Annex 11E: Maternal and Perinatal Death - Reporting Forms

FEDERAL MINISTRY OF HEALTH

MATERNAL DEATH REVIEW FORM 1 - NOTIFICATION

(MPDSR FORM 1)

Note:

This form must be completed by the attending officer in the health facility or community based informer for all maternal deaths including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy

This form must be completed immediately after death by the last person who attended to the patient, and submit to the head of the health Facility or person responsible for maternal health in the LGA for onward transmission to the appropriate health authorities – in the State and/or the Federal Ministry of Health within 24 hours.

1. Date of Death being reported (dd/mm/yy) or

Date this maternal death occured (day/month/year):.....

2. Time of Death being reported or

Time of death (specify "During pregnancy, At delivery, during delivery, during the immediate post partum period, or long after delivery").....

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

4. Name of Facility where death occurred:.....

5. Local Government Area:.....

6. State:.....

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

a. [ ] Tertiary Health Institution
b. [ ] General Hospital
c. [ ] Primary Health Care Centre
d. [ ] Faith based Institution
e. [ ] Private for profit
f. [ ] TBA's place
g. [ ] On the way/ before arrival to health facility
h. [ ] Home
i. [ ] Other (specify) .....

8. Ownership of Facility: (Tick √ one box)

a. [ ] Federal Government
b. [ ] State Government
c. [ ] Local Government Council
d. [ ] Faith –based
e. [ ] Private
f. [ ] other (specify) .....

9. Patient Identity:.....

10. Case Note No.(if hospitalized): .....

11. Age (years): .....

12. Gravidity(Total numbers of previous pregnancies): .....

13. Parity(Total numbers of previous deliveries): .....

14. Suspected cause of death: (Tick √ one box)

a. [ ] Hemorrhage
b. [ ] Pre-eclampsia / eclampsia
c. [ ] Puerperal sepsis
d. [ ] Prolonged/Obstructed labour
e. [ ] Ruptured uterus
f. [ ] Complications of abortions
g. [ ] Ectopic pregnancy
h. [ ] Other (specify) .....

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

a. [ ] Yes
b. [ ] No

16. Condition of the baby at the time of delivery (Tick √ one box)

a. [ ] Alive
b. [ ] Fresh Still birth
c. [ ] Macerated still birth
d. [ ] Not applicable

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

Telephone numbers.....

Emails.....

Address: .....

Signature: ..... Date: .....

Maternal Death Reporting Form		
The form must be completed for all deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy		
	Questions / Variables	**Answers**
1	Country	
2	District/State/Local Governement	
3	Reporting Site	
4	How many of such maternal deaths occurred cumulatively this year at this site?	
5	Date this maternal death occured (day/month/year)	
6	Maternal death locality (Village or Town)	
7	Record's unique identifier (year-Country code-District-site-maternal death rank)	
8	Maternal death place (Community, health facility, district hospital, referral hospital or private hospital, on the way to health facility or hospital)	
9	Age (in years) of the deceased	
10	Gravida: how many times was the deceased pregnant?	
11	Parity: how many times did the late deliver a baby of 22 weeks/500g or more?	
12	Time of death (specify "During pregnancy, At delivery, during delivery, during the immediate post partum period, or long after delivery")	
13	If abortion: was it spontaneous or induced?	
Maternal death history and risk factors		
14	Was the deceased receiving any antenatal care? (Yes/No)	
	Did she have Malaria? (Yes or No)	
15	Did she have Hypertension ? (Yes or No)	
16	Did she have Anaemia? (Yes or No)	
17	Did she have Abnormal Lie? (Yes or No)	
18	Did she undergo any Previous Caesarean Section? (Yes or No)	
19	What was her HIV Status? (choose "HIV+; HIV-; or Unknown HIV status")	
	Delivery, puerperium and neonatal information	
20	How long (hours) was the duration of labor	
21	What type of delivery was it? (choose one from "1=Vaginal non assisted delivery, 2= vaginal-assisted delivery (Vacuum/forceps), or 3=Caesarean section"	
22	What was the the baby status at birth? (Alive or Stillborn)	

