



MINISTRY OF PLANNING  
DEVELOPMENT AND  
SPECIAL INITIATIVES

# HOSPITAL-BASED VITAL STATISTICS IN PUNJAB



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# REGISTRATION & QUALITY OF HOSPITAL-BASED RECORDS OF VITAL STATISTICS (BIRTHS & DEATHS) IN PUNJAB PROVINCE

Mr Saeed Alvi (Consultant) has prepared this report with the funding support by the UNICEF under Technical Support Unit for CRVS

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# ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BOD	Bed Occupancy Rate
CRMS	Civil Registration Management System (NADRA)
CRVS	Civil Registration and Vital Statistics
CCF	Congestive Cardiac Failure
CMH	Combined Military Hospital
COAD	Chronic Obstructive Airway Disease
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular accident
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
DHIS	District Health Information System

EDO-H	Executive District Officer - Health
HMIS	Health Management Information System
IMR	Infant Mortality Rate
ICD	International Classification of Diseases
IHD	Ischemic Heart Disease
MMR	Maternal Mortality Rate
MI	Myocardial Infarction
NADRA	National Database and Registration Authority
PDHS	Pakistan Demographic & Health Survey
PHD	Provincial Health Department
PSPU	Policy & Strategic Planning Unit
PITB	Punjab Information Technology Board
RTA	Road Traffic Accident
TFR	Total Fertility Rate
TB	Tuberculosis

## EXECUTIVE SUMMARY



CRVS is the occurrence of live births, deaths (with cause), fetal death (defined as the death of a fetus before birth), marriage, divorce, legal separation, adoption, recognition of parenthood, and migration. Currently, Pakistan does not produce disaggregated vital statistics reports from civil registration data as the coverage of civil registration is too low.

The Technical Support Unit established under the Ministry of Planning, Development and Special Initiatives has been mandated to take necessary steps, in coordination with the provincial health departments and development partners for the improvement of CRVS in general and the CRVS data sources in particular. To undertake this task, it is critical first to understand the existing situation of mortality data sources, level of implementation and the current practices.

A study is thus being launched to identify the current arrangements or readiness available in terms of physical, human/training, IT support, capacity and other resources in tertiary and secondary hospitals, to assess current practice of birth, death, and COD registration in hospitals, to analyze current practice of birth and mortality data/ICD coding availability, coordination and use and mortality data analysis and trends on the cause of death. To support the provincial health management of Punjab and the development partners with correct mortality patterns and its causes, an in-depth study approach was adopted by focusing on true data collection from the selected hospitals in the following areas:

- Mortality Data Registration, Availability, Quality, and Use
- Causes of Death Analysis, occurring at Hospitals, based on DHIS Data
- Birth Registration Data and Graphs based on DHIS and other Data Sources

A purposive sampling technique was used for the selection of data collection sites (health facilities). However, the focus was on 25 major tertiary care and DHQ hospitals in Punjab. Multiple activities were organised as per the approved plan, duly vetted by the provincial health department, Punjab (Lahore) to complete this task. In this context, an official



letter from the Directorate of Health Services, Punjab (Lahore) for institutional permission was obtained, and the respective (selected) district headquarters hospitals and tertiary hospitals of the province were approached for data collection. An adequate international literature search was done and reviewed to make this study comprehensive and compelling. Two data collection questionnaires were developed in consultation with the stakeholders.

During the field visit for data collection from the selected hospitals, it was observed that the no standardised data format (with ICD-coding) is available. So for this limitation, data on causes of death were collected from Lahore-based hospitals, where 64,296 death records were analysed by disease/age group. The analytical view of the data was then interpreted in this report.

# IMPORTANCE OF BIRTH & DEATH REGISTRATION

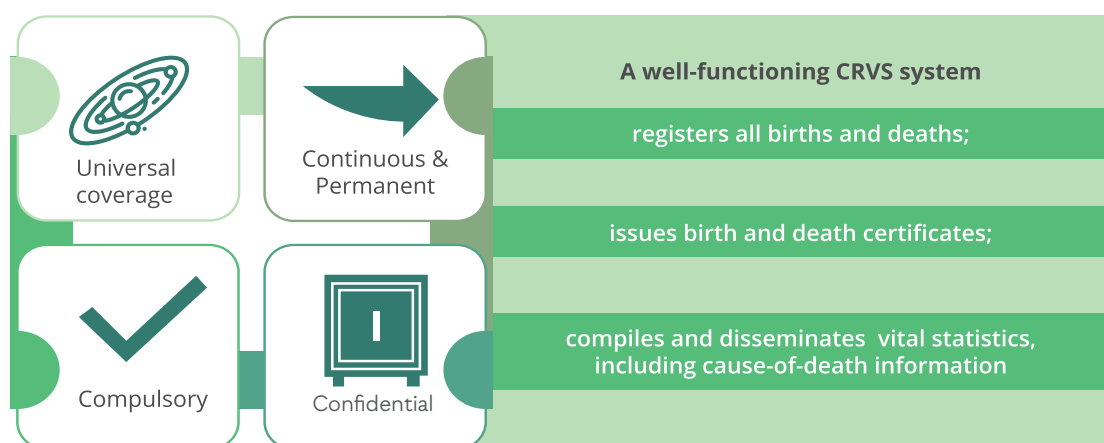


Why do we need a birth certificate? Indeed, the issuance of a birth certificate is consistent with the Convention on the Rights of the Child that states that every child should be registered immediately after birth. In almost all societies, a birth certificate is an essential basic legal document that gives identity to a child. It automatically bestows several rights, such as the right to healthcare, nationality, schooling, passport, property ownership, voting, formal employment, or access to banking services. On the other hand, for the family of the deceased, a death certificate ensures their right to inherit property, to access business and financial entitlements, and to claim any available insurance benefits.

Registration is also vital for national planning. The civil registration records of births and deaths are necessary for countries to compile accurate, complete, and timely vital statistics, which, along with population censuses, are central to estimating population size, especially for small areas. Without knowing the size and composition of the local population, how can local authorities decide how much – and what type of essential services to provide?

Similarly, the cause of death data from civil registration system is vital for pinpointing the diseases and injuries that are cutting lives short and for planning preventive services to avoid premature mortality. Cause of death data is also useful to inform governments about the outbreak of a fatal disease. Once the outbreak was spotted it was important to look back in time to see which recent deaths might have been occur from the disease but not diagnosed, it is important to trace those who had contact with the victim.

## CORE PRINCIPLES OF NATIONAL CRVS SYSTEM



It requires a robust system of registration. Without such data policymakers lack reliable evidence to design policies—they are “flying blind.” When governments fly blind then they often make policies based on ideology, anecdotes or for political considerations, rather than on evidence.

Unfortunately, there remain considerable gaps in the availability and quality of these crucial data in many parts of the world. It presents a significant challenge to evidence-based public policy. Only about 65 per cent of all births are registered globally, and only about one-third of the world’s 55 million annual deaths are recorded through civil registration. Up to 80 per cent of deaths that occur outside of health facilities are not counted.

Currently, Pakistan does not produce disaggregated, vital statistics reports from civil registration data as the coverage of civil registration is too low. The statistical office uses data of the population census and other surveys such as the Demographic Health Survey to produce vital statistics regularly.

The following is the implementation status of CRVS in Pakistan, taken from the UNICEF South Asia Annual Report 2019. In developed societies, we take it for granted that all children are registered at birth and that all people are registered when they die with a medically assigned cause of death. We hardly think about birth and death registration because we rarely are the initiators; it is usually the institution where the birth takes place that registers the baby, and the undertaker who registers a death.

## IMPLEMENTATION STATUS

● Complete   
 ● In progress   
 ● Not started   
 ● No information

National CRVS coordination mechanism	<span style="color: green;">●</span>	Inequality assessment	<span style="color: red;">●</span>
Comprehensive assessment	<span style="color: green;">●</span>	National CRVS strategy	<span style="color: blue;">●</span>
National targets	<span style="color: green;">●</span>	National CRVS focal point	<span style="color: green;">●</span>
Monitoring and reporting plan	<span style="color: blue;">●</span>	Reporting to ESCAP	<span style="color: green;">●</span>

Source: 'Get Every One in the Picture' website :<[www.getinthepicture.org/country/pakistan](http://www.getinthepicture.org/country/pakistan)> Last accessed 28 August 2018. UNICEF Country Office

## KEY FACT AND FIGURES



According to the latest census, Pakistan is the sixth most populous country (207.77 million) with 64 per cent of its population living in rural areas. On the national scale, the average population growth rate has declined from 2.6 per cent in 1998 to 2.4 per cent in 2017. There has been rapid population growth since it came into existence and given the current rate of population growth, Pakistan will be the fifth most populous country globally by 2050. An important fact is that the country is blessed with energetic youth aged 10-24 years comprising 32 per cent of the population

The province-wise population proportion shows that Punjab has the largest population of 110 million (56 per cent) and is the second-largest province with an area of 205,345 square kilometres. Administratively, Punjab is divided into nine divisions, 36 districts, 142 tehsils and 3,464 union councils. Punjab Healthcare System comprises 43 teaching hospitals, 26 district headquarter hospitals, and 125 tehsils headquarter hospitals, 317 rural health centres, and 2,505 basic health units.

Neonatal mortality is on the decline globally with the world's neonatal mortality rate falling from 37 deaths per 1,000 live births in 1990 to 19 per 1,000 live births in 2016. The result is a drop in neonatal deaths worldwide from 5.1 million in 1990 to 2.6 million in 2016. (UNICEF Data-2015- 2016).

As per UNICEF statistics, Pakistan's maternal and neonatal mortality rates are amongst the highest in the world. Nearly 178 women die during every 100,000 live births.

The following are some key statistics (WHO)

- Every day, approximately 830 women die of causes related to pregnancy and childbirth.
- Ninety-nine per cent of all maternal deaths occur in developing countries.
- Maternal mortality is higher in women living in rural areas and among more impoverished communities.
- Between 1990 and 2015, maternal mortality worldwide dropped by about 44 per cent.
- Between 2016 and 2030, as part of the Sustainable Development Goals, the target is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

The latest Punjab Annual Health Report (2017-2018) shows that maternal mortality ratio (MMR), which indicates the risk of death per pregnancy, is 227/1,000 live births. The main reason for this high MMR is very low utilisation of family planning services as the current CPR is reported to be 38.3 per cent. An estimated 14,000 Pakistani women die every year of pregnancy-related causes. Pakistan ranks 26th in the world for under-5 child mortality rates (96/1000 live births) compared to under-one year (76/1000 live births).

# GLOBAL LEADING CAUSES OF DEATH



Measuring how many people die each year, and why they died, is one of the most important means along with gauging how diseases and injuries are affecting people for assessing the effectiveness of a country's health system.

The statistics on cause-of-death help health authorities determine the focus of their public health actions. A country in which deaths from heart disease and diabetes rise rapidly over a few years, for example, has a keen interest in starting a vigorous programme to encourage lifestyles to help prevent these illnesses. Similarly, if a country recognises that many children are dying of pneumonia, but only a small portion of the budget is dedicated to providing effective treatment, it can increase spending in this area.

High-income countries have systems in place for collecting information on causes of death. Many low- and middle-income countries do not have such systems, and the numbers of deaths from specific causes have to be estimated from incomplete data. Improvements in producing high-quality cause-of-death data are crucial for improving health and reducing preventable deaths in these countries.

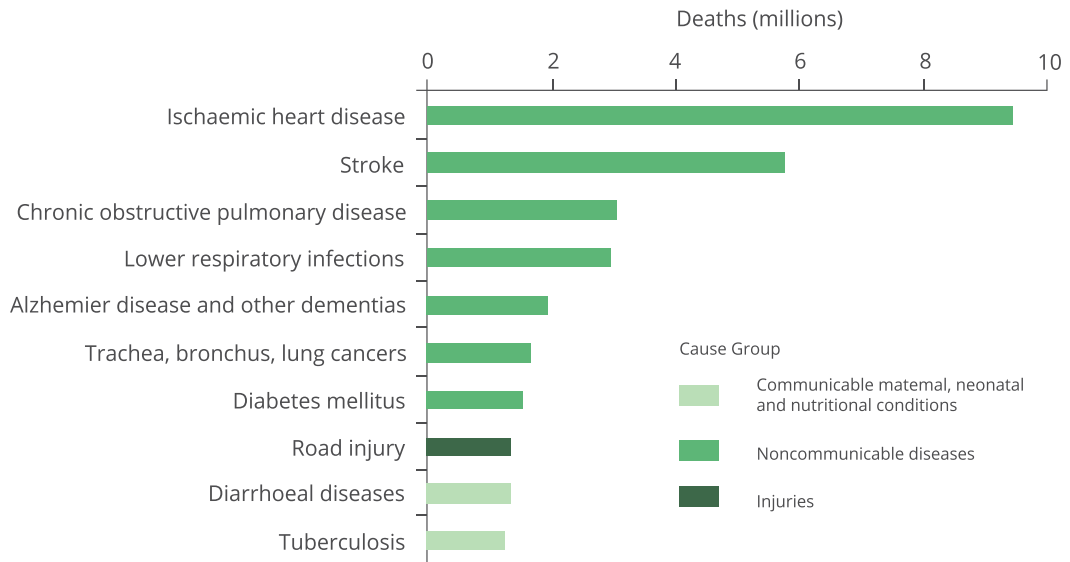
As per WHO, of the 56.9 million deaths worldwide in 2016, more than half (54 per cent) were due to the top 10 causes.

Ischaemic heart disease and stroke are the world's biggest killers, accounting for a combined 15.2 million deaths in 2016. These diseases have remained the leading causes of death globally in the last 15 years. The chronic obstructive pulmonary disease claimed 3.0 million lives in 2016, while lung cancer (along with trachea and bronchus cancers) caused 1.7 million deaths. Diabetes killed 1.6 million people in 2016, up from less than one million in 2000. Deaths due to dementias more than doubled between 2000 and 2016, making it the 5th leading cause of global deaths in 2016 compared to 14th in 2000.

Lower respiratory infections remained the deadliest communicable disease, causing 3.0 million deaths worldwide in 2016. The death rate from diarrheal diseases decreased by almost one million between 2000 and 2016 but still caused 1.4 million deaths in 2016. Similarly, the number of tuberculosis deaths decreased during the same period but it is still among the top 10 causes with a death toll of 1.3 million. HIV/AIDS is no longer among the world's top 10 causes of death, having killed 1.0 million people in 2016 compared with 1.5 million in 2000. Road injuries killed 1.4 million people in 2016, about three-quarters (74 per cent) of whom were men and boys.

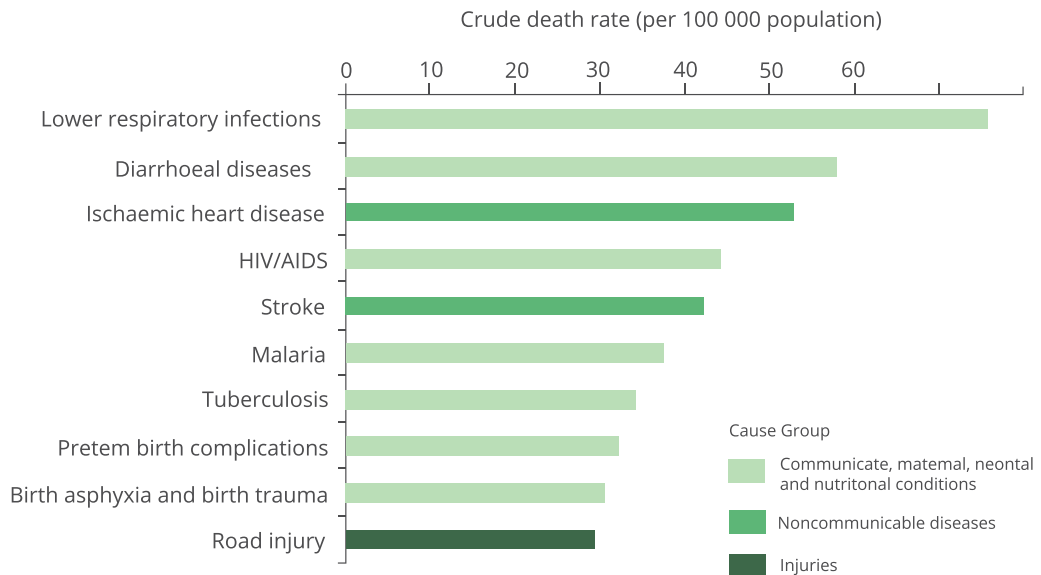


## TOP TEN GLOBAL CAUSES OF DEATHS-2016



Source: Global Health Estimates 2016 Deaths by Cause, Age, Sex by Country and Region, 2000-2016 Geneva, World Health Organisation; 2018.

