**KETUA PENGARAH KESIHATAN MALAYSIA**
Kementerian Kesihatan Malaysia
Aras 12, Blok E7, Kompleks E,
Pusat Pentadbiran Kerajaan Persekutuan
62590 PUTRAJAYA

Tel.: 03-8000 8000
Faks: 03-8889 5542

Ruj.Kami : KKM.600-30/4/1 Jld.10 ( 51 )
Tarikh : 30 Ogos 2023

**SEPERTI SENARAI EDARAN**

YBhg. Datuk/ Dato' Indera/Dato'/ Datin/Tuan/Puan,

**KERJASAMA PERKONGSIAN DATA BERKAITAN PROGRAM KESIHATAN BAYI DAN KANAK-KANAK DARIPADA PENGAMAL PERUBATAN SWASTA**

Dengan segala hormatnya perkara diatas adalah dirujuk.

2. Untuk makluman, pengamal perubatan swasta memainkan peranan yang penting dalam penjagaan kesihatan kanak-kanak di Malaysia. Kerjasama yang baik di antara pihak Kementerian Kesihatan Malaysia dan pengamal perubatan swasta telah lama terjalin dan diharapkan akan berterusan untuk mencapai visi dan misi secara bersama.

3. Untuk makluman juga, Bahagian Pembangunan Kesihatan Keluarga (BPKK), Kementerian Kesihatan Malaysia telah menghasilkan dokumen *Child Health 2021-2030: A National Framework to Reduce the Under-5 Mortality and Support Child Growth & Development.* Objektif utama adalah mengurangkan mortaliti yang boleh dicegah dan mempromosi persekitaran yang menyokong tumbesaran dan perkembangan optima kanak-kanak. Pelaksanaan Pelan Tindakan Kesihatan Kanak-Kanak ini juga merupakan tanggungjawab semua agensi dan komuniti dan tidak terhad kepada sektor kesihatan awam dan KKM sahaja.

4. Sehubungan dengan itu, KKM memohon kerjasama daripada pengamal perubatan swasta dalam perkongsian data berkaitan program kesihatan bayi dan kanak-kanak. Pengumpulan maklumat serta kualiti data perlu ditingkatkan dalam usaha mendapatkan gambaran pencapaian liputan dalam penjagaan kesihatan bayi dan kanak-kanak yang komprehensif di Malaysia. Data yang diperlukan adalah berkaitan:

i. Program Saringan *Congenital Hypothyroidism*
ii. Program Saringan Kekurangan Enzim G6PD
iii. Program Imunisasi Kebangsaan
iv. Notifikasi dan Pelaporan Kes Lahir Mati dan Kematian Kanak-kanak Bawah 5 tahun

5. Kaedah perkongsian data-data ini adalah melalui:

   i. Manual Format:
      a. Program Saringan *Congenital Hypothyroidism*
      b. Program Saringan Kekurangan Enzim G6PD
      c. Program Imunisasi Kebangsaan
      d. Borang notifikasi dan pelaporan kes lahir mati dan kematian kanak-kanak bawah 5 tahun

   ii. Format atas talian melalui sistem MyVAS bagi perkongsian data Program Imunisasi Kebangsaan adalah amat digalakkan

6. <u>Reten dan pelaporan secara manual perlu dihantar setiap bulan iaitu pada atau sebelum 10hb bulan berikutnya</u> kepada Pejabat Kesihatan Daerah masing-masing di mana lokasi pengamal perubatan swasta berada.

7. Selaras dengan matlamat untuk kepentingan bersama dan meningkatkan jalinan kerjasama dua-hala, pencapaian dan data yang dikumpulkan dari pengamal perubatan swasta akan dikongsikan melalui platform yang sesuai.Mohon kerjasama YBhg. Datuk/ Dato' Indera/ Dato'/ /Datin/Tuan/Puan agar dapat memanjangkan perkara ini kepada hospital dan pengamal perubatan swasta.

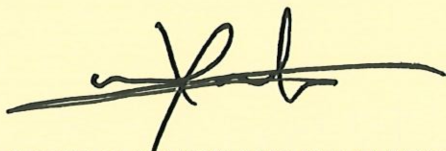
8. Kerjasama dan perhatian YBhg. Datuk/ Dato' Indera/ Dato'/Datin/Tuan/Puan dalam perkongsian data amatlah dihargai dan didahului dengan ucapan terima kasih.

Sekian.

**"MALAYSIA MADANI"**

**"BERKHIDMAT UNTUK NEGARA"**

*Yang menjalankan amanah,*



**(DATUK DR MUHAMMAD RADZI BIN ABU HASSAN)**
Ketua Pengarah Kesihatan Malaysia

s.k.

Timbalan Ketua Pengarah Kesihatan (Kesihatan Awam)
Kementerian Kesihatan Malaysia

Timbalan Ketua Pengarah Kesihatan (Perubatan)
Kementerian Kesihatan Malaysia

Pengarah
Bahagian Amalan Perubatan
Kementerian Kesihatan Malaysia

Pengarah
Bahagian Pembangunan Kesihatan Keluarga
Kementerian Kesihatan Malaysia

Pengarah
Bahagian Kawalan Penyakit
Kementerian Kesihatan Malaysia

**SENARAI EDARAN**

Presiden
Malaysian Medical Association

Presiden
Persatuan Hospital Swasta Malaysia

Pengarah
Jabatan Kesihatan Negeri Perlis

Pengarah
Jabatan Kesihatan Negeri Kedah

Pengarah
Jabatan Kesihatan Negeri Pulau Pinang

Pengarah
Jabatan Kesihatan Negeri Perak

Pengarah
Jabatan Kesihatan Negeri WP Kuala Lumpur/Putrajaya

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Jabatan Kesihatan Negeri N.Sembilan

Pengarah
Jabatan Kesihatan Negeri Melaka

Pengarah
Jabatan Kesihatan Negeri Johor

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Jabatan Kesihatan Negeri Pahang