Maternal Death Reporting Form		
The form must be completed for all deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy		
	Questions / Variables	**Answers**
23	In case the baby was born alive, is he/she still alive or died within 28 days after his/her birth ? (choose 1=Still alive, 2=neonatal death, 3=died beyond 28 days of age)	
24	Was the deceased referred to any health facility or hospital? (Yes/No/Don't know)	
25	If yes, how long did it take to get there? (hours)	
26	Did the deceased receive any medical care or obstetrical/surgical interventions for what led to her death? (Yes/No/Don't know)	
27	If yes, specify where and the treatment received*	
28	Primary cause of the Maternal Death	
29	Secondary cause of the Maternal Death	
30	Analysis and Interpretation of the information collected so far (investigator's opinion on this death)	
31	Remarks	
32	Maternal death notification date (day/month/year)	
33	Investigator (Title, name and function)	
	* Treatment received	
	I.V. Fluids; Plasma; Blood Transfusion; Antibiotics; Ocytocin; Anti-seizure drugs; Oxygen; Anti-malarial; Other medical treatment; Surgery; Manual removal of placenta; Manual intra uterin aspiration; Curettage, laporotomy, hysterctomy, intsrumental delivery (Forceps;Vacuum), Caesarian section, anetshesia (general, spinal, epidural , local)	
	Definitions	
	Gravida: The number of times the woman was pregnant- Parity**:** Number of times the woman delivered a baby of 22 weeks/500g or more, whether alive or dead	

FEDERAL MINISTRY OF HEALTH

PERINATAL DEATH NOTIFICATION FORM (PNDR 1)

GENERAL INSTRUCTIONS

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

DETAILS OF THE DECEASED AND MOTHER

1. **PND Case Number:** ☐☐☐☐ / ☐☐ / ☐☐ / ☐☐☐
2. **File Number (*health facility*):** ☐☐☐☐☐☐☐☐☐☐

3. **Physical Address or locality where mother lived:** (LGA, Name of village, Code)

4. **Family Contact No:**

5. **Age of mother (years):** ☐☐ (estimate if age is unknown)

6. **Locality where death occurred: LGA:** _____ **State:** _____

7. **Place where death occurred: (√ one box)**

1. ☐ Tertiary Teaching Hospital
2. ☐ Federal Medical Centre
3. ☐ General Hospital
4. ☐ Primary Health Care Centre
5. ☐ Stand alone Maternity Unit
6. ☐ TBA
7. ☐ Home
8. ☐ On the way/before arrival at H/F
9. ☐ Other (specify) _____

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

1. ☐ Federal MOH
2. ☐ State MOH
3. ☐ Private
4. ☐ LGA
5. ☐ Faith-based
6. ☐ Other