## TOP TEN CAUSES OF DEATHS IN LOW-INCOME COUNTRIES - 2016



Source: Global Health Estimates 2016:Deaths by Cause, Age, Sex by Country and Region, 2000-2016. Geneva, World Health Organization;2018. World Bank list of economies (June 2017). Washington, DC: The world Bank Group; 2017 [<https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>]

# BACKGROUND INFORMATION



Improvement of birth, death and cause-of-death information is an essential component of the National Plan for Strengthening of Civil Registration and Vital Statistics (CRVS). This subject is in fact considered one of the core thematic areas of support for national CRVS promotion. Public health planning needs to be based on reliable and timely data on the leading causes of death and disability. Similarly, determination of mortality causes and patterns are critical for the healthcare managers and planners.

Information on the levels and patterns of mortality among different population groups is essential for public health planning and the effective allocation of resources to healthcare. There is no precedence in the country for central-level data aggregation/consolidation and analysis for birth, death, and causes of deaths. On the contrary, such statistics are frequently requested by governments, researchers, donors and international development partners for their multiple uses. There could be two primary sources of such information a) Hospital-based information b) community-based data sources. Mostly the government-based hospitals lack a systematic electronic hospital information system. Though there exists a standard health information system to support district health authorities, some consistent/standard health information system is not available for public sector tertiary care hospitals. Similarly, there are issues relating to some proper data recording and reporting of community-based deaths or use of verbal autopsy. Such information is usually available in district and tertiary hospitals in a disorganised, fragmented, and unanalysed form.

Ideally, there is need for some proper registration of all deaths, with certification and coding of their cause by a qualified physician based on the international classification of diseases and related health problems as it is a standard for generating cause-of-death statistics. Though most of the deaths with certified causes occur in hospitals but unfortunately, not all hospitals have the same level of achievement, practice or norms for labelling the cause of deaths. This practice also varies from hospital to hospital, and province to province, and in capacities.

It seems reasonable to expect tertiary hospital-based (teaching) physicians to correctly identify patients' underlying causes of death since such hospitals are expected to have established clinical protocols for monitoring disease progression. Physicians in hospitals could be the most authentic source for correctly ascertaining their patients' cause of death and then communicating that to some central repository. For the community-based deaths, procedures need to be developed for the use of verbal autopsy tools after training of community-based health workforce or other staff.

The Technical Support Unit established under the Ministry of Planning, Development and Special Initiatives has been mandated to take necessary steps, in coordination with the provincial health departments and development partners for the improvement of CRVS in general and the CRVS data sources in particular. It is critical first to understand the existing situation of mortality data sources, level of implementation, and the current practices to undertake this task.

This study is thus being launched to address all such questions.

1. What are current arrangements or readiness available in terms of physical, human/ training, IT support, capacity, and other resources in the tertiary and secondary hospital?
2. What is current practice of birth, death and COD registration for the hospital?
3. The current practice of birth and mortality data / ICD coding availability, coordination and use.
4. Mortality Data Analysis and trends on the cause of Death?

### STUDY OBJECTIVES:

The specific objectives of the study are to;

- Develop a standard (ICD-enabled) format on which mortality data is to be captured from tertiary and secondary care hospitals and to capture data from all possible hospitals (tertiary, DHQs, THQs) on the standard pattern after converting them from existing formats.

- Establish current birth and mortality patterns by using available data by age, sex, location, and cause both for hospital-based and the community-based deaths (verbal autopsy).
- Critically analyse and interpret the current practice and capacities for CRVS data in general. It should focus on determination of death and cause-of-death recognition/labelling, registration, ICD-coding, data transfer, infrastructure available (physical, HR, IT), for consolidation and analysis from both hospital and community-based events.
- Identification of barriers and enablers for improvement of CRVS and cause of death information
- Determine the state of art/best practice private hospitals/ CBOs having / practicing good mortality recording or reporting of data.
- Get doable concrete solutions and road map for improvement.

# METHODOLOGY ADOPTED



## DATA COLLECTION APPROACH:

An in-depth study approach was adopted by focusing on accurate data collection from the selected hospitals in the areas listed below to support the provincial health management of Punjab and the development partners with correct mortality patterns and their causes.

- Mortality Data Registration, Availability Quality and Use
- Causes of Death Analysis occurred at Hospitals based on DHIS Data.
- Birth Registration Data and Graphs based on DHIS and Other Data Sources

## SAMPLING TECHNIQUE:

A purposive sampling technique was used for the selection of data collection sites (health facilities). However, the focus was on 25 major tertiary care and DHQ hospitals in Punjab. The names of hospitals are in the following table:

SR. #	NAME OF THE HOSPITAL	DISTRICT
1.	Jinnah Hospital, Lahore	Lahore
2.	Mayo Hospital, Lahore	Lahore
3.	Services Hospital, Lahore	Lahore
4.	Sir Ganga Ram Hospital, Lahore	Lahore
5.	Children Hospital, Lahore	Lahore

6.	Lahore General Hospital, Lahore	Lahore
7.	Govt. Nawaz Sharif Yaki Gate Hospital, Lahore	Lahore
8.	Doctors Hospital, Johar Town, Lahore	Lahore
9.	Iqra Medical Complex, Johar Town, Lahore	Lahore
10.	Al-Shafi Hospital, Allama Iqbal Town, Lahore	Lahore
11.	Shaheed Benazir Hospital, Rawalpindi	Rawalpindi
12.	Holy Family Hospital, Rawalpindi	Rawalpindi
13.	THQ Hospital, Gujjar Khan	Rawalpindi
14.	THQ Hospital, Taxila	Rawalpindi
15.	DHQ Hospital, Gujranwala	Gujranwala
16.	THQ Hospital, Wazirabad	Gujranwala
17.	THQ Hospital Kamoke	Gujranwala
18.	Cheema Heart Complex, Gujranwala	Gujranwala
19.	DHQ Hospital, Sargodha	Sargodha
20.	Nishtar Hospital, Multan	Multan
21.	Nishtar Burn Unit, Multan	Multan
22.	DHQ Hospital, Faisalabad	Faisalabad
23.	Allied Hospital, Faisalabad	Faisalabad
24.	Bahawalpur Victoria Hospital, Bahawalpur	Bahawalpur
25.	Sheikh Zayed Hospital, Rahim Yar Khan	Rahim Yar Khan

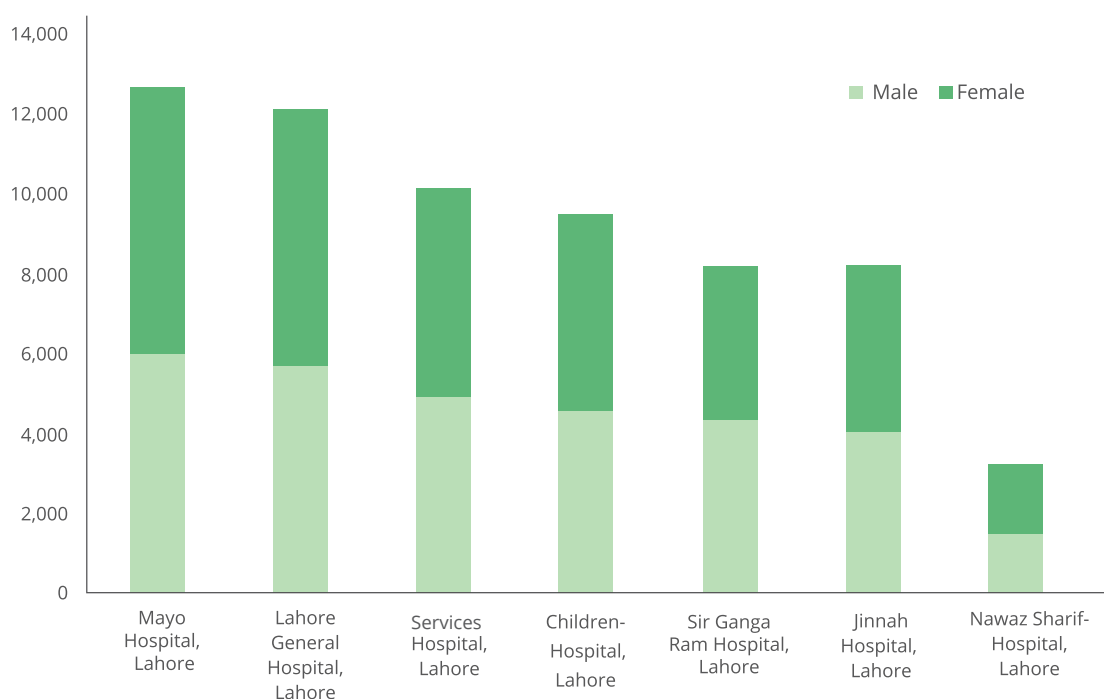
## DATA ENTRY AND ANALYSIS:

Excel and SPSS were used for data entry and analysis. For this purpose, the SPSS data entry screen was developed according to questionnaires and the collected data entered into the computer. After a thorough data cleaning and consolidation process, the desired analysis was carried out covering all aspects of the study.

## DATA LIMITATION:

During the field visit to the selected hospitals for data collection, it was observed that there was no standardised data format (with ICD-coding) available. So for this limitation, data on causes of death were collected from Lahore-based hospitals, wherein 64,296 death records were analysed by disease/age group.

NUMBER OF DEATHS REGISTERED BY GENDER



## ACTIVITIES ACCOMPLISHED



The following activities were organised as per the approved plan, duly vetted by the provincial health department, Punjab (Lahore) to complete this task. The key activities are as under: -

### COORDINATION FOR INSTITUTIONAL SUPPORT:

In this context, an official letter from the Directorate of Health Services, Punjab (Lahore) for institutional permission was obtained, and the respective (selected) district headquarters hospitals and tertiary hospitals of the province were approached for data collection (copy annexed).

### LITERATURE REVIEW:

The registration of mortality and cause of death procedures and the form enforced at respective organisations (i.e. hospitals) were reviewed to make the study comprehensive and compelling. An adequate international literature search was done and reviewed. The world's leading causes of death were also studied to match the national situation with a global perspective.

### DEVELOPMENT OF DATA COLLECTION TOOLS:

The following two questionnaires were developed in consultation with the stakeholders. The contents of these questionnaires were based on the study objectives. A pre-testing round of these questionnaires was done at Jinnah Hospital, Lahore.

- Mortality & Morbidity Data Management Mechanism: A detailed questionnaire covering all areas relating to the topic having close and open-ended questions was designed. The purpose of this questionnaire was to measure the functional mechanism for the compilation of essential health data (annexed).



- Causes of Death Analysis: This was the second tool based on ICD-coding to analyse hospital burden, number of deaths with cause by disease-group, and gender and age-group. However, data to measure hospitals' status with their bed capacity, bed occupancy rate and patients attended (indoor/out/emergency) during 2014 was incorporated (annexed).

### DATA COLLECTION / FIELD ACTIVITIES:

In total 25 leading hospitals (both tertiary and district) in Punjab (list annexed) were visited to gather the required information.

### DATA CONSOLIDATION AND ANALYSIS



Based on information received on two formats, all data was entered in excel and then converted into the SPSS programme for further analysis. However, DHIS Data 2018 was also obtained from the DGHS, Punjab on the key indicators like the position of hospital beds and bed occupancy rate, the burden of diseases, and deaths registered.

# STUDY KEY FINDINGS



## SECTION A: STATUS OF MORTALITY DATA REGISTRATION, AVAILABILITY QUALITY AND USE

Twenty-five leading hospitals (both tertiary and district) in Punjab (list annexed) were visited to gather the required record of vital events. Some of the key findings are described below.

### MORTALITY STATISTICS

Our analysis of the data from selected hospitals revealed that almost all hospitals visited during the study, register and keep records of deaths that occurred on their premises during admission. Determining of causes of death is being done jointly by the administrative and clinical departments where the deceased patients were admitted. The final death registration is the responsibility of the administrative department.

Asked, to whom the hospital authorities report the information about death, the majority of hospitals (18) informed they reported it to the provincial or district health authority. The other seven hospitals said they don't report to any authority. Here the notable point is that none of the hospitals shares this information with the National Database and Registration Authority (NADRA), the federal body responsible for uniform death recording system for compiling and matching national-level death-toll data.

It is also very discouraging that some hospitals (6) still follow a manual system of hospital data recording (including births and deaths). Eleven hospitals have a mixed system (e.g. electronic and manual) for such data recording. Eight hospitals have a proper MIS system of data collection and reporting (see graph above).

## LABELING CAUSE OF DEATH / ICD CODING

To define proper cause of death is one of the cores need to recognise the exact cause of death. It was noted with concern that none of the sampled hospitals follows ICD- coding system for death recording. Moreover, they do not use standard or uniform “death certificate” in their hospitals and have their own in-house developed certificate (specimen annexed). On the issue of ICD-coding or implementation, the majority of hospitals said they had planned such implementation in the near future with the support of the Punjab Health Department. It was asked as to what kind of data compilation practises exist in the absence of ICD-coding. It was observed that almost all hospitals compile death data manually or by using a PC-based Excel application.

### STATUS OF DATA REGISTRATION & REPORTING



## DATA COMPLETENESS / COVERAGE

As far as the completeness of death data among hospitals is concerned, it was observed that about 19 hospitals had the level of completeness between 60-69 per cent. Only three hospitals came up with a 70 per cent-plus response. The remaining two hospitals confirmed the level of completeness between 50-59 per cent. Regarding registration coverage, including foreign residents, none of the hospitals has such an option in their manual or computerised data system.

## MORBIDITY STATISTICS

Along with mortality, the morbidity statistics were also analysed. For this purpose, the required data was gathered from the same sampled hospitals. Analysis of some key areas indicated that all the hospitals do prepare the morbidity information of their patients. Nevertheless, that is being done for indoor patients mainly and not for the outdoor patients. However, no remarkable change was seen on the use of ICD-coding practises for morbidity data recording, as none of the sampled hospitals has implemented such coding practises as yet.

## SPECIFIC DISEASE SURVEILLANCE

All sampled hospitals (100%) have implemented disease specific surveillance system that has been implemented by the Punjab Health Department. However, it was observed to be covering Dengue Fever only as for the last few years, the dengue fever was an epidemic in Punjab.

## ICD CODING PRACTICES / REPORTING FOR DISEASE SURVEILLANCE

None of the hospitals was seen following ICD-coding practises for disease surveillance, which is a severe discrepancy on the part of health management. However, the Punjab Health Department (Policy and Strategic Planning Unit (PSPU)) in consultation with Punjab Information Technology Board (PITB) has developed a standardised death slip/certificate with Android-based mobile application to capture all deaths in the hospitals (First Phase) on a standardised ICD-10 coding. Initially, training of trainers on the application has been conducted by the PSPU Health Department with support of the Technical Support Unit-CRVS, Ministry of P Planning, Development and Special Initiatives Islamabad (see Annex-E for details).