Pengarah
Jabatan Kesihatan Negeri Terengganu

Pengarah
Jabatan Kesihatan Negeri Kelantan

Pengarah
Jabatan Kesihatan Negeri Sabah

Pengarah
Jabatan Kesihatan Negeri Sarawak

Pengarah
Jabatan Kesihatan Negeri WP Labuan

Lampiran 1

# Reten Saringan Congenital Hypothyroidism

**Hospital/Clinic :** **YEAR:**

| | | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | No. of live births at hospital/KK | | | | | | | | | | | | | |
| b | No. live birth as BBA | | | | | | | | | | | | | |
| c | No. samples screened | | | | | | | | | | | | | |
| d | No. samples rejected | | | | | | | | | | | | | |
| e | No. of normal TSH | | | | | | | | | | | | | |
| f | No. samples with high TSH | | | | | | | | | | | | | |
| g | No. samples with borderline TSH | | | | | | | | | | | | | |
| h | No. samples with borderline TSH and low FT4 | | | | | | | | | | | | | |
| i | No. needing retesting (f+h) | | | | | | | | | | | | | |
| j | No. of patient retested | | | | | | | | | | | | | |
| k | Actual recall rate ; (i/c)x 100 | | | | | | | | | | | | | |
| l | No. of confirmed cases | | | | | | | | | | | | | |
| m | No. of confirmed cases treated < 14 days | | | | | | | | | | | | | |

Lampiran 2

# Reten Saringan G6PD

**Hospital/Clinic :** **YEAR:**

| | | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | No. of G6PD screening conducted | | | | | | | | | | | | | 0 |
| b | No. of G6PD deficient detected | | | | | | | | | | | | | 0 |

Lampiran 3

# Reten Program Imunisasi Kebangsaan

## *sekiranya tidak mengguakan sistem MyVAS

FORMAT RETEN PERKHIDMATAN IMUNISASI KANAK-KANAK (0 - <6 TAHUN) DI FASILTI SWASTA

HOSPITAL/ KLINIK; ............................................................ BULAN: .......................................... TAHUN: .................................

NEGERI: ..............................

| Bil | Nama | Umur | No Kad My Kid / Pasport | Alamat | No Telefon Ibu/Bapa/ Penjaga | Imunisasi (Tandakan / pada kolum ruang berkaitan) | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | BCG | | Hep B | | | | DtaP/ IPV + HIB | | | | DtaP-IPV-HepB-HIB | | | | MMR | | PCV | | | JE | | Measles |
| | | | | | | <24 jam | >24 jam | Dos 1 | Dos 2 | Dos 3 | Dos 4 | Dos 1 | Dos 2 | Dos 3 | Tamb. | Dos 1 | Dos 2 | Dos 3 | Tamb. | Dos 1 | Dos 2 | Dos 1 | Dos 2 | Dos 3 | Dos 1 | Dos 2 | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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## BORANG NOTIFIKASI KEMATIAN LAHIRMATI (*STILLBIRTH*)

**(Borang ini perlu dihantar dalam tempoh 24 jam selepas masa bersalin ke PKD terdekat)**

**Hospital/Klinik Kesihatan :**

**Daerah :** **Negeri :**

**1. Nama Kes:** ..................................................................................................................

**2. Tarikh Lahir :** .... / .... / ....... **Masa:** .............(24 jam eg 2050H)

**3. Nombor Kad Pengenalan :** ............................ ☐ MyKad Ibu ☐ Dokumen Lain: ...............

**4. Nama Ibu/Penjaga :** ..................................................................................................................

**5. Berat Lahir:** ............gram **POA/POG:** ...... minggu ☐ **FSB** ☐ **MSB**

**6. Jantina Kes :** ☐ Lelaki ☐ Perempuan ☐ Indeterminate

**7. Warganegara :** ☐ Ya ☐ Bukan Warganegara - LEGAL ☐ Pendatang tanpa Izin - ILLEGAL

**8. Bangsa :** ☐ Melayu ☐ Cina ☐ India ☐ Orang Asli ☐ Bumiputera Sabah (Nyatakan) ..............
☐ Bumiputera Sarawak (Nyatakan) ................ ☐ Lain-lain (Nyatakan).......................

**9a. Alamat Kediaman Sekarang:** **9b. No. Tel:** ............................

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

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

**Bandar:** ............................ **Daerah:** .............................. **Negeri:** ...............................

**10. Tempat Bersalin :** Sila tanda ( √ ) * Bulatkan yang berkenaan

☐ *Hospital/ Klinik Kerajaan ☐ Dalam perjalanan
☐ *Hospital/ Klinik Swasta ☐ Rumah
☐ *Hospital/ Klinik Universiti ☐ Lain-Lain
☐ *Hospital/ Klinik ATM Nyatakan: ................................

**11. Sebab Kematian**

Immediate Cause:..................................................................................................................

Underlying Cause: ..................................................................................................................

**12. Ulasan Lanjut (jika ada):**

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

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

**Dilaporkan oleh :**

**Nama :** **Tandatangan:**

**Tempat Bertugas:** **Jawatan dan cop rasmi:**

**Tarikh:** **No. Telefon:**

****Tarikh dan masa borang diterima oleh PKD:**

**Note: Sila lengkapkan semua bahagian – Semua ruangan wajib diisi.**

**SULIT**

## BORANG NOTIFIKASI KEMATIAN KANAK-KANAK DI BAWAH UMUR 5 TAHUN (0 - < 5 TAHUN)

**(Borang ini perlu dihantar dalam tempoh 24 jam masa kematian ke PKD)**

**Hospital/Klinik Kesihatan :**

**Daerah:** **Negeri :**

**1. Nama Kes:** ..........................................................................................................
**2. Tarikh Lahir :** ...... / ...... / .......... **Masa:** .................... (24 jam, cth:17.56)
**3. Nombor Kad Pengenalan :** ........................................ ☐ MyKid ☐ MyKad Ibu

**4. Nama Ibu/Penjaga :** ..........................................................................................

**5. Umur Kes :** .......................... ☐ 0-27 hari ☐ 28-364 hari ☐ 1 tahun - <5 tahun

**6. Jantina Kes :** ☐ Lelaki ☐ Perempuan ☐ Indeterminate

**7. Warganegara :** ☐ Ya ☐ Bukan Warganegara (LEGAL) ☐ Pendatang Tanpa Izin (ILLEGAL)

**8. Berat Lahir (bagi kes neonatal):** .................... gram

**9. Bangsa :** ☐ Melayu ☐ Cina ☐ India ☐ Orang Asli ☐ Bumiputera Sabah (nyatakan) ....................
☐ Bumiputera Sarawak (nyatakan) ................. ☐ Lain-lain (nyatakan)........................

