

Implementation of recommendations;

Issue annual report on key findings and recommendations (Confidential Enquiry Report on Maternal, Perinatal and Child Deaths);

Organise trainings and awareness workshop;

Develop guidelines, tools and other materials needed which shall serve as the Standard Operating Procedures for carrying out MPCDSR processes and implementation in Nigeria based on its revised version, as approved by designated authority.

Anticipate future expansion and develop implementation plans;

Make quarterly reports to the Honourable Minister through the Permanent Secretary (submitted through the DFH as the head of secretariat).

Give support to the State/FCT MPCDSR Steering Committees in the implementation of MPCDSR plans and processes.

Ensure, accordingly that MPCDSR implementation in Nigeria follow the National Strategic Health Development Plan, and its Monitoring and Evaluation Framework.

7.4 MEETINGS

The meetings of the National MPCDSR Steering Committee shall be convened by the Chairman or his representative subject to his approval and shall hold quarterly. The Chairman may convene an emergency meeting whenever the need arises. The meetings shall be held at such a place and time as the Chairman may determine.

The Chairman shall preside over all meetings of the National Steering Committee and in his/her absence, any other member appointed for that purpose by the Chairman may preside over a meeting.

The quorum for meetings shall be half of the members of the committee.

The committee shall have the powers to regulate its own proceedings, subject to the provisions of this guideline.

The agenda of the meetings of the committee shall in addition to any other items, include the following;

- Recitation of MPCDSR code of conduct as provided in this guideline;
- Deliberation on the minutes of the preceding meeting;
- Updates on action points/recommendations made at the previous meeting (be presented by the "Recommendations Officer");
- Presentation of the report of the Technical Sub-Committees for deliberation on all recently assembled MPCDRS reports from states, facilities and communities;
- Compilations of new and updated recommendations, with specification of their destination.

7.5. The Reproductive Maternal Neonatal Child Adolescent and Elderly Health plus Nutrition (RMNCAEH +N) Technical and Quality Delivery Sub-committee shall be the Technical Sub-Committee of National MPCDSR Steering Committee.

This Technical Sub-Committee shall also include a representative of the Department of Family Health, Health Planning Research & Statistics, Hospital Services, Public Health, Academia (Consultants Obstetrics and Gynaecologist and Paediatrician/Neonatologists), NPHCDA, Partners and representative of other stakeholders, as approved by the MPCDSR Steering Committee.

7.6. The Technical Sub-Committee shall hold meetings regularly as the Chairman may determine, provided that it shall hold a meeting one week prior to the quarterly meeting of the National MPCDSR Steering Committee.

The Technical Sub-Committee shall have the following responsibilities;

Give expertise in maternal, newborn and child health and provide supportive services to the National MPCDSR Steering Committee;

Discuss with different development partners their likely support, including technical assistance for implementation;
Undertake in-dept analysis of maternal, perinatal and child deaths;
Examine all recent experience with Maternal, Perinatal and Child Deaths Surveillance and Response or similar surveys in Nigeria;
Make appropriate recommendations on required capacity building of officers to implement MPCDSR objectives;
Make specific and practical recommendations for strengthening MPCDSR;
Technical Sub-Committee shall meet before every National MPCDSR Committee quarterly meeting to analyse MPCDSR reports assembled from states/MPCDSR facilities;
May co-opt other members within or outside the steering committee as it deems fit.

7.7. The RMNCAEH +N Accountability, Data and Knowledge Management Sub-committee shall serve as the Monitoring and Evaluation Sub-Committee of the National MPCDSR Committee.

The responsibilities of this M & E Sub-Committee shall include:

Examine the recent surveys periodically and assess their accuracy, quality assurance procedures, content, and data analysis and dissemination procedures;
Work closely with donors and implementing partners to develop specific and practical plans and protocols that would provide results for robust MPCDSR at all levels;
Periodically summarize key data and make recommendations in comprehensive reports so that it can be used by managers and policy makers for quality-of-care improvement;
Assess capacities of key Monitoring and Evaluation institutions for undertaking MPCDSR at all levels;
Propose key M & E systems strengthening required to report credible and verifiable data;
Suggest how MPCDSR linkage to NHMIS and the DHIS can be strengthened.
Advocate and liaise between MPCDSR National Steering Committee and relevant agencies and organizations.
Ensure timely reporting of all MPCDSR activities through the National MPCDSR Electronic Platform(www.noqanetwork.ng)
Periodically summarize key data and make recommendations in comprehensive reports in very simple terms so that it can be understood by community gate keepers and laymen"
Facilitate the development and dissemination of annual report on MPCDSR implementation at all levels of health care in Nigeria.
Ensure that MPCDSR implementation in Nigeria follow the National Strategic Health Development Plan and its Monitoring and Evaluation Framework.

7.8. The Reproductive Maternal Neonatal Child Adolescent and Elderly Health plus Nutrition (RMNCAEH +N) Resource and Advocacy Mobilization Sub-Committee shall also serve as MPCDSR Advocacy Sub-committee.

The responsibilities of the Advocacy Sub-Committee include;

Establishment of a sustainable MPCDSR implementation by constantly ensuring political will at all levels of governance through advocacy;
Increase access to quality maternal, perinatal and child health in Nigeria;

Work with the States‟ MPCDSR advocacy sub-committees to facilitate establishment and sustainability of State MPCDSR;
Rapidly scale up implementation of MPCDSR at the State level through advocacy in collaboration with the State MPCDSR advocacy sub-committee;
Protect the implementation of MPCDSR through effective awareness creation and support for proper legislation; and
Facilitate the implementation of the recommendations of the National Steering Committee.

8. STATE LEVEL MPCDSR

8.1. MEMBERSHIP

There shall be a State MPCDSR Committee for each State of the Federation and the Federal Capital Territory.

The State MPCDSR Steering Committee shall be chaired by the Hon. Commissioner of Health, State Ministry of Health and Mandate Secretary of Health in FCT.

The State Steering Committee shall include the following persons as approved by HCH;

Vice Chairman 1: Who shall be a Consultant Obstetrician and Gynaecologist and member of Society of Gynaecology and Obstetrics of Nigeria. (SOGON)

Vice Chairman 2: Who shall be a Consultant Paediatrician /Neonatologist and member of Paediatrics Association of Nigeria (PAN)

Secretariat will be domiciled in the Department of Family Health.

Desk Officer: Must be a Senior Technical Officer in Maternal/Child health Unit of the Department of Family Health.

Executive Secretary/Director General Hospital Management Board (State Health Facility MPCDSR Coordinator).

Executive Secretary Primary Health Care Development Board/Agency (PHC MPCDSR Coordinator).

Director Primary Health Care in State Ministry of Health.

Director Department of Planning Research and Statistics.

Ministry of Finance/Budget.

Director Nursing / Midwifery Services.

Private Health Establishment Regulatory Unit in State Ministry Of Health (Private Practice Regulators).

Guild of Medical Directors.

Association of General Private Medical Practitioners of Nigeria (AGPMPN).

Local Government Service Commission.

Director, Pharmaceutical Services,

Consultant Pathologist/Head of Laboratories & Blood Transfusion services,

Representative of State Chapter of National Council of Women Society (NCWS),

Representative of National Population Commission,

Representative of Society of Gynaecology and Obstetrics,

Representative of Paediatrics Association of Nigeria,

Representative of RMNCAEH+N Programme

State Reproductive Health Coordinator

State Safe Motherhood Coordinator

- State Child Health Coordinator
- State HMIS Officer
- State DSNO Officer
- Chairman QoC TWG and /or QoC Focal Person
- State Coordinator National Population Commission
- Representative of CSOs in Maternal, Perinatal and Child Health

8.2. The Commissioner for Health/Permanent Secretary in each state Ministry of Health shall perform oversight roles on the States Steering Committees. Their roles in specific terms shall include:

- Provide overall leadership for MPCDSR in the state.
- Ensure proper monitoring and supervision of all MPCDSR activities in the state.
- Make available all necessary resources for the smooth running of MPCDSR in the state.
- Ensure that all recommendations emanating from MPCDSR activities in the state are implemented.

8.3. TENURE

The tenure of the committee shall be as below:

- The Chairman shall hold office for the period as Honourable Commissioner of Health
- The Vice Chairman 1 and Vice chairman 2 of the Committee shall hold office for four-year tenure, renewable once.
- Other members of the committee will serve a term of three years renewable only for a term.

8.4. FUNCTIONS

The functions of the State MPCDSR Steering Committee shall include the following:

- Be responsible for planning and establishing the mechanism for the MPCDSR activities at State level.
- Ensure that Public Facility/Community MPCDSR committees notify and review all maternal, perinatal and child deaths.
- Ensure that Private Facility MPCDSR committees notify and review all maternal, perinatal and child deaths.
- Track accumulated data on notifications on maternal, perinatal and child deaths.
- Provide oversight and consultation to the health care providers in the State.
- Ensure regular review of the maternal, perinatal and child death cases.
- Provide support for scaling up MPCDSR activities in the State.
- Synthesize the data, interpret the results and make recommendations for action towards reduction of avoidable maternal, perinatal and child deaths.
- Prepare quarterly, and/or annual report and ensure dissemination of the report.

Provide regular capacity building for MPCDSR officers and prevent abrupt turnover of trained staff.
Monitor implementation of recommendations including state response to maternal, perinatal and child deaths.
Monitor implementation of recommendations from Private Facility MPCDSR Committee.
Constitute Sub-Committees with membership from within and outside the main committee. These shall include the Technical sub-committee, M and E sub-committee and Advocacy subcommittee.
Each state shall have Sub-committees which shall include; Technical Sub-committee, M&E Sub-committee and Advocacy Sub-committee.

The appointment of the Sub-committees shall be a sole responsibility of the State MPCDSR Steering Committee.

Members of *State Technical Sub-committee* shall include but not limited to the following persons/Officers:

- MDCPSR Desk Officer,
- Representative of the Department of Health Planning Research and Statistics;
- National Population Commission representative, and
- Public Health Department officer, who keeps record of notifications sent on maternal and perinatal deaths.
- State Primary Health Care Development Agency representative
- Department of Family Heath representative.

The roles of the *State Technical Sub-committee* shall include:

Give expertise in maternal, newborn and child health and provide supportive services to the State MPCDSR Steering Committee;
Engage different Development partners for support, including technical assistance for implementation;
Make specific and practical recommendations for strengthening MPCDSR;
Undertake in-depth analysis of maternal, perinatal and child deaths in the State;
Examine all recent experiences with Maternal, Perinatal and child Deaths Surveillance and Response or similar surveys in the State/Nigeria;
Make appropriate recommendations on required capacity building of officers to implement MPCDSR;
Identify and other existing quality of care efforts in the State and establish linkage of MPCDSR with them;
Technical Sub-Committee shall meet before every State MPCDSR Steering Committee quarterly meeting to analyse MPCDSR reports assembled from all MPCDSR facilities and the communities;
Perform other duties assigned by the main State MPCDSR Steering Committee;
May co-opt other members within or outside the State MPCDSR steering committee as it deems fit

The roles of the State M&E Sub-committee shall include:

- Examine recent relevant surveys periodically and assess their accuracy, quality assurance procedures, content, and data analysis and dissemination procedures;
- Work closely with donors and implementing partners to develop specific and practical plans and protocols that would provide results for robust MPCDSR in the State;
- Periodically summarize key data and make recommendations in comprehensive reports so that it can be used by managers and policy makers on quality-of-care improvement;
- Assess capacities of key M&E institutions for undertaking the MPCDSR at State levels;
- Propose key Monitoring and Evaluation Systems strengthening required to report credible and verifiable data;
- Suggest how MPCDSR linkage to National Health Management Information System and the District Health Information System can be strengthened in the state;
- Perform other duties assigned by the main State MPCDSR Steering Committee;
- May co-opt other members within or outside the State MPCDSR steering committee as it deems fit.
- Coordinate all MPCDSR M&E implementation plan including National MPCDSR electronic platforms
- Summarize key data and make recommendations in simple reports such that it can be used for advocacy to community gate keepers.
- Facilitate the development and dissemination of annual report on MPCDSR implementation at all levels of health care in the State.
- In order to avoid double-counting, efforts must be made at LGA and State data processing units to identify deaths that are simultaneously captured at community and facility levels.

The roles of the *State Advocacy Sub-committee* include:

- Establish a sustainable MPCDSR implementation by constantly ensuring political will at all levels of governance through advocacy.
- Work with the National and LGA advocacy MPCDSR sub - committees to facilitate establishment and sustainability of state MPCDSR.
- Increase access to quality maternal, perinatal and child healthcare in Nigeria.
- Rapidly scale up implementation of MPCDSR at the State level through advocacy in collaboration with National MPCDSR advocacy sub-committee.
- Protect the implementation of MPCDSR through effective awareness creation and support for proper legislation.
- Perform other duties assigned by the main State MPCDSR Steering Committee;
- May co-opt other members within or outside the State MPCDSR steering committee as it deems fit.

8.5. MEETINGS

The meetings of the State MPCDSR Steering Committee shall be convened by the Chairman or his representative subject to his approval and shall hold quarterly. The Chairman may convene an emergency meeting whenever the need arises:

The meetings shall be held at such a place and time as the Chairman may determine.

The Chairman shall preside over all meetings of the State Steering Committee and in his/her absence, any other member appointed for that purpose by the Chairman may preside over a meeting.

The quorum for meetings shall be half of the members of the committee.

The committee shall have the powers to regulate its own proceedings, subject to the provisions of this guideline.

The agenda of the meetings of the committee shall in addition to any other items, include the following:

- Recitation of MPCDSR code of conduct as provided in this guideline;
- Deliberation on the minutes of the preceding meeting;
- Updates on action points/recommendations made at the previous meeting;
- Presentation of the report of the Technical Sub-Committees for deliberation on all recently assembled MPCDRS reports from states, facilities and communities;
- Compilations of recommendations, with specification of their destination; and
- Scheduling of the next meeting.

9. FACILITY LEVEL MPCDSR

Each Public and Private Health Facility should establish an MPCDSR Committee which shall be domiciled in the office of the Head of the Facility.
The roles of the Head of Facility include:

- Provision of overall leadership for MPCDSR in the facility;
- Provision of all necessary resources for the smooth running of MPCDSR in the facility;
- Ensure that all recommendations emanating from MPCDSR activities are implemented.
- Ensure Facility MPCDSR Committee conducts review meetings at least monthly or as emergency when required.
- Ensure that prepared MPCDSR forms and Committee Session reports are sent to the State MPCDSR Committees within 72 hours of completion of committee meeting.
- Compulsorily develop and disseminate annual report on MPCDSR implementation in the Facility

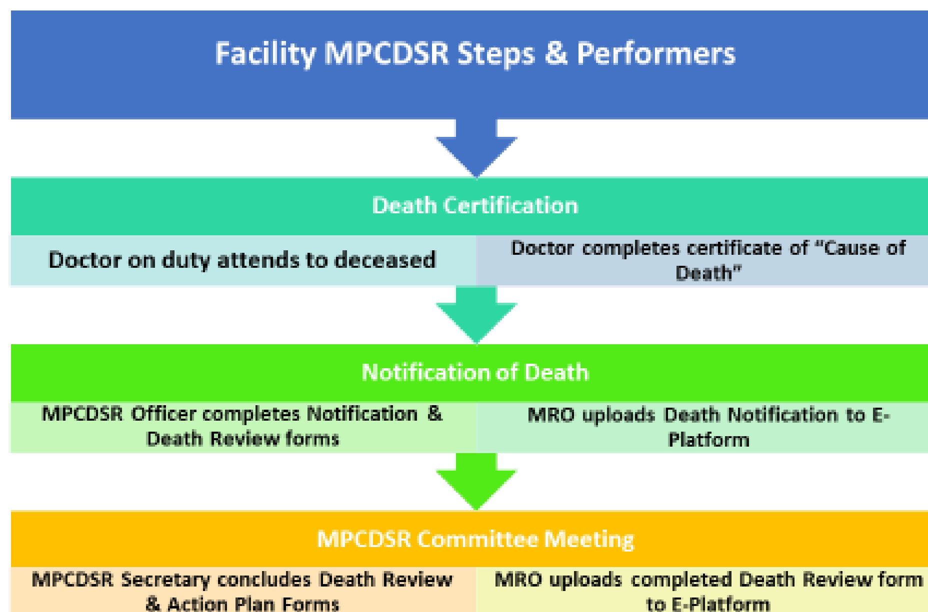

Figure 9.1: Steps involved in Facility MPCDSR implementation

9.1. PUBLIC HEALTH FACILITY MPCDSR

MPCDSR implementation Process will be carried out by the existing Maternal and Perinatal Death Quality, Equity and Dignity (MPD-QED) Committee in the Tertiary Health Facility.

Membership of *Public Health Facility MPCDSR Committee* shall comprise of the following:

- Chairman: Medical Director/ Director of clinical services/Head of facility in the absence of the former

Secretary I: Head of Obstetrics and Gynaecology for Secondary Health Facilities.
Secretary II: Head of Paediatrics/ Neonatology for Secondary Health Facilities.

Head/representative of the following departments as may be available:

- Nursing/midwifery
- Pathology
- Preventive/ community medicine
- Anaesthesia
- Haematology& Blood Bank
- Labour/ maternity ward
- Neonatal ward
- Medical records
- Medical social welfare
- Pharmacy
- MPCDSR Officer I –Obstetrics and Gynaecology
- MPCDSR Officer II- Paediatrics
- DSNO Focal Person
- NPC Registrar (Civil Registration and Vital Statistics)
- Member of a local Women`s Group.
- Other persons may be included in the committees by the Head of each facility who shall inaugurate the committees within their respective facilities.

Note that MPCDRS Desk Officers shall be nominated by the Head of Department of Obstetrics and Gynaecology and that of Paediatrics.

Membership of *Tertiary Public Health Facility MPCDSR Committee* shall comprise of the following: The MPD4QED team is transited to implementation of MPCDSR as approved by Honourable Minister of Health and as passed National Assembly MPCDSR Bill.

Chairman: Chief Medical Director
Vice Chairman: Medical Advisory Committee/ Director of Clinical Services,
Secretary I: Head of Department, Department of Obstetrics and Gynaecology for Tertiary Health Facilities.
Secretary II: Head of Department, Department of Paediatrics for Tertiary Health Facilities.
MPCDSR Focal Person: Coordinator MPD4QED Department of Obstetrics and Gynaecology for Tertiary Health Facilities.
MPCDSR Focal Person: Coordinator MPD4QED Department of Paediatrics for Tertiary Health Facilities.
MPD4QED Zonal Coordinator
Head/Representative of the following departments as may be available:

- Nursing/midwifery
- Pathology
- Preventive/ community medicine
- Anaesthesia
- Haematology& Blood Bank

- Labour/ maternity ward
- Neonatal ward
- Medical records
- Medical social welfare
- Pharmacy
- MPCDSR Desk Officer I –Obstetrics and Gynaecology
- MPCDSR Desk Officer II- Paediatrics
- Member of a local Women`s Group.
- Department of Family Health
- DSNO Focal Person
- NPC Registrar (Civil Registration and Vital Statistics)
- Other persons may be included in the committees by the Head of each facility who shall inaugurate the committees in their respective facilities.