## AVAILABILITY OF IT INFRASTRUCTURE

Presence of optimal IT support and computer technology is essential not only for gathering and sharing accurate and timely data but also to compile reports and generate automated ICD codes at the hospital level. Accordingly, when inquired about the availability of IT support at the managerial and clinical levels of hospitals, only eight hospitals (out of 25) informed that more than 80 per cent of their offices/clinics have computers and network support. Between 40-80 per cent availability was reported by other 11 hospitals. In the remaining hospitals, less than 40 per cent computerisation was reported and network support. For others, between 40 – 80% availability was reported by other 11 hospitals. In remaining hospitals less than 40% computerization was reported.



In the IT context, when asked about the provision of internet facility, majority of the respondents (17) informed that DSL outage was problematic. There were issues with bills and availability of trained staff. On the whole, 40-80 per cent of their offices and clinics had internet access. It means, if the management decides to implement ICD-coding practices for mortality and morbidity data recording, its operation may not be an issue.

## SECTION B: BIRTH & DEATH ANALYSIS BASED ON DHIS DATA

The District Health Information System (DHIS) has evolved as an efficient online system that generates reliable, authoritative, useable and plausibly comprehensible data and comparative statistics. The DHIS addresses the dynamics of evidence-based healthcare planning and decision-making at various levels. The performance of districts, healthcare facilities, and vertical programmes, is being assessed based on real-time DHIS data that is available both electronically and manually. Reporting compliance is more than 99 per cent. In 2013, the Punjab government decided to include 43 DHQs and teaching hospitals and specialised hospitals for reporting under DHIS.

**Picture: MIS Section / DHIS Cell – Punjab, Lahore**



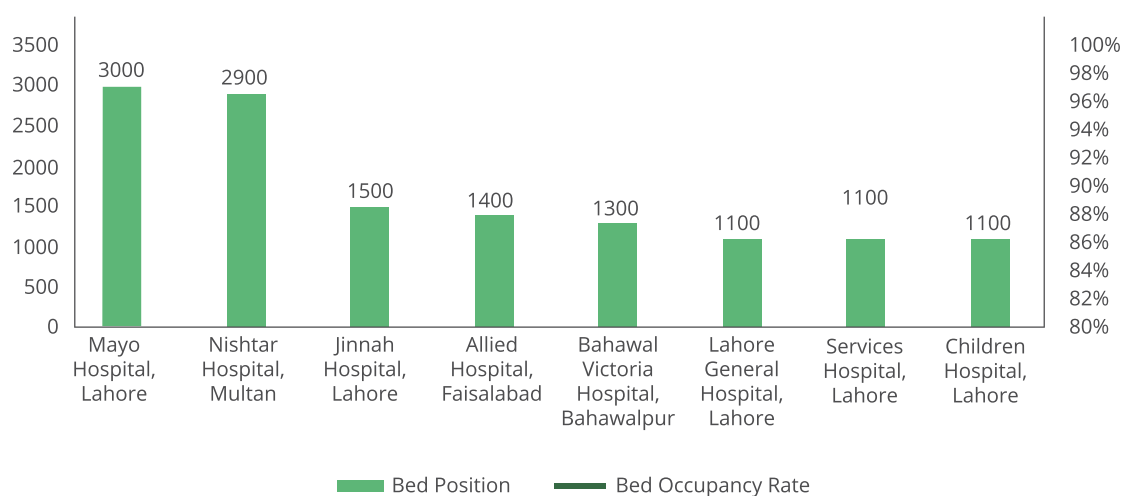
Table-1 shows Annual Depiction of Birth and Still Births under DHIS-Punjab. (2013-2018)

Year	Live Births	Live Births with Low Birth Weight	Still Births
2013	610,905	22,607	8,450
2014	648,556	26,638	11,240
2015	807,140	30,474	14,030
2016	1,136,625	29,583	16,749
2017	1,236,828	33,463	17,153
2018	1,239,560	33,824	23,630
Sub total	5,679,614	176,589	91,252

### STATUS OF HOSPITALS BEDDING CAPACITY & OCCUPANCY RATE

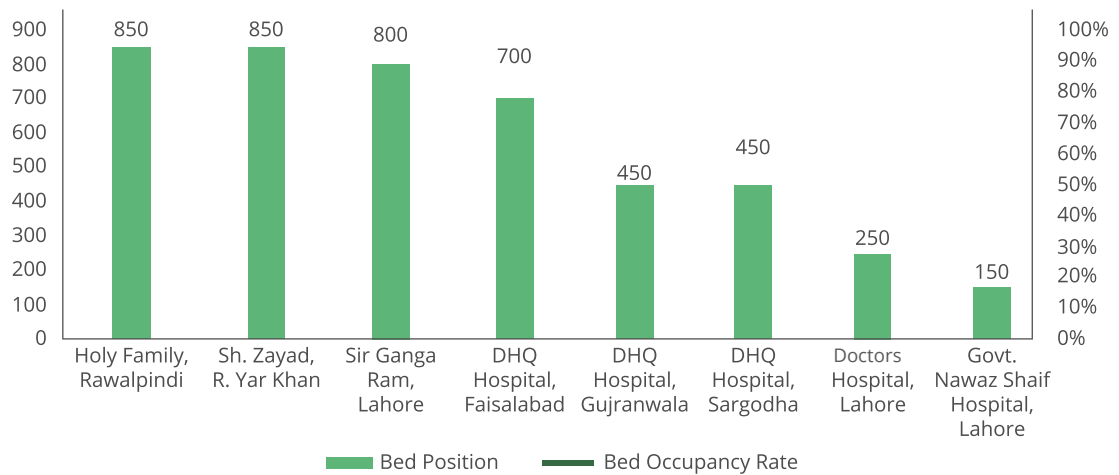
Out of the 25 hospitals visited during the study, Mayo Hospital, Lahore was the biggest in Punjab with an indoor capacity of 3000 beds. It was followed by Nishtar Hospital and Burn Centre (2900 beds), and Jinnah Hospital, Lahore (1500 beds). Details of the bedding capacity of all hospitals and the occupancy rate is reflected in the graph below.

#### NUMBER OF BEDS AND BED OCCUPANCY RATE (HOSPITALS WITH MORE THAN 1000 BEDS- 2018)



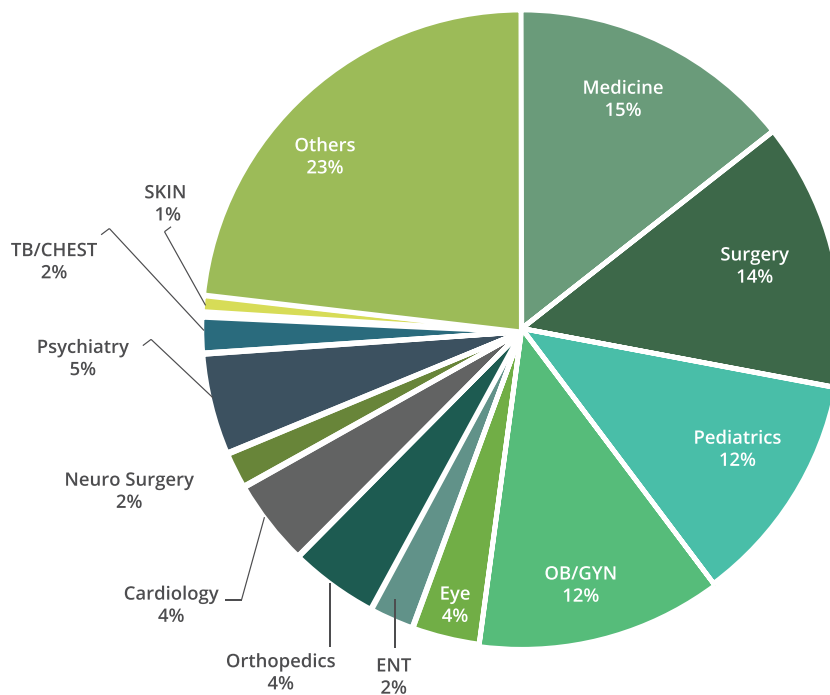


### NUMBER OF BEDS AND BED OCCUPANCY RATE (HOSPITALS WITH MORE THAN 1000 BEDS- 2018)



Following graph shows the beds available by type of specialty in Punjab province.

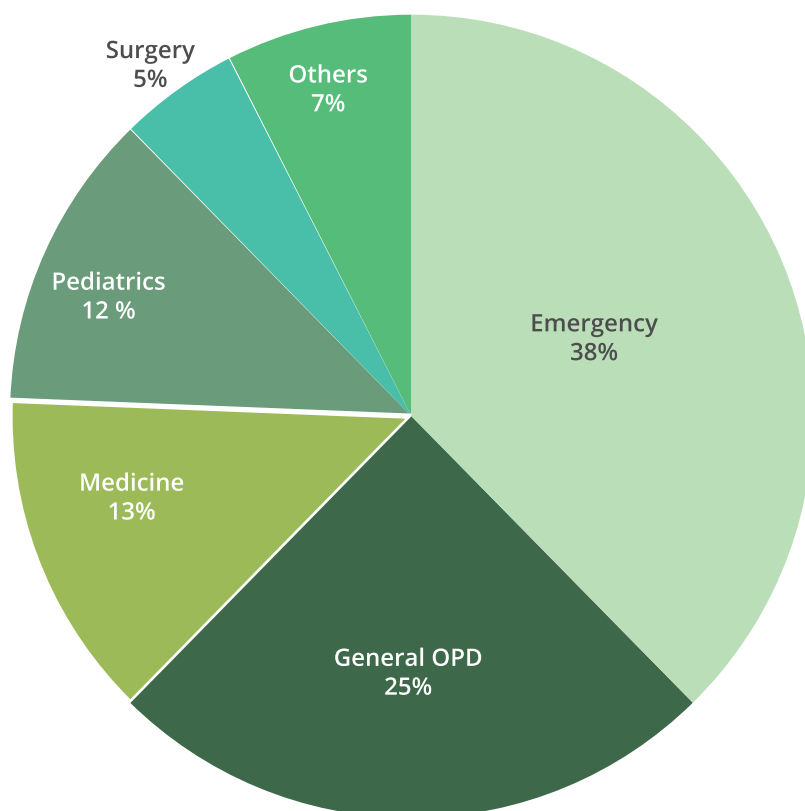
### % AGE OF BEDS BY CATEGORY (PUNJAB - DHIS DATA 2018 - ALL HOSPITALS)



## Overall Patients Load/In-flow (OPD) by Specialty

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### TOTAL PERCENTAGE OUTPATIENT ATTENDANCE BY CATEGORY (PUNJAB - DHIS DATA 2018 - ALL HOSPITALS)



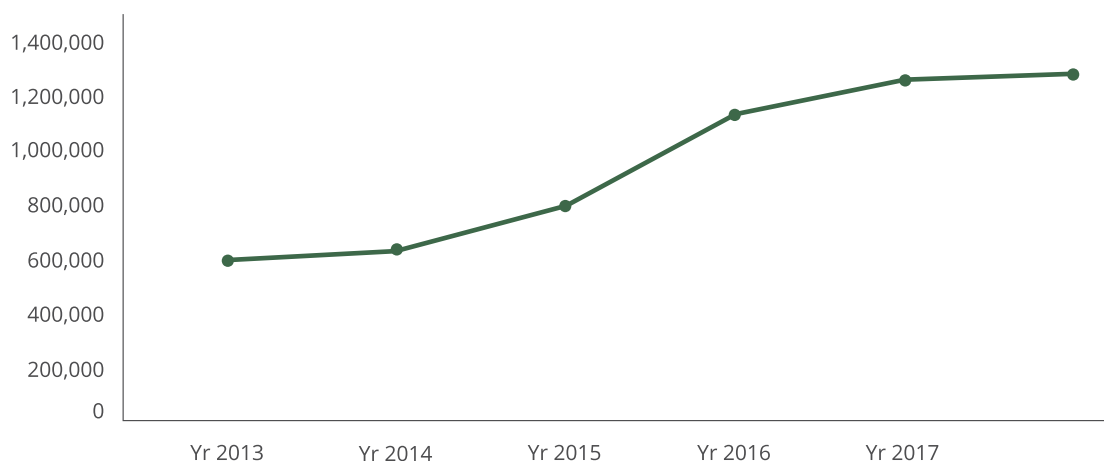
## SECTION B-1: STATUS OF BIRTH REGISTRATION IN HOSPITALS BASED ON DHIS DATA

DHIS is a vital birth registration source at the public health facilities. The picture below shows the section of the DHIS monthly data recording form (for secondary-level hospitals). Significant information is collected every month in each DHIS reported hospitals/health facility across Pakistan. There is a dire need to link this data to the local government registration database and NADRA data sets.

Section VIII: Maternal and Newborn Health (From Maternal Health and Obstetric Registers)					
1.	1 <sup>st</sup> Antenatal Care visits (ANC-1)		9.	Live births with LBW<2.5kg	
2.	ANC-1 women with Hb. <10g/dl		10.	Still births in the facility	
3.	Antenatal Care revisit, in the facility		Neonatal deaths in the facility		
4.	1 <sup>st</sup> Postnatal Care visit (PNC_1) in the facility		11.	Birth trauma	
Deliveries in the facility			12.	Birth Asphyxia	
5.	Normal vaginal deliveries		13.	Bacterial sepsis	
6.	Vacuum/Forceps deliveries		14.	Congenital Abnormalities	
7.	Cesarean Sections		15.	Prematurity	
8.	Live births in the facility		16.	Hypothermia	

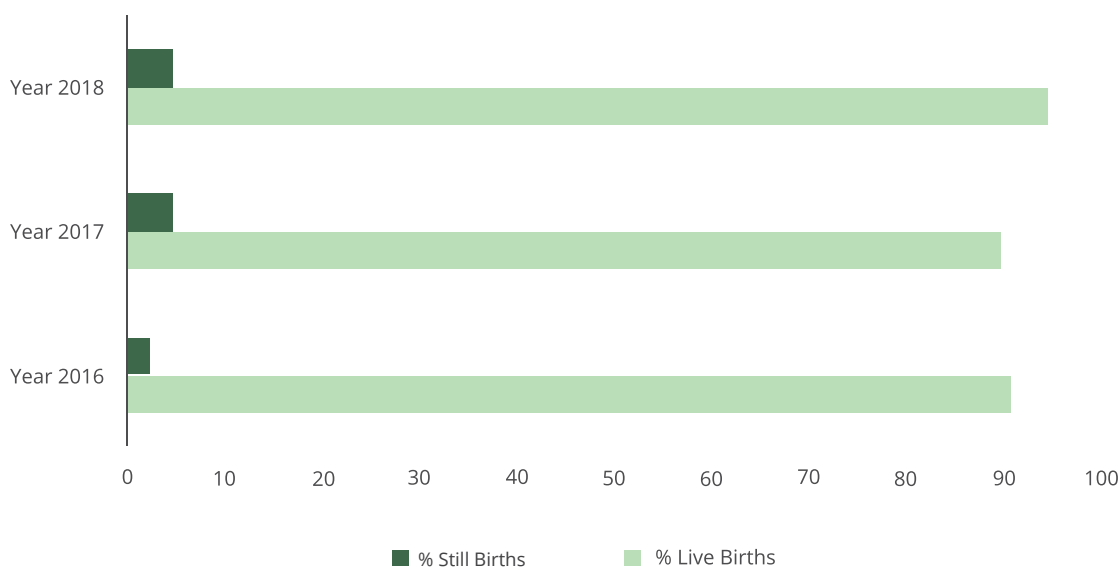
In graph below over the year's significance improvement in birth registration are recorded at all government level health facilities.