**9a. Alamat kediaman sekarang:** **9b. No Tel:** ............................................
..........................................................................................................
..........................................................................................................
**Bandar:** .............................. **Daerah:** ................................ **Negeri:** ................................

**10. Tarikh Kematian :** ...... / ...... / .......... **Masa:** .................... (24 jam, cth:17.56)

**11. Tempat kematian :** Sila tanda ( √ )

☐ *Hospital / Klinik Kerajaan ☐ Dalam perjalanan
☐ *Hospital / Klinik Swasta ☐ Di tempat kejadian (cth: kolam, jalan raya)
☐ *Hospital / Klinik Universiti Nyatakan: ................................
☐ Rumah Sendiri ☐ Lain-lain (cth: RSAT)
☐ Rumah Pengasuh Nyatakan: ................................
☐ Taska

Alamat Kematian:
.................................
.................................
.................................

**12. Sebab kematian**
Immediate Cause: ..........................................................................................
Underlying Cause: ..........................................................................................

**13. Ulasan Lanjut (jika ada):**
..........................................................................................................
..........................................................................................................

**Dilaporkan oleh :**
**Nama :** **Tandatangan:**

**Tempat Bertugas:** **Jawatan dan cop:**

**Tarikh:** **Telefon:**

****Tarikh dan masa borang diterima oleh PKD:**

**Nota Penting: 1. Semua ruangan wajib diisi**
**2. *Potong mana yang tidak berkenaan**

SU5MR CR- 1/2020

# STILLBIRTH & UNDER 5 MORTALITY CONSOLIDATION REPORT

**STATE:** **DISTRICT:**

<table>
<tr><td colspan="2">Name:</td><td>Sex: M / F</td><td>DOB:<br><br>Age:</td></tr>
<tr><td colspan="2">MyKid:</td><td colspan="2" rowspan="2">Race: Malay / Chinese / Indian / OA<br><br>Others (state):</td></tr>
<tr><td colspan="2">MIC:</td></tr>
<tr><td colspan="2">Date & Time of Death:<br><br>Place of death:</td><td colspan="2">Home Address:</td></tr>
<tr><td colspan="4">Antenatal History (list antenatal issues, medical problem, social concern)</td></tr>
<tr><td colspan="4">Perinatal History (place of delivery, perinatal events, gestation, mode of delivery, BW, resuscitation, Apgar score, NICU/SCN admission)</td></tr>
<tr><td colspan="4">Neonatal History (comorbidity, postnatal visits, hospital admission, feeding issue, social concern)</td></tr>
<tr><td colspan="4">Childhood History (main carer, immunization, comorbidity, hospital admission, growth, development, social concern)</td></tr>
<tr><td colspan="4">Events leading to death (timeline terminal events, investigation (laboratory/radiological, post mortem)</td></tr>
<tr><td colspan="4">Cause of death<br><br>1a:<br><br>1b:<br><br>1c:<br><br>1d:</td></tr>
</table>

| 2:<br><br>ICD10 classification: | | |
|---|---|---|
| Death category: Please tick ( / ) one column either A/B/C and choose (a) or (b) or both as appropriate: | | |
| A. Preventable ☐<br>a) Medically treatable ☐<br>b) Public health issue ☐ | B. Not preventable ☐<br>a) Palliative case ☐<br>b) Non palliative case ☐ | C. Undetermined ☐<br>a) Post-mortem done ☐<br>b) Pending special Ix ☐ |
| **Shortfalls:** (as determined during district U5M meeting) | | |
| **Remedial Actions:** (as determined during district U5M meeting) | | |
| **Medical Officer: (Name, designation)** | **Verified By: (Name, designation)** | |
| **Neutral Assessor: (Name, designation)**<br><br>**Comment:**<br><br>**Recommendation.** | | |

# UNDER FIVE DEATHS IN MALAYSIA
# MINISTRY OF HEALTH MALAYSIA

## STILLBIRTH & UNDER 5 MORTALITY DEATH FORM

Please complete a form for all of birth ≥ 500gm or 22 completed weeks of pregnancy if birth weight is not known.

****Important Note:

1. FOR STILLBIRTH, please complete ALL SECTIONS EXCEPT SECTION 3 and 4
2. FOR NEONATAL DEATH, please complete ALL SECTIONS
3. FOR 28 DAYS - <5 YEARS, please complete ALL SECTIONS EXCEPT SECTION 5 and 6A

**A. Reporting Centre/District** ..........................................

MRN:

**B. Date of form filled/ Date of Interview:** __ __ / __ __ / __ __

☐ Hospital death ☐ Non hospital death

☐ Fresh Stillbirth (≥500g or ≥22 weeks gestation)
☐ Macerated Stillbirth (≥500g or ≥22 weeks gestation)
☐ Early neonatal death (0-6 days and BW ≥500g)
☐ Late neonatal death (7-27 days and BW ≥ 500g)

* Birth Weight (g): _________ (earliest weight recorded)

☐ 28 days - < 1 year
☐ 1 year - < 5 years

## SECTION 1: PATIENT DETAILS (ALL DEATHS)

| | | | | |
|---|---|---|---|---|
| **1.Name:** | | | | |
| **2. MyKid No/ Other ID No:** | ☐☐☐☐☐☐☐☐☐☐☐☐ *(Please fill in the MyKid number.If there is no MyKid no., fill in new or old IC of mother or father or guardian or any other identification document number. Please tick (V) the ID document for the ID no given.)* | ☐ MyKid No<br>☐ Mother's IC<br>☐ Father's IC<br>☐ Guardian's IC | ☐ Other ID document Specify: (eg. Passport no.) ..........................................<br>..........................................<br>☐ No document | |
| **3. Residence:** | a. Postcode: | b. City/ Town: | c. District: | d. State: |
| **4. Current address:** | | | | |
| **5. Ethnicity: citizen only** | ☐ Malay<br>☐ Chinese<br>☐ Indian | ☐ Orang Asli<br>☐ Bumiputera Sabah, specify: ......................<br>☐ Bumiputera Sarawak, specify: ...................... | ☐ Other Malaysian, specify:...................... | |
| **6. Gender:** | ☐ Male | ☐ Female | ☐ Indeterminate | ☐ Unknown |
| **7. Immunisation status: (up to age)** | ☐ Not applicable | ☐ Complete | ☐ Not complete<br>Please specify: .................................. | |