Note that MPCDRS Desk Officers shall be nominated by the Head of Department of Obstetrics and Gynaecology and that of Paediatrics.

The Public MPCDSR Facility Committee shall perform the following functions:

Identify all Maternal, Perinatal and Child deaths in the facility and promptly dispatch notifications to the Disease Surveillance Information Officer at the Local Government Health Department and State Ministry of Health.

Ensure facility based MPCDSR forms are completed accurately and timely

Retrieve case notes as soon as possible and keep them safe.

Hold regular MPCDSR meetings within 2 to 4 weeks‟ interval at which case(s) will be discussed/ reviewed and report and recommendations compiled.

Prepare MPCDSR forms and Committee Session report which are sent to the State and National Steering Committees within 72 hours.

Follow up committee local recommendations to ensure their implementation.

9.2. PRIVATE HEALTH FACILITY MPCDSR

The Private Facility Regulatory Department of the State Ministry of Health will be responsible for the enforcement of implementation of MPCDSR in the Private Health Facilities in each State and the FCT. Membership of the Private Health Facility MPCDSR Team shall include but not be limited to the following:

Chairman - Medical Director/Head of the facility

Secretary I - Head, Obstetrics & Gynaecology / Maternity

Secretary II - Head of Paediatrics

MPCDSR Officer(s) - A medical officer

Member of a local women group and other relevant Non-Governmental Organizations (NGOs)

Head of the following Units:

- Nursing/Midwifery
- Pathology/Laboratory

- Haematology & Blood bank
- Labour/Maternity ward
- Neonatal ward
- Medical records
- Medical Social Welfare
- Pharmacy
- Department of Family Health

The functions of the *Private Health Facility MPCDSR Committee* include:

a) To identify all maternal, perinatal and child deaths in the private health facility and promptly dispatch notifications to the Disease Surveillance Notification Officer at the Local Government Health Department and State Ministry of Health. This shall be through completion of the notification form and/or National MPCDSR electronic platform.
b) To ensure facility MPCDSR forms are completed accurately and on time and dispatched promptly.
c) To retrieve case notes of maternal, perinatal and child deaths as soon as possible and keep them safe.
d) Hold regular MPCDSR meetings within 2 to 4 weeks interval where case(s) will be discussed in a non-threatening manner.
e) Compile quarterly and yearly reports and recommendations from the private facility MPCDSR and submit to the Director, Primary Health Care at Local Government.
f) To follow up Private MPCDSR Team recommendations to ensure they are implemented.

10. PRIMARY HEALTHCARE LEVEL MPCDSR

10.1. NATIONALSUB-COMMITTEE

10.1.1.. Membership

There shall be a National Sub-committee on PHC MPCDSR, and the chairman shall be a member of the MPDSR-QOC National Steering committee of the *National Emergency Maternal and Child Health Intervention Centre (*NEMCHIC) of NPHCDA (Figure 7.1). This Sub-Committee shall be responsible for providing oversight on the implementation of MPCDSR at the Primary Health Care (PHC) Centres and at the Community levels in all States and the FCT. This Sub-committee will have replica at the State, LGA and Ward levels as sub-committees of *State Emergency Maternal and Child Health Intervention Centre (*SEMCHIC) and the *Local Government Emergency Maternal and Child Health Intervention Centre* (LEMCHIC) and the Ward Development Committee respectively.

The Executive Director/Chief Executive (ED/CEO) Officer -NPHCDA shall appoint a Chairman for the National Sub-committee on PHC MPCDSR. Other members of the Sub-committee shall include:

a) Director of Civil Registration and Vital Statistics of National Population Commission (NPC) serve as the Co-Chair.
b) The Director Community Health Services NPHCDA
c) The Director Primary Health Care Systems Development NPHCDA
d) The Director Planning, Research and Statistics NPHCDA
e) Programme Manager NEMCHIC
f) Deputy Programme Manager 1 of the NEMCHIC-
g) Deputy Programme Manager-2 of the NEMCHIC
h) Team lead of M&E working group of the NEMCHIC- Secretariat
i) Team lead of Service delivery working group of the NEMCHIC
j) Team lead of Advocacy, Communication and Community Engagement working group of the NEMCHIC
k) Focal person for PHC Quality of Care NEMCHIC
l) A Desk Officer Civil Registration and Vital Statistics of National Population Commission
m) A representative of National Association of Nurses and Midwives
n) A representative of the Association of Primary Health Practitioners of Nigeria (APHPN)

o) A representative of the Community Health Practitioners Board
p) The Desk officer MPCDSR (Reproductive Health), Federal Ministry of Health
q) Development Partners
r) Civil Society Organizations
s) Faith Based Organizations
t) Any other Member as appointed by the NPHCDA ED/CEO

10.1.2. Tenure

Members of the National Sub-committee on PHC-MPCDSR shall hold office according to existence of the NEMCHIC structure; at the exit of NEMCHIC, membership shall then be revised in alignment with the exit strategy.

10.1.3. Functions

The committee shall have oversight support and strategic guidance from the ED/CEO of NPHCDA, Director Community Health Services Department, Director Primary Healthcare Systems Department, Director Planning Research and Statistics (PRS) of (NPHCDA), Director of Planning Research and Statistics of NPC and NEMCHIC Programme Manager
The National Sub-Committee on PHC-MPCDSR shall perform the following functions:

a) Provide leadership and coordination for the implementation of PHC-MPCDSR and ensure accountability at all levels of implementation.
b) Provide technical and programmatic support for the implementation of PHC-MPCDSR at PHC and Community levels
c) Intervene in the resolution of specific problems requiring high level support and review progress on agreed activities.
d) Make specific and practical recommendations for strengthening PHC-MPCDSR to the national steering committee on MPCDSR
e) Ensure political will at all levels of governance for the implementation of PHC-MPCDSR.
f) Engage with different MDAs and development partners for their support, including technical assistance for implementation of PHC-MPCDSR.

g) Facilitate the implementation of the recommendations of the National Steering Committee regarding PHC-MPCDSR.

Other Tasks may include:

h) Rapidly scale up of the establishment and implementation of PHC-MPCDSR through advocacy
i) Periodically assess the accuracy, content and quality of surveillance reports, and make recommendations for use by health managers and policy makers to improve the quality of maternal and child Care at the PHC and community level.
j) Develop a comprehensive M&E plan and make recommendations on M&E systems strengthening required to support credible and verifiable PHC-MPCDSR data provision and dissemination.
k) Make appropriate recommendations on required capacity building for Officers to implement PHC-MPCDSR.
l) Conduct trainings and workshops to build capacity on PHC-MPCDSR
m) Develop guidelines, tools, training documents and other materials needed for PHC-MPCDSR
n) Ensure integration of PHC MPDSR with PHC Quality of Care

10.1.4. Meetings

The Committee shall meet quarterly, unless otherwise convened to meet in special circumstances.

10.2. STATE SUB-COMMITTEE

10.2.1. Membership

There shall be a State Sub-committee on PHC-MPCDSR, as a sub-committee of the *State Maternal and Child Health Intervention Centre* (SEMCHIC):

Chairman – Executive Secretary of State Primary Healthcare Board (SPHCB) or any other competent senior staff He/she may appoint

Co-Chair – National Population Commission State coordinator

NPHCDA state coordinator

Director Family Health Services Department, SPHCB

Director, Community Health Services Department, SPHCB

Director, Primary Healthcare Systems Department, SPHCB

Director, Planning Research and Statistics, SPHCB

Programme Manager of the SEMCHIC (Secretary)

Team lead for service delivery working group, SEMCHIC

State Safe Motherhood Coordinator

The Desk Officer MPCDSR (Reproductive health) of the State Ministry of Health

The Desk Officer MPCDSR (Child health) of the State Ministry of Health

A representative of the National Association of Nurses and Midwives

A representative of the Community Health Practitioners Board - State Branch

Development Partners

Civil Society Organizations

Faith based organizations.

Other members of SEMCHIC as may be deemed necessary

10.2.2. Tenure

Members of the State Sub-committee on PHC-MPCDSR shall hold office for the lifespan of SEMCHIC. At the exit of SEMCHIC, membership shall then be revised in alignment with the exit strategy.

10.2.3. Functions

The State Sub-committee on PHC MPCDSR shall perform the following functions:

a) Be responsible for the implementation of the PHC-MPCDSR activities at State level
b) Ensure that all maternal, perinatal and child deaths in the PHC facilities and communities are notified and reviewed by the relevant PHC-MPCDSR committees.
c) Support the scale-up of PHC-MPCDSR activities in the state

d) Work with the relevant sub-committee at the state level to interpret PHC-MPCDSR data and make recommendations for action towards the reduction of avoidable maternal, perinatal and child deaths.
e) Provide regular capacity building for PHC-MPCDSR officers
f) Periodically assess the accuracy, content and quality of surveillance reports, and make recommendations for use by health managers and policymakers at the state level to improve the quality of maternal, perinatal and child care.
g) Engage closely with donors and implementing partners to implement specific and practical plans and protocols that would provide results for robust PHC-MPCDSR
h) Make recommendations on M&E systems strengthening required to support credible and verifiable PHC-MPCDSR data provision and dissemination at the state level
i) Take actions escalated by the LEMCHIC identified as required to avert future deaths
j) Advocate for resources and other support required for implementation of PHC-MPCDSR

k) Ensure that causes of maternal, perinatal and child death that are related to Quality of Care gaps are included in Quality Improvement Plans

l)

10.2.4. <u>Meetings</u>

The PHC-MPCDSR meetings shall be quarterly and align with the mode of operations of SEMCHIC, and provide regular progress updates on PHC -MPCDSR implementation to the wider SEMCHIC and State Steering Committee on MPCDSR.

10.3. LGA SUB-COMMITTEE

10.3.1. <u>Membership</u>

There shall be an LGA Sub-committee on PHC MPCDSR as a sub-committee of the *Local Government Emergency Maternal and Child Health Intervention Centre* (LEMCHIC) with the Director PHC of the LGA providing oversight. The following shall be members:

a) The LEMCHIC Coordinator (Secretary)
b) The Medical Officer of Health (MOH)

c) Maternal and Child Health (MCH) Coordinator
d) The DSNO of the LGA
e) M&E officer of the LGA
f) LGA Health promotion officer.
g) A representative of Association of Nurses and Midwives, LGA Branch
h) A representative of the Community Health Practitioners Association, LGA Branch
i) Development Partners
j) Community based Organizations
k) Faith based organizations
l) Any other LGA officer that LEMCHIC may be deemed necessary

10.3.2. Tenure

Members of the LGA Sub-committee on PHC-MPCDSR shall hold office according to existence of the LEMCHIC structure; at the exit of LEMCHIC, membership shall then be revised in alignment with the exit strategy.

10.3.3. Functions

The responsibilities of this Sub-Committee shall include:

a) Be responsible for the implementation of the PHC-MPCDSR activities at LGA level
b) Ensure that all maternal, perinatal and child deaths in the PHC facilities and communities are notified and reviewed by the relevant PHC-MPCDSR committees.
c) Interpret PHC-MPCDSR data and take actions that will avert deaths from similar occurrences
d) Make recommendations to higher authorities for action towards the reduction of avoidable maternal, perinatal and child deaths.
e) Provide regular capacity building for PHC-MPCDSR officers
f) Periodically assess the accuracy, content and quality of surveillance reports, and make recommendations for use by health managers and policy makers at the LGA level to improve the quality of maternal, perinatal and childcare.

g) Engage closely, all community structures and stakeholders for support to PHC- MPCDSR implementation at the LGA level.
h) Advocate for resources and other support required for implementation of PHC-MPCDSR

i) Support the scale-up of other PHC-MPCDSR activities in the LGA

10.3.4. Meetings

The LGA -MPCDSR subcommittee is responsible for implementing PHC- MPCDSR at the LGA level and shall provide reports to the state subcommittee on a monthly basis. The committee is also expected to conduct a mortality audit for all reported cases in the LGA. The Director PHC must endorse all reports of this committee before it is transmitted.

10.4. PHC FACILITY MPCDSR Sub-COMMITTEE

10.4.1. Membership

There shall be one (1) PHC facility MPCDSR committee in every ward, domiciled in the ward focal PHC facility which will be responsible for implementing PHC MPCDSR related activities in the ward.

Membership of Primary Health Care Public MPCDSR Facilities shall include:

a) Chairman: The person in charge (OIC) of the of the ward focal PHC facility
b) Secretary: Head of the maternity services of the ward focal PHC facility,
c) Desk Officer: Midwife/Nurse of the ward focal PHC facility
d) Representative of the Community Health Extension Workers
e) The ward focal person
f) Medical Record Officer
g) Chairman, Ward Development Committee
h) Community Women Leader
i) Invited community member
j) Heads of all other PHC facilities within the ward or representative

10.4.2. Tenure

Members of the Facility Sub-committee on PHC-MPCDSR shall hold office for his/her service period.

10.4.3. <u>Functions</u>

The PHC MPCDSR Facility Committee shall perform the following functions;

a) Identification of all Maternal, Perinatal and Child deaths in the facility and promptly dispatch notifications to the Disease Surveillance and Notification Officer (DSNO) at the Local Government Health Department and State Ministry of Health.
b) Ensure facility based MPCDSR forms are completed accurately and timely
c) Retrieve case notes as soon as possible and keep them safely.
d) Hold regular monthly MPCDSR meetings during which case(s) will be discussed/ reviewed, and compile a report and recommendations.
e) Prepare completed MPCDSR forms and Committee Session report which are sent to the LEMCHIC within 72 hours of each meeting.
f) Follow up on all committee recommendations to ensure their implementation and triangulate findings from report of Quality of Care assessment with Quality related findings from mortality audit and develop harmonized Quality Improvement Plans.

10.4.4. <u>Meetings</u>

The Focal PHC facility MPCDSR subcommittee shall provide reports to the LGA PHC MPCDSR sub-committee on a monthly basis. The committee is also expected to conduct a mortality audit for all reported cases in the ward. The PHC facility MPCDSR should meet frequently, at least monthly. The Chairman of the committee (Officer in Charge (OIC) of the ward focal PHC) should endorse all reports of this committee before they are transmitted.

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10.5. COMMUNITY MPCDSR COMMITTEE

10.5.1. <u>Membership</u>

There shall be a Community MPCDSR sub-committee of the Ward Development Committee. This committee shall work closely with the PHCs of the ward and the WDC. The committee shall have the following members:

1. Chairman Ward Development Committee (Chairman)
2. Officer In-charge of the Ward Focal PHC (Secretary)
3. Representative of the WDC in the PHC facility quality improvement team
4. Local Government - Ward Councillor representing the community
5. Ward level NPC Members
6. CHIPS agent and/ or other volunteers
7. Community Head/Leaders for each Community within the ward
8. Representative of religious bodies
9. Community Health Practitioners (Community Health Officers/Community Health Extension Workers)
10. A community TBA representative/Traditional healers.
11. Representatives of Community based Organizations (CBOs)
12. Any other community member that may be necessary.

10.5.2. Tenure

The Community MPCDSR committee members shall hold office for his/her for his/her service period.

10.5.3. Functions

The sub-committee on Community MPDCSR shall perform the following functions:

Identification of the maternal and perinatal deaths

Follow-up, discussing and analyze problems to find solutions to maternal and perinatal deaths problems through;

Identify both probable medical, social and other contributory causes leading to maternal and perinatal deaths through Verbal, Social autopsy and Community Dialogue

Ensure Final cause of death determination is done by the LGA Medical Officer of Health

Assess community and family members‟ perception about the quality and access to health care

Identify community level barriers (delays in seeking care) that contributed to the maternal / and or perinatal death

Engage in community-based awareness creation and health education towards enlightening the community dwellers on its activities and matters connected with maternal and perinatal mortality as well as improving their health care seeking behaviour.

Prepare Committee Session reports which are sent to the PHC facility MPCDSR committee

Collaborate with the Facility Level Committees and Local Government Health authorities in the monitoring of Maternal and Perinatal deaths

10.5.4. <u>Meetings</u>

The Community MPCDSR subcommittee shall provide reports to the PHC facility MPCDSR committee on a Monthly basis, after collating and reviewing their data. The committee is also expected to follow up on mortality audit for all reported cases in the community. The Chairman of the Community MPCDSR subcommittee must endorse all reports of this committee before it is transmitted.

11. PROMOTION OF MPCDSR REPORTING IN NIGERIA

Reporting of maternal, perinatal and child death provides an opportunity for the legal documentation on *Civil Registration and Vital Statistics* (CRVS). It is an important input for construction of Life Tables, which are crucial for national inter-sectoral planning. CRVS reporting has been poor at all levels of the health system in Nigeria and MPCDSR is intended to improve it in the following manner:

Community mobilization through facilitated participatory learning and action cycles.

Legal framework to ensure timely reporting of deaths.

Sensitization of all relevant line MDAs on MPCDSR reporting.

Institutionalize MPCDSR reporting into preservice institutions curriculum.

High level advocacy and capacity building of Traditional and Religious leaders to influence MPCDSR reporting.

Capacity building and supportive supervision of healthcare workers at all levels on effective reporting of MPCDSR.

Relevant stakeholders should ensure that MPCDSR data as contained in HMIS tools be filled by health care workers and captured in the national dashboard

Deploy media strategy including social, and new media and ensure effective engagement with media institutions and platforms to raise awareness about MPCDSR.

Provide educational materials and visual aids with MPCDSR information and messages.

Adoption of relevant Social Behavioural Change Strategies.

12. DEATH CERTIFICATION AND ICD-11 CODING

Death is one of the vital events recorded in a Civil Registration and Vital Statistics (CRVS) system and its documentation is the basis for the legal approval for the burial or other disposal of deceased individuals. Hence, *Medical Certification of Cause of Death* and *Death Registration* (which derive from the former) are critical sources of national mortality statistics used to determine the prevailing lethal medical conditions in any country. Other benefits of death certification and registration includes: sourcing of data for epidemiologic investigations, and to substantiate an assertion of death.

There are three standard tools involved in certification of cause of death which are: International form for Medical Certificate of Cause of Death (completed by physician or coroner who confirmed the death), *Recertification Certificate of Cause of Death* (also referred to as "*Death Certificate*", issued by NPC) and *Permit for Burial*.

12.1. GUIDE FOR CERTIFICATION OF "CAUSE OF DEATH"

The registration of deaths in the Country is a statutory responsibility of National Population Commission (NPC) enacted by laws and regulations, who issues the "Death Certificate".

The accuracy of the country‟s *Death Register* and *Death Certificates* is dependent on the quality of the information on the *Medical Certificate of Cause of Death* issued from the physicians and coroners. To ensure generation of quality mortality statistics, the following conditions should be adhered to:

- Identification of three categories of "Cause of Death" in each death of a child or adult in a facility: Underlying (or Primary) Cause of Death; Immediate (or Final) Cause of Death; and Antecedent Cause(s) of Death, and their entry into a *Medical Certificate of Cause of Death*.
- Identification of Main and Minor Causes of Perinatal Causes of Death and Major and Minor Maternal Causes of Perinatal Death in each perinatal death in the facility, and their entry into a *Medical Certificate of Cause of Death*
- Use a standard form that conforms in content to the *New International Medical Certificate of Cause of Death* (Figure 13.1).
- Its completion should be legible in black ink, without abbreviations or alterations.

INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH

	CAUSE OF DEATH	Approximate interval between onset and death
I		
Disease or condition directly leading to death *	(*a*) . . . . due to (or as a consequence of)	. . . .
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(*b*) . . . . due to (or as a consequence of)	. . . .
	(*c*)	. . . .
II		
Other significant conditions contributing to the death, but not related to the disease or condition causing it	. . . .	. . . .
	. . . .	. . . .
* This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		

THE WOMAN WAS:

□ Pregnant at the time of death

□ Not pregnant at the time of death (but pregnant within 42 days)

□ Pregnant within the past year

Figure 12.1: Showing the New International Medical Certificate of Cause of Death

The death certifier should be a physician or coroner who must be:

Familiar with national regulations and standards on medical certification of death.
Utilize the standard forms in reporting cause of death.
Employ ICD-11 standard to ascribe cause of death to individual case.
Complete relevant portions of the medical certificate of cause of death.
Duly sign the original certificate, which is in triplicates (copies given to next-of-kin, facility records and remitted to NPC for death registration and certification).

12.2. ICD-11 CERTIFICATION OF MATERNAL, NEWBORN AND CHILD DEATHS

The *International Statistical Classification of Diseases and Related Health Problems*, or ICD, is the WHO"s foundation for identifying health trends and statistics worldwide, and contains codes for injuries, diseases and causes of death. It provides a common language that allows health professionals to share health information across the globe. ICD-11 is its eleventh version, (which has 55 000 unique codes for injuries, diseases, and causes of death are included, compared with 14 400 for ICD-10), was launched in June 2018. This was adopted by the 72nd World Health Assembly in 2019 and came into effect on January 1, 2022. This version is available as a downloadable software, for offline use at: https://appsonwindows.com/apk/7322551/ (download LD Player to access it: https://www.memuplay.com/download-memu-on-pc.html. The version for online use is at: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/848321559.

Every maternal, perinatal and child death must be assigned with ICD-11 code, based on their *Underlying Cause of Death*. Although the Final (Immediate) Cause of Death and Antecedent (Contributory) Cause(s) of Death can also be assigned ICD-11 codes, they are of less significance. The use of the software is simple (Figure 13.2): it merely requires the typing of the "Cause of Death" into the "Search" space and it will generate the range of codes, from which the one that best fits the case at hand is selected.

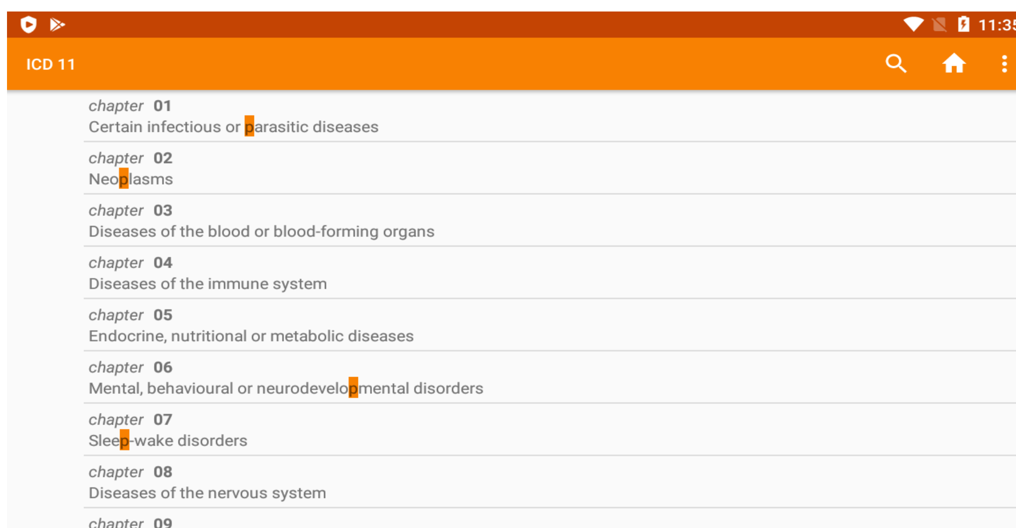


Figure 12.2: Showing the Homepage of the ICD-11 software when installed.

In addition to its HMIS value, ICD-11 coding is valuable to national health programme managers; data collection specialists; local and international researchers for comparing and tracking progress in health and determining the allocation of health resources, reimbursement, guidelines etc, as illustrated in Figure 13.3. Consequently, every maternal, perinatal and child death should be assigned appropriate ICD-11 code.

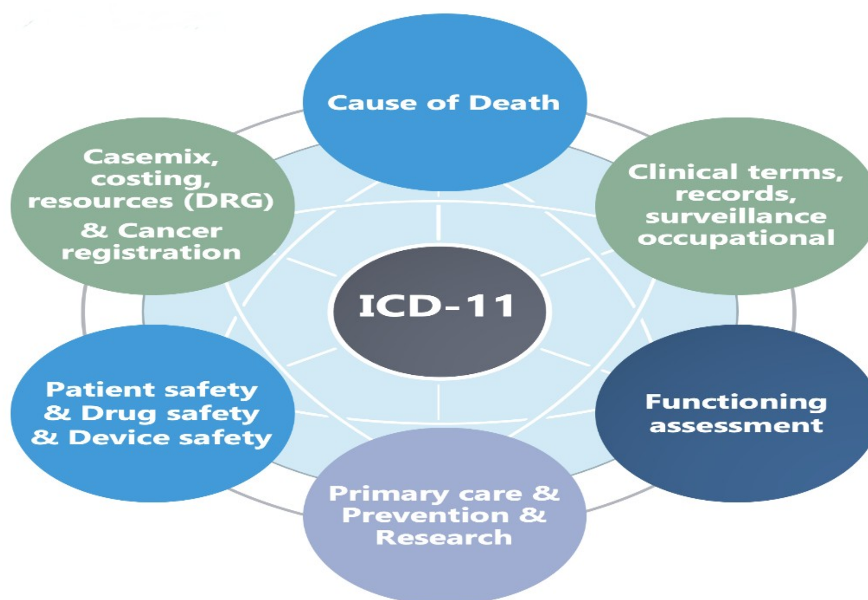


Figure 12.3: Showing the Uses of ICD-11 Coding

13. SURVEILLANCE IN MPCDSR

13.1. WHAT IS SURVEILLANCE?

The surveillance component of MPCDSR is the act of carefully tracking every maternal, perinatal and child death with the purpose of identifying modifiable factors that can be addressed for the prevention of reoccurrence through appropriate action or response.

Public health surveillance component of MPCDSR involves continuous interpretation of data essential for the planning, implementation and evaluation of public health practice. Surveillance in principle can be either passive or active. For MPCDSR purpose, active surveillance format is mostly employed.

Active surveillance involves targeted searching for cases, and provides more timely and less variable data. The immediate added value of active surveillance of maternal/perinatal/child deaths would include timely notification of events, assessment and confirmation of cases, increased awareness and advocacy, and most importantly accountability for health services, policy makers, managers and civil society for monitoring progress.

The term surveillance is not new and has been used with reference to maternal health to address maternal death reviews, audits, confidential enquiries, or at demographic surveillance sites. However, converting surveillance systems and responses originally developed for communicable and non-communicable diseases for the purpose of eliminating maternal/perinatal/child mortality has only recently been adopted as a framework with guidelines for implementation being developed.

The MPCDSR if adequately and effectively implemented has potential to strengthen the health system at all levels. Significant reduction of maternal, perinatal and child mortality will require counting every case and collection of information by Integrated Disease Surveillance and Response (IDSR) to permit an effective response that prevents future deaths. Every maternal, perinatal and child death or case of life-threatening complication can provide indications on practical ways of addressing its causes and determinants.

13.2. SURVEILLANCE SYSTEM IN NIGERIA

Disease Surveillance and Notification (DSN) in Nigeria was introduced in 1988 after the Yellow Fever outbreak of 1986/87. The outbreak affected 10 out of the then 19 states in the country with over 16,000 cases and 3,000 deaths. Forty-two (42) communicable notifiable diseases were addressed by the system. [12] However, some weaknesses/gaps were identified in the DSN which includes non-existent laboratory network, presence of vertical surveillance systems for various control programmes, and irregular data analysis and interpretation.

In view of these gaps, WHO Africa Region in September 1998 during the Regional Committee meeting in Harare introduced Integrated Disease Surveillance and Response (IDSR) that was endorsed by the Health Ministers of member states including Nigeria. The aim was to strengthen the surveillance system using an integrated approach. This was reviewed in 2013 to include maternal and perinatal deaths.

[12] Nigerian Medical Journal: Niger Med J. 2015 may-june;56(3): 161-168

Maternal, Perinatal and Child Deaths Surveillance and Response will leverage on IDSR Strategies for implementation at all levels. This made maternal, perinatal and child deaths notifiable events. The flow of information follows the existing flow of data already in existence in IDSR. All notification of deaths will be to the Local Government Area (LGA) Disease Surveillance and Notification Officers (DSNOs).

14. IDSR SURVEILLANCE GOAL FOR MATERNAL, PERINATAL & CHILD DEATH

The objectives of this surveillance are to:

- Estimate and monitor the magnitude and other characteristics of maternal, perinatal, child mortalities
- Identify risk factors and high-risk areas for maternal / perinatal/ child mortality, to inform programme decision
- Evaluate programmes aimed at reducing maternal / perinatal/ child mortality
- Detect cases using the Standard Case Definition
- Use of standard method for reporting priority diseases
- Cover all public and private health facilities (Primary, Secondary and Tertiary) and communities.

14.1. OPPORTUNITIES DERIVED FROM IDSR

Some of the opportunities derivable from incorporating MPCDSR into IDSR include the following:

- The provision of necessary framework and guidance for the strengthening of skills and rational use of human and material resources.
- Strengthening of Early Warning Alert system, e.g., Fatality Rate.
- Ensuring compliance by all tiers of government and communities with all the policies supporting the establishment and implementation of a sound and effective IDSR.
- Incorporation into the National Health Management Information System (NHMIS) in order to adequately address the issue of integrated disease surveillance.
- Ensuring the establishment of functional public health laboratory networks in the country.
- Effective communication between the Federal, States and LGAs.

14.2. IDSR/ MPCDSR DATA FLOW IN NIGERIA

The IDSR and MPCDSR data flow is as shown in Figures 15.1 and 15.2.

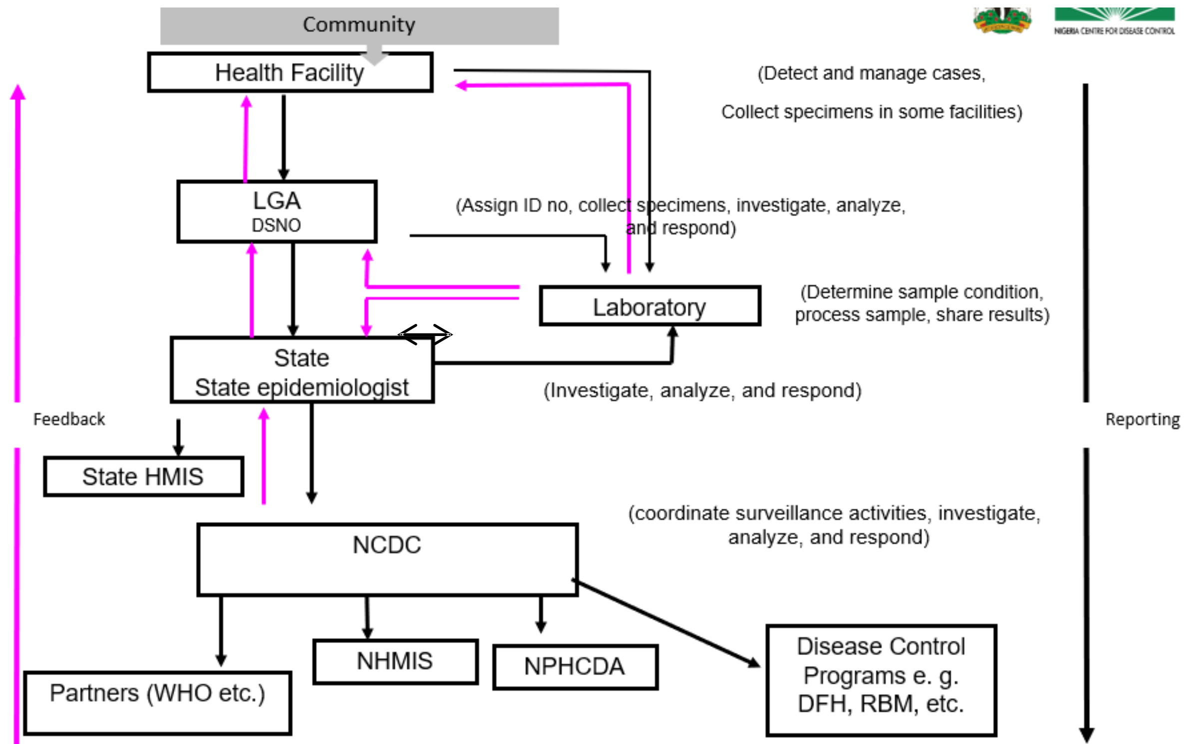


Figure 14.1: Showing IDSR Data flow in Nigeria

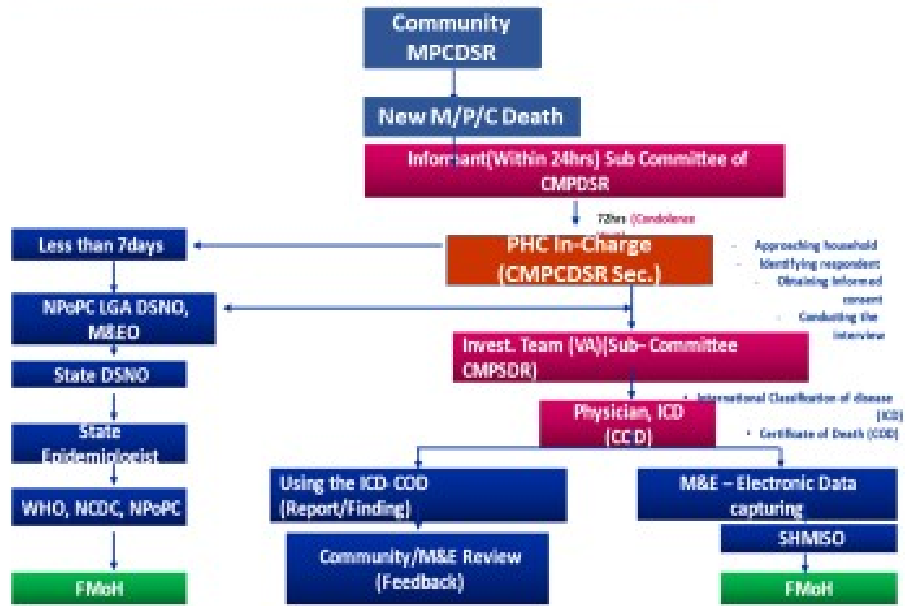


Figure 14.2. MPCDSR Information Flow in Nigeria

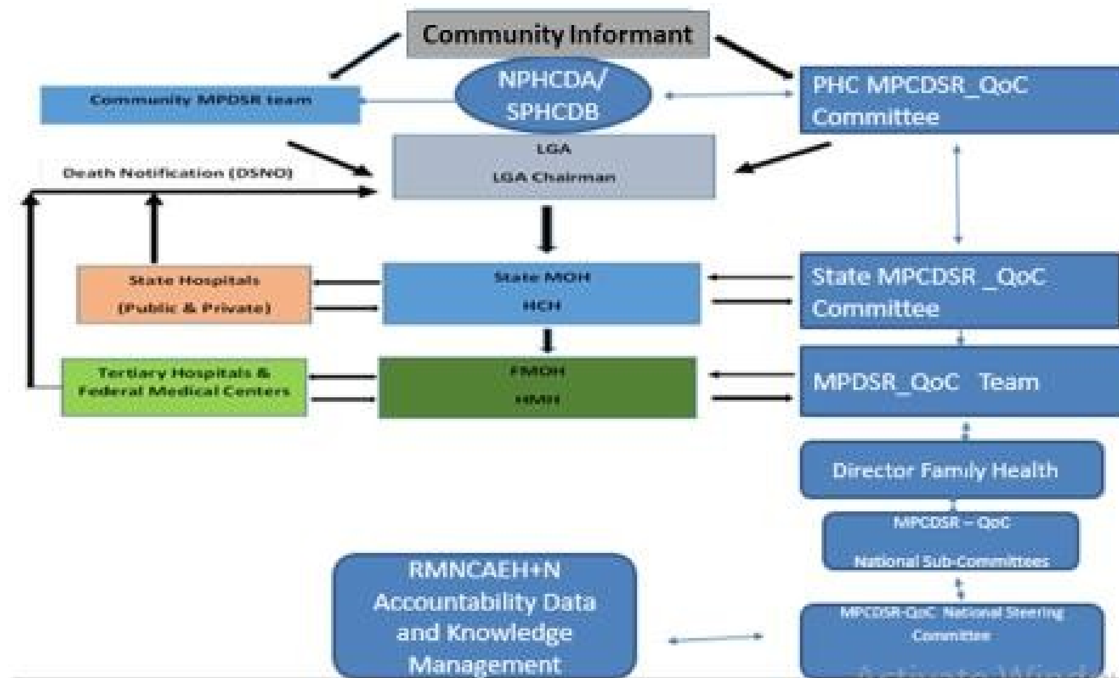


Figure 14.3: Showing the MPCDSR Coordination Mechanism

15. RESPONDING TO THE MODIFIABLE FACTORS IN MPCDSR

This is the response by action to recommendations that are made during the review meetings on Maternal, Perinatal and Child Deaths. This is a pre-requisite to achieving Quality of Care in the facility and thereby reducing the Level 3 Delay. It is required that an MPCDSR Response Coordinator be appointed at each level of care to facilitate the process of responding to the modifiable factors. In Tertiary facilities, where QoC Focal persons already exist, they will serve as the MPCDSR Response Coordinator, while other facilities appoint theirs. Their responsibility is to ensure that the recommendations are acted on by the authorities to which the Committee intends them, and give feedback at subsequent meetings until the modifiable factors in reference are mitigated.

The response component of implementing MPCDSR at all levels are the actions, efforts or changes put in place to improve Quality of Care and prevent future maternal, perinatal and child deaths in a health facility. Quality of healthcare is a measure of adequacy and attainment of minimum standards in the services rendered , especially their suitability for

preserving, restoring and sustaining health of the target populations. Quality of care in facilities is measured in six domains: **Safety -** avoiding injuries to patients from care that is intended to help them; **Effectiveness** – avoiding overuse and misuse of care; **Patient-Centeredness** – providing care that is unique to a patient's needs. **Timeliness –** reducing wait times and harmful delays for patients and providers; **Efficiency** – avoiding waste of equipment, supplies, ideas and energy; and **Equity –** providing care that does not vary across intrinsic personal characteristics. Consequently, the death review process in any health facility continually assesses each of these domains, as were served on the deceased, in order to identify gaps in services that should be remedied. It is therefore necessary for recommendations from Facility MPCDSR to be intimately and promptly linked with all the other existing quality-of-care improvement processes and programs in each facility such as the Medical Advisory Committee (MAC), Directorate of Clinical Services, Infection Control Committee, etc.