### LIVE BIRTH REGISTRATION OVER THE YEARS (DHIS ALL HEALTH FACILITIES)

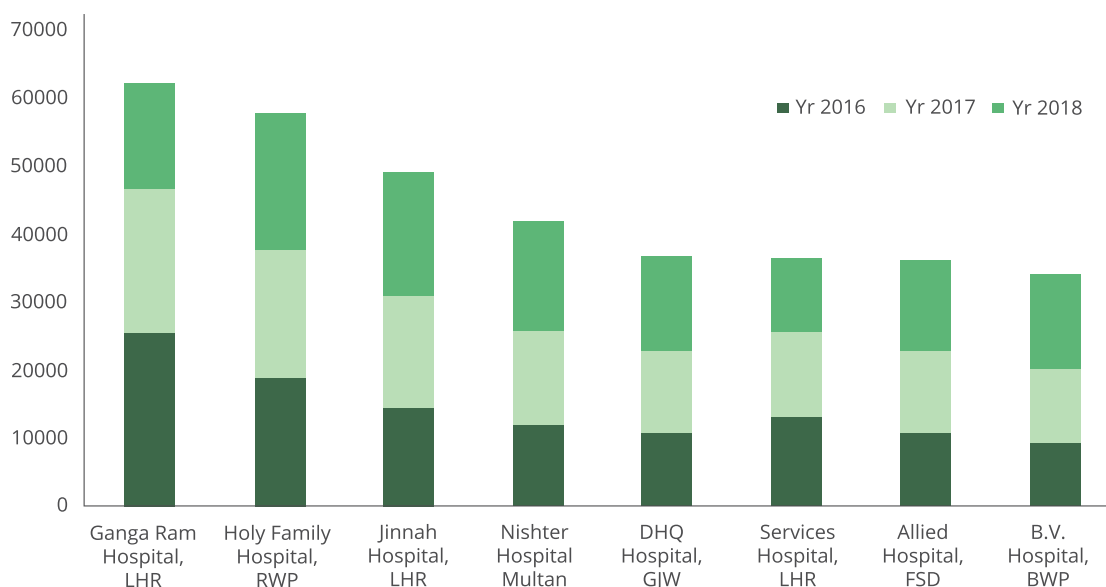


In Graph below DHIS data shows that % age of Live births against all type of deliveries in all type of government health facilities are significantly high in Punjab, however due to some reason still births slightly increased over the year from 2016-2018.

### % AGE LIVE AND STILLBIRTHS IN HOSPITALS



### NUMBER OF LIVE BIRTHS IN HOSPITALS



Deliveries by Type and status of Live Births and Still Births Registration in the Hospitals-  
DHIS Data – Punjab 2018.

Hospital Name	Reporting Year	OB/ GYN - Admissions	Normal Vaginal Deliveries	Vacuum/ forceps deliveries in facility	Cesarean Sections	Live births in the facility	Live births with LBW (<2.5kg)	Stillbirths in the facility
Allied Hospital Faisalabad	Yr 2016	42245	6193	127	5633	10893	1879	1060
	Yr 2017	32789	6134	163	6751	11994	2578	1052
	Yr 2018	36381	6867	125	7591	13391	2024	1192
Nishter Hospital Multan	Yr 2016	30376	6361	42	5869	12255	2584	17
	Yr 2017	32146	6901	66	6473	13411	2305	29
	Yr 2018	39189	7494	100	8614	16208	2499	0
B.V. Hospital Bahawalpur	Yr 2016	22884	4580	65	5420	9657	1248	408
	Yr 2017	22669	6770	88	6181	10610	1062	329
	Yr 2018	22040	6418	89	7902	13950	219.27	459
DHQ/ Teaching Hospital Gujranwala	Yr 2016	14669	5521	0	5434	10793	177	164
	Yr 2017	16569	5720	1	6707	12280	87	148
	Yr 2018	19304	6120	0	7816	13700	211	247
Services Hospital	Yr 2016	19217	6299	772	6268	13133	701	192
	Yr 2017	19952	5983	243	6747	12734	863	224
	Yr 2018	16467	5337	152	5414	10644	540	218
Jinnah Hospital	Yr 2016	12302	8251	180	6579	14505	519	505
	Yr 2017	15191	9613	148	7286	16520	207	430
	Yr 2018	18016	10104	152	8390	18341	538	322
Sir Ganga Ram Hospital Lahore	Yr 2016	8230	12463	0	12990	25453	0	0
	Yr 2017	8989	10778	0	20742	21330	0	0
	Yr 2018	10075	7809	0	7797	15606	0	0
Holy Family Hospital Rawalpindi	Yr 2016	41162	12265	495	7139	18815	2839	1043
	Yr 2017	39890	12536	411	7008	18835	2767	1120
	Yr 2018	43122	13031	462	7796	20174	2496	1115

## SECTION B-2: CAUSES OF DEATH ANALYSIS BASED ON DHIS DATA

DHIS also captured total admissions and deaths by priority diseases from all public health facilities. The picture below shows the relevant section of the DHIS monthly data recording form (for secondary-level hospitals). In this section, there is a limitation of non-availability of the age-wise distribution of deaths. However, the relevant information is available in DHIS to analyse the data by each district, and each facility over time.

Section XIII-B Cases attending Indoors (From abstract forms for indoor)		Total Admissions	Total Deaths
<b>Medical</b>			
1.	Diarrhea/Dysentery<5		
2.	Diarrhea/Dysentery>5		
3.	Pneumonia<5		
4.	Pneumonia>5		
5.	Malaria		
6.	Asthma		
7.	Chronic Obstructive Airways		
8.	Pulmonary tuberculosis		
9.	Extra pulmonary tuberculosis		
10.	Enteric /Typhoid fever		
11.	Diabetes Mellitus		
12.	Viral Hepatitis A and E		
13.	Viral Hepatitis B		
14.	Viral Hepatitis C		
15.	Meningitis		
16.	Chronic liver diseases		
17.	Chronic renal diseases		
<b>Cardiac Diseases</b>			
18.	Congestive Cardiac Failure (CCF)		
19.	Hypertension		
20.	Ischemic Heart Diseases (IHD)		
<b>Vaccine preventable Diseases</b>			
21.	Neonatal Tetanus		
22.	Acute Flaccid Paralysis		
<b>Surgical</b>			
23.	Acute Appendicitis		
24.	Burns		
25.	Cholelithiasis/Cholecystics		
26.	Hernias		
27.	Hyperplasia of prostate		
28.	Urolithias is		

Section XIII-B Cases attending indoors (From abstract forms for indoors)		Total Admissions	Total Deaths
<b>Orthopedic Diseases</b>			
29.	Arthropathics		
30.	Fractures		
<b>Eye</b>			
31.	Cataract		
32.	Corneal Opacity		
33.	Glaucoma		
<b>ENT</b>			
34.	Chronic Otitis Media		
35.	DNS		
<b>Gynaecological</b>			
36.	Fibroid Uterus		
37.	Inflame diseases of female pelvic organs PID		
38.	Uterine Prolapse		
39.	Vesico Vaginal Fistula		
27.	Hyperplasia of prostate		
<b>Obstetrics/ Maternal Complications</b>			
40.	Antepartum Hemorrhage		
41.	Complications of abortion		
42.	Ectopic pregnancies		
43.	Postpartum Hemorrhage		
44.	Pre-Eclampsia/Eclampsia		
45.	Prolonged /Obstructed Labor		
46.	Puerperal Sepsis		
47.	Rupture Uterus		
48.	Other obstetric complications		
<b>Neurological/Neurosurgical</b>			
49.	CVA stroke		
50.	Head Injuries		
<b>Mental Behavior Disorders</b>			
51.	Drug Abuse		
52.	Mental disorder		
<b>Any other unusual diseases (specify)</b>			

## 10-LEADING HOSPITALS BASED CAUSES OF DEATHS (REGISTERED)

TOP DISEASES WITH REGISTERED NUMBER OF DEATHS (PUNJAB - DHIS DATA 2018 - ALL HOSPITALS)

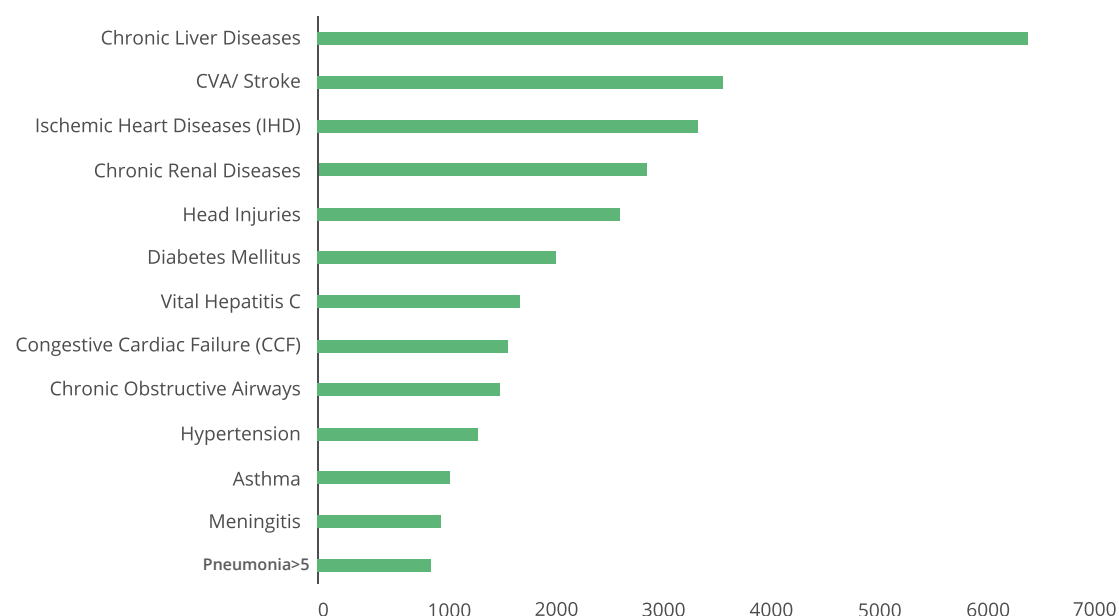
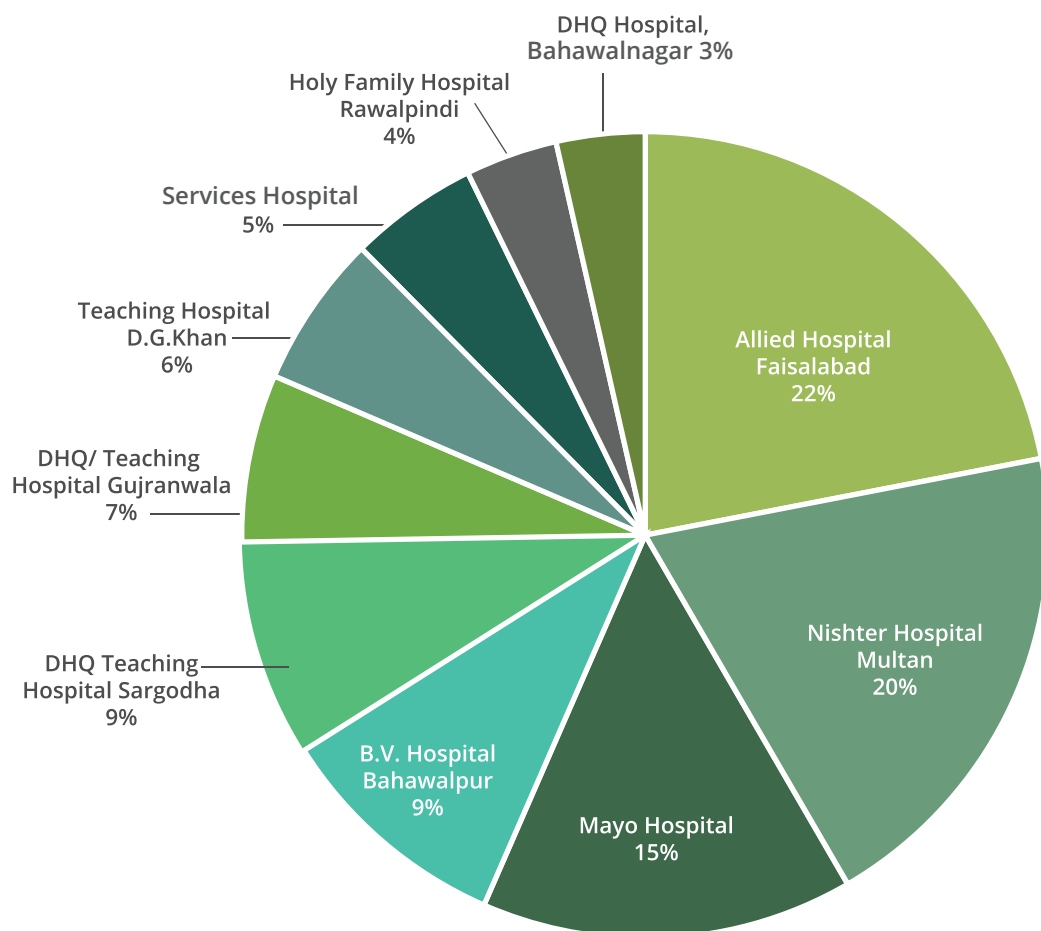


Table: Year wise Death Registration (DHIS Data – All Hospitals - Punjab)

Years	2013	2014	2015	2016	2017	2018
Neonatal Deaths	10,480	12,681	11,772	1,612	210	166
Infant Deaths Reported LHW	41,219	36,876	37,431	22,793	27,687	14,622
Diarhoea Less 5 years Deaths	6,676	600	1,415	989	628	611
Pneumonia Less 5 years Deaths	663	654	580	954	731	1,035
Maternal Complications Deaths	377	639	539	49	-	-
Maternal Deaths Reported LHW	1,713	1,342	1,417	1,756	2,127	1,035
Malaria Deaths	53	35	82	32	94	84
Pulmonary TB Deaths	606	779	949	906	883	936
Hepatitis B Deaths	254	65	132	246	309	348



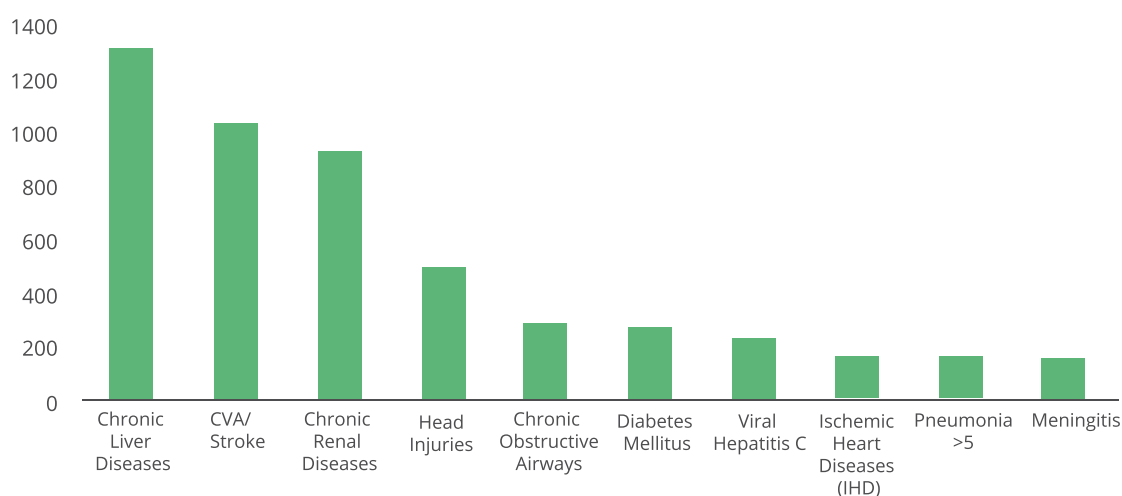
## LEADING HOSPITALS WITH % AGE OF DEATHS (REGISTERED IN DHIS 2018)



## 10-LEADING HOSPITALS BASED CAUSES OF DEATHS (REGISTERED IN DHIS 2018)

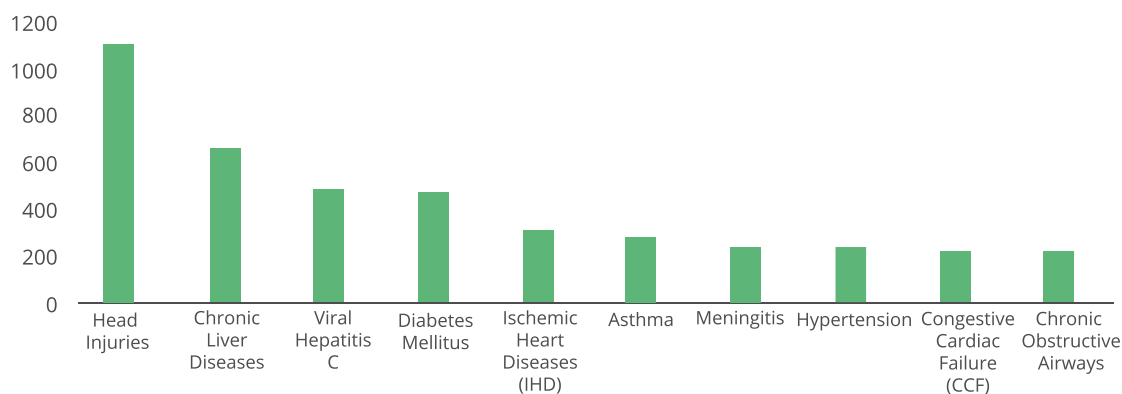
The 10-leading causes of death in Allied Hospital – Faisalabad among all ages were attributed to chronic liver disease (#1317). This was followed by Cardio Vascular Diseases (#1034), Chronic Renal diseases 939, and head injuries (#502) (See Graph below)

### ALLIED HOSPITAL FAISALABAD



### NISHTAR HOSPITAL MULTAN

The ten leading causes of deaths in Nishtar Hospital, Multan among all ages are reflected in the illustration below. Head injuries were the leading cause of death in 2018. It was followed by chronic liver disease, viral hepatitis C and diabetes mellitus.