## SECTION 2: PARENT DETAILS (ALL DEATHS)

| **8. Parents** | **Mother's details** ☐ unknown | **Father's details** ☐ unknown |
|---|---|---|
| a. Age | ............ years | ................ years |
| b. Citizen | ☐ Citizen ☐ Non Citizen (legal) ☐ Non Citizen (illegal)<br>Country of origin, specify:.......................... | ☐ Citizen ☐ Non Citizen (legal) ☐ Non Citizen (illegal)<br>Country of origin, specify:.......................... |
| c. Education level | ☐ No formal education ☐ Primary ☐ Secondary<br>☐ College/University ☐ Others, specify: .................... | ☐ No formal education ☐ Primary ☐ Secondary<br>☐ College/University ☐ Others, specify: .................... |
| d. Occupation | Please specify: .................................................... | Please specify: .................................................... |
| e. Marital status | ☐ Married ☐ Unmarried ☐ Divorced ☐ Widow ☐ Unknown | |
| f. Combined household income (RM) | ☐ <1000 ☐ 1001-3000 ☐ 3001-5000 ☐ 5001-7000 ☐ 7000 and above<br>☐ No Income ☐ On social welfare support ☐ unknown | |

## SECTION 3 : PATIENT'S DEATH DETAILS (0 - <5 years)

| | | |
|---|---|---|
| **9a. Date of Birth: (dd/mm/yyyy)** | ___ / ___ / ___ | **9b. Age at death:** ............................................ **(year/month/day/hour/min)** |
| **10. Date and time of Death:** | a. Date (dd/mm/yyyy) ___ / ___ / ___ | **b. Time:** ___ ___ : ___ ___ AM/PM |
| **11.Death Certificate issued by:** | ☐ Medical personnel specify: ............................................ | ☐ Non Medical personnel specify: ............................ |
| **12. Cause of death: (as in death certificate)** | | |

## SECTION 3a: HOSPITAL DEATH ONLY (0 - <5 years)

| | |
|---|---|
| **13. Place of death (livebirth only):** | ☐ University hospital<br>☐ Government hospital with specialist → ☐ District ☐ General<br>☐ Government hospital without specialist<br>☐ Private hospital/maternity home < 50 beds with specialist<br>☐ Private hospital/maternity home <50 beds without specialist<br>☐ Private hospital/maternity home > 50 beds<br>☐ Military hospital |

| | | | | | | |
|---|---|---|---|---|---|---|
| **14. Hospital Treatment:** ( Tick (√) one) | a. Highest level of care received: | ☐ PICU | ☐ SCN/NICU | ☐ Main ICU | ☐ PHDW ☐ A&E | ☐ Others: specify ................ |
| | | ☐ Paed Medical Ward | ☐ Paed Surgical Ward | ☐ Labour room | | |
| | b. Highest level of person managing | ☐ HO | ☐ Specialist | ☐ Others: specify ...................................... | | |
| | | ☐ MO | ☐ Consultant | | | |

## SECTION 3b: NON HOSPITAL DEATH ONLY (0 - <5 years)

| | | | |
|---|---|---|---|
| **15. Place of Death:** ( Tick (√) one) | ☐ Health clinic<br>☐ Private clinic<br>☐ University clinic<br>☐ Alternative Birthing Centre | ☐ Home<br>☐ Caretakers' house<br>☐ Nursery<br>☐ En route/ during transport<br>☐ At the scene (eg accident site) | ☐ Rumah Sakit Angkatan Tentera (RSAT)<br>☐ Others, specify: .......................... |

## SECTION 4: (0 - < 5 years)

| 16. Symptom(s) of current illness leading to death: | ( Tick (√) one or more boxes) | | <u>Duration (day(s) OR hours(s) if less than a day):</u> | | | <u>Duration (day(s) OR hours(s) if less than a day):</u> |
|---|---|---|---|---|---|---|
| ☐ Not applicable | ☐ | Fever | | ☐ | Lethargy | |
| | ☐ | Cough | | ☐ | Unconsciousness | |
| | ☐ | Difficult breathing | | ☐ | Not able to drink /feed | |
| | ☐ | Diarrhoea | | ☐ | Others, specify | |
| | ☐ | Convulsion | | | | |

**Please complete number 17 ONLY IF you (√) one or more boxes in 16 (Except Not Applicable)**

| | ( Tick (√) one) | Place of Treatment: ( Tick (√) one or more boxes) | | | No of times: |
|---|---|---|---|---|---|
| **17. Treatment(s) received for current illness?**<br><br>☐ Not applicable | ☐ Yes → Please attach additional information if any | ☐ | a.Hospital | Government | |
| | | | | University | |
| | | | | Pivate | |
| | | | | Othes,specify......................... | |
| | | ☐ | b.Clinic | Government | |
| | | | | University | |
| | | | | Private | |
| | | | | Others,specify......................... | |
| | | ☐ | c.Unknown | | |
| | ☐ No → Please attach additional information if any | **(Reason(s):** ( Tick (√) one or more boxes) | ☐ | Self-medication | |
| | | | ☐ | Traditional / complemenary treatment | |
| | | | ☐ | No transport | |
| | | | ☐ | Unaware child is seriously il | |
| | | | ☐ | Others, specify......................... | |

| 18.Co-Morbid Condition | If Yes, state condition(s): ( Tick (√) one or more boxes below) | |
|---|---|---|
| ( Tick (√) one)<br>☐Yes<br>☐ No<br>☐ Not applicable | ☐ | Cerebral Palsy |
| | ☐ | Chronic Lung Disease |
| | ☐ | Malnutrition |
| | ☐ | Congenital Anomaly, specify: ................................................... |
| | ☐ | Cardiac Disease, specify: ........................................................ |
| | ☐ | Malignancy, specify: ............................................................. |
| | ☐ | Condition from perinatal period, specify: ................................. |
| | ☐ | Immunodeficiency, specify: ...................................................... |
| | ☐ | Others, specify: ................................................................. |