The Quality-of-Care Team of each health facility (whose responsibilities cover all the preventive and curative arms of the facility) should therefore be intimately integrated or harmonized with the MPCDSR response (which derive from services to mothers, perinates and children).

16. MONITORING AND EVALUATION, AND RESEARCH

Monitoring and Evaluation (M&E) of the MPCDSR itself is necessary to ensure that the MPCDSR system is well-established, functioning appropriately and improves with time until services of the highest standards are sustained. Monitoring of the MPCDSR system should be carried out at all levels of the healthcare delivery: The community, Health facility (Primary, Secondary and Tertiary), LGA, State and National levels.

The data generated from the MPCDSR processes should be directly linked at all levels, to the existing HMIS. The HMIS is an established nationwide Health Information Management System that collects, collates and analyzes MNCH and other health care service delivery data at all levels ~~of care~~ in all the 36 States ~~and~~ plus FCT. Opportunities abound in this system for sustainability through integration of the MPCDSR tools into the LGA or State Health Management Information System software (SHMIS). The NHMIS software has space for maternal, perinatal

and child death information which should be expanded and used to accommodate those from the MPCDSR tools.

During the evolution of the MPCDSR, the FMOH acquired a web-based platform called the National Obstetrics Quality Assurance (NOQA) Network (www.noqa-network.ng) which has now been changed to National MPCDSR electronic platform in line with the MPCDSR bill. This platform is user friendly and has established capacity for electronic collection on the National MPCDSR data in health facilities across the country. An integration of this network with the DHIS 2 platform has commenced.

16.1. RESPONSIBLE PERSONS FOR DATA GENERATION AND TRANSMISSION FROM MPCDSR SITES

The generation of MPCDSR data and their electronic transmission from the respective sites ~~up~~ to the NHMIS/DHIS 2 (and NOQA platform (until ongoing merger is completed) should be the responsibilities of the following officers:

At the Community and LGA levels, (LGA M & E Officer and Director PHC)

At the facility level, the Medical /Health Record Officer (MRO/HRO)/Officer in-Charge PHC

At the State level, State HMIS/MPCDSR Desk Officers

At the National level, National MPCDSR Desk officer FHD

The criteria for selecting the above-mentioned officers are:

1. Letter of expression of interest to the HMH
2. Institutionalization of MPCDSR at State and Facility level including data management
   a. Data entry - This is mandatory by the medical record officer at the facility level and M&E officer at the local government for PHC and Community MPCDSR
   b. Completeness – All data entry must be completed in quality and quantity at least 80% monthly reporting rate
   c. Timeliness – All data entry must be completed on or before the 7th of the preceding month
   d. Analysis – All data entry must be analysed monthly at the Facility, every two months by the State and quarterly at the National

e. Data sharing/reporting - All data must be shared monthly at the Facility, Bi-monthly at the State and quarterly at the National

f. Data use – Actionable data use should be a continuous exercise for informed decision making

3. Each State and the FCT is expected to process and pass their MPCDSR Bill for the enactment of extant laws~~,~~ if this has not already been done.

When tracked, the indicators should reveal:

i. whether one or more of the steps in the MPCDSR process is or not reaching expected targets; and

ii. whether the pattern of prevailing maternal, perinatal and child mortalities,~~-~~are improving or not.

16.2. INDICATORS AND TARGETS

The important indicators and targets in MPCDSR are shown in Table 1.

Table 16.1: Monitoring Indicators and Targets in MPCDSR

S/N	Indicators	Target
1	% of Maternal/ Perinatal / Child death that is a notifiable event.	100%
2	% of the National Maternal, Perinatal and Child death review committee meetings held annually.	100%
3	% of States Maternal / Perinatal/ Child mortality reports that are published annually.	100%
4	% of National/States/Facilities/Communities with Maternal, Perinatal & Child death review committee~~s~~	100%
5	% of Maternal, Perinatal and Child deaths notified within 24 hours at facility level monthly.	>90%
6	% of Community Maternal, Perinatal and Child deaths are notified within 48 hours.	>80%
7	% of Community Maternal, Perinatal and Child deaths with „zero report‟ monthly	100%
8	% of Health facilit~~y~~ies with evidence of review committee meeting consistently in preceding 3 months	100%
9	% of Health facilit~~y~~ies reviews that include recommendation	100%
10	% of Health facility committee recommendations that are implemented	80%
11	% of Verbal autopsies conducted for suspected maternal deaths	80%
12	% of notified Maternal deaths that are reviewed by CBMPCDSR	90%
13	% of community reviews that include recommendations	100%
14	% of community reviews recommendations that are implemented	80%
15	% of reviews that included community participation and feedback	100%
16	% of Committees with MNC quality-of-care recommendations	100%
17	% of committee recommendations that are implemented Immediate: <3 months Short term: 3 months to 6 months	100%

	Long term: After 6 months	
18	% of data entry reporting rate (Completeness)	100%

In addition to instituting ongoing monitoring of indicators that provide a quick snapshot review of whether the MPCDSR system is improving or not, a more detailed periodic evaluation is valuable and necessary.:-Since the main purpose of MPCDSR is to lead to actions that reduce maternal, perinatal and child deaths, such periodic evaluation should include the quality of information collated, and the acceptability, timeliness, and data quality of the MPCDSR scheme.

16.3. RESEARCH IN MPCDSR

The Federal Ministry of Health is the custodian of every data generated on MPCDSR, including the e-platform. Therefore, data generated from MPCDSR activities are intended for analysis, publication, for research to generate evidences for decision making in planning and budgeting, and for conference presentations at local and international forums.

16.4. THE PROCESS OF ACCESSING MPCDSR DATA FOR RESEARCH PURPOSE

The following are the requirements for accessing and using MPCDSR data for conducting any research.

- Approval from National Health Research Ethics Committee (NHREC).
- Application to the Honourable Minister of Health for access to the MPCDSR Data, accompanied with the NHREC approval.
- Upon completion of the research, a copy of the research findings should be submitted to the office of the Honourable Minister of Health prior to publication.
- Acknowledgement of the Nigerian MPCDSR team must be included in the publication.

17. LEGISLATION ON MPCDSR

For the MPCDSR to become institutionalized in Nigeria, it is pertinent that appropriate enabling laws be enacted by the National and State Legislative Assemblies. Following the passage of the

MPCDSR Bill by the National Assembly, it is envisaged that it will be accented to by the ~~Mr~~ President. The highlights of the Federal legislation are as follows:

i. MPCDSR processes and information cannot be used for litigation processes. In the event of recourse to litigation by relatives of a deceased mother, child or newborn, information required must be sourced from outside the MPCDSR process, even when a death inquiry is undertaken.
ii. Maternal, Perinatal and Child deaths are notifiable medical conditions that should be promptly reported to the Disease Surveillance Information Officer.
iii. On account of the confidentiality of ~~the~~ MPCDSR processes, Health workers and Committee members should preserve the identity of deceased, relatives and facilities.
iv. Enforcement of “No name, No Blame” is exclusive to the MPCDSR process, in order to ensure full participation and disclosure by all health workers. In the event that a punitive measure is deemed necessary, another committee other than that of the MPCDSR should be set up to investigate the matter.
v. All states are encouraged to adapt/adopt the above laws in accordanc~~e~~ to with their local contexts. This should include promotion of Maternal, Perinatal and Child death reporting as embedded in the IDSR list.

18. INTEGRATION, SUSTAINABILITY AND CAPACITY BUILDING

18.1. INTEGRATION AND SUSTAINABILITY

To achieve effective integration, quality of care gaps must be identified during death audit and included in quality improvement plan at all levels of implementation for appropriate action (Response).

The ultimate means of capturing information on all deaths, including: Maternal, Perinatal and Child deaths, should be the main focus of the Civil Registration and Vital Statistics (CRVS) as it exists in the developed countries and is in its early stage here. The MPCDSR activities should strengthen the CRVS system in the country, through the well-established engagement with the National Population Commission (NPC). In this regard, copies of the MPCDSR reports should be sent to the NPC to facilitate the transition, especially when uploading through DHIS 2/NOQA platforms.

The existing operational structure of NPC is one Vital/Civil registration officer per ward, resident in the ward, provides the necessary framework, capacity and guidance to complement community surveillance of Maternal, Perinatal and Child deaths for compliance with all the relevant policies. It should now support the establishment and implementation of an effective MPCDSR that seamlessly link the National Health Management Information System (NHMIS) to the CRVS in a single continuum between the Federal, States, LGAs, Wards and Communities.

The MPCDSR and MNCH QoC committees will be integrated and harmonised across all levels of governance and healthcare (National, States, LGAs, Facilities and communities). At the National level, the steering committee shall be headed by the HMH while the Commissioner of Health shall head the committee at the State level. There will be 3 RMNCAEH+N subcommittees namely: Technical/Quality, Advocacy and M&E across all levels, which will be headed by the Committee Chairman. A Secretary will be appointed to assist the Chairman in each sub-committee. The secretariat shall be domiciled in the office of the Director, Family Health Department at both National and State levels.

At Primary Health Care Level, the Executive Director will oversee MPCDSR and MNCH QoC activities within as Chair National PHC Sub Committee with Chairman National Population Commission Shall Co-Chair. The PM NEMCHIC shall be the secretary. The MPDCSR will domiciled in the M&E working group while the MNCH QoC will domicile in the Service

Delivery Working Group the State PHC Sub -committee will be headed by Executive Secretary while the National Population State Coordinator will be the Co-Chair. He will oversee the MPCDSR and QoC team activities through the Focal Persons. The State PM SEMCHIC shall serve as the secretary. There will be 3 subcommittees namely: SEMCHIC Advocacy and Communication Working Group, SEMCHIC M&E Working group and SEMCHIC Service Delivery Working Group.

National MPCDSR e-platform is the data capturing tool for MPCDSR in Nigeria. The hub is domiciled in the Galaxy backbone that works with the Department of Information Communication and Technology (ICT) in conjunction with the Department of Family Health Federal Ministry of Health. ICT Department shall be responsible for the system administration while the Department of Family Health will be responsible for the technical deliverables arising from the functionality of the platform. The platform will be inter-operable with DHIS2.

The funding of MPCDSR e-platform will be supported with the budgetary allocation, at all level of health care in line with MPDSR bill.

MPCDSR implementation is integrated into IDSR platform which provide enabling environment for the inclusion of Maternal, Perinatal, Child death on the IDSR list. The Disease Surveillance and Notification Officers are members of MPCDSR at all levels and because of the inclusion of maternal Perinatal and Child Death on the IDSR list, gives opportunity for active surveillance of the deaths and certification.

19. CAPACITY BUILDING

The pre-service and in-service training curricula of the following cadres of health workers should be reviewed to reflect and build their capacities to participate in or conduct comprehensive MPCDSR/QoC activities: Doctors, Nurse/Midwives, Medical Laboratory Scientists/Technicians, Pharmacists and Community Health practitioners (JCHEWs/CHEWs/CHOs). The respective regulatory institutions should liaise with the FMOH to achieve this curricula integration of the MPCDSR.

In the case of in-service training for health care workers, this will consist of a 6-day integrated MPCDSR/QoC training. The first 3 days will focus on Maternal, Perinatal and Child death review process while the next 3 days will focus on the response of Quality of Care (MNCH QoC) component of the training.

20. MPCDSR TOOLS

MPCDSR FORM 1

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

MATERNAL DEATH NOTIFICATION FORM

Note

- This form should be completed (in triplicate) for all maternal deaths (immediately after certification of death) by the facility MPCDSR Officer and/or Person who managed the case.
- It should be submitted to the head of the Health Facility for onward transmission to the Disease Surveillance Notification Officer (DSNO) in the LGA/State within 24hours.
- It should be simultaneously completed on the e-platform (uploaded) by the Facility MRO or LGA M & E Officer

Patient Identification Code.: (**MD/State/Town/ Hospital /Month/Year/Serial No**.): …………………………………………………………………………………………………

1. Patient Case Note No. (if hospitalized):…………………………………………………………………………………..

2. Name of Facility where death occurred:……………………………………………………

3. Local Government Area (LGA):……………………………………………………………………………………

4. State:………………………………………………………………………………………

5. Type of Facility where death occurred (Tick √ one box)

a. [ ] Tertiary Health Institution b. [ ] Secondary health facility

c. [ ] Primary Health Care Centre d. [ ] Faith based Institution

e. [ ] Private health facility f. [ ] On the way/ before arrival to health facility

g. [ ] Other (specify) ………………………………………………………………………

6. Date of Death being reported (dd/mm/yy):……………………………………………………

7. Date of Admission to Facility (if on admission) (dd/mm/yy):…………………………………

8. Age (years):…………………..……………………………………………………………

9. Gravidity (Total numbers of pregnancies) ……………………………………………………

10. Parity (Total numbers of previous deliveries) ………………………………………………

11. Underlying cause of death (Tick √ one box)

a. [ ] Hemorrhage b. [ ] Pre-eclampsia / eclampsia

c. [ ] Puerperal sepsis d. [ ] Prolonged/obstructed labour

e. [ ] Ruptures Uterus f. [ ] Complications of abortions

g. [ ] Ectopic pregnancy h. [ ] Other (specify) …………………………

12. At the time of death, was the baby delivered? (Tick √ one box)

a. [ ] Yes b. [ ] No c. [ ] Not applicable

13. Condition of the baby at time of maternal death (Tick √ one box)

a. [ ] Alive b. [ ] Dead c. [ ] Not applicable

Name of Person reporting: ………………………………………………………………………
Designation: ……………………………………………………………………………………
Telephone number………………………………………………………………………………
Email……………………………………………………………………………………………
Address: …………………………………………………………………………………………
Signature: ……………………………………………… Date: …………………………………

MPCDSR FORM 2

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

HEALTH - FACILITY BASED MATERNAL DEATH REVIEW FORM

Note:

- This form should be completed for all Maternal deaths. The MPCDSR Officer should complete necessary portion of this form and present to the MPCDSR Secretary I (Head of Obs & Gynae/Officer in-Charge) for the MPCDSR Review meeting within 1 month and follow up on the implementation of the action plan. Its information should be uploaded by the MRO to the NHMIS/NOQA platform.
- The original form should be retained at health facility and copies submitted to the LGA M&E officer and the MPCDSR Desk Officer at the State Ministry of Health (SMOH) and FMOH
- The Case Identification Code should be the same as on the notification form, MPCDSR Form 1

Patient Identification Code.: (**MD/State/Town/ Hospital /Month/Year/Serial No**.): ………………………………………………………………………………………………………

SECTION 1: HEALTH INSTITUTION/FACILITY WHERE DEATH OCCURRED.

1.1 Name and location of Facility where death occurred: …..…………………………………………

1.2 Local Government Area:………………………………………………………………………

1.3. State……………………………………………………………………………………………

1.4. Where the death occurred (Tick √ one box)

a. [ ] Tertiary Health Institution b. [ ] Secondary health facility
c. [ ] Primary Health Care Centre d. [ ] Faith based Institution
e. [ ] Private health facility f. [ ] On the way/ before arrival to health facility
g. [ ] Other (specify) ………………………………………………………………………………

SECTION 2. SOCIO-DEMOGRAPHIC DETAILS OF DECEASED.

2.1. Hospital No. /Case Note No.(if hospitalized): ……………………………………………………

2.2. Age (years):……………………………………………………………………………………….

2.3. Residence: (Tick √ one box) a. [ ] Rural b. [ ] Urban

2.4. Marital Status: (Tick √ one box)

a. [ ] Married b. [ ] Not married c. [ ] Divorced
d. [ ] Separated e. [ ] Widowed

2.5. Educational level (Completed): (Tick √ one box) a. [ ] None b. [ ] Primary c. [ ] Secondary
d. [ ] Higher e. [ ] Not Known

2.6. Occupation:……………………………………………………………………………………

2.7. Occupation of spouse/partner :……………………………………………………………………

2.8. Religion: (Tick √ one box)

a. [ ] Christianity b. [ ] Islam c. [ ] Traditional African Religion
d. [ ] Other (specify) ……………………………………………………………………………….

2.9. Ethnic Group: (Tick √ one box)

a. [ ] Hausa / Fulani b. [ ] Yoruba c. [ ] Igbo
d. [ ] Other (specify) ………………………………………………………………………………

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

3.1. 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) ……………………………………………………………………………

3.2. Past Surgical Operations: (Tick √ one or more boxes)
a. [ ] Cesarean Section b. [ ] Myomectomy c. [ ] Manual Vacuum Aspiration (MVA) d. [ ] D and Ce. [ ]Laparatomy f. [ ] cervical tear repairs
g. [ ] Others (specify) …………………………………………………………………….
3.3. No. of previous live births ……………………………………………………………
3.4. No. of previous Still births…………………………………………………………
3.5. No. of previous miscarriages/ abortions ………………………………………………..
3.6. No. of previous ectopic pregnancies ………………………………………………

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

4.1. Date of Admission to Facility (if on admission) (dd/mm/yy): …………………………….
4.2. Time of Admission (- -/-- am/pm) : ....
4.3. Admitted from: (Tick √ one box): a. [ ] Another facility b. [ ] Home
c. [ ] Other (specify) ……………………………………………………………………
4.4. If referred from another facility, please indicate name of facility:
…………………………………………………………………………………………
…………………………………………………………………………………………
4.5. a. If referred from another facility, please indicate distance (Km) : ………………………
b. Time of referral (- -/-- am/pm) : ....
4.6. Condition on Admission: (Tick √ one box)
a. [ ] Stable b. [ ] Critically ill c. [ ] Dead on Arrival (DOA)
4.7. 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. [ ] Other (specify) ……………………………………………………………………
4.8. Pregnancy Status at Admission: (Tick √ as appropriate)
a. [ ] Before 28 weeks gestation b. [ ] After 28 weeks gestation c. [ ] Intrapartum
d. [ ] Postpartum

SECTION 5: ANTENATAL CARE (ANC)

5.1. Was index pregnancy planned? (Tick √ one box) a. [ ] Yes b. [ ] No c. [ ] Not known
5.2. Did she receive ANC? a. [ ] Yes b. [ ] No c. [ ] Not known
5.3. Place where Antenatal Care (ANC) was provided: (Tick √ one box)
a. [ ] Tertiary Health Institution b. [ ]Secondary Health Facility
c. [ ] Primary Health Care Centre d. [ ] Faith based health facility
e. [ ] Private Health facility f. [ ] TBA"s place g. [ ] Church h. [ ] No ANC
5.4. Gestational Age at commencing ANC ……………………………………………….
5.5. Total No. of ANC visits: ……………………………………………………………….
5.6. Who was the main ANC provider? (Tick √ one box)
a. [ ] Obstetrician/Gynaecologist Consultant; b. [ ] Obstetrician/Gynaecologist – Resident; c. [ ] Midwife; d. [ ] Medical Officer; e. [ ]Nurse; f. [ ] CHEW;
g. [ ]TBAs; h. [ ] Other (specify) ……………………………………………………
5.7. 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) …………………………..