## SECTION C: CAUSES OF DEATH ANALYSIS (BASED ON HOSPITAL / FIELD DATA)

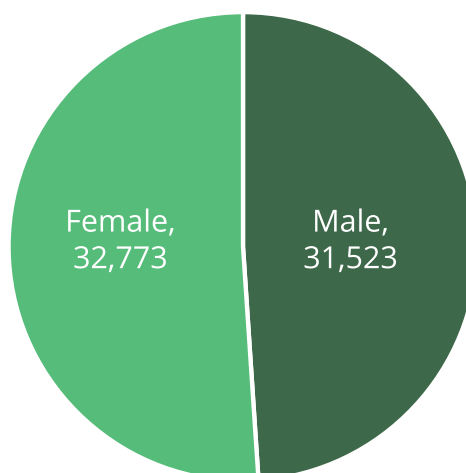
### OVERALL SUMMARY COD DATA 2018 (SELECTED LAHORE BASED HOSPITALS)

This analysis is based on the following Lahore-based selected hospital records for 2018. They show that out of overall death by gender, 51 per cent were female and 49 per cent male. Overall, 64,296 deaths were recorded during the one-year period.

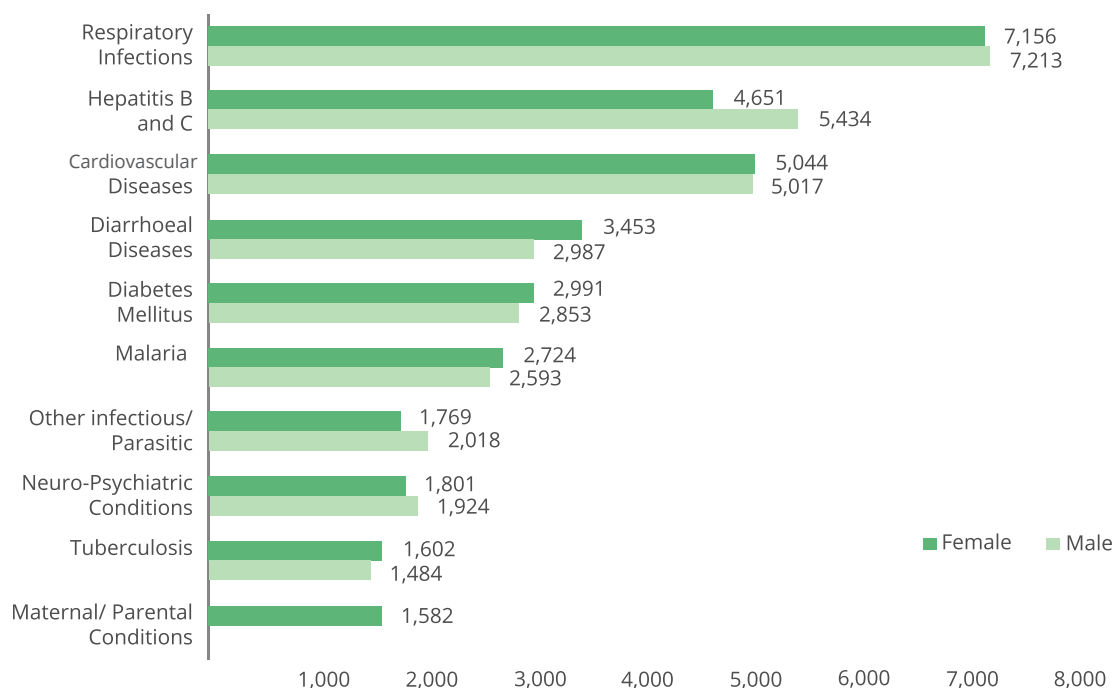
- Jinnah Hospital, Lahore
- Services Hospital, Lahore
- Mayo Hospital, Lahore
- Lahore General Hospital, Lahore
- Children Hospital, Lahore
- Sir Ganga Ram Hospital, Lahore
- Govt. Nawaz Sharif Hospital, Lahore

The illustrations below show the total number and five major causes of death by gender. Deaths due to respiratory infections, hepatitis (B & C), cardiovascular disease, diarrhoeal diseases and diabetes mellitus were the five most common in 2018.

NUMBER OF DEATHS BY GENDER



## NUMBER OF DEATHS BY GENDER AND MAJOR CAUSES

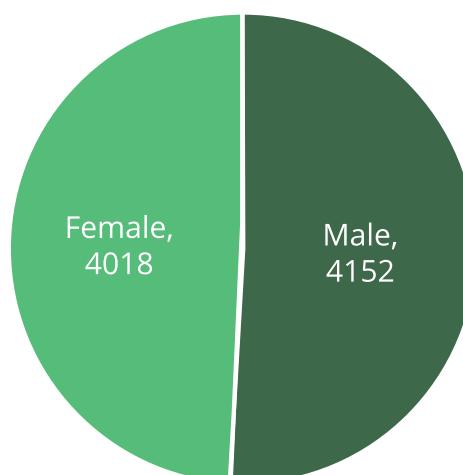


## HOSPITAL WISE DETAILED CAUSES OF DEATH ANALYSIS

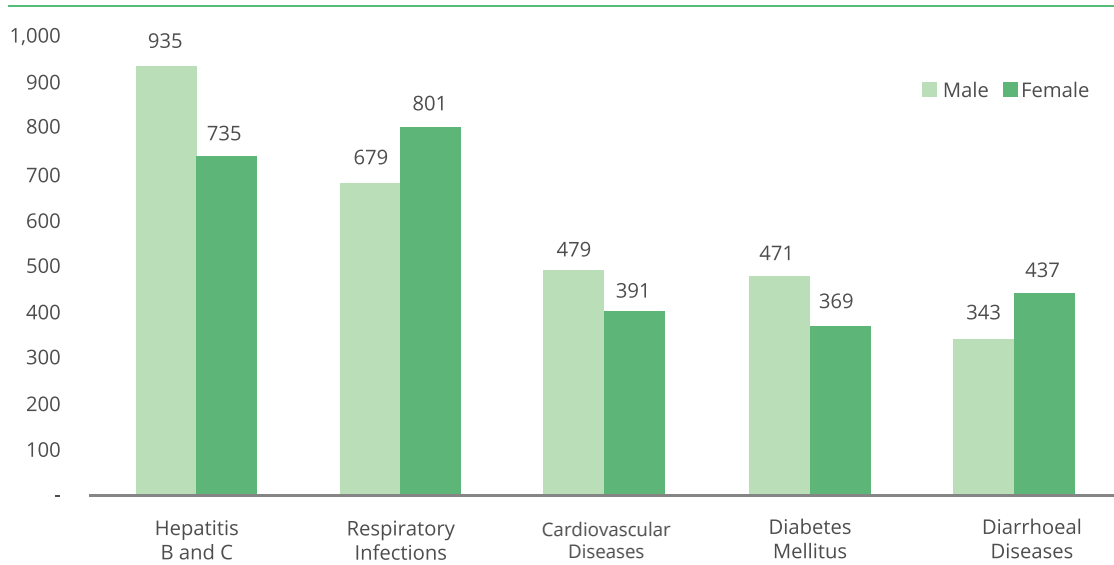
### Jinnah Hospital Lahore – CoD Data 2018

This analysis is based on Hospital records for 2018. They show that out of overall death by gender 49 per cent were female and 51 per cent male. Overall 8170 deaths were recorded during the year. The graphs show the total number and five major causes of death by gender. Deaths due to hepatitis (B &C) and respiratory infections and cardiovascular diseases were the most common in 2018.

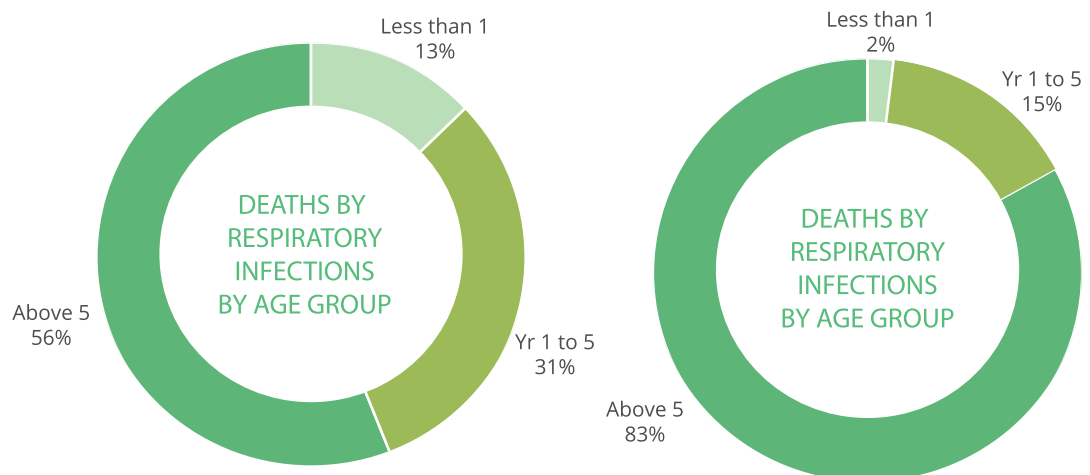
### NUMBER OF DEATHS BY GENDER



### NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The pie chart below describes the percentage of deaths by age group due to hepatitis (B & C) and respiratory infections. Viral hepatitis, including hepatitis A, B, and C, are a group of distinct diseases that affect the liver. Complications of acute respiratory infection are severe and can result in permanent damage and even death.

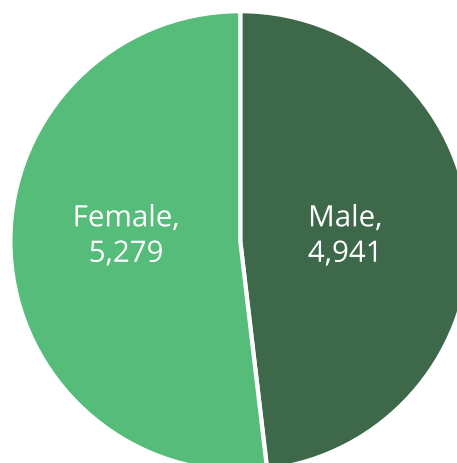


## HOSPITAL WISE DETAILED CAUSES OF DEATH ANALYSIS

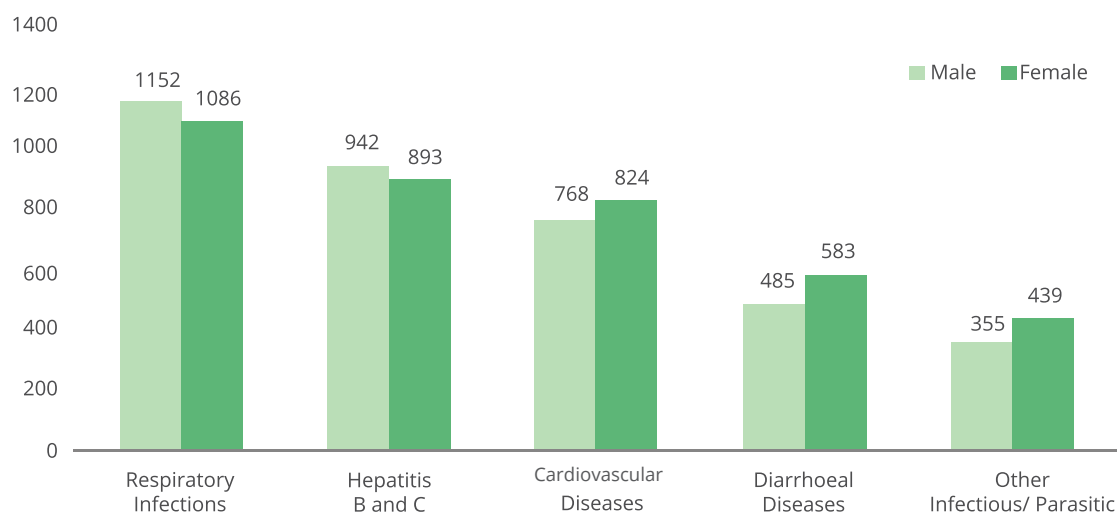
### Services Hospital Lahore – CoD Data 2018

Services Hospital records showed that out of overall death by gender, 52 per cent were female and 48 per cent male. Overall 10,220 deaths were recorded during the year. The graphs show the total number of deaths and five major causes of death by gender. Deaths due to respiratory infections, hepatitis (B & C) and cardiovascular disease were the most common in 2018.

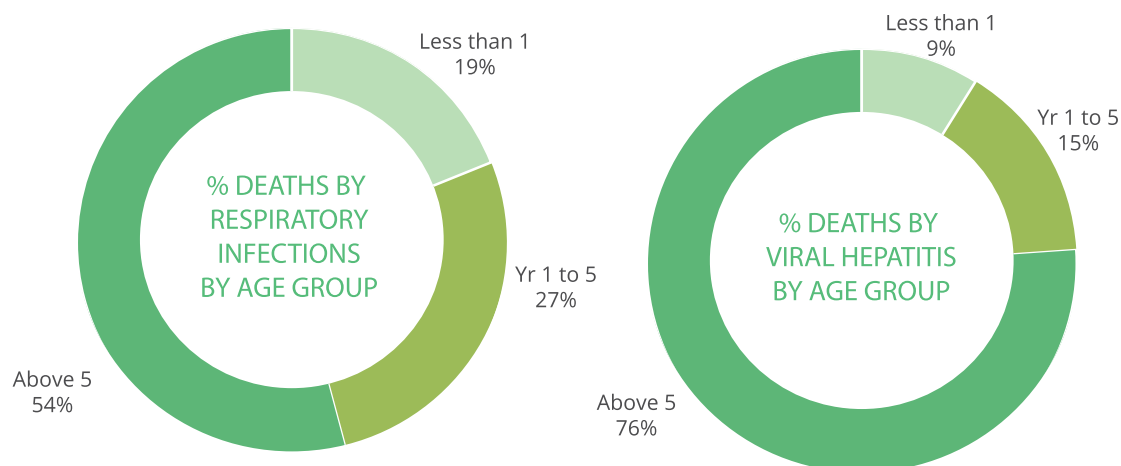
NUMBER OF DEATHS BY GENDER



NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The following pie chart shows the percentage of deaths by age group due to respiratory infections and viral hepatitis. Overall, 46 per cent deaths due to respiratory infections in Services Hospital, Lahore were of children under five years of age. Twenty-four per cent of deaths due to viral hepatitis, were recorded among the under-5 age group.