## SECTION 5: FOR STILLBIRTH AND NEONATAL DEATH ONLY

### MOTHER PREGNANCY DETAILS

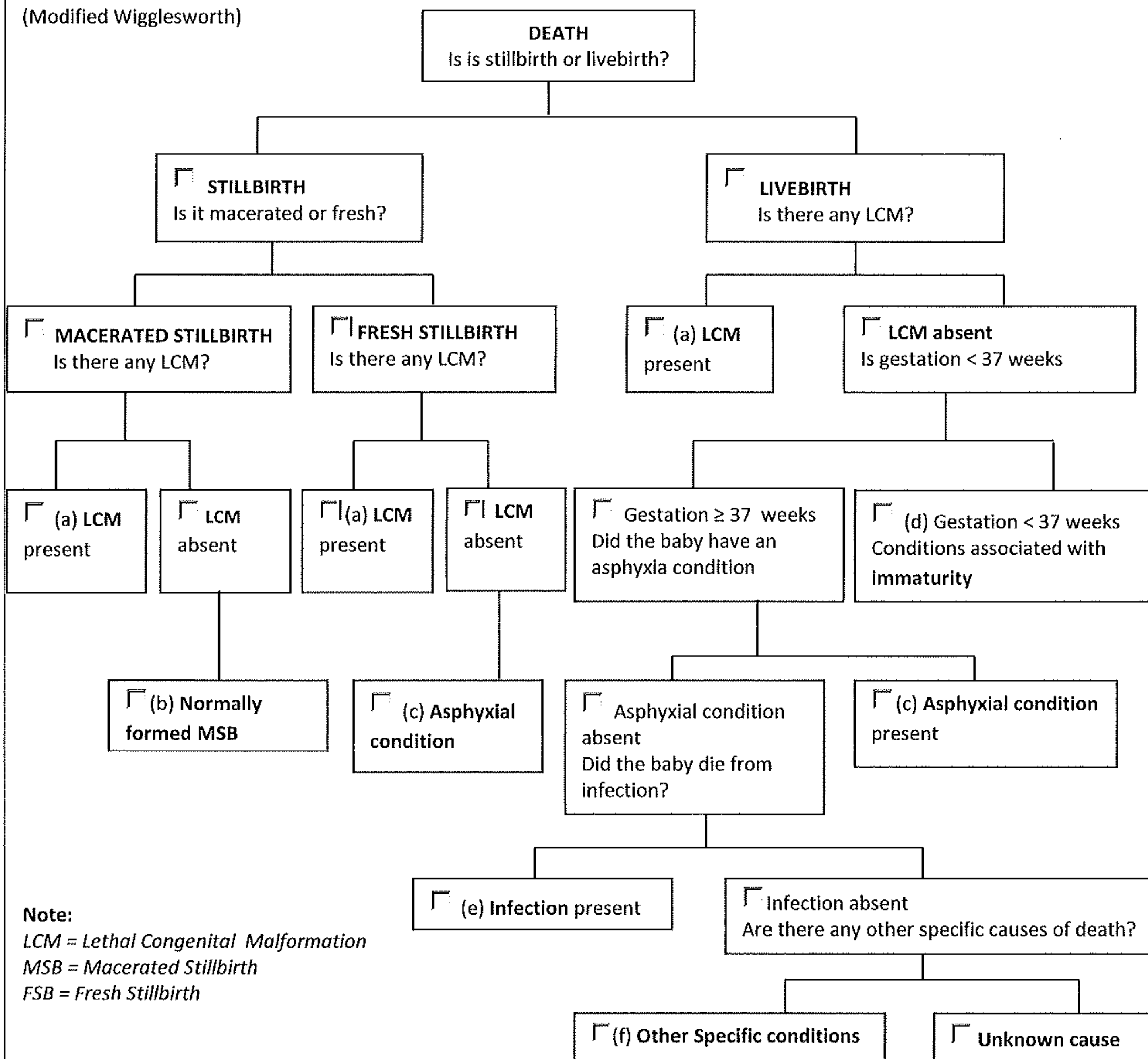
| | |
|---|---|
| 19. Gravida .......... Para ........... Abortion ......... ☐ Unknown | |
| 20. Gestational age at delivery : .................................. (weeks/ days) ☐ Unknown | |
| 21. Gestational age based on: | ☐ LMP ☐ Ultrasound ☐ Neonatal assessment ☐ Unknown |
| 22. Date and time of delivery: | **a. Date** (dd/mm/yyyy) [ ] / [ ] / [ ] **b.Time:** [ ][ ] : [ ][ ] AM/PM |
| 23. Place antenatal care received: | ☐ Health Clinic ☐ Government Hospital with specialist<br>☐ Private hospital/clinic ☐ Government Hospital without specialist<br>☐ No antenatal care ☐ Mobile clinics ☐ Others, specify: ...........................<br>**District:** ................................. **State:** ...............................................<br>*Please indicate the District and State with most number of antenatal visits* |
| 24.Place of delivery: | ☐ Home<br>☐ Health clinic<br>☐ Private hospital/maternity home<br>☐ University hospital<br>☐ Government hospital with specialist → ☐ District ☐General<br>☐ Government hospital without specialist<br>☐ Military hospital<br>☐ ABC<br>☐ Enroute/ During trasnsport<br>☐ Others, specify: ........................<br>☐ Unknown |
| 25. Delivery details: | 1. Delivery type: ☐ Vaginal ☐ Instrumental ☐ Caesarean |
| | 2. Delivered by: ☐ Specialist<br>☐ MO with > 6 months O & G experience<br>☐ MO with < 6 months O & G experience<br>☐ MO with no O & G experience<br>☐ House Officer<br>☐ Staff Nurse<br>☐ Community nurse/Government Midwife<br>☐ Traditional Birth Attendant → ☐ Trained ☐ Untrained<br>☐ Unattended<br>☐ Others, specify: ................................<br>☐ Unknown |
| 26. No. of fetuses/babies in this pregnancy | ☐ Singleton ☐ Twins ☐ Triplets ☐ Others, specify: .......................<br>For multiple pregnancies, please specify: ($1^{st}$, $2^{nd}$, $3^{rd}$ etc)<br>☐ Birth order: ................ ☐ unknown |