5.8. Other Comments on ANC period, including complications:
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………….

SECTION 6: INVESTIGATIONS DONE – Please attach the results

6.1. PCV, Hb, - a. [ ] Yes b. [ ] No c. [ ] Not known

6.2. Blood group a. [ ] Yes b. [ ] No c. [ ] Not known

6.3. Genotype, a. [ ] Yes b. [ ] No c. [ ] Not known

6.4. Urinalysis a. [ ] Yes b. [ ] No c. [ ] Not known

6.5. Syphilis screening and confirmation a. [ ] Yes b. [ ] No c. [ ] Not known

6.6. HIV test a. [ ] Yes b. [ ] No c. [ ] Not known

6.7. Electrolyte and Urea a. [ ] Yes b. [ ] No c. [ ] Not known

6.8. Hepatitis B [ ] & C [ ] screening a. [ ] Yes b. [ ] No c. [ ] Not known

6.9. Ultrasound Scan a. [ ] Yes b. [ ] No c. [ ] Not Known

7.0 COVID-19 testing a. [ ] Yes b. [ ] No c. [ ] Not

7.1 Other relevant test: Specify:…………………… a. [ ] Yes b. [ ] No c. [ ] Not

SECTION 7: LABOUR AND DELIVERY

7.1. Pregnancy outcome: (Tick √ one box)

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

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

a. [ ] Tertiary Health Institution b. [ ] Secondary Health facility
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 j. [ ] Not applicable

7.3. How was she delivered? (Tick as applicable)

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

7.4. If laboured, was Parthograph used? (Tick √ one box) a. [ ] Yes b. [ ] No c. [ ] Not know

7.5. If laboured, what was the duration of the 1st stage? ……………………

7.6. If laboured, what was the duration of the 2nd stage? …………………….

7.7. If laboured, what was the duration of the 3rd stage? …………………….

7.8. Main attendant at delivery: (Tick as applicable)
a. [ ] Obstetrician/Gynaecologist – Consultant b. [ ] Obstetrician/Gynaecologist – Resident
c. [ ] Medical Officer d. [ ] Midwife e. [ ] Nurse f. [ ] CHEW g. [ ] TBAs
h. [ ] Self i [ ] Other (specify) ……………………………………………………
7.9. Gestational Age at delivery (In weeks): ……………………………………………………
7.10. Complications in labour and delivery? (Tick √as applicable)
a. [ ] Haemorrhage b. [ ] Infections c. [ ] Pre-eclampsia/Eclampsia
d. [ ] Prolonged labour e. [ ] Obstructed labour f. [ ] Ruptured Uterus. g. [ ] Other (specify) ……………………………………………………………………………
7.11. Other Comments on labour and Delivery:
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

SECTION 8: POSTPARTUM AND POST ABORTAL PERIOD
8.1. Postpartum /Postabortal complications: (Tick √as applicable)
a. [ ] Haemorrhage b. [ ] Infections c. [ ] Pre-eclampsia/Eclampsia
d. [ ] Depression e. [ ] Other (specify) …………………………………………

8.2. Other Comments on Postpartum / post-abortion care including complications:
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

SECTION 9: PERINATAL INFORMATION
9.1. Birth Weight (kg) ………………………………………………
9.2. Apgar Score at 1 minute……………………........................
9.3. Apgar Score at 5 minutes……………………………………….
9.4. Apgar Score at extended minutes ……………………………...
9.5. Fetal outcome (Tick √ one box) a. [ ] Alive. [ ] Fresh Still birth c. [ ] macerated-still birth d. [ ] Early neonatal death

SECTION 10: PROCEDURES/INTERVENTIONS
10.1. Interventions in early pregnancy: (Tick √ one or more boxes)
a. [ ] Evacuation b. [ ] Laparotomy c. [ ] Hysterectomy
d. [ ] Blood transfusion e. [ ] Nil f. [ ] Other (specify)
…………………………………………………………………………………………
10.2. 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. [ ] Other (specify) ……………………………………………………………………
10.3. 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. [ ] Other (specify)
……………………………………………………………………………………………………

10.4. 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. [ ] Anti -shock garment k. [ ] Other (specify) ……………………………………….

10.5. Anesthetics 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. [ ] Other (specify)
……………………………………………………………………………………………………

SECTION 11. TIME AND CAUSES OF DEATH

11.1. Date of death (dd/mm/yy): ………………………………………………………………
11.2. Time of death (- -/-- am/pm) : ……………………………………………………………
11.3. Period: (Tick √ one box)
a. [ ] First trimester b. [ ] Second trimester c. [ ] Third trimester
d. [ ] Labour/delivery e. [ ]Post-partum
11.4. **Primary (underlying) Cause of Death:** …………………………………………………..
(Specify ICD-11 Code: ……………………………………………………………………….)

11.5. **Final (immediate) Cause of Death** ……………………………………………………
(Specify ICD 11 code: ………………………………………………………………………….)
11.6. **Contributory (Antecedent) Causes of Death** …………………………………………
(Specify ICD 11 code: …………………………………………………………………………..)
11.7. Autopsy performed? (Tick √one box) a. [ ] Yes b. [ ] No c. [ ] Not known
If yes, please attach a copy of the report.

SECTION 12. CASE SUMMARY

12.1. Please supply a summary of the events surrounding the death. (Attach summary)
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
…………………………………………………………………………………….

SECTION 13. IN YOUR OPINION, WERE ANY OF THESE FACTORS PRESENT?
(Tick √one box)

13.1. Delay in woman seeking help? a. [ ] Yes b. [ ] No
13.2. Refusal of treatment or Admission? a. [ ] Yes b. [ ] No
13.3. Lack of transport from home to health care facility? a. [ ] Yes b. [ ] No
13.4. Lack of transport between health care facilities? a. [ ] Yes b. [ ] No
13.5. Health services communication breakdown? a. [ ] Yes b. [ ] No

13.6. Lack of facilities, commodities, equipment or Consumables in facility?
a. [ ] Yes b. [ ] No

13.7. Lack of human resources in facility? a. [ ] Yes b. [ ] No

13.8. Lack of expertise, training or education in facility staff? a. [ ] Yes b. [ ] No

13.9. Delays in giving care in facility? a. [ ] Yes b. [ ] No

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

THIS FORM IS COMPLETED BY-

NAME: …………………………………………………………………………………………….
ADDRESS…………………………………………………………………………………………
RANK: ……………………………………………………………………………………………
TELEPHONE………………………………………………………………………………………
E-MAIL: ……………………………………………………………………………………………
SIGNATURE…………………………………………….Date…………………………………….

MPCDSR FORM 3

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND R

RECOMMENDATIONS & ACTION PLAN FORM

Note: This form must be completed by MPCDSR (or CBMPCDSR) Committee Secretary following every M
Information includes recommendations and mapped out implementation plan and actions.

Patient Identification Code.: (**MD or PD/State/Town/ Hospital /Month/Year/Serial No**………

1. Facility reporting (include name of Town) ……………………………………………………………
2. LGA………
3. State………
4. Hospital number………………………………………………………………………………………………
5. Date of Death……………………………………………………………………………………………………

Underlying Cause of Death……S/N	**ISSUES IDENTIFIED**	**ACTION REQUIRED**	**LEVEL FOR (Family, F Communi Fe**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

8.			
9.			
10.			
11.			
12.			
13.			
14.			

THIS FORM IS COMPLETED BY-

NAME: ……………………………………………………………………………………………………
ADDRESS……………………………………………………………………………………………………
RANK: ……………………………………………………………………………………………………
TELEPHONE……………………………………………………………………………………………………
E-MAIL: ……………………………………………………………………………………………………
SIGNATURE…………………………………………………………Date……………………………………………

MPCDSR FORM 4

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND R

QUARTERLY RESPONSE TRACKING FORM.

This form should be completed by the MPCDSR Officer/Secretary at Health Facility and Community to t made by the Committee.

Period covered: (dd/mm/yyyy)

S/N	Maternal, perinatal or child death	Date of Death	Facility/ Town	LGA	State	Hospital No	ID No	Cause of Death	Death Notified Y/N
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

11.									
12.									
13.									

THIS FORM IS COMPLETED BY-

NAME: ………
ADDRESS……
RANK: ………
TELEPHONE………………………………………………………………………………………………………
E-MAIL: ……
SIGNATURE…………………………………………………………Date……………………………………

MPCDSR FORM 5

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

ANNUAL MATERNAL, PERINATAL AND CHILD DEATH SUMMARY REPORT

Annual summary reports must be prepared by MPCDSR (or CBMPCDSR) Committee Secretary and submitted to the State / National MPCDSR Desk Officer through the Office of the head of facility/community. The required information includes-

1. Name of Facility / Community reporting ……………………………………………………………
2. LGA…………………………………………………………………………………………….
3. State…………………………………………………………………………………………….
4. Period being reported ……………………………………………………………..,,,,,,,,,,,,,,,,……….
5. Number of live births…………………………………………………………………………...
6. Number of still births…………………………………………………………………………..
7. Number of Maternal deaths ……………………………………………………………………
8. Underlying Causes of Maternal deaths:

S/N	Diagnosis	No. of deaths	No. survived from same condition	Case Fatality rate
I	Haemorrhage			
ii.	Pre-eclampsia/Eclampsia			
iii	Prolonged/Obstructed labour			
iv	Ruptured Uterus			
v	Unsafe abortion			
vi	Sepsis			
vii	Ectopic pregnancy / others			
viii.	Indirect – Medical causes			
	Total			

9. Main Causes of Perinatal deaths

S/N	Diagnosis	No. of deaths	No. survived from same condition	Case Fatality rate
I	Prematurity			
ii.	Low birth weight			
iii	Birth Asphyxia			
iv	Sepsis			
V	Jaundice			
vi	Congenital malformation			
vii	Tetanus			
viii.	Others			
	Total			

10. Main Causes of Child Deaths

S/N	Diagnosis	No. of deaths	No. survived from same condition	Case Fatality rate

I.	Neonatal Disorders			
II.	Diarrheal Diseases			
III.	Lower Respiratory Tract Infections			
IV.	Malaria			
V.	Meningitis			
VI.	Invasive Non-Typhoid Salmonella (iNTS)			
VII.	Whooping			
VIII.	Sexually Transmitted Infections excluding HIV			
IX.	Tuberculosis			
X.	HIV/AIDS			
	Total			

11. Maternal Mortality Ratio ………………………………………………………………………
12. Perinatal Mortality Rate ……………………………………………………………………….
13. Under-5 Child Mortality Rate: …………………………………………………………………

Name of Officer ………………………………Signature/Date………………………………………

MPCDSR FORM 6

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

PERINATAL DEATH NOTIFICATION FORM

Note

- This form should be completed (in triplicate) for all Perinatal deaths (immediately after certification of death) by the facility MPCDSR Officer and/or Person who managed the case.
- It should be submitted to the head of the Health Facility for onward transmission through the MRO to the Disease Surveillance Notification Officer (DSNO) in the LGA/State within 24hours, by upload to the NHMIS/NOQA platform.
- It should also be completed on the e-platform

Patient Identification Code.: (**PD/State/Town/ Hospital /Month/Year/Serial No**.):
…………………………………………………………………………………………………

1. Patient Case Note No. (if hospitalized):……………………………………………………
2. Name of Facility where death occurred: …………………………………………………..
3. Local Government Area (LGA):……………………………………………………………
4. State:…………………………………………………………………………………………
5. Where death occurred (Tick √ one box)
   a. [ ] Tertiary Health Institution b. [ ] Secondary health facility
   c. [ ] Primary Health Care Centre; d. [ ] Faith based Institution
   e. [ ] Private health facility f. [ ] On the way/ before arrival to health facility
   g. [ ] Other (specify): ………………………………………………………………
6. Date of Death being reported (dd/mm/yy):…………………………………………………
7. Date of Admission to Facility (if on admission) (dd/mm/yy): …………………………….
8. Age of Mother (years):……………………..………………………………………………
9. Condition of the baby at time of perinatal death (Tick √ one box)
   a. [ ] Born Alive b. [ ] Stillborn c. [ ] Unborn
10. Date of Birth (dd/mm/yy) ………………………………………………………………
11. Gestation at birth (weeks) ………………………………………………………………
12. Birth weight (grams) ……………………………………………………………………
13. Apgar Score at 1 min and 5 mins ………………………………………………………
14. Main Perinatal Cause of Death……………………………………………………………
    (Specify ICD-11 Code ……………………………………………………………………)
14. Main Maternal cause of death (if any): …………………………………………………
    (Specify ICD-11 Code ……………………………………………………………………)
16. Classification of perinatal death (Tick √ one box)
    a. [ ] Early neonatal death b. [ ] Fresh stillbirth c. [ ] Macerated stillbirth

Name of Person reporting: ……………………………………………………………………
Designation: ……………………………………………………………………………………
Telephone: number……………………………………………………………………………
Email……………………………………………………………………………………………
Address: …………………………………………………………………………………………
Signature: ……………………………………………Date: …………………………………

MPCDSR FORM 7

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

PERINATAL DEATH REVIEW FORM

NOTE

- This form should be completed for all perinatal deaths (including stillbirths and early neonatal deaths)
- The MPCDSR Officer should complete necessary sections of this form and present to the MPCDSR Secretary II (Head of Paediatrics) for the MPCDSR Review meeting within 1 month and follow up on the implementation of the action plan. Its information be uploaded by MRO to the NHMIS/NOQA platform.
- The original form should kept at the health facility, copies each submitted to the LGA M&E officer and the MPCDSR Desk Officer at the State Ministry of Health (SMOH) and FMOH
- The code should be the same as on the Perinatal Death Notification form, MPCDSR Form 6

Patient Identification Code.: (**PD/State/Town/ Hospital /Month/Year/Serial No**.):……

……………………………………………………………………………………………

1. DETAILS OF MOTHER

1.1. Hospital No. /Case Note No. (if hospitalized): ……………………………………………………
1.2. Age (years):…………………………………………………………………………………………
1.3. Residence: (Tick √ one box) a. [ ] Rural b. [ ] Urban
1.4. Marital Status: (Tick √ one box)
a. [ ] Married b. [ ] Not married c. [ ] Divorced
d. [ ] Separated e. [ ] Widowed
1.5. Educational level (Completed): (Tick √ one box)
a. [ ] None b. [ ] Primary c. [ ] Secondary d. [ ] Higher
e. [ ] Not Known
1.6.
Occupation:………………………………………………………………………………………
1.7. Religion: (Tick √ one box)
a. [ ] Christianity b. [ ] Islam c. [ ] Traditional African Religion
d. [ ] Other (specify) …………………………………………………………………………
1.8. Ethnic Group: (Tick √ one box)
a. [ ] Hausa / Fulani b. [ ] Yoruba c. [ ] Igbo
d. [ ] Other (specify) ……………………………………………………………………………
1.9 Maternal Parity………………………………………………………………………………
1.10. Maternal Gravidity ………………………………………………………………………

2. ADMISSION AT FACILITY WHERE PERINATAL DEATH OCCURRED

2.1 Date of admission of mother to facility: (dd/mm/yy)………………………………………
2.2 Date of admission of newborn from home: (dd/mm/yy) ………………………………..

2.3 Admitted from: (Tick √ one box)
a. [ ] Health facility b. [ ] TBA c. [ ] Home

d. [ ] Other (specify) ……………………………………………………………………………
2.4 Name of referring facility (if applicable): ………………………………………………...

2.6 Foetal Heart Rate on admission: (Tick √ one box)
a. [ ] Absent b. [ ] Normal c. [ ] Abnormal (>180 or < 100)
2.7 Condition of mother on admission: (Tick √ one box)
a. [ ] Stable b. [ ] Critically ill c. [ ] Dead on arrival (DOA)

3. ANTENATAL CARE

3.1 Did she receive antenatal care? (Tick √ one box) a. [ ] Yes b. [ ] No
If No skip to section 4
3.2 If "Yes" total number of visits: ……………………………………………………..

3.3 Any complication (s) identified: a. [ ] Yes b. [ ] No
3.4 If "Yes" specify:……………………………………………………………………….

3.5 Any action taken on identified danger signs? a. [ ] Yes b. [ ] No
3.6 If "Yes" to 3.5, tick all that apply:

a. [ ] Referred b. [ ] Anaemia treatment
c. [ ] Treatment of hypertension. d. [ ] Malaria treatment
e. [ ] Treatment of PROM f. [ ] PMTC of HIV
g. [ ] Treatment of syphilis (VDRL +) h. [ ] Treatment of infection
i. [ ] Tetanus vaccination of mother j e. [ ] Other (specify): ……………………………

4. DELIVERY AND PUERPERIUM

4.1 Time interval from rupture of membranes to delivery (Hrs) ………………………..

4.2 Condition of liquor: : (Tick √ one box)
a. [ ] Clear b. [ ] Meconium stained c. [ ] Blood stained

4.3 Date of delivery:(dd/mm/yy):…. …………………………………………………………

4.4. Was a partograph used during labour? a [ ] Yes; b. [ ] No; c. [ ] Not known

4.5 Duration of labour: (Tick √ one box)
a. [ ] Less than 12 hours b. [ ] 12 to 24 hours c. [ ] More than 24 hours

4.6. Did she have problems during labour or delivery of this baby? a [ ] Yes b. [ ] No
If yes, what was/ were the problems? ……………………………………………………………

4.7. Place where baby was delivered (level of facility): (√ one box)

a. [ ] Home b. [ ] PHC
c. [ ] Secondary facility d. [ ] Tertiary facility
e. [ ] On the way before arrival at facility f. [ ] TBA
g. [ ] Other (specify):……………………………………………………………………. ..

4.8 Mode of Delivery: (√ one box)

a. [ ] SVD b. [ ] Vacuum
c. [ ] Forceps d. [ ] Caesarean Section
e. [ ] Breech delivery f. [ ] Destructive delivery
g. [ ] Other (specify): ……………………………………………………………………

4.9. Delivered by: (√ one box)

a. [ ] Specialist (Obstetrics & Gynaecology) b. [ ] Medical officer
c. [ ] Midwife d. [ ] Nurse e. [ ] CHEW
f. [ ] J CHEW g. [ ] CHO h. [ ] TBA
i. [ ] Other (specify): …………………………………………………………………………………

4.10 Was the baby weighed after delivery? a [ ] Yes b. [ ] No

4.11 If "Yes", Birth weight (grams) ……………………………………………………………

4.12 Was the Apgar score determined at delivery? a [ ] Yes b. [ ] No

4.13. If no, did the baby cry at birth a [ ] Yes b. [ ] No

4.14 If "yes" to 4.12: 1 min Apgar score: ………………………….

4.15 If "yes" to 4.12: 5 min Apgar score: …………………………

4.16 If "yes" to 4.12: Extended min Apgar score: …………………

4.17 Newborn resuscitation done with bag and mask? a [ ] Yes b. [ ] No

4.18 Did baby cry immediately after birth? a [ ] Yes b. [ ] No

4.19 Did the baby have any bruise or marks of injury at birth? a [ ] Yes b. [ ] No

4.20 Was the baby able to suck breast well after delivery? a [ ] Yes b. [ ] No

4.21 Did the baby have any other problem(s) before baby died? a [ ] Yes b. [ ] No

If "yes" What was/ were the problem(s)?