9. **Name of Health Facility:** _____

10. **Primary cause of death:** _____

11. **Final cause of death:** _____

12. **Modifiable contributing factors:**

13. Classification of perinatal/Newborn death (√ one box):

☐ Neonatal death ☐ Fresh stillbirth ☐ macerated stillbirth

14. Birth weight: ☐☐☐☐ grams **15. Gestation at birth:** ☐☐ weeks

16. Date of Birth

17. Date of ☐☐/☐☐/☐☐ **18. Date of** ☐☐/☐☐/☐☐

Admission: **Death**

19. Name of Reporting Officer: _____

20. Designation: _____

21. Date: ☐☐/☐☐/☐☐

22. Signature: _____

The form must be completed for selected perinatal deaths, comprising of stillbirths and neonatal deaths		
Questions / Variables		Answers
Identification		
1	Country	
2	District/State	
3	Reporting site/facility	
4	Perinatal death locality (village or town or LGA)	
5	Place of death (community, health facility, district hospital, referral hospital or private hospital, on the way to health facility or hospital)	
6	Date this perinatal death occurred (day/month/year)	
7	Record's unique identifier (year-country code-district-site) for the mother.	
8	Record's unique identifier (year-country code-district-site) for the baby (diseased).	
Pregnancy progress and care (Perinatal death history and risk factors)		
9	Mother's age (in years)	
10	Type of pregnancy (singleton/twin/higher multiples)	
11	Did the mother of the deceased receive any antenatal care? (Yes/No/Unknown),	
12	If yes to 11, how many visits?_____	
13	Did the mother of the deceased have malaria? (Yes/No/Unknown)	
14	If yes to 13, did the mother receive treatment _ (Yes/No/Unknown)	
15	Did the mother of the deceased have pre-eclampsia disease ? (Yes/No/Unknown)	
16	If yes to15, did the mother receive any treatment? (Yes/No/Unknown)	
17	Did the mother of the deceased have severe anaemia (HB,7g/dl)? (Yes/No/Unknown)	
18	If yes to 17, did the mother receive any treatment? (Yes/No/Unknown)	
19	Did the mother of the deceased have recommended maternal immunizations (e.g. tetanus toxoid) (Yes/ No/Unknown)	
20	Did the mother of the deceased have Rhesus factor (Rh) or ABO incompatibility? (Yes/ No/ Unknown)	
21	If Rhesus positive, did the mother of the deceased receive Anti-D injection during this baby's pregnancy? (Yes/ No/Unknown)	
22	Did the deceased present in an abnormal Lie (including breech presentation)? (Yes/ No/ Unknown)	
23	What was the HIV status of the mother? (choose "HIV+; HIV-; or Unknown HIV status")	
24	What was the status of the syphilis test of mother? (Positive (+) or negative (-))	
Labour, birth, puerperium		
25	Date of birth (day/month/year)	

26	Attendance at delivery (Nurse/midwife/doctor/other-specify).	
27	Was fetal heart rate assessed on admission? (Yes, No)	
	What type of delivery was it? (choose one from "1=Vaginal non assisted delivery, 2= vaginal-assisted delivery (Vacuum/forceps), or 3=Caesarean section	
28	Sex of the baby (1=male; 2=female, 3=ambiguous)	
29	Birth weight in grams(>=2500; 1500-2499 (LBW); 1000-1499g (VLBW); <1000 (ELBW))	
30	Did the mother of the deceased have premature rupture of membranes (PROM) (Yes/No/ Unknown)	
31	Did the mother of the deceased have foul smelling liquor?	
32	Gestational age (in weeks) Method of estimation: Ultrasound /LMP (DD/MM/YY)	
33	How long (hours) was the duration of labor	
	Information on the death and actions taken before and after the death	
30	If stillbirth – gestational age (in weeks) of the deceased	
31	If neonatal death – age (in days) of the deceased	
32	If the deceased baby was born alive what was the APGAR Score ?.	
33	If the deceased baby was born alive, wasresuscitation with bag and mask conducted?.	
34	If the deceased baby was born alive was he/she referred to any health facility or hospital? (Yes/No/Unknown)	
35	If the deceased baby was born alive did he/she receive any other medical care beyond resuscitation? (Yes/No/Unknown)	
	If yes, specify where and the treatment received:* I.V. Fluids; Blood/Plasma transfusion; Antibiotics; Oxygen; Other medical treatment;	
	Primary cause of death:	
	Secondary cause of death:	
	Maternal condition (if applicable)	
34	Timing of death (1-fresh stillbirth; 2-macerated stillbirth)	
35	Any physical malformation noted on the deceased? (Yes/No)	
	If yes, type of birth defect (with full description):	
	Investigator's report	
36	Analysis and interpretation of the information collected so far (investigator's opinion on this death)	
37	Perinatal death notification date (day/month/year)	
38	Investigator (Title, name and function)	

Still Births and Neonatal Deaths Weekly Summary Reporting Form

The form must be completed for stillbirths and neonatal deaths								
Questions/Variables								**Answers**
Identification								
1	Data for the month of							
2	Country							
3	LGA							
4	Reporting site/facility							
5	Births							
		Total Births	Stillbirths deaths			Neonatal		
			Antepartum	Intrapartum	Unknown	Early	Late	
	<1000 g (ELBW)							
	1000–1499 g (VLBW)							
	1500–1999 g (LBW)							
	2000–2499 g (MLBW)							
	2500 + g							
	Total							
Pregnancy progress and care (Perinatal death history and risk factors)								
6	Multiple pregnancies							
7	Born before arrival							
8	Mode of delivery							
	Normal vaginal delivery		Vacuum		Forceps		Caesarean	Unknown
9	Gestational age							
	Term	Post-term	Ext preterm (<1000g)		Very preterm (1000-1499)		Mod preterm (1500-2499)	Unknown
10	HIV status							
	Negative			Positive			Unknown	
11	Syphilis serology							
	Negative			Positive		Unknown		
12	Maternal age							
	>34 y		20-34		18-19 y		<18 y	Unknown