| 27. Current obstetric/ medical problems: | | Yes | No | Unknown |
|---|---|---|---|---|
| | 1. Hypertensive disorders of pregnancy | ☐ | ☐ | ☐ |
| | 2. Diabetes Mellitus | ☐ | ☐ | ☐ |
| | 3. Heart disease in pregnancy | ☐ | ☐ | ☐ |
| | 4. HIV | ☐ | ☐ | ☐ |
| | 5. Syphilis | ☐ | ☐ | ☐ |
| | 6. Vaginal bleeding | ☐ | ☐ | ☐ |
| | 7.Persistent anaemia in pregnancy | ☐ | ☐ | ☐ |
| | 8. Prolonged rupture of membrane | ☐ | ☐ | ☐ |
| | 9. Preterm labour | ☐ | ☐ | ☐ |
| | 10. IUGR | ☐ | ☐ | ☐ |
| | 11. Post Date | ☐ | ☐ | ☐ |
| | 12. Other medical illnesses, specify: ........................................ | ☐ | ☐ | ☐ |

| 28. Timing of death (stillbirth only) | ☐ Not in labour ☐ After admission ☐ Before admission<br>☐ In labour ☐ Unknown |
|---|---|

29. Classification of Death (Modified Wigglesworth)

Please tick the relevant box to reach correct classification




**Note:**
*LCM = Lethal Congenital Malformation*
*MSB = Macerated Stillbirth*
*FSB = Fresh Stillbirth*

**30. Death Classification**

Note:
SB = Stillbirth
ND = Neonatal Death

- ☐ (a)Lethal Congenital Malformation/Defect (SB & ND)
  Specify:
  - ☐ Neural Tube Defects (eg anencephaly, large spina bifida)
  - ☐ Complex/cyanotic heart disease
  - ☐ Recognisable syndrome (eg Edward, Patau)
  - ☐ Not Recognisable syndrome eg multiple gross congenital abnormalities
  - ☐ Hydrop Foetalis
  - ☐ Others, please specify: ......................................
- ☐ (b) Normally formed MSB (SB)
- ☐ (c) Asphyxial condition (SB & ND)
- ☐ (d) Immaturity (ND)
- ☐ (e) Infection (ND)
- ☐ (f) Other Specific causes (ND),
  Specify:
  - ☐ kernicterus/severe neonatal jaudince
  - ☐ Haemorrhagic disease of newborn/Vitamin K deficiency
  - ☐ Others, please specify: ....................................
- ☐ (g) Unknown (ND)

## SECTION 6: TO BE FILLED UP BY MEDICAL OFFICER IN CHARGE/SPECIALIST AT PLACE OF DEATH

### SECTION 6A : SHORTFALLS IN CASE MANAGEMENT (FOR STILLBIRTH AND NEONATAL DEATH):

| 1. ANTENATAL CARE | | | Yes | No | NA |
|---|---|---|---|---|---|
| 1.1 | Insufficient antenatal care provided /unbooked. If yes, specify .......................................... | | ☐ | ☐ | ☐ |
| 1.2 | Delay or lack of consultation in high-risk pregnancy .If yes, specify .......................................... | | ☐ | ☐ | ☐ |
| 1.3 | Inadequate management of | | | | |
| | 1.3.1 | Previous bad obstetric history | ☐ | ☐ | ☐ |
| | 1.3.2 | Diabetes mellitus | ☐ | ☐ | ☐ |
| | 1.3.3 | Hypertension/PE/Eclampsia | ☐ | ☐ | ☐ |
| | 1.3.4 | Anaemia | ☐ | ☐ | ☐ |
| | 1.3.5 | Post date (≥ 41 weeks) | ☐ | ☐ | ☐ |
| | 1.3.6 | Antepartum haemorrhage | ☐ | ☐ | ☐ |
| | 1.3.7 | Cephalopelvic disproportion | ☐ | ☐ | ☐ |
| | 1.3.8 | Multiple pregnancy | ☐ | ☐ | ☐ |
| | 1.3.9 | Preterm prelabour rupture of membranes/prelabour rupture of membrane | ☐ | ☐ | ☐ |
| | 1.3.10 | Growth restricted fetus/IUGR | ☐ | ☐ | ☐ |
| | 1.3.11 | Cervical incompetence | ☐ | ☐ | ☐ |
| 1.4 | Failure to effect in-utero transfer. If yes, specify.......................................................... | | ☐ | ☐ | ☐ |
| 1.5 | Inadequate/inappropriate maternal drugs | | | | |
| | 1.5.1 | Provider factor (specify). ( Tick (√) one) ☐ public ☐ private | ☐ | ☐ | ☐ |
| | 1.5.2 | Patient factor. If yes, specify........................................................................ | ☐ | ☐ | ☐ |
| 1.6 | Patient factor | | | | |
| | 1.6.1 | Non-compliance to medical advice/treatment. If yes, specify........................................................ | ☐ | ☐ | ☐ |
| 1.7 | Inadequate maternal monitoring (eg. blood pressure, urine and weight gain) | | | | |
| | 1.7.1 | Misinterpretation of tests | ☐ | ☐ | ☐ |
| | 1.7.2 | Delay in action taken ( Tick (√) one) ☐ provider ☐ patient | ☐ | ☐ | ☐ |
| 1.8 | Inadequate fetal monitoring (FKC/CTG/Daptone) | | ☐ | ☐ | ☐ |
| | 1.8.1 | Specify......................................................... | | | |

| **Comments by Head of Department / Officer-in-Charge: Please attach additional information if any.** | **Prepared by:**<br>**Name:**<br><br>**Designation:**<br><br>**Date:** |
|---|---|