4.22 Convulsion a [ ] Yes b. [ ] No

4.23 Unconscious a [ ] Yes b. [ ] No

4.24. Neck retraction a [ ] Yes b. [ ] No

4.25. Bulging fontanelle a [ ] Yes b. [ ] No

4.26 Inability to open the mouth a [ ] Yes b. [ ] No

4.27 Jaundice a [ ] Yes b. [ ] No

4.28. Bleeding a [ ] Yes b. [ ] No

4.29. Skin rashes containing pus a [ ] Yes b. [ ] No

4.30 Fever a [ ] Yes b. [ ] No

4.31. Cough a [ ] Yes b. [ ] No

4.32 Difficult breathing a [ ] Yes b. [ ]

No

4.33 Fast breathing a [ ] Yes b. [ ]

No

4.34 Stopped breathing a [ ] Yes b. [ ]

No

4.35. Cold to touch a [ ] Yes b. [ ]

No

4.36. Discharge from cord a [ ] Yes b. [ ]

No

4.37. Others (Specify):…………………………………………………………………………………

4.38 Was care sought during the illness? a [ ] Yes b. [ ] No
If yes, Tick against Facilities where care was sought:
Home [ ]; Traditional birth attendant [ ]; Church [ ]; Health facility [ ]; Other [ ](specify)
………………………………………………………..:……………………………

4.39. Where did this newborn die?
a. [ ] Home b. [ ] Traditional birth attendant c. [ ] Church
c. [ ] Health facility d. [ ] Other (specify) ………………………………………

4.40 Outcome for newborn: (√ one box):
a. [ ] Fresh still birth b. [ ] Macerated Still Birth c. [ ] Early Neonatal Death (ENND)

If NND:

4.42. Date of death (dd/mm/yy) ……………………………………………………………….

5. Main Perinatal Cause of Death (Identified by the Reviewers)

5.1 Main Perinatal Cause of Death (√ appropriate boxes):

a. [ ] Birth asphyxia b. [ ] Birth trauma
c. [ ] Congenital abnormality d. [ ] Sepsis
e. [ ] Intra-uterine death with unknown reason f. [ ] Dehydration due to diarrhoea
g. [ ] Neonatal tetanus h. [ ] Respiratory Distress Syndrome
i. [ ] Neonatal Jaundice j. [ ] Necrotising Enterocolitis
k. [ ] Other (specify): ……………………………………………………………………………

5.2 Main Maternal Cause of Death, if any (√ appropriate boxes):

a. [ ] Spontaneous premature birth b. [ ] Hypertensive disorders / (pre)-eclampsia
c. [ ] Intrapartum asphyxia d. [ ] Antepartum haemorrhage
e. [ ] Congenital abnormality f. [ ] Pre-existing maternal disease
g. [ ] Maternal infection h. [ ] Breech delivery
i. [ ] Shoulder dystocia j. [ ] Cord problems (prolapse, knot, entanglement)
j. [ ] Prolonged / obstructed labour e. [ ] Other (specify ………………………………

6. ASSOCIATED FACTORS THAT CONTRIBUTED TO DEATH

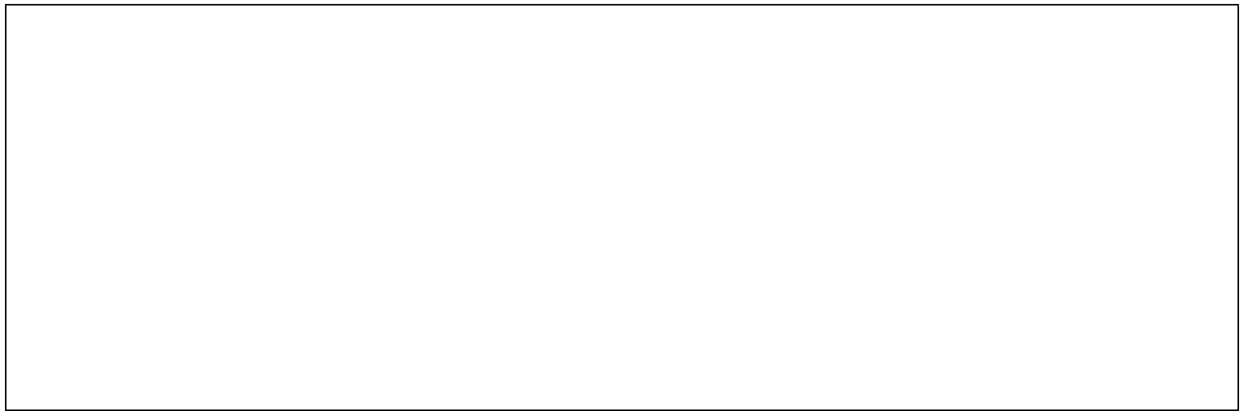
(Tick √ appropriate boxes, to be extracted as far as possible from records)

Factors	Causes	Yes	No	Remarks (use back of page if necessary)
6.1 Health worker factors	Lack of necessary midwifery/obstetric/Neonatal Care 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			
	Availability of functional Newborn equipment (_incubator, Ambu bag and Oxygen)			
	Multiple referrals without stabilization			
	Inadequate monitoring of newborn after birth			
	Inadequate response to maternal disease/complication			
	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			
	Other (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 medicines			
	Lack of essential equipment, including 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 practices			
	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			
	Unsafe traditional/cultural practices			
	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 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. FORM COMPLETED BY:

Name: ……………………………………………………………………………..

Designation: …..…………………………………………………………………………

Telephone: ……………………………………………………………………………….

E-mail: ………………………………………………………………………………….

Date (dd/mm/yy) ……………………………………………………………………

Signature:…………………………………………………………………………………….

NB: Complete MPCDSR case summary form after the Facility MPCDSR Committee Review Meeting.

MPCDSR FORM 8

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

CHILD DEATH NOTIFICATION FORM

Note

- This form should be completed (in triplicate) for all Child deaths (immediately after certification of death) by the facility MPCDSR Officer and/or Person who managed the case.
- It should be submitted to the head of the Health Facility for onward transmission to the Disease Surveillance Notification Officer (DSNO) in the LGA/State within 24hours
- It should also be completed on the e-platform

Patient Identification Code.: (**CD/State/Town/ Hospital /Month/Year/Serial No**.): …………………………………………………………………………………………………

1. Patient Case Note No. (if hospitalized): ……………………………………………………
2. Name of Child who died: …………………………………………………………………
3. Gender: [F/M]………………………………………………………………………………
4. Date of Birth (dd/mm/yy) …………………………………………………………………
5. Age of child (specify - years/months/weeks/days) …………………………………………
6. Birth weight (grams) ………………………………………………………………………
7. Present Weight of Child who died [kg]:……………………………………………………
8. Name of Facility where death occurred:…………………………………………………..
9. Local Government Area (LGA):……………………………………………………………
10. State:………………………………………………………………………………………
11. Where death occurred (Tick √ one box)
    a. [ ] Tertiary Health Institution b. [ ] Secondary health facility
    c. [ ] Primary Health Care Centre; d. [ ] Faith based Institution
    e. [ ] Private health facility f. [ ] On the way/ before arrival to health facility
    g. [ ] Other (specify) ………………………………………………………………………..
12. Date of Death being reported (dd/mm/yy):……………………………………………….
13. Time of death [am/pm]……………………………………………………………………
14. Date of Admission to Facility (if on admission) (dd/mm/yy): ………………………………
15. Age of Mother (years): ……………………………………………………………………
16. Describe how the child‟s illness started and progressed) …………………………………..
17. Distance and time to reach the health facility: _[ ] km _[ ] hrs
18. Mode of transport (specify): ………………………………………………………………
19. Was the child referred from another health facility? a. [ ]No; b. [ ]Yes (specify)……………………………………………………………………………………
20. Delay in transport or referral [ ] No; [ ] Yes; (why): ……………………………………
22. Mother attended antenatal care: a. Number of visits [ ]; Gestation age at first visit [ ]
23. For how long were the membranes ruptured before baby was born: [ ] hrs
24. Duration of labour: [ ] hrs.
25. Place of birth: [ ] Hospital; [ ]Health Facility; [ ]Home / village [ ]Unknown
26. Apgar score at 1 min [ ]; at 5 min [ ]. If unknown, did the child cry immediately after delivery [ ]No; [ ]Yes; [ ] unknown

27. Vaccination status: a. [ ] Vaccines up to date for age; b. [ ]Some vaccines received but not complete for age; c. [ ] No vaccines ever received
28. Nutritional status: a. [ ] Normal nutrition; b. [ ]Moderate acute malnutrition; c. [ ]Severe acute malnutrition; d. [ ]No information
29. Investigations done and key results:
…………………………………………………………………………………
……
………..
30. List the diagnoses made:
………

Primary (Underlying)Cause of Death: ……………………………………………………
(Specify ICD-11 Code ……………………………………………………………………)

Antecedent Cause(s) of Death: …..………………...
(Specify ICD-11 Code ……………………………………………………………………)

Final (Immediate) Cause of Death: ……………………………………………………
(Specify ICD-11 Code ……………………………………………………………………)

31. What environmental or social factors were involved in the child‟s death? Choose the most appropriate as listed in the standard operating procedure, and provide details:
……………………
……
………..
……..
32. What treatment did the child receive? (List all the treatments given and the date prescribed):
……….
………..
………..
33. Were there any complications of treatment? (Specify):
……………………………………………………
……
………..
34.Were any necessary treatments not available at the time the child presented? [ ] No; [ ]Yes; (please specify):

……
……
35. List the modifiable factors involved in this child‟s death:
…………………………………………………
……
……………………………………………
……
……
…………………………………………………………………………………………..
36. List actions that could prevent similar
deaths…………………………………………………………………….
……
……
…………………………………………………………………………………………..
……
…………………………………………

Name of Person reporting: ……………………………………………………………………
Designation: …………………………………………………………………………………….
Telephone number………………………………………………………………………………
Email………………………………………………………………………………………………
Address: ……………………………………………………………………………………………
Signature: ……………………………………Date: ……………………………………………

MPCDSR FORM 9

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

CHILD DEATH REVIEW FORM

NOTE

- This form should be completed for all child deaths.
- The MPCDSR Officer should complete necessary sections of this form and present to the MPCDSR Secretary II (Head of Paediatrics) for the MPCDSR Review meeting within 1 month and follow up on the implementation of the action plan. Its information should be uploaded to the NHMIS/NOQA platform by the MRO.
- The original form should kept at the health facility, copies each submitted to the LGA M&E officer and the MPCDSR Desk Officer at the State Ministry of Health (SMOH) and FMOH
- The code should be the same as on the child Death Notification form, MPCDSR Form 6

Patient Identification Code.: (**CD/State/Town/ Hospital /Month/Year/Serial No**.):

………………………………………………………………………………………………

1. ADMISSION AT FACILITY WHERE CHILD DEATH OCCURRED

1.0 Date of admission of child to facility: (dd/mm/yy)………………………………………
1.1 Date of admission of child from home: (dd/mm/yy) …………………………………...

1.2 Admitted from: (Tick √ one box)
a. [ ] Health facility b. [ ] TBA c. [ ] Home

d. [ ] Other (specify) ………………………………………………………………………………
1.3 Name of referring facility (if applicable): …………………………………………………..

1.4 Child Heart Rate on admission: (Tick √ one box)
a. [ ] Absent b. [ ] Normal c. [ ] Abnormal (>180 or < 100)
1.5 Condition of child on admission: (Tick √ one box)
a. [ ] Stable b. [ ] Critically ill c. [ ] Dead on arrival (DOA)

Place of death: Tick the most appropriate. “Hospital” is applicable for both outpatient and inpatient departments.
Days child was sick before presentation: Fill in the number of days the child was sick with the illness that led to this admission.
Date of hospital admission: Fill in date of admission to this hospital for this admission.
Describe how the child‟s illness started and progressed. Extract information from the medical records and perhaps ask the caregiver for more information.
Distance and time travelled to reach the health facility: __ __ km __ __ hours. Interview the caregiver to establish the time they took from the point of origin before arriving at the hospital (from the referring facility or from home if applicable)
Mode of transport: Transport from home or referring facility, e.g. ambulance, bicycle, taxi, public transport
Was the child referred from another health facility? Write Yes if the child was referred for this admission episode.

Delay in transport or referral: From the caregiver‟s perception. Check the medical notes and/or interview the caregiver. If YES ask the caregiver the reason for delay.
Had the child been an inpatient in the past 3 months? Refers to inpatient care in any health facility. If Yes, indicate how many days ago if < 1 month or how many months if > 1 month ago.
Vaccination status: Check the medical notes. If not indicated, check the "wellbaby" booklet, if available. Compare vaccines given with the recommended national vaccination schedule.
Nutritional status: Check recordings of mid–upper arm circumference or weight–height Z score. If both are missing, check recorded weight. Enter nutritional status as classified in the medical notes. If not classified, refer to the WHO growth charts to classify nutritional status: normal nutrition (> –2 Z scores weight for age or weight for length or mid–upper arm circumference ≥ 12.5 cm for age 6–59 months); moderate malnutrition (–2 to –3 Z scores or mid–upper arm circumference 11.5–12.4 cm for age 6–59 months); severe malnutrition (< –3 Z scores, mid–upper arm circumference < 11.5 cm for age 6–59 months or kwashiorkor);
Investigations done: Check medical records and laboratory order forms. Tick the box if test done, and indicate results in the space given. If no results are available, indicate No results. List any other tests done under "Others".
List the diagnoses made: Primary cause of death: The immediate cause of death, which is the acute illness that led to death, such as pneumonia, diarrhoea, malaria or poisoning. Sometimes a more specific diagnosis is possible, such as "pneumonia due to Streptococcus pneumoniae" or "falciparum malaria", but, depending on diagnostic tests available, often only a clinical diagnosis can be made. Other immediate causes of death include "acute leukaemia" if the child died directly from the consequences of the cancer or its treatment, or "accidental trauma". Underlying chronic or comorbid condition: Any other condition that the child had, such as malnutrition or anaemia or a chronic condition such as cerebral palsy, epilepsy or congenital heart disease. If a child with congenital heart disease died of secondary pneumonia, the immediate cause is pneumonia, and the underlying condition is congenital heart disease. If a child with congenital heart disease died of heart failure, congenital heart disease is the immediate cause. Associated diagnoses: These include all other conditions not directly related to the primary diagnosis. 56 57
What environmental or social factors were involved in the child‟s death? Extract information from the medical records, and perhaps ask the caregiver for more information. Possible environmental and social factors are:
What treatment did the child receive? Extract the treatment prescribed during this admission episode from the treatment chart.
Were there any complications of treatment? Check the medical and nursing notes; perhaps ask nurses and clinicians for more information.
Were any necessary treatments not available at the time the child presented? Check the treatment charts, medical and nursing notes; perhaps ask nurses and clinicians for more information.
Were there modifiable factors in the child‟s death? This, the core task of the audit, will be discussed further during the audit meeting. A modifiable factor is something that might have prevented the death if a different course of action had been taken. When modifiable factors are recognized and addressed, there is potential for positive change.

2. DETAILS OF MOTHER

2.1. Hospital No. /Case Note No.(if hospitalized): ………………………………………………
2.2. Age (years):…………………………………………………………………………………
2.3. Residence: (Tick √ one box) a. [ ] Rural b. [ ] Urban
2.4. Marital Status: (Tick √ one box)
a. [ ] Married b. [ ] Not married c. [ ] Divorced

d. [ ] Separated e. [ ] Widowed

2.5. Educational level (Completed): (Tick √ one box)

a. [ ] None b. [ ] Primary c. [ ] Secondary d. [ ] Higher

e. [ ] Not Known

2.6. Occupation: …………………………………………………………………………………..

2.7. Religion: (Tick √ one box)

a. [ ] Christianity b. [ ] Islam c. [ ] Traditional African Religion

d. [ ] Other (specify) ……………………………………………………………………………

2.8. Ethnic Group: (Tick √ one box)

a. [ ] Hausa / Fulani b. [ ] Yoruba c. [ ] Igbo

d. [ ] Other (specify) ……………………………………………………………………………

2.9 Maternal Parity ………………………………………………………………………………

2.10 Maternal Gravidity ……………………………………………………………………………

3. ANTENATAL CARE

3.1 Did she receive antenatal care? (Tick √ one box). a. [ ] Yes b. [ ] No

If No skip to section 4

3.2 If "Yes" total number of visits: ……………………………………………………….

3.3 Any complication (s) identified: a. [ ] Yes b. [ ] No

3.4 If "Yes" specify:………………………………………………………………………….

3.5 Any action taken on identified danger signs? a. [ ] Yes b. [ ] No

3.6 If "Yes", tick all that apply:

a. [ ] Referred b. [ ] Anaemia treatment

c. [ ] Treatment of hypertension. d. [ ] Malaria treatment

e. [ ] Treatment of PROM f. [ ] PMTC of HIV

g. [ ] Treatment of syphilis (VDRL +) h. [ ] Treatment of infection

i. [ ] Tetanus vaccination of mother j e. [ ] Other (specify): …………………………

4. DELIVERY AND PUERPERIUM

4.1 Did she have problems during labour or delivery of this baby? a [ ] Yes b. [ ] No

If yes, what was/ were the problems?

………………………………………………………………………………………………………

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

a. [ ] Home b. [ ] PHC

c. [ ] Secondary facility d. [ ] Tertiary facility

e. [ ] On the way before arrival at facility f. [ ] TBA

g. [ ] Other (specify): ………………………………………………………………

4.3 Mode of Delivery: (√ one box)

a. [ ] SVD b. [ ] Vacuum

c. [ ] Forceps d. [ ] Caesarean Section

e. [ ] Breech delivery f. [ ] Destructive delivery

g. [ ] Other (specify): ………………………………………………………………….

4.4. Delivered by: (√ one box)

a. [ ] Specialist (Obstetrics & Gynaecology) b. [ ] Medical officer
c. [ ] Midwife d. [ ] Nurse e. [ ] CHEW
f. [ ] J CHEW g. [ ] CHO h. [ ] TBA
i. [ ] Other (specify): ……………………………………………………………………

4.5 Birth weight (grams) ……………………………………………………………

4.6.Any other Significant findings

4.7.Was care sought during the illness? a [ ] Yes b. [ ] No

If yes, list Facilities

Home [ ]; Traditional birth attendant [ ]; Church [ ]; Health facility [ ];

Other [ ] (specify) ……………………………………………………….:………..

4.39. Where did this child die?

a. [ ] Home b. [ ] Traditional birth attendant c. [ ] Church
c. [ ] Health facility d. [ ] Other (specify) …………………………………………

4.42. Date of death (dd/mm/yy) ………………………………………………………….

5. CAUSE OF DEATH (Identified by the Reviewers)

5.1 Final (Immediate) Cause of Death: ……………………………………………………………

(Specify ICD-11 Code ……………………………………………………………………………..)