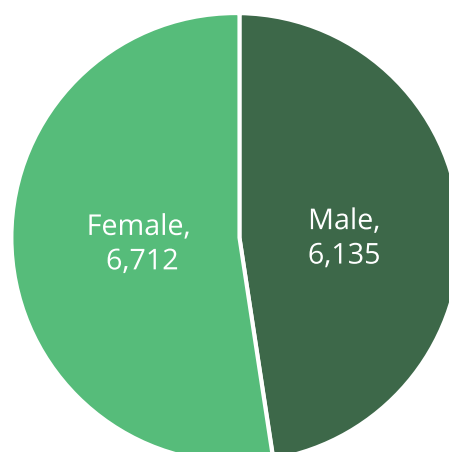


## HOSPITAL WISE DETAILED CAUSES OF DEATH ANALYSIS

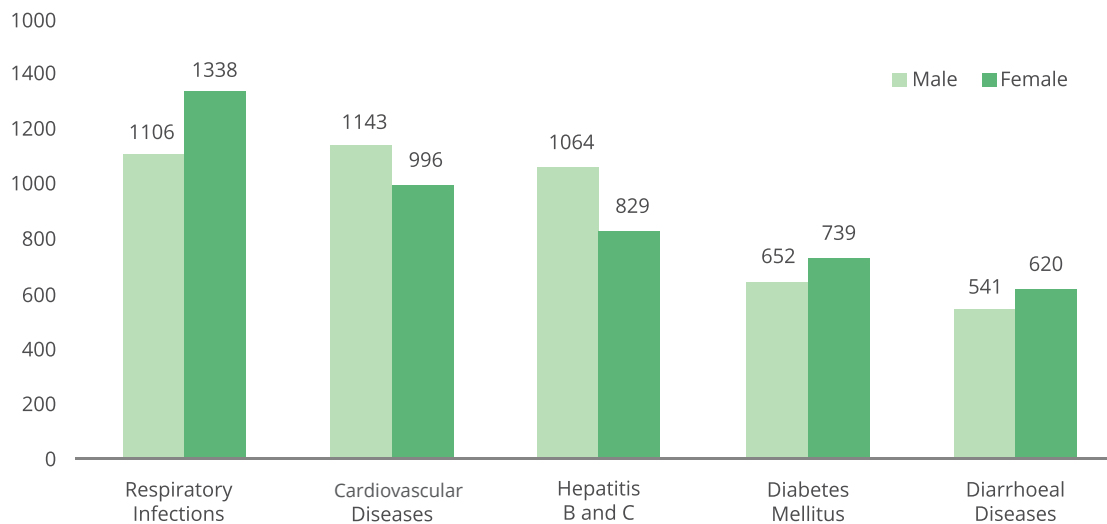
### Mayo Hospital Lahore – CoD Data 2018

The records of Mayo Hospital, Lahore showed that out of overall deaths, 52 per cent were female and 48 per cent male. Overall, 12,847 deaths were recorded during one year. The graphs show the total number of deaths and five major causes of death by gender. Deaths due to respiratory infections, cardiovascular diseases and hepatitis (B & C) were the most common in 2018.

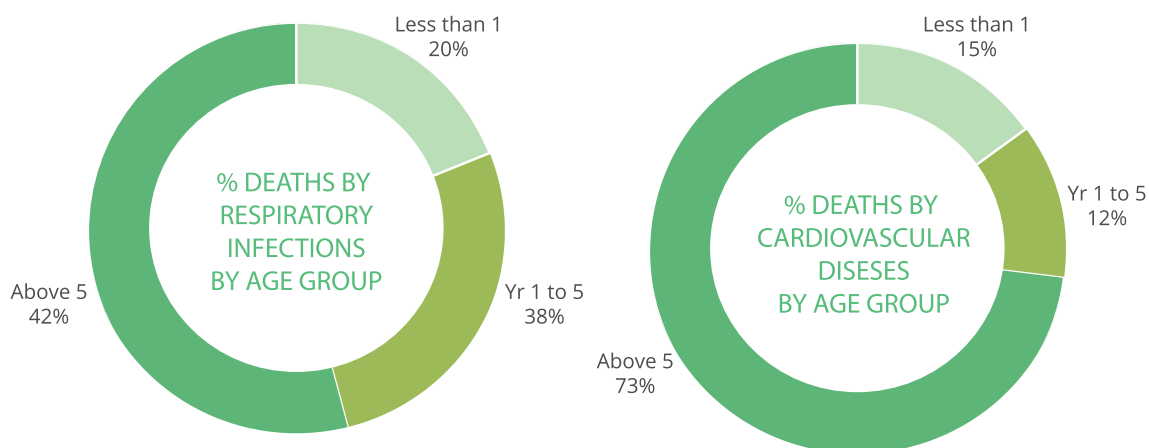
### NUMBER OF DEATHS BY GENDER



### NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The pie chart show below reflects the percentage of deaths by age group due to respiratory infections and viral hepatitis. Overall, 58 per cent of deaths due to respiratory infections in Mayo Hospital, Lahore were in the under-5 year of age bracket. Twenty-seven per cent of deaths due to cardiovascular diseases were recorded among the under-5 age group.



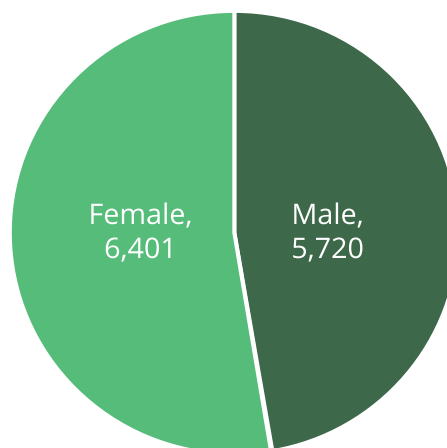


## HOSPITAL WISE DETAILED CAUSES OF DEATH ANALYSIS

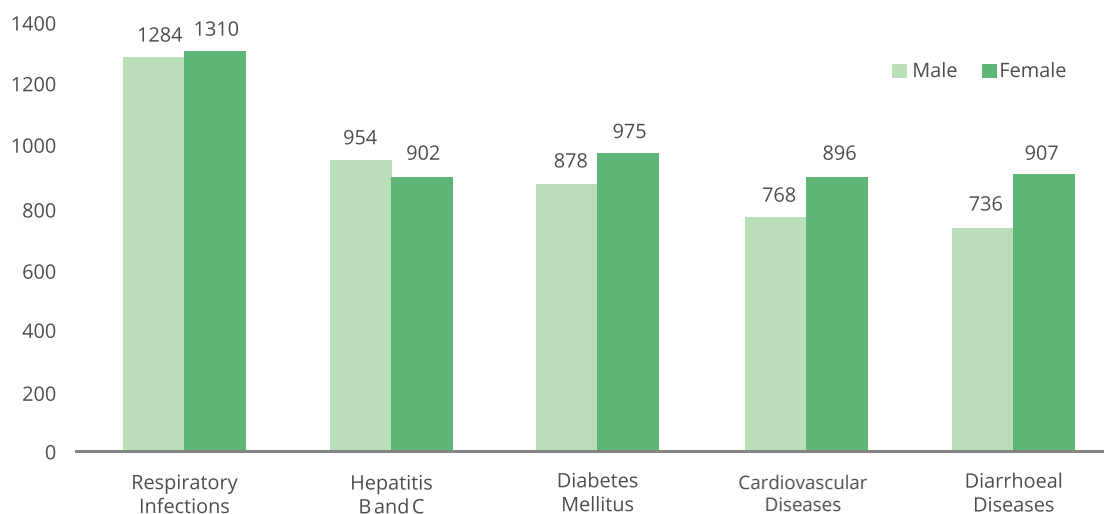
### Lahore General Hospital- CoD Data 2018

Lahore General Hospital records showed that out of overall deaths 53 per cent were female and 47 per cent male. Overall 12,121 deaths were recorded during the one-year period. The relevant illustrations show the total number of deaths and five major causes of death by gender. Deaths due to respiratory infections, hepatitis (B & C) and diabetes mellitus were the most common in 2018.

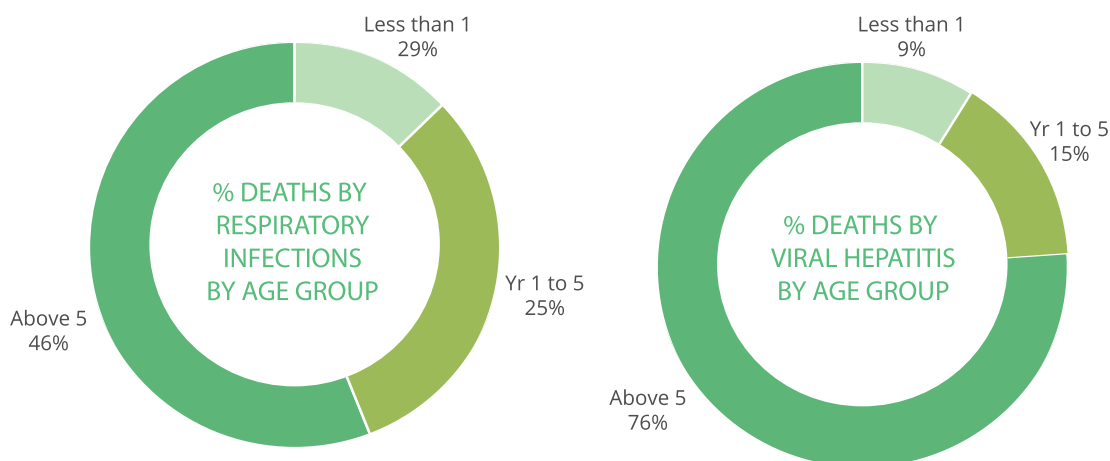
NUMBER OF DEATHS BY GENDER



NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The following pie chart shows the percentage of deaths due to respiratory infections and viral hepatitis by age group. Overall, 54 per cent of deaths due to respiratory infections were among the under-5 age group. Twenty-four per cent of deaths due to viral hepatitis were recorded in the under-5 age bracket.

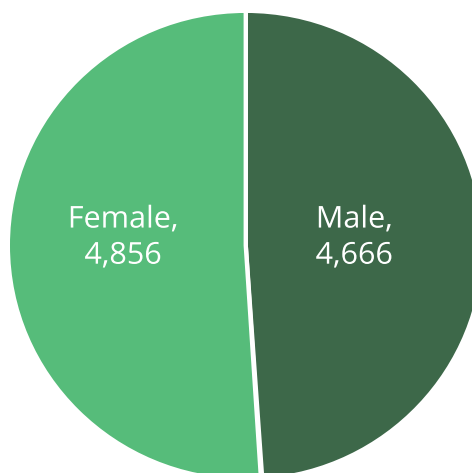


## HOSPITAL-WISE DETAILED CAUSES OF DEATH ANALYSIS

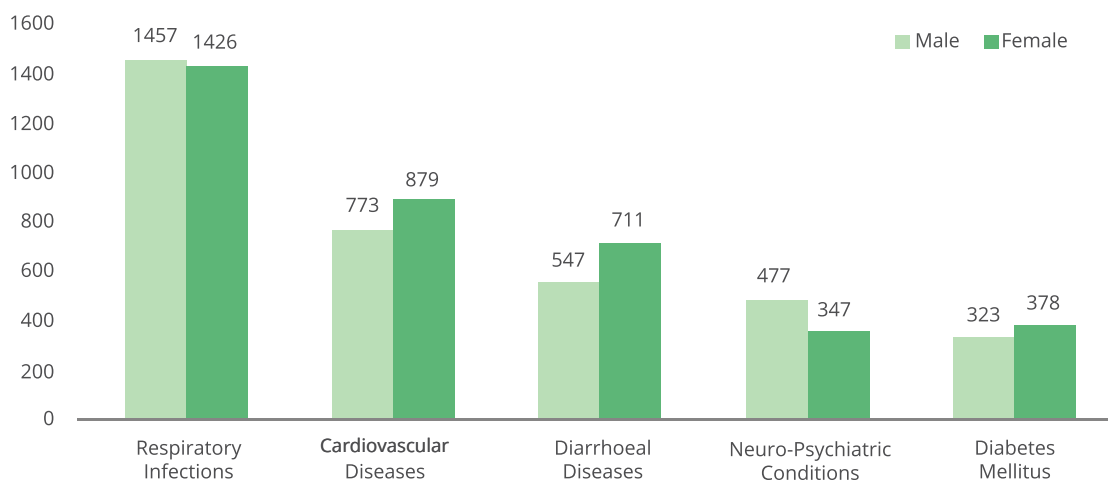
### Children Hospital- CoD Data 2018

The Children Hospital records showed that out of overall deaths 51 per cent were female and 49 per cent male. Overall 9,522 deaths were recorded during the one-year period. The illustrations show the total number of deaths and five major causes of death by gender. Deaths due to respiratory infections, cardiovascular diseases and diarrhoeal diseases were the most common in 2018.

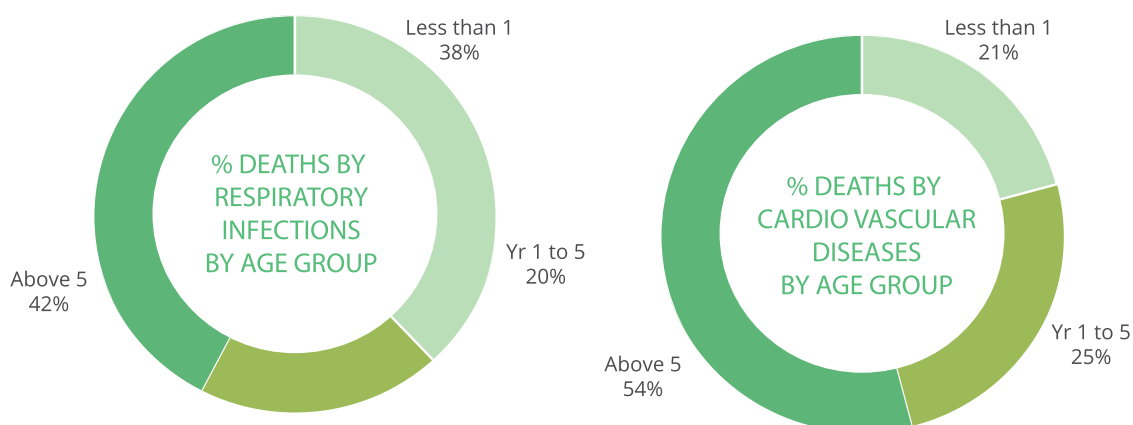
### NUMBER OF DEATHS BY GENDER



### NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The pie chart below reflects the percentage of deaths by age group due to respiratory infections and viral hepatitis. Overall 58 per cent of deaths due to respiratory infections at the Children Hospital, Lahore were among the under-5 age group. Forty-six per cent deaths due to cardiovascular diseases were recorded among the under-5 age bracket.