| 2. INTRAPARTUM CARE | | | Yes | No | NA |
|---|---|---|---|---|---|
| 2.1 | Unsuitable place (home/hospital) for delivery. If yes, specify....................................................................... | | ☐ | ☐ | ☐ |
| 2.2 | Failure to perform Caesarean Section on time | | ☐ | ☐ | ☐ |
| | 2.2.1 | Caesarean Section too early | ☐ | ☐ | ☐ |
| | 2.2.2 | Caesarean Section too late | ☐ | ☐ | ☐ |
| | 2.2.3 | Hospital factor. If yes, specify......................................................................... | ☐ | ☐ | ☐ |
| | 2.2.4 | Patient factor. If yes, specify......................................................................... | ☐ | ☐ | ☐ |
| 2.3 | Induction of labour | | ☐ | ☐ | ☐ |
| | 2.3.1 | Induction of labour too early. If yes, specify....................................................................... | ☐ | ☐ | ☐ |
| | 2.3.2 | Induction of labour too late. If yes, specify............................................................... | ☐ | ☐ | ☐ |
| 2.4 | Inadequate intrapartum monitoring. If yes, specify.................................................................. | | ☐ | ☐ | ☐ |
| 2.5 | Delay/lack of consultation/action taken. If yes, specify....................................................................... | | ☐ | ☐ | ☐ |
| 2.6 | Inadequate management of ( Tick (√) one) ☐ public hospital ☐ private facilities ☐ ABC | | | | |
| | 2.6.1 | Preterm delivery | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| | 2.6.2 | Prolonged labour | ☐ | ☐ | ☐ |
| | 2.6.3 | Breech and other malpresentation | ☐ | ☐ | ☐ |
| | 2.6.4 | Fetal distress | ☐ | ☐ | ☐ |
| | 2.6.5 | Obstructed labour | ☐ | ☐ | ☐ |
| | 2.6.6 | Instrumental deliveries | ☐ | ☐ | ☐ |
| | 2.6.7 | Sepsis in mother | ☐ | ☐ | ☐ |
| | 2.6.8 | Abruptio | ☐ | ☐ | ☐ |
| | 2.6.9 | Others, specify ………………… | ☐ | ☐ | ☐ |

| | |
|---|---|
| **Comments by Head of Department / Officer-in-Charge: Please attach additional information if any.** | **Prepared by:**<br>**Name:**<br><br>**Designation:**<br><br>**Date:** |

| **3. NEONATAL (FOR NEONATAL DEATH ONLY)** | | | | | |
|---|---|---|---|---|---|
| | ☐ Government hospital ☐ Private facilities | | | | |
| | | | Yes | No | NA |
| 3.1 | Inadequate resuscitation | | ☐ | ☐ | ☐ |
| 3.2 | Delay in recognition/treatment of | | | | |
| | 3.2.1 | Malformation | ☐ | ☐ | ☐ |
| | 3.2.2 | Haemorrhage | ☐ | ☐ | ☐ |
| | 3.2.3 | Sepsis | ☐ | ☐ | ☐ |
| | 3.2.4 | Jaundice | ☐ | ☐ | ☐ |
| | 3.2.5 | Infection | ☐ | ☐ | ☐ |
| 3.3 | Inadequate management of | | | | |
| | 3.3.1 | Respiratory distress | ☐ | ☐ | ☐ |
| | 3.3.2 | Meconium aspiration | ☐ | ☐ | ☐ |
| | 3.3.3 | Low birth weight | ☐ | ☐ | ☐ |
| | 3.3.4 | Other neonatal factors (e.g renal failure, asphyxia)……………………………………. | | | |
| 3.4 | Delay/failure to transfer to an appropriate of care | | ☐ | ☐ | ☐ |
| 3.5 | Inadequate stabilization before and during transfer | | ☐ | ☐ | ☐ |
| 3.6 | Delay or lack of consultation with a senior Dr/Specialist | | ☐ | ☐ | ☐ |
| 3.7 | Family neglect or ignorance | | ☐ | ☐ | ☐ |
| 3.8 | Inadequate management due to | | | | |
| | 3.8.1 | Inadequate staff | ☐ | ☐ | ☐ |
| | 3.8.2 | Inadequate equipment | ☐ | ☐ | ☐ |

| | |
|---|---|
| **Comments by Head of Department / Officer-in-Charge: Please attach additional information if any.** | **Prepared by:**<br>**Name:**<br><br>**Designation:**<br><br>**Date:** |

| **3.9 Reported by:** | | **3.10. Verified by:** | |
|---|---|---|---|
| **Name (in block letters):** | | **Name (in block letters):** | |
| **Designation:** | | **Designation:** | |
| **Signature:** | | **Signature:** | |
| **Date:** | | **Date:** | |

## SECTION 6B: REMEDIABLE FACTORS (FOR ALL DEATHS) To be filled up by District/Hospital Committee

**4. REMEDIABLE CLINICAL FACTORS:** Present ☐ Absent ☐ (Tick which applicable)

Note: HC : Health Centre H PS : Hospital with Paediatric Specialist HN PS : Hospital with no Paediatric Specialist
H O&G: Hospital with O&G Specialist HN O& G: Hospital with no O&G Specialist PR : Private Clinic/Hospital

| | ANTEPARTUM | | | | INTRAPARTUM | | | | POSTPARTUM-< 28 days / 28 days -< 5 years | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HC | H O&G | HN O&G | PR | HC | H O&G | HN O&G | PR | HC | H PS | HN PS | PR |
| 4.1 Inappropriate delegation of duties | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.2 Failure to inform seniors | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.3 Failure to inform other specialists | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.4 Failure of combined care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.5 Failure of communication | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.6 Failure to diagnose | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.7 Failure to appreciate severity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.8 Inadequate, inappropriate or delayed therapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.9 Delayed / failure of referral | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.10 Failure of home visits / defaulter tracing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4.11 Failure of adherence to protocols | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**5. REMEDIABLE NON-CLINICAL FACTORS** Present ☐ Absent ☐ (Tick which applicable)