5.2 Primary (Underlying) Cause of Death: ………………………………………………………

(Specify ICD-11 Code ……………………………………………………………………………..)

5.3. Antecedent Cause(s) of Death: ……………………………………………………………

(Specify ICD-11 Code ……………………………………………………………………………..)

6. Associated Factors that Contributed to Death

(Tick √ 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 nursing/paediatric Care skills			
	Inadequate resuscitation			
	Availability of functional equipment			
	Multiple referrals without stabilization			
	Inadequate monitoring of the child			
	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 medicines			
	Lack of essential equipment, including resuscitation			
	Lack of laboratory facilities			
	Non availability of blood			
6.3 Patient/ Family Factors	Mother or both parents dead or Informal adoption			
	Unsafe home environment			
	Failure to recognise danger signs			
	Delay in decision making or getting permission			
	Preference for care at home or by TBA			
	Unsafe traditional/cultural practices			
	Use of traditional medicine			
	Unsafe medical treatment			
	Refusal of treatment – non-compliance to advice			
	Poor household sanitation			
	Unsafe household water supply			
	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			
	Unsafe traditional/cultural practices			
	Transport problems			
	Delay in deciding to refer			

6.5 Other factors (specify)				

7. Case Summary after Assessment of Child Death by Review Committee

(Provide a detailed 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, child care). Use back of page if necessary.

8. Form Completed by:

Name: …………………………………………………………

Designation: ……………………………………………..

Telephone: ………………………………………………

E-mail: …………………………………………………………..

Signature……………………………………… Date (dd/mm/yy)…..………………

NB: Complete MPCDSR case summary form after the Facility MPCDSR Committee Review Meeting.

MPCDSR FORM 10

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

VERBAL AUTOPSY FORM

Note:
This verbal Autopsy form should be completed by the Community MPCDSR Secretary for all maternal deaths (including abortions and ectopic gestation related deaths) and for perinatal deaths (stillbirths and death of newborns within 7 days of life) and child deaths.
One form should be completed for one death (mother or baby) after verbal autopsy has been carried out

GENERAL INFORMATION

1. **Maternal/Perinatal/Child Death Case Identification No.** ……………………………………………

2. Ward: ……………………………………………………………………………………………….

3. Village: ……………………………………………………………………………………………

4. Local Government Area ………………………………………………………………………………

5. State: ……………………………………………………………………………………………..

6. Name of Deceased (Initials only) ……………………………………………………………………

7. Name of Husband (If married) Initials only …………………………………………………………

8. Date of Death: ………………………………………………………………. …………………………

9. Name of Respondent. ……………………………………………………………………………………

10. Relationship of Respondent to Deceased ………………………………………………………………

11. Probable cause of Death ……………………………………………………………………………

12. Date of investigation: ………………………………………………………………………………

MODULE – I
This segment should be completed on every maternal death.

1. BACKGROUND INFORMATION: Kindly (√)tick or fill in the correct answer for each question
All questions are in respect of the deceased (mother or newborn)
1.1 Resident Visitor☐

1.2 Type/period of death (mother)
Abortion/Miscarriage ☐ Antenatal ☐ During Delivery☐ Post-natal ☐

1.3 Place of death Home ☐ TBA‟s place☐ On the way/ before arrival to health facility☐
Other (specify) …………………………………………………………………………………………

1.4 Specify the name and place of the village where death occurred……………………………………….

………

1.5 Onset of fatal illness Date ……………………………… Time __ __:__ __ _ _

1.6 Admission in final health institution (if applicable) Date………………………. Time __ __:__ __ _ _

1.7 No. of previous pregnancies (Gravidity) specify …..……………………….. ……………………….

1.9 Age of pregnancy (If applicable). Specify in weeks …………………………………………………

1.10 Age at death, Specify (Years) ……………………………………………………………………….

2. FAMILY HISTORY: Details of Deceased Woman/Mother

2.1. Age at marriage, Specify (years) ……………………………………………………………………

2.2. Religion: Muslim [ ] Christian [ ] Traditional [ ] Others [ ]………………………………

2.3. Educational status: None [ ] Q"uaranic/Islamiyya [ ] Primary [ ] Secondary [ ] Tertiary [ ]

2.4. Occupation: Professional/technical/Managerial [ ] Clerical, Sales & services [ ] Skilled Manual [ ] Unskilled Manual [ ] Agriculture [ ] Unknown [ ] Others (Specify)……………………………………………………………………………………….

3. INFANT SURVIVAL

(THIS SEGMENT SHOULD BE COMPLETED FOR EVERY "CHILD" FROM THE PREGNANCY, WHETHER BORN ALIVE OR NOT.)

3. 1Newborn: Alive [ ] Dead [ ]

3.2. Child: Alive [ ] Dead [ ]

3.3 Unborn: [ ]

3.3 If dead: Macerated Stillbirth [ ] Fresh Stillbirth [ ] Early Neonatal Death [ ] Others (specify)…………………………………………………………………………………………

3.3 Sex of baby: Male [ ] Female [ ] Not known [ ]

Size of baby at birth: Small [ ] Average [ ] Big [ ]

3.4 Activity at birth: Cried at birth [ ] Moderate Response [ ] Weak Response [ ]

3.5 Did the baby have any problem before death? Yes [ ] No [ ]

What was/ were the problem(s)? (Tick √ one box, as applicable)

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 [ ]

4. AVAILABILITY OF HEALTH FACILITIES, SERVICES AND TRANSPORT

4.1 Name and location of the nearest government / private facility providing Emergency Obstetric and Newborn Care Services (EmONC) ……………………………………………………………..

4.2 Distance of this facility from the residence (Km)………………………………………………………………………………………….

4.3 Number of health institutions visited before death (names in the order of visits) if applicable.
…………………………………………………………………………………………………
…………………………………………………………………………………………………

4.4 Reasons given by providers for the referral (if Applicable)
No explanation given ☐ Lack of blood ☐ Lack of skilled staff ☐
Others (specify)………………………………………………………………………………….

5. CURRENT PREGNANCY (To be filled from the information given by the respondents)
5.1 Ante Natal Care YES ☐ NO ☐
5.2 If yes, Place of Antenatal check-up
Health clinic ☐ PHC centre ☐ General Hosp ☐ Tertiary Hosp ☐ Private Hos ☐
☐ Comprehensive PHC ☐ Others specify…………………………………………………

5.3 Number of antenatal check-ups, Specify:…………………………………………………………...

MODULE – II

6. **DURING THE ANTENATAL PERIOD**

6.1 Did the mother have any problem during antenatal period?
Yes ☐ No ☐ Not known ☐

6.2 If yes, was she referred anytime during her antenatal period?
Yes ☐ No ☐ Not known ☐

6.3 If YES, did she attend any hospital?
Yes ☐ No ☐ Not known ☐

6.4 What was/were the symptom(s) for which she sought care? (multiple entry allowed)
Head ache ☐ Oedema ☐ Anaemia ☐ High blood pressure ☐ Bleeding p/v ☐

No foetal movements ☐ Fits ☐ Sudden excruciating pain ☐ High fever with rigor ☐

Others (specify)……………………………………………………………………………

6.5 Reasons for not seeking care from the hospital (If applicable) (multiple entries allowed)
Did not know Implication/Severity of the complications ☐ Referred Institution far away ☐

Skilled attendant not available ☐ No money ☐ Beliefs and customs ☐ Lack of transport ☐ Others (specify)…………………………………………………………………………………………

7 THE FOLLOWING QUESTIONS SHOULD BE ANSWERED ONLY WHEN THE DEATH INVOLVED AN ABORTION, OTHERWISE SKIP THEM:

7.1 Did she die while having an abortion/miscarriage or within 6 weeks after having an abortion/ miscarriage?

Yes ☐ No ☐ Don‟t know ☐

7.2 If the death was from an abortion, was it spontaneous or induced?

Spontaneous ☐ Induced ☐ Don‟t know ☐

7.3 If the abortion was induced, how was it induced?

Oral medicine ☐ Traditional vaginal herbal application ☐ Instrumentation ☐ Don‟t know ☐

7.4 Where was the abortion induced?

Home ☐ PHC ☐ General Hosp ☐ Tertiary Hosp ☐

Private Hosp ☐ Don‟t know ☐ Others specify……………………………………………

7.5 Who performed the abortion?

Doctor ☐ Nurse ☐ Chew ☐ Don‟t know ☐ Others (specify)…………………………………………………………………………………………

7.6 Were there any complications? Yes ☐ No ☐

7.7 If yes, what were the complications?

High fever ☐ Foul smelling discharge ☐ Bleeding ☐ Shock ☐ Others specify……..………………………………………………………………………………..

7.8 Did the family seek care? Yes ☐ No ☐

7.9 Where did she seek care?

Home ☐ PHC ☐ General Hosp ☐ Tertiary Hosp ☐

Private clinic ☐ Don‟t know ☐ Other specify………………………………………

7.10 How many weeks was the pregnancy at the time of abortion ☐

7.11 Date of spontaneous abortion/ date of termination of pregnancy ☐

MODULE – III

(THESE QUESTIONS SHOULD BE ASKED IF THE WOMAN EXPERIENCED LABOUR/DELIVERY)

8. INTRANATAL SERVICES (LABOUR)

8.1 Place of delivery

Home ☐ PHC ☐ General Hosp ☐ Tertiary Hosp ☐ Private Hosp ☐

Transit ☐ Others, specify………………………………………………………………..

8.2 Admission (not applicable for home delivery and transit): Date ………………….Time __ __:__ __ _ _

8.3 Delivery: Date………………………. Time __ __:__ __ _ _

8.4 Time interval between onset of pain and delivery (in hours) Time __ __:__ __ _ _

8.5 Who conducted the delivery?

Doctor ☐ Staff Nurse / Midwife ☐ CHEWS ☐ TBA ☐

Others specify……………………………… …………………………………………………………

8.6 Type of delivery

Normal ☐ Assisted ☐ Caesarean ☐

8.7 If Multiple births – Number ☐ No. Alive ☐
8.8 During the process of labour/delivery did the mother have any problems?
If yes, specify
……………………………………………………………………………………………………
……………………………………………………………………………………………………
8.9 Did she seek treatment, if yes by whom and what was the treatment given? (Give details)
……………………………………………………………………………………………………
……………………………………………………………………………………………………
8.10 Was she referred? Yes ☐ No ☐ Don‟t know ☐
8.11 Did she attend the referral centre? Yes ☐ No ☐ Don‟t know ☐
8.12 In case of non-compliance of referrals state the reasons.
Intensity of complications not known ☐ Institution far away ☐ Beliefs & customs ☐
No money ☐ No skilled attendant available ☐ Lack of transport ☐ Others
………………………
8.13 Was there delay in: Decision making ☐ Mobilizing funds ☐ Arranging transport ☐
Others specify……………………………………………………………………………………
8.14.Was any information given to the relatives about the nature of complications from the hospital?
Yes ☐ No ☐

8.15 Was there any delay in initiating treatment? Yes ☐ No ☐
8.16 If yes, describe
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

MODULE – IV
(THESE QUESTIONS SHOULD BE ASKED IF THE WOMAN EXPERIENCED PUERPERIUM)
9. POST NATAL PERIOD
9.1 No. of Postnatal check-ups, specify……………………….
9.2 Did the mother have any problem following delivery? Yes ☐ No ☐ Don‟t know ☐
9.3 Onset of the problem Date……………….. Time __ __:__ __ _ _
9.4 Specify problems during Post Natal period
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
9.5 Did she seek treatment? Yes ☐ No ☐
9.6 If yes, from whom?
Doctor ☐ Nurse ☐ Midwife ☐ CHO/CHEW ☐ Others
(specify)…………………………………………………………………………………………

What was the treatment given? (give details)

……………………………………………………………………………………………………
……………………………………………………………………………………………………
9.7 Was she referred? Yes ☐ No ☐ Don‟t know ☐ Not applicable ☐
9.8 Did she attend the referral center? Yes ☐ No ☐ Don‟t know ☐ Not applicable ☐
9.9 In case of non-compliance with referrals, state the reasons:
Severity/implication of complications not known ☐ Institution far away ☐ No money ☐
No skilled attendant ☐ Belief & customs ☐ Lack of transport ☐
Others……………………………………………………………………………………………..

10: REPORTED CAUSE OF DEATH

10.1 Did a doctor/ nurse/Midwife/CHO/CHEW at the Health Facility tell you the cause of death? Yes ☐ No ☐ Don"t know ☐

10.2 If yes, what was the cause of death? ☐

11. OPEN HISTORY (NARRATIVE FORMAT) (EXPLORE)

11.1 Name and address of the facilities she went – decisions and time taken for action
……
……
……

11.2 How long did it take to make the arrangements to go from home to other facilities and why those referrals were made and how much time was spent at each facility and time spent at each facility before referrals were made and difficulties faced throughout the process.
……
……
……
……

11.3 Transportation method used……………………………………………………………………………………………………
……

11.4 Transportation cost? (at each stage of referral)……………………………………………………………………………………………………

11.5 Travel time – at each stage……………………………………………………………………………………………………

11.6 Care received at each facility?..
………………………………………………………………………………………………………..

11.7 Total money spent by the family……….…………….……………………………………………………………………………

a. How did the family arrange for the money?...

S/N	Name of investigators	Designation	Telephone no.	Signature

12. Form Completed by:

Name: ……………………………………………………………………….

Designation: ……………………………………………………………………..

Telephone: ……………………………………………………………………….

E-mail: ……………………………………………………………………….

Signature…………………………………… **Date** (dd/mm/yy)…..………………

MPDSR FORM 11

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

COMMUNITY MPCDSR COMMITTEE MEETING SUMMARY FORM

Note:

This form should be completed by the Community MPDSR Secretary for all maternal, perinatal or child deaths that occur in the community using the filled verbal autopsy form.
The purpose of the meeting is to consider the gaps identified during verbal autopsy and think about anything that the community and the health facility can do in future to prevent other women from dying from similar causes.
The purpose of this meeting is NOT to find fault with any individual or to put blame on the woman, the family, the community, or the health staff. The purpose is to give everyone an opportunity to think about how things could be improved IN FUTURE.
The original form should be retained with the Secretary and copies together with the health record if available submitted to the nearest hospital if the woman died there or to the nearest ward focal PHC.

GENERAL INFORMATION

Maternal/Perinatal/Child Death Case Identification No. ………………………………………………

Ward: ………………………………………………………………………………………………..

Village: ………………………………………………………………………………………………

Local Government Area …………………………………………………………………………….

State: ………………………………………………………………………………………………..

Name of Deceased (Initials only) ………………………………………………………………….

Date of Death: ……………………………………………………………. ……………………

Probable cause of Death ……………………………………………………………………………

Date of meeting: ……………………………………………………………………………………

Part 1: Summary of community contributing factors and suggested strategies		
1.1	Community factors which may have contributed to (NAME"s) death? Think „but why" to identify each of the contributing factors	

1.2	For each contributing factor record the strategy that will help us get from where we are now (contributing factor causing deaths) to where we want to be (Contributing factor no longer exists)	
Part 2: Summary of health facility contributing factors and suggested strategies		
2.1	What are the Health facility factors which may have contributed to (NAME‟s) death? Think „but why‟ to identify each of the contributing factors	
2.2	For each contributing factor record the strategy that will help us get from where we are now (contributing factor causing deaths) to where we want to be (Contributing factor no longer exists)	

Date of meeting: ___/___/_____		
Person's present		
Position	Name	Present?
1.		Yes/No
2.		Yes/No
3.		Yes/No
4.		Yes/No
5.		Yes/No
6.		Yes/No
7.		Yes/No
8.		Yes/No
9.		Yes/No
10.		Yes/No
11.		Yes/No
12.		Yes/No
13.		Yes/No
14.		Yes/No
15.		Yes/No

Name of Person reporting: …………………………………………………………………………….
Designation: ………………………………………………………………………………………

Telephone number…………………………………………………………………………………….
Email……………………………………………………………………………………………………
Address: ………………………………………………………………………………………………
Signature: ……………………………………………… Date: ……………………………………

MPDSR FORM 12

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

SOCIAL AUTOPSY FORM

Note:

This form should be completed by the CMPCDSR committee Secretary for all maternal, perinatal or child deaths that occur in the community using the CMPCDSR review meeting summary form
The purpose of this meeting is to consider community factors which may have contributed to the death and plan community strategies to prevent similar deaths occurring in the future.
The purpose of this meeting is NOT to find fault with any individual or to put blame on the woman, the family, the community, or the health staff. The purpose is to give everyone an opportunity to think about how things could be improved IN FUTURE.
The action tracker will be used to review progress at the monthly CMPDSR committee review meeting.
The original form should be retained with the Secretary and copy submitted to the nearest hospital if the woman died there or to the nearest ward focal PHC.

GENERAL INFORMATION

Serial No……………………………………………………………………………………………

Maternal/Perinatal/Child Death Case Identification No. ………………………………………………

Ward: ………………………………………………………………………………………………

Village: ……………………………………………………………………………………………

Local Government Area ………………………………………………………………………………

State: ………………………………………………………………………………………………

Date of meeting: ……………………………………………………………………………………….

Part 1: Summary of events leading up to death, including the contributing factors and strategies identified by the CMPCDSR team to be red to the community

<table>
<tr><td colspan="3">Part 2: Opinion of community on contributing factors to the maternal death and strategies to prevent future deaths</td></tr>
<tr><td>2.1</td><td>Community factors which may have contributed to (NAME‟s) death?

Think „but why‟ to identify each of the contributing factors

Suggest maximum 2</td><td>Contributing factor 1:

Contributing factor 2:</td></tr>
<tr><td>2.2</td><td>For each contributing factor record the strategy that will help us get from where we are now (contributing factor causing deaths) to where we want to be (Contributing factor no longer exists)</td><td>Strategy 1:

Strategy 2:</td></tr>
<tr><td rowspan="4">2.3</td><td rowspan="4">Break each strategy in to action points. These should be definite actions that can be done by individuals.

Think „who, how, when?‟

Persons responsible for implementing these action points should sign the following declaration:</td><td>Action point 1:

Person responsible:
Signature:</td></tr>
<tr><td>Action point 2:

Person responsible:
Signature:</td></tr>
<tr><td>Action point 3:

Person responsible:
Signature:</td></tr>
<tr><td>Action point 4:

Person responsible:
Signature:</td></tr>
</table>

Part 3: Actions tracker					
S/N	**Action**	**Responsible person**	**Due date**	**Date of verification**	**Status**

Name of Person reporting: ……………………………………………………………………………
Designation: ………………………………………………………………………………………
Telephone number…………………………………………………………………………………
Email………………………………………………………………………………………………
Address:
……………………………………………………………………………………………………
Signature: ……………………………………………… Date: ……………………………………….