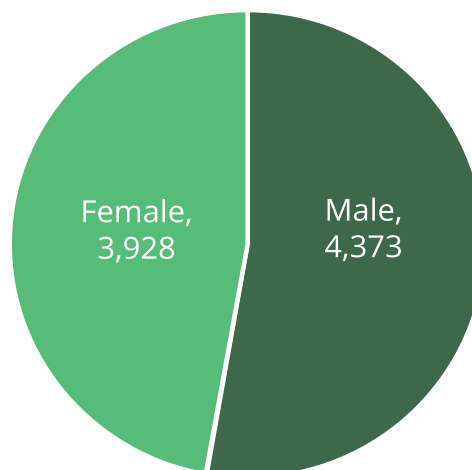


## HOSPITAL WISE DETAILED CAUSES OF DEATH ANALYSIS

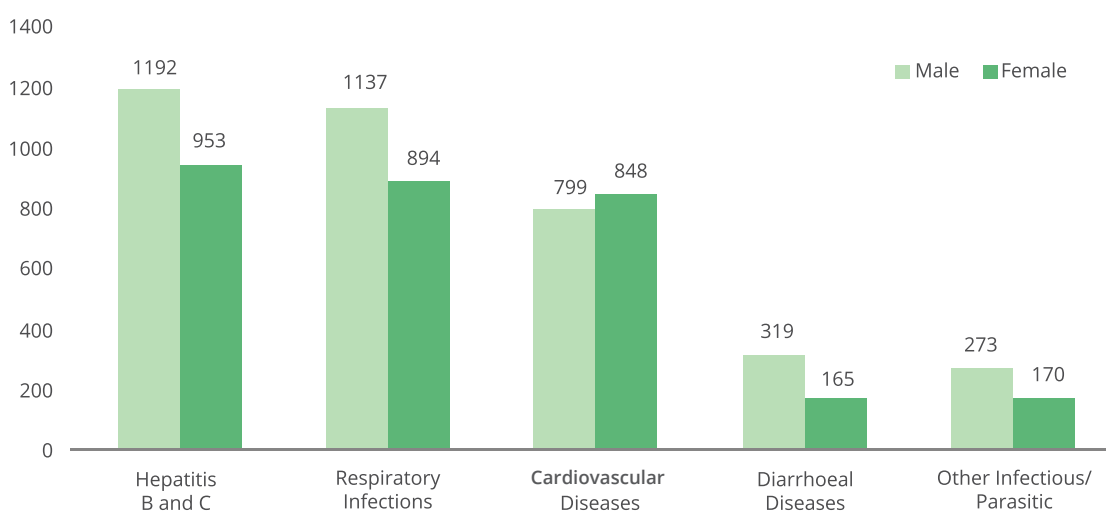
### Sir Ganga Ram Hospital- CoD Data 2018

Hospital records showed that out of overall deaths, 47 per cent were female and 53 per cent male. Overall 8,301 deaths were recorded during the one-year period. The illustrations show the total number of deaths and five major causes of death by gender. Deaths due to hepatitis (B & C), respiratory infections and cardiovascular diseases were the most common in 2018.

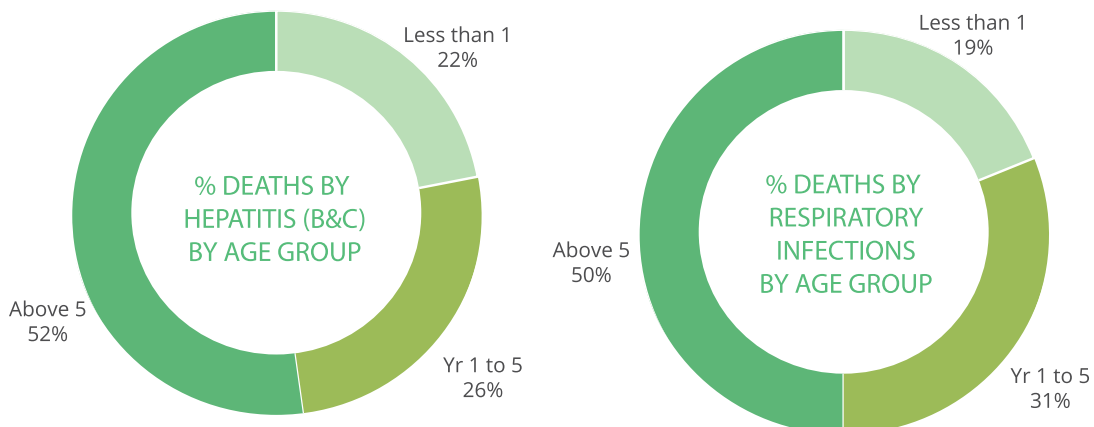
NUMBER OF DEATHS BY GENDER



NUMBER OF DEATHS BY GENDER AND FIVE MAJOR CAUSES



The following pie chart describes the percentage of deaths by age group due to viral hepatitis and respiratory infections. Overall, 48 per cent deaths due to hepatitis at the Children Hospital, Lahore were among the under-5 age group. Fifty per cent deaths due to respiratory infections were recorded among the under- 5 age group. Cardiovascular disease was the third leading cause of death.



## CONCLUSION & RECOMMENDATIONS



Punjab province has good coverage and distribution of health infrastructure in the public sector. However, there still exist many gaps in the system in terms of mortality data availability, the existence of data systems, data generation, development, consolidation, analysis and its use in the health sector.

Currently, ICD-coding, which is an international standard system of data recording, is not being practised in the hospitals. Despite the availability of modern data computer technology, most hospitals still rely on a manual system for data aggregation and analysis. The situation of IT infrastructure is not satisfactory except in some hospitals. Neither a standard certificate for the cause of death is used nor is adequate labelling of the cause practised by the health staff.

Given the significance of mortality and morbidity statistics to health management and planning, the capacities need to be built to address this issue as one of the health sector's priorities. A need exists to address this issue through a well thought out plan, where a more thorough assessment of the hospital-to-hospital situation is made in terms of human and physical resources and capacities desired to improve the situation.


The following are some key recommendations for the development of a specific action plan and improvement of the current practice of data collection and reporting for the strengthening of the health system.

- a. There is an urgent need to develop a comprehensive plan for improvement of hospital-based morbidity and mortality statistics.

- b. Through a hospital-to-hospital review regarding its resources, infrastructure, and capacities in terms of hospital statistics in general and mortality, in particular, an improvement plan be developed.
- c. Hospital MIS/statistical unit be revitalised to take the leading role in development, capacity building and system maintenance and be actively involved in CRVS activities through IT-based projects.
- d. Need for immediate adaptation, piloting and implementation of ICD-10 coding for certifying the cause of deaths on a standard pattern, and it must be made mandatory in all tertiary care hospitals.
- e. To improve mortality statistics, a standard death certificate with ICD-enabled cause of death be developed and implemented in the tertiary and secondary hospitals to start with, and it must be filled by at least MO of the unit.
- f. To develop a national provincial policy to record and certify cause those led to death of persons.
- g. Hospital death review committees be formulated or reactivated and streamlined with clear terms of reference and roles. These should go for an in-depth review of the causes of death coding on a monthly basis. Verbal autopsy be made mandatory of all received dead cases.
- h. For improving data quality there is a need for a more interactive approach by sending regular feedback to coders/UC secretaries after quality check and evaluations
- i. Instead of manual or use of simple excel sheets for data aggregation and use, some demand-driven hospital MIS softwares be developed and launched in government hospitals. If so, these needs to be uniformed and with analytical features.
- j. Enhanced use of technology be encouraged for ICD-coding in hospitals
- k. A culture of developing annual reports by the hospitals should be promoted to review causes of deaths along with their distribution patterns in area, gender and age.
- l. There is a need to strengthen the analytical capacity of decision-makers and data users.
- m. IT-based centre with trained human resource needs to be a compulsory part of the hospital management
- n. All the hospitals must be integrated in terms of referral of patients.
- o. All unknown deaths be received with exact causes of deaths.

# PROPOSED STANDARDIZED DEATH SLIP

Policy Strategic and Planning Unit of Punjab Health Department is currently the focal point for CRVS strengthening in the Punjab Health Department PSPU, jointly working with Punjab Information Technology Board (PITB) on the development of standardised mobile application and corresponding standardised death slip (pictured below) to be used in all health facilities of Punjab Health Department.

SLIP/CERTIFICATE OF DEATH (Duplicate)		
وفات نامہ		
Rural Health Center, Phagwari, Murree, Rawalpindi		
<b>DECEASED'S BIODATA : ( متوفی کا سوانحی خاکہ )</b>		
NAME OF DECEASED ( متوفی کا نام ) : hdbxh	MRN ( مراجع نمبر ) : abhdxh	
DATE OF BIRTH ( تاریخ پیدائش ) : 24 Jun 2009	AGE (at time of death) ( عمر ) : 10 y 0 m 0 d	
GENDER ( جنس ) : Male	MARITAL STATUS ( ازدواجی حالت ) : Single	
RELIGION ( مذہب ) : Islam	CNIC (Deceased/Guardian) ( قومی شناختی کارڈ نمبر ) : -	
ADDRESS ( پتہ ) : hdbxh , Faleh Jang , Adcock , Punjab		
<b>DECEASED'S DETAILS : ( متوفی کی تفصیلات )</b>		
DATE OF ADMISSION (if applicable) ( تاریخ داخلہ ) :	DATE OF DEATH ( تاریخ موت ) : 24 Jun 2019	
RECEIVED DEAD : Yes	DEPARTMENT ( شعبہ ) : hdxj	
DEAD BODY HANDED OVER TO : ( میت وصول شدہ ) : vzhz	CNIC OF DEAD BODY HANDED OVER TO : ( قومی شناختی کارڈ نمبر ) : -	
RELATION WITH DECEASED ( میت سے تعلق ) : dhjsh	UNIT : dhjsh	
<b>CAUSE OF DEATH : ( موت کا سبب )</b>		
<b>Part I</b>		<b>Is Autopsy Recommended?</b>
a) DIAGNOSIS / IMMEDIATE CAUSE OF DEATH		
Due to (as consequence of)		
b) PRIMARY CAUSE		
Due to (as consequence of)		
c) SECONDARY CAUSE		
Due to (as consequence of)		
d) UNDERLYING CAUSE		
Due to (as consequence of)		
<b>Part II : Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.</b>		
Name & Signature of the Doctor (with PMDC Number): 9999		
(To be declared and handed over to the relative of the deceased)		
This document is not valid in court of law		



# REFERENCES

- National Vision 2016 – 2025 published by Ministry of National Health Services Regulations & Coordination (<http://www.mnhsrsc.gov.pk>)
- UNICEF (2015-2016) Pakistan Statistics ([http://www.unicef.org/infobycountry/pakistan\\_pakistan\\_statistics.html#120](http://www.unicef.org/infobycountry/pakistan_pakistan_statistics.html#120))
- World Health Organization (<http://who.int>)
- Pakistan Demographic Health Survey 2016-17 conducted by National Institute of Population Studies, Islamabad (<http://www.nips.org.pk>)
- Jinnah Hospital Lahore (<http://www.aimc.edu.pk/jhl.html>)
- Mayo Hospital, Lahore (<http://www.mayohospital.gop.pk>)
- Services Institute of Medical Sciences (Services Hospital) Lahore (<http://www.sims.edu.pk>)
- Children Hospital, Lahore (<http://www.chich.edu.pk>)
- Sir Ganga Ram Hospital (Fatima Jinnah Medical College for Women), Lahore (<http://www.fjmc-neurosurgery.com.pk>)
- Nishtar Medical College & Hospital, Multan (<http://www.nhm.gop.pk>)
- District Health Information System - Punjab – Lahore (<http://www.Dhispb.com>)

# ANNEXURE

## ANNEX - A

### CURRENT COD PRACTICE COLLECTION TOOL

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#### MORTALITY DATA REGISTRATION, AVAILABILITY, QUALITY AND USE

Name of Hospital \_\_\_\_\_

Address;

Reporting Year:

Contact Details:

Bed Position:

Bed Occupancy Rate \_\_\_\_\_

#### MORTALITY STATISTICS

1. Do you have death registration system in your hospital?
  - Yes, compulsory
  - Yes, non-compulsory
  - Partially
  - No
  - Don't know
2. Who is be responsible for the final data of registration of death at the Hospital Level?
  - Hospital Administrator.
  - Respective Clinical Departments.
  - Administrative Department.
  - Hospital Statistics/MIS Unit.
  - Other (please specify):

3. Who is responsible for determining the cause of death?
  - Hospital Mortality Committee.
  - Respective Clinical Departments.
  - Hospital Statistics/MIS Unit.
  - Other (please specify):
  
4. Where is death reported from hospital?
  - Civil registry
  - Local health authority.
  - Central Health Authority
  - NADRA /Local Bodies
  - Local police authority
  - Other (please specify):
  
5. How is mortality information from hospital collected?
  - Proper electronic system of data collection and consolidation.
  - Manual System of data collection and consolidation.
  - Mix of electronic and manual systems.
  - Other (please specify):
  
6. What is your hospital estimated completeness of overall registered deaths?
  - < 50%
  - 50-59%
  - 60-69%
  - 70-79%
  - 80-89%
  - 90+%
  - Information not available
  
7. Does the registration system coverage include foreign residents?
  - Yes
  - No
  - Not applicable

8. What proportion of registered deaths from hospitals have a statement of cause of death?

- < 50%
- 50-59%
- 60-69%
- 70-79%
- 80-89%
- 90+%
- Information not available

9. What proportion of deaths with a statement of cause are based on the knowledge of a doctor who managed the patient before death?

- < 50%
- 50-59%
- 60-69%
- 70-79%
- 80-89%
- 90+%
- Information not available

10. If the cause-of-death statistics provided are compiled by Date of occurrence or date of registration.

- Date of occurrence
- Date of registration

11. Describe the coding procedure:

- Centralized/ Decentralized,
- done at the unit level Locally coded but checked at the statistical unit level
- Other(please specify):

12. Who certifies death?

- Physician Coroner Other (Please specify)
- This field can be used only when Other is selected above.
- Paramedics Staff/Nurses.

13. Who selects the underlying cause of death (UC) on the medical certificate and assigns an ICD code to the UC?
  - The certifier A physician other than the certifier
  - A non-medical coder
  - An automated computerized system
  - Other (please specify).
14. Is there some standard Certificate used with medically certified causes of death?
15. Is that certificate provincially standardized or developed by the hospital?
16. Is the International Form of Certificate with medically certified causes of death used?
  - Yes
  - No
  - Don't know
  - If NO, please send a copy of the certificate in use
17. Do you prepare hospital based analysis of death statistics?
  - Yes
  - No
  - Don't know.
18. What form of certificate is used for reporting causes of foetal and/or perinatal deaths?
  - The International form of Certificate of Cause of Death?
  - The International form of Certificate of Perinatal Deaths?
  - A special form for perinatal deaths? please send a specimen
  - Other, please send a specimen
  - Don't know
19. Is the ICD used for coding certified causes of death?
  - Yes
  - No
  - Don't know

20. If Yes, please choose:

- 3-character categories are used?
- 3 and 4-character categories are used?
- Other, please specify:
- This field can be used only when Other is selected above

21. Is ICD implementation achieved or planned?

- Planned
- Partially implemented
- implemented reporting to WHO
- Don't know

22. Please fill in the table below giving date ranges for the ICD version in use for mortality statistics?

Version	Start year	End Year
ICD-6		
ICD-7		
ICD-8		
ICD-9		
ICD-10		

23. Are there some basic or refresher training envisaged for ICD Coding?

24. Specify expected year of implementation? Please correct the year value

25. Are the ICD Rules for Classification used to select the underlying cause of death?

- No
- Yes
- Don't know.