| | | ANTEPARTUM | | | | INTRAPARTUM | | | | POSTPARTUM-< 28 days / 28 days - < 5 years | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HC | H O&G | HN O&G | PR | HC | H O&G | HN O&G | PR | HC | H PS | HN PS | PR |
| 5.1 Paediatrician | None | | | | | | | | | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | | | | | | | | | ☐ | ☐ | ☐ | ☐ |
| 5.2 MO with >6/12 experience in Paediatric | None | | | | | | | | | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | | | | | | | | | ☐ | ☐ | ☐ | ☐ |
| 5.3 MO experience in anaesthesia | None | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.4 O&G Specialist | None | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | |
| 5.5 Theatre staff | None | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.6 Laboratory services | Available | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.7 Blood support | Available | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.8 NICU/SCN | Available | | | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | | | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.9 PICU | Available | | | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | | | | | | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.10 Transport | Available | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Unavailable | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.11 Inaccessibility/ Remoteness | Yes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | No | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5.12 Overall ability to handle the emergency identified | Adequate | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Inadequate | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| 6. PATIENT/FAMILY FACTORS | Present ☐ | | Absent ☐ | (Tick which applicable) | | |
|---|---|---|---|---|---|---|
| 6.1 Antenatal care (for stillbirths and neonatal deaths only) | ☐ | Adequate (8 visits or more) | ☐ | Inadequate ( < 8 visits), specify ................................................ | ☐ | Unbooked |
| 6.2 Delay in seeking treatment | ☐ | Yes | ☐ | No | | |
| 6.3 Non-compliance to advice | ☐ | Yes | ☐ | No | | |
| 6.4 Non-compliance/refuse admission | ☐ | Yes | ☐ | No | | |
| 6.5 Non-compliance to therapy | ☐ | Yes | ☐ | No | | |
| 6.6 Transport Problem | ☐ | Yes | ☐ | No | | |
| 6.7 Others: Please specify.................................. | ☐ | Yes | ☐ | No | | |

## SECTION 7 : DECISION BY HOSPITAL/DISTRICT UNDER 5 MORTALITY TECHNICAL COMMITTEE MEETING

| | | | |
|---|---|---|---|
| **7.1 Cause of Death:** | **a.IMMEDIATE CAUSE (final disease or condition resulting in death)** | | |
| | | | |
| | **b.Sequentially list conditions if any leading to the cause listed in a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death)** | | |
| | | | |
| **7.2 Suspected Child Abuse and Neglect (SCAN)** | ☐ Yes ☐ No ☐ Not sure | | |
| **7.3 Postmortem** | ☐Yes ☐ No ☐ Not Applicable | | |
| **7.4 ICD Classification of Cause of Death:** ( Tick (√) one) | ☐ | Certain Infectious & parasitic disease, specify: | **Specify Details:** |
| | ☐ | Neoplasm, specify: | |
| | ☐ | Disease of blood & immune system, specify: | |
| | ☐ | Endocrine, nutritional, metabolic, specify: | |
| | ☐ | CNS, specify: | |
| | ☐ | Circulatory system, specify: | |
| | ☐ | Respiratory, specify: | |
| | ☐ | Gastro-intestinal, specify: | |
| | ☐ | Genitourinary tract, specify: | |
| | ☐ | Condition from perinatal period, specify: | |
| | ☐ | Congenital malformation, specify: | |
| | ☐ | Injuries & external causes, specify: | |
| | ☐ | Symptoms, signs & abnormal findings not elsewhere classified (NEC), specify: | |
| | ☐ | Others, specify: | |
| **7.5 Substandard Care** Tick (√) one | ☐ Yes ☐ No | | |
| **7.6 Preventable Death** Tick (√) one | ☐ Yes ☐ No ☐ Undetermined | | |
| **7.7 Remedial Action by district/ hospital:** | | | |

| **Report Prepared by:** | | **Verified by:** | |
|---|---|---|---|
| **Designation** | | **Designation** | |
| **Date** | | **Date** | |

**7.8 Consolidation Report : (0- < 5 years) (by District Medical Officer of Health) – please use additional sheet**
**Please include**

i. Particular of patient and family
ii. History of current illness
iii. Co-morbid condition
iv. Cause of Death / Classification of Death
v. Preventable Death OR Not Preventable Death
vi. Substandard Care

| Conclusion:<br>(by District Medical Officer of Health) | |
|---|---|
| Validated by: | |
| Signature: | |
| Designation: | PEGAWAI KESIHATAN DAERAH |
| Date: | |

## SECTION 8 : DECISION BY STATE UNDER 5 MORTALITY TECHNICAL COMMITTEE MEETING

| 8.1 Cause of Death: | a.IMMEDIATE CAUSE (final disease or condition resulting in death) | |
|---|---|---|
| | | |
| | b.Sequentially list conditions if any leading to the cause listed in a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death) | |
| | | |
| 8.2 Suspected Child Abuse and Neglect (SCAN) | ☐ Yes ☐ No ☐ Not sure | |
| 8.3 Postmortem | ☐ Yes ☐ No ☐ Not Applicable | |
| 8.4 ICD Classification of Cause of Death:<br>( Tick (√) one) | ☐ Certain Infectious & parasitic disease, specify: | Specify Details: |
| | ☐ Neoplasm, specify: | |
| | ☐ Disease of blood & immune system, specify: | |
| | ☐ Endocrine, nutritional, metabolic, specify: | |
| | ☐ CNS, specify: | |
| | ☐ Circulatory system, specify: | |
| | ☐ Respiratory, specify: | |
| | ☐ Gastro-intestinal, specify: | |
| | ☐ Genitourinary tract, specify: | |
| | ☐ Condition from perinatal period, specify: | |
| | ☐ Congenital malformation, specify: | |
| | ☐ Injuries & external causes, specify: | |
| | ☐ Symptoms, signs & abnormal findings not elsewhere classified (NEC), specify: | |
| | ☐ Others, specify: | |
| 8.5 Substandard Care ;<br>Tick (√) one | ☐ Yes ☐ No | |
| 8.6 Preventable Death ;<br>Tick (√) one | ☐ Yes ☐ No ☐ Undetermined | |
| 8.7 Remedial Action by State: | | |

| Conclusion:<br>(by State Director of Health) | |
|---|---|
| Validated by: | |
| Signature: | |
| Designation: | PENGARAH KESIHATAN NEGERI |
| Date: | |