MPCDSR FORM 13

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

SUPPORTIVE SUPERVISION CHECKLIST

1. STATE MPDSR ADMINISTRATION

(To be administered to a top Management Staff HCH/PSH/DPH/DMS/DHS/DNS/DCH/ E.S PHCDA/ Private Hospital (AGPMP/ Guild MD)/ Head Military Hospital))

S/N	Assessment Criteria	0= No/NONE	1= YES /PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1	Are you involved in the administration of MPDSR? (Verify)				
2	How often do MPDSR Steering Committee meet? (Verify)				
3	Did you attend any meetings in the last four months? (Verify)				
4	Are activities implemented within the MPDSR plan? (Sight plan)				
5	Is there an up-to-date daily register for staff movement? (Verify)				
6	Are there monthly management meetings with TMC to brief MPDSR activities? (verify with report or minutes of meeting)				
7	Do members of the TMC attend these management meetings?				
8	Do you have free maternal and child services? *** Specify package offered.				
9	Do you have functional SHMIS scheme?				
10	Do you carry out quarterly supervisory visits from the SPHCDA/HMB? Sight supervisory visit report				
11	Do you receive monthly supervisory visits from the LGA? Sight supervisory visit report				
	Total Score--------/11 x 10%				

2. LGA MPCDSR ADMINISTRATION

(To be administered to PHC Coordinator)

S/N		0= No/ None	1= YES/ PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1	Are you involved in the administration of MPCDSR your LGA? (Verify)				
2	How often do MPCDSR Committee meet? (Verify)				
3	Did you attend the any meetings in the last four months? (Verify)				
4	Are activities implemented within the MPCDSR plan? (Sight plan)				
5	Is there an up-to-date daily register for staff movement? (Verify)				
6	Are there monthly management meetings with TMC to brief MPCDSR activities? (verify with report or minutes of meeting)				
7	Do members of the TMC attend these management meetings?				
8	Do you have free maternal and child services? *** Specify package offered.				
9	Do you have functional SHMIS scheme?				
10	Do you carry out quarterly supervisory visits from the LGA to PHCs? Sight supervisory visit report				
11	Do you receive quarterly supervisory visits from the State?				

<table>
<tr><td></td><td>Sight supervisory visit report</td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="5">Total Score--------/11 x 10%</td></tr>
</table>

NAME OF FACILITY……………..…………………………..WARD…..…………...………………

LGA.………………..…………………………….STATE………………………DATE……………….

HEALTH FACILITY: PRIMARY………… SECONDARY…………… TERTIARY……………..

NAME OF SUPERVISOR……………………………………………………………………………

PHONE NUMBER OF SUPERVISOR…………………………………………………………..

3. Ward MPCDSR Administration

(To be administered to WDC chairman)

S/N		0= No/NONE	1= YES/PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1	Are you involved in the administration of MPCDSR your ward? (Verify)				
2	How often do MPCDSR Steering Committee meet? (Verify)				
3	Did you attend the any meetings in the last four months? (Verify)				
4	Are activities implemented within the MPCDSR plan? (Sight plan)				
5	Are MPCDSR activities discussed during WDC meetings? (verify with report or minutes of meeting)				
6	Do members of the MPCDSR Committee attend these meetings?				
7	Do you receive quarterly supervisory visits from the LGA? Sight supervisory visit report				
	Total Score--------/7 x 10%				

4. HEALTH FACILITY MPDSR ADMINISTRATION

(To be administered to officer-in-Charge of Health Facility)

S/N		0= No/NONE	1= YES, PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1	Do you have Skill birth attendants at the Facility? (Verify)				
2	How many skill birth attendants do you have ?(Verify)				
3	Do you have MPCDSR Committee? (Verify)				
4	If (3) is yes, do they meet monthly. If No skip 5				
5	If (4) is yes , How many times have they met in the last 3 months (Verify)				
6	Are there monthly management meetings with staff? (verify with report or minutes of meeting)				
7	Do you hold community dialogue meeting				
8	Do you have free maternal and child services? *** Specify package offered.				
9	Does the facility provide 24-hour service?				
10	Do you receive quarterly supervisory visits from the LGA? Sight supervisory visit report				
11	Do you receive monthly supervisory visits from the LGA? Sight supervisory visit report				
12	Is there two-way referral system (sight feedback)				
13	Is there triage MPCDSR SOP & guidelines (verify)				
14	Is there Partograph labour safety SOPs & guidelines (verify)				
15	Is there infection control SOPs & guidelines (verify)				
16	Does your facility have MNCH protocol? (verify)				
	Total Score--------/16 x 10%				

5. EXTERNAL ENVIRONMENT & PHYSICAL INFRASTRUCTURE

(To be administered to officer-in-Charge of Health facilities)

S/N		0= No/NONE	1= YES, PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1	Is the road to facility accessible?				
2	Is the environment generally neat and tidy? (Observe)				
3	Is the facility space adequate for different interventions?				
4	Are the walls intact [no cracked walls]?(observe)				
5	Is the roof intact [no leaking roof]? (observe)				
6	Is the state of ventilation adequate (observe)				
7	**Availability of portable water?**				
8	Is the sewage disposal system adequate?				
9	Is waste disposal system adequate?				
10	Is sharp disposal system in place?				
11	Does this facility carry out quarterly rodent and pest control?				
12	**Is there a functional backup source of power supply?****				
13	Are there separate Toilet Facilities for males and females				
14	Is the health facility fenced? (fence)				
	Total Score-----------/28 x 20%				

NB: Questions in bold receive double marks

**** Graded scoring**

S/N		0= No/NONE	1= YES/PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY) State actual number available
1	Medical Officer				
2	Nurse /Midwives				
3	CHO				
4	CHEWS				
5	J CHEWS				
6	Pharmacy Technician				
7	Environmental Health Officer				
8	Medical Records officer				
9	Medical Lab Scientist/ Technicians				
10	Support Staff Health Attendant				
11	Security Personnel				
12	General Maintenance Staff				
13	Others				Specify……
14	How many staff do you have on MPCDSR committee				
15	**Is there any deficit in MPCDSR committee members**				
16	**If (14) is Yes specify**				
	STAFF TRAINING				
17	Do you have a staff trained on MPCDSR?				
18	Do you have staff trained in ELSS?				
19	Do you have staff trained in LSS?				
20	Do you have Staff trained in MLSS?				
21	Do you have staff trained on Essential Newborn Care?				
22	Do you have staff that is computer literate?				
	Total Score-------------/22 x 10%				

6.

FINANCIAL MANAGEMENT (To be administered to the officer In Charge of facility)

S/N	(Verify availability)	0= No/NONE	1= YES/PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY)
1.	Does this facility receive impress?				
2.	If (1) is yes, do you use it for MNCH activities/items				
3	Is there a Drug Revolving Fund (DRF) system? (Verify)				
4.	Is there a separate (DRF) account at state // LGA/Facility				
5	Is there a DRF committee? (Verify with minutes of meeting attendance)				
6	How regular is the DRF committee meeting? (Verify minutes)				
7	Are monthly DRF returns up to date? (Verify with sales book, bank teller)				
8	Is functional NHIS/SHIS services available				
	Total Score:……..…/8 x 10%				

7. HUMAN RESOURCES and Staff training (To be administered to the officer In Charge of Health Facility)

8. MEDICINE, SUPPLIES & EQUIPMENT (To be administered to the officer in charge of Pharmacy or in charge of Health Facilities)

S/N	Questions	0= No/NONE	1= YES/PARTIALLY ADEQUATE	2=ADEQUATE	COMMENTS (IF ANY) State actual number available
1	Availability of Essential Medicines List? (verify)				
2	Presence of medicine store? (verify)				
3	Availability of drugs stock monitoring tools (Binard, inventory card, Ledger)?				
4	Availability of an up-to- date record of expired and lost drugs? (verify)				
5	System for mopping and disposal of expired drugs available? (verify)				
6	Are there maternity drugs - Antibiotics (ampiclox, ampicilin) Cotrimoxazole, Metronidazole Oxytocin Ergomentine Misoprostol				

	Anti-retroviral drugs Magnesium Sulphate Tetanus Toxoid Vaccine Intravenous Fluid Multivitamins Albendazole Iron supplements Folic Acid Paracetamol Others…………………………………………				
7	Are there perinatal drugs? Vitamin K Sodium bicarbonate Parenteral Antibiotics (Ampiclox) Diazepam/Phenobarbitone Adrenaline (*Not for use at PHC level)* Others………………………………………..				
8	Availability of standard equipment list at the health facility? (verify)				
9	Any documentation in the health facility of equipment shortfalls (verify)updated equipment inventory				
10	Availability of plans for meeting equipment shortfalls? (verify)				
11	STI/HIV Test kits				
12	Ready to use therapeutic foods				
13	Others (specify)				
	Total score …………/26 x 10%				

9. MNCH EQUIPMENTS AND MATERIALS

	Equipment and Supplies	0= No/NONE	1= YES	COMMENTS		Medicines	0= No	1= YES	COMMENTS
1	Delivery Pack/Clean birth kits				20.	Oxytocin/ergometrine			
2	Sphygmomanometer				21.	Lidocaine			
3	Adult Stethoscope and Pinnard Stethoscope				22.	Misoprostol			
4	Oxygen				23.	Magnesium Sulphate			
5	NG tube				24.	Diazepam			
6	Oropharyngeal airway.				25.	Parenteral Antibiotic			
7	Ambu bag / mask				26.	Calcium Gluconate			
8	Delivery Beds				27.	IV Fluids			
9	Partograph				28.	Analgesic			

10	Clinical thermometer				29.	Maternity Drug store			
11	Suction equipment				30.	Neonatal Drug store			
12	Syringes and Needles								
13	Anti-Shock Garments								
14	Protective garments.								
15	IV Giving set								
16	Laboratory Test Kit								
17	Gloves								
18	Safety box								
19	Functional Ultrasonography machine								

Total score=……………/19 x 10%

10. HEALTH MANAGEMENT INFORMATION SYSTEMS

S/N	Data management	0= No/NONE	1= YES	COMMENTS (IF ANY)		HMIS Minimum Requirement	0= No/NONE	1= YES	COMMENTS (IF ANY)
1.	Do you submit MPCDSR monthly summary report on time to the state					HMIS tools with stock to last at least six months			
2.	Are the NHMIS registers available (check user‟s guide for the list)					Solar powered calculators			
3.	Do you notify maternal and perinatal deaths to LGA DSNO					Internet service/modem			
4.	Does your facility collaborate with NPopC in issuing death certificate?					Reference Manual			
5.	Have you taken any decision or action based on analysed MPCDSR report data?					Computer or Android phones			
	Total Score …../5 x 10%								

MPCDSR Form 14

FEDERAL MINISTRY OF HEALTH

MATERNAL, PERINATAL AND CHILD DEATH SURVEILLANCE AND RESPONSE

SOCIAL AUTOPSY GUIDE

Social Autopsy: "Social autopsy" refers to an interview process aimed at identifying social, behavioral, and health systems contributors to maternal and child deaths. It is often combined with a verbal autopsy interview to establish the biological cause of death. Two complementary purposes of social autopsy include providing population-level data to health care programmers and policymakers to utilize in developing more effective strategies for delivering maternal and child health care technologies, and increasing awareness of maternal and child death as preventable problems in order to empower communities to participate and engage health programs to increase their responsiveness and accountability. Social, behavioral, and preventive factors included in the updated Pathway Analysis social autopsy questionnaire include:

Social factors

• Mother‟s education, literacy, age at marriage

• Household possessions, husband‟s education, breadwinner‟s occupation

• Duration of residence in community and time to reach usual health provider

• Social capital (community joint action, helpful persons/groups, denial of services)

Maternal factors (including care seeking for complications)

• Antenatal care (blood pressure, urine and blood, counseling on food and care seeking), tetanus toxoid, insecticide-treated bed net use, malaria prophylaxis

• Birthplace and attendant, partograph, handwashing, clean delivery surface

• Knowledge of and care seeking for pregnancy, labor, and delivery complications

• Constraints to health care seeking and compliance with referral advice for maternal complications

• Quality of health care services (treatment, referral, and reasons for referral for complications)

Care seeking for child illnesses

• Newborn and child illness recognition, health care seeking, compliance with treatment, and referral advice

• Constraints to health care seeking and compliance with treatment and referral advice

• Quality of health care services (treatment, referral, and reasons for referral of sick children).

Others are

Finance
Economic status and out of pocket expenditure, NHIS/community insurance
Transport
Belief system {Fatalistic, Religious, Socio-cultural}
Male factor
Security issues
Health system

MPCDSR FORM 15

COMMUNITY DIALOGUE

AGENDA

VENUE:

TIME	ACTIVITIES	RESPONSIBLE PERSON/FACILITATORS
1.	Arrival	All
2.	Opening prayer	Volunteer
3.	Welcome Address	
4.	Objective of Community Dialogue	
5.	Identification of at risk Pregnancies	
6.	Evaluation /Questions	
7.	Transport to the Hospital	
8.	Evaluation/ Questions	
9.	Delivery	
10.	Evaluation/ Questions	
11.	Family Planning/ Contraceptives	
12.	Evaluation/ Question	
13.	Hygiene	
14.	Evaluation/ Questions	
15.	Nutrition	
16.	Adolescent Sexual Reproductive Health	
17.	Evaluation/ Questions	

18.	Male Involvement	
19.	Evaluation/ Questions	
20.	Maternal, Newborn, Child deaths reporting and review	
21.	Evaluation/ Questions	
22.	Adolescent Sexual Reproductive Health	
23.	Evaluation/ Questions	
24.	Data management	
25.	Evaluation/ Questions	
26.	Death Reviews	
27.	Evaluation/ Questions	
28.	Conclusions/ Closing	
29.	Refreshments	

21. APPENDICES

21.1. Appendix 1. Identification Number Coding Instruction

FEDERAL MINISTRY OF HEALTH

MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

IDENTIFICATION NUMBER CODING INSTRUCTION

Start with **MD** (if Maternal Death) or **PD** (if Perinatal Death).

Followed by

STATE = 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 number of that death in the year= Three decimal figure

For example

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

The deceased identification No. is **MD/FCT/DUT/PHC/06/14/005**

2. A perinatal death occurred in JUTH, Jos, Plateau state on 11th October 2016. This was the 12th death that year

The deceased identification No. is PD**/PLA/JOS/JUT/10/16/012**

21.2. Appendix 2. Grid Analysis of Maternal, Perinatal and Child Deaths in Health Facilities MPCDSR Committees

FEDERAL MINISTRY OF HEALTH

MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

GRID ANALYSIS OF MATERNAL, PERINATAL & CHILD DEATHS FOR FACILITY MPCDSR COMMITTEE

INSTRUCTIONS: This tool is intended for use during each death review meeting. It presents a sequence of questions that can be read out to members to guide the critical thinking that enable them identify significant issues contributory to death of the deceased.
In the chain of events described below, note which dysfunctions appeared and explain why it is a dysfunction (by comparing with standards of good practices):

1. ITINERY BEFORE ADMISSION

i. 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?

ii. 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

i. 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

i. 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

ii. 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

iii. 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

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

5. PATIENT MONITORING

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

6. INFORMATION IN PATIENT FILE

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

7. CASE SUMMARY:

i. The main problems identified in the case management
ii. The positive and strong observations in the case management
iii. The main causes of dysfunctions/mismanagement identified
iv. The medical cause of death and the contributing factors

21.3. Appendix 3. Consent Form for Verbal Autopsy Interview

FEDERAL MINISTRY OF HEALTH

MATERNAL AND PERINATAL, CHILD DEATH SURVEILLANCE AND RESPONSE

CONSENT FORM FOR VERBAL AUTOPSY INTERVIEW

INSTRUCTIONS:

The content of this consent form should be read clearly to prospective respondents (relative, neighbor or associate of deceased mother/newborn/ child who is familiar with events leading to the death) for verbal interviews before their consent is sought. It may have to be readout in the local language of the respondent, to ensure adequate communication.

1. My name is: ……………………………………….. of …………………………………………
2. Our Local, State and Federal Governments have commenced the interviewing of people to study why women or newborn babies/children die, this is to provide insight into what actions should be taken to improve health services.
3. This interview will seek general information on the deceased, including information on her pregnancy, delivery, after-delivery period (Puerperium) and newborn. Simple questions will be asked that will not take more than one hour of your time.
4. It is likely that some of the questions may raise your emotions on some memories that are hurtful.
5. The benefits from this interview are not immediate, they come later, as they provide our leaders and governments insight into the most frequent causes of death of women and newborns and give clues on means of preventing future such deaths.
6. I assure you that all information you provide will be treated with the utmost secrecy and your name will be concealed from government records as this interview will be coded.
7. You are free to accept or decline my request to respond to this interview or discontinue the interview after starting. Be assured that declining to participate will not attract any negative consequence.

Do you agree to participate in this interview? Yes ☐ No ☐

Interviewer‟s Name: ……………………………………………………………………………….

Interviewer‟s Signature: …………………………………… Date: …………………………………

Respondent‟s Name: …………………………………………………………………………………

Respondent‟s relationship to the deceased: ………………………………………………………………

21.4. Appendix 4. Grid Analysis Guide for Maternal, Perinatal and Child Death Review for Community MPCDSR Committee

FEDERAL MINISTRY OF HEALTH

MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

GRID ANALYSIS OF MATERNAL & PERINATAL CHILD DEATHS FOR COMMUNITY MPDSR COMMITTEE

INSTRUCTIONS:

This guide is used by the CMPDSR committee that shoulder the responsibility of analysing each maternal and perinatal death. After the case is presented to the committee, a discussion is held to ensure members have clear understanding of the events leading to the death.

Thereafter, the chairman reads out the successive items listed in the middle column for members to respond if they were applicable to the case being reviewed, in the case of which ticks (√) are made into the right-hand column (as the "determinants" or "contributory factors" to deceased's death, for which "Recommendations" or "Action Plan" will be considered in the next step of the meeting).

1	LOCAL GOVERNMENT AREA	
2	WARD	
3	FACILITY	
4	VILLAGE	
5	NAME OF THE DECEASED	
6	NAME OF HUSBAND/OTHER RELATIVE (FATHER/MOTHER)	
7	DATE OF DEATH: TIME OF DEATH:	
8	NAME OF RESPONDENT/INFORMANT & PHONE	
9	RELATIONSHIP OF RESPONDENT TO DECEASED	
10	PROBABLE CAUSE OF DEATH	
11	DATE OF INVESTIGATION	
12	NAME & DESIGNATION OF THE INVESTIGATOR(S)	
13	PHONE NUMBER & SIGNATURE OF INVESTIGATOR(S)	

Types of Delay	**Contributory Factors**	**Factors Identified in this Case (Tick as applicable)**
Delay Type 1	No antenatal care (ANC)	
	Late booking of ANC or infrequent visits	
	Failure to recognize 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	
	Failure to recognize danger signs	
Delay Type 2	No health facility within 5km radius	
	Lack of roads/hard- to- reach areas	
	Lack of transportation	
	Delayed arrival to referral health facility	
Delay Type 3	Delayed arrival to next health facility from a referring facility	
	Delayed treatment after admission	
	Delay due to poor facility infrastructure (electricity, water etc)	
	Delay due to lack of equipment or supplies	
	Human error or mismanagement	
Others (Specify):	1	
	2	

Was this death preventable? Yes ☐ No ☐ Not sure ☐

If Yes, list preventable factors:

3.
4.
5.
4.
5.

6

7

8.