26. What is record keeping system in hospitals? Is the data properly stored /archived?

27. Is that stored in computers or manually?

28. If in computers, in what programme (Excel, proper software).

29. How frequently the data is analyzed and reports developed?

30. Is this data used in planning and decision making or in annual meetings?

31. Comments:

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### Morbidity Statistics

1. Do you prepare morbidity statistics of hospital admissions?

- Yes, compulsory
- Yes, non compulsory
- No
- Don't know

2. Do you prepare morbidity statistics of out-patient visits?

- Yes, compulsory
- Yes, non-compulsory
- No
- Don't know

3. What proportion of outpatients and inpatients is included in these statistics (%). Identify separately.

- < 50%
- 50-59%
- 0-69%
- 70-79%
- 80-89%
- 90+%

4. If ICD-10 is used for morbidity coding in type (Check all that apply)

- Medical records
- Reimbursement
- Disease surveillance
- Insurance purposes
- Surveys

5. Who assigns an ICD code? (Check all that apply)

- A physician in contact with the patient
- A physician other than the one in contact with the patient
- A coder (non physician with special training)
- A lay person without any special training
- An automated computerized system
- Other (please specify):

This field can be used only when other is selected above

5.1 Who assigns code for more that 80% of the cases that are coded

- A physician in contact with the patient
- A physician other than the one in contact with the patient
- A coder (non physician with special training)
- A lay person without any special training
- An automated computerized system
- Other (as specified in the previous question)
- There is no profession that assigns code for more than 80% of the cases

6. Comments

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## Surveillance

1. Do you have hospital based surveillance system for specific diseases?
  - Yes
  - No
  - Don't Know
2. If yes please list the diseases under surveillance
3. Is ICD Used in this context?
  - Yes
  - No
  - Don't know

## Cancer Statistics

1. In your hospital, do you have a system of cancer registries in place?
  - Yes
  - No
  - Don't know
2. Do the registries use :
  - Only ICD
  - Only ICD-O
  - A combination of both
  - Other (please specify)
3. Estimated coverage of visits.
  - < 50%
  - 50-59%
  - 60-69%
  - 70-79%
  - 80-89%
  - 90+%
  - Information not available

4. Estimated coverage of cancer types

- More than 80% of cancer types
- 40%-80% of cancer types
- Less than 40% of cancer types
- Don't Know

**ICD implementation (General Questions)**

1. Questions on the current IT infrastructure in the managerial levels in hospitals

- More than 80% have computers
- 40%-80% have computers
- Less than 40% have computers
- Don't Know

2. Computer availability at the doctor's offices

- More than 80% have computers
- 0%-80% have computers
- Less than 40% have computers
- Don't Know

3. Computer availability at the regional (health) administrative units

- More than 80% have computers
- 40%-80% have computers
- Less than 40% have computers
- Don't Know

4. Internet availability at the hospitals

- More than 80% have internet connection
- 40% - 80% have internet connection
- Less than 40% have internet connection
- Don't Know
- More than 80% have internet connection
- 40% - 80% have internet connection
- Less than 40% have internet connection
- Don't Know

5. Internet availability at the doctor's offices
  - More than 80% have internet connection
  - 40% - 80% have internet connection
  - Less than 40% have internet connection
  - Don't Know
  
6. Internet availability at the regional (health) administrative units
  - More than 80% have internet connection
  - 40% - 80% have internet connection
  - Less than 40% have internet connection
  - Don't Know
  
7. Internet availability at the provincial (health) administration
  - Available
  - Not available
  - Don't Know
  
8. Is there any provincial health related database for mortality & morbidity statistics?
  - Yes
  - No
  - Don't know
  
9. Can hospital submit the required data, claims etc in electronic format?
  - Yes
  - No
  - Don't know
  
10. Internet access: please outline any Internet access limitations in the hospital and the impact this has on ICD implementation.
  
11. If translation was selected as a problem in the previous question, please select the most appropriate reason for this.
  - Financial
  - human resources
  - linguistic
  - other (please specify) This field can be used only when Other is selected above

#### 14. Comments

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15. For what uses and purposes could ICD-10 work for you? (Please check the ones that are in use as well as the ones that might be used in the future)

- Mortality Medical documentation
- Reimbursement system
- Social insurance
- Surveillance
- Other Morbidity use
- Don't know

16. Please specify if there are other uses and purposes not listed in the previous question

17. What is the legal framework?

- International mandates to update and implement acknowledged
- International mandates to update and implement motivators
- National legislation require implementation of ICD

18. When was the last update done (year)? Please correct the year value

19. Is the responsible institution aware of the updating process at WHO?

- Yes
- No

## ANNEX-B

### CAUSES OF DEATHS IN MAJOR HOSPITALS

#### DATA COLLECTION FORM

Name of Hospital \_\_\_\_\_

Contact Details:

Bed Position:

Bed Occupancy Rate \_\_\_\_\_

Departments	Total	Male	Female
1.			
2.			

#### Patients Attendance during the Year

Departments		Total	Male	Female
1.	Indoor			
	Outdoor			
	Emergency			

## Number and Cause of Deaths as per ICD-10 Coding During the Year:

Group Name	Sub-Group	ICD Code	Male			Female		
			< 1 Yr	1 – 5 Yrs	> 5 Yrs	< 1 Yr	1 – 5 Yrs	> 5 Yrs
1) Tuberculosis	TB chest	1005						
	TB abdomen	1006						
	Tuberculosis *	3004						
2) Diarrheal Diseases	Diarrhoea	1004						
	Diarrhoea & astroenteritis *	3002						
	Intestinal infections	1004						
	Intestinal infections *	3003						
3) Childhood-Duster diseases	Tetanus	1008						
	Tetanus *	3005						
	Diphtheria *	3006						
	Acute Poliomyelitis *	3010						
	Measles *	3011						
4) Bacterial Meningitis	Meningococcal infection	1011						
	Meningitis *	3027						
	Meningitis	1059						
5) Hepatitis B	Viral hepatitis	1019						
6) Malaria	Malaria	1021						
	Malaria *	3014						
7) Other infectious/Parasitic	Other infectious diseases	1025						
	Other infectious/parasitic *	3015						
	Septicemia *	3009						
	Septicemia	1012						
	Neonatal Sepsis	3045						
8) Respiratory infectious	Pneumonia	1074						
	Acute Lower RTI	1075						
	Other viral disease	3013						
	Pneumonia	3022						
	Other Acute Respiratory Infections							
9) Maternal Conditions	Deaths Due to Pregnancy	1087						
	Septic Abortion	1088						
	Obstetric Causes	1089						
	Pregnancy / Child Birth / Puerperium	1091						
	Complication of Preg	3038						
	Low Birth wt / Prematurity	3039						
10) Prenatal Conditions	Birth injury	3040						
	Birth asphyxia	3041						
	Resp. distress of Newborn	3042						
	Hydrocephalus and Spina Bifida	3050						
	Cong. Malformations of Nervous Sys	3051						
	Congenital Malformations of heart	3052						
	Cong. Malformations of CVS	3053						
	Down's syndrome	3054						
	Other Congenital Malformation	3055						
	Sudden Infant Death	3067						
<i>* Regarding Infant or Child</i>								
11) Nutritional Deficiencies	Anemia	1049						
	Malnutrition	1053						
	Anemia *	3021						
	Malnutrition / nutritional deficiencies *	3024						
12) Malignant Neoplasm's	Leukemia *	3017						
	Remainder of Malignancies *	3018						
	Ca Oral Cavity	1027						
	Ca Oesophagu	1028						
	Ca Stomach	1029						
	Ca Colon	1090						
	Leukemia *	3017						
	Ca Liver	1031						
Ca Pancreas	1032							

	Ca Larynx	1033					
	Ca Lung	1034					
	Ca Breast	1036					
	Ca Cervix	1037					
	Ca Uterus	1038					
	Ca Ovary	1039					
	Ca Prostate	1040					
	Ca Bladder	1041					
	Ca Brain	1042					
	Non Hodgkins Lymphoma	1043					
	Multiple Myeloma	1044					
	Leukemia	1045					
	Remainder of Malignancies	1046					
13) Diabetes Mellitus	Diabetes Malignancies	1052					
14) Endocrine & Blood Disorders	Endocrine, Nutritional, Metabolic Dis. *	3023					
	Dis. Of Immune Mech	1050					
	Endocrine/Nutri/Metb.Dis.	1054					
	Remainder Diseases of Blood *	3022					
	Rem .of Endocrine + Metabolic Dis. *	3025					
15) Neuro-Psychiatric Conditions	Dis of Nervous System *	3026					
	Other Diseases of CNS *	3028					
	Mental/behavior disease	3056					
	Remainder of Mental diseases	1057					
16) Sense Organ Diseases	Remainder of CNS Disease	1061					
	Diseases of Eye	1062					
17) Cardio Vascular Diseases	Rheumatic Heart diseases	1065					
	Hypertensive diseases	1066					
	IHD/Mi ( heart attack	1067					
	CCF/Heart Block/Hypovolumic shock	1068					
	CVA (Stroke)	1069					
	Atherosclerosis	1070					
	Remainder Dis of CVS	1071					
	Diseases of Circulatory system *	3030					
	Rheumatic Heart diseases	1065					
	Hypertensive diseases	1066					
18) Respiratory Diseases	IHD/Mi ( heart attack	1067					
	Gastric / Duodenal Ulcers	1076					
	Disease of Liver	1077					
	Remainder Dis. Of Diges. Sys	3034					
19) Digestive Diseases	Other disease of digestive system. *	1079					
	Gastric / Duodenal Ulcers	1079					
	Disease of Liver	1080					
	Remainder Dis. Of Diges. Sys	1081					
20) Genitourinary Diseases	Other disease of digestive system. *	3035					
	Acute/Chronic renal failure	1085					
	Diseases of Genitourinary	1086					
	Other Dis of genitourinary sys. *	3036					
21) Musculo-Skeletal Disease	Acute/Chronic renal failure	1085					
	Dis. of Musculoskeletal system	1083					
22) Unintentional Injuries	RTA/Head injury	1096					
	Falls	1097					
	Burns	1099					
	Poisoning	1100					
	RTA/Head injury Burns *	3061					
	Burns *	3064					
	Accidental Poisoning *	3065					
	Fire Arm+Ext. Causes *	3067					

Only relevant information pertaining to respective age group and sex is to be filled.

ANNEX-C

DHIS MONTHLY FORM (HOSPITAL)

Month: April, Year: 2019		Date of Submission: 07-05-2019	
Total Working Days: 31		Hospital Monthly DHIS Report JINNAH HOSPITAL Tehsil LAHORE District LAHORE	

Section I- Identification													
1. Facility ID#	04	04	20	10	00	3. Signature of Facility In-charge							
2. Facility Name	Jinnah Hospital, Lahore					4. Designation: Medical Superintendent							

Section III- Outpatient Attendance From OPD Register														
Specialty	New cases										Total	Follow up	No. of cases of Maternity (CSY)	Referred Amended
	MALES					FEMALE								
	<1 year	1-40	41-100	101-400	401+	<1 year	1-40	41-100	101-400	401+				
1. General OPD	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Medicine	0	210	1410	3400	1540	0	210	1450	1150	4300	31790	0	0	0
3. Surgery	0	20	60	150	100	0	20	60	170	70	300	0	0	0
4. Pediatrics	100	300	510	0	0	100	300	710	0	0	400	0	0	0
5. Eye	10	10	30	10	10	0	20	60	90	70	300	0	0	0
6. ENT	0	150	60	90	150	0	70	100	110	40	600	0	0	0
7. Orthopedics	0	10	30	100	100	0	10	40	150	100	300	0	0	0
8. Psychiatry	0	0	60	20	30	0	0	20	30	40	150	0	0	0
9. Dental	0	20	130	40	10	0	70	30	40	30	200	0	0	0
10. Skin	10	10	40	40	10	0	20	70	100	100	300	0	0	0
11. OB/GYN	0	0	0	0	0	0	0	100	100	300	100	0	0	0
12. Emergency Casualty	10	100	100	100	10	10	100	100	10	100	300	0	0	0
13. Home Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14. UNCLASSIFIED	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Cardiology	0	0	10	20	30	0	0	10	20	30	200	0	0	0
16. Others	20	30	40	50	60	100	20	30	40	50	60	70	80	90
17. Urology/Nephrology	0	0	10	20	30	0	0	10	20	30	40	0	0	0
18. Physiotherapy	0	10	20	30	40	0	0	10	20	30	40	0	0	0
19. Burn Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Oncology	0	10	20	30	40	0	0	10	20	30	40	0	0	0
<b>Grand Total</b>	<b>100</b>	<b>300</b>	<b>500</b>	<b>1000</b>	<b>1000</b>	<b>1000</b>	<b>300</b>	<b>1000</b>	<b>1000</b>	<b>3000</b>	<b>10000</b>	<b>0</b>	<b>0</b>	<b>0</b>

Section IV: Cases attending OPD From OPD Register	
1. Acute Upper respiratory infections	40
2. Pneumonia - FTM	30
3. Pneumonia - FTM	40
4. TB sputum	10
5. Chronic Obstructive Pulmonary Disease	10
6. Asthma	0
Gastro Intestinal Disease	
7. Diarrhoea - Duration > 14 days	10
8. Diarrhoea - Duration > 14 days	0
9. Enteric Tuberculous Disease	0
10. Worm Infections	0
11. Peptic Ulcer Disease	0
12. Cancer of Liver	0
Urinary Tract Disease	
13. Urinary Tract Infection	0
14. Nephritis (Glomerular)	0
15. Sexually Transmitted Infections	0
16. Acute Renal Failure	0
Other Communicable Disease	
17. Suspected Malaria	0
18. Suspected Meningitis	0
19. Fever due to other causes	0
Vaccine Preventable Disease	
20. Suspected Measles	0
21. Suspected Viral Hepatitis	0
22. Suspected Neonatal Tetanus	0
Cardiovascular Disease	
23. Ischemic Heart Disease	0
24. Hypertension	0
Skin Disease	
25. Scabies	0
26. Dermatitis	0
27. Cutaneous Leishmaniasis	0
Endocrine Disease	
28. Diabetes Mellitus	0
Mental Health	
29. Depression	0
30. Drug Dependence	0



## ANNEX-D

### SAMPLES OF EXISTING DEATH CERTIFICATE USED IN HOSPITALS

**DHQ HOSPITAL, GURJRWALA**

**DEATH CERTIFICATE**

Date: \_\_\_\_\_

This is to certify that Deceased Name: \_\_\_\_\_

S/O, W/O/ D/O: \_\_\_\_\_ aged about: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ NIC No.: \_\_\_\_\_

OPD Chit No.: \_\_\_\_\_ or Ward/ Casualty: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

Date of Death: \_\_\_\_\_

Cause of Admission: \_\_\_\_\_

Signature of Medical Officer/  
Incharge Ward

**Countersignature**



# JINNAH HOSPITAL LAHORE

## DEATH CERTIFICATE



Department: \_\_\_\_\_ Unit: \_\_\_\_\_

Name Mr. /Mrs. / Miss		Medical Record No.		
Father's / Husband Name		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		
NIC No.		Marital Status		Age
		S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>		
Address: House No. Street No. Town. Tehsil / Dist.		Date of Admission		Date & Time of Death.
		Day	Month	Year
Identification Marks: 1. 2.		Place of Death		Time of Death: am / pm
Condition at the time of Admission		Stable      Sick      Critical		
<b>CAUSE OF DEATH</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> This does mean mode of dying e.g. heart failure asthenia etc. It means the disease injury of complication which caused death;  <b>ANTECEDENT CAUSES</b> Morbid condition, if any, giving rise to the above cause, stating the underlying condition last.  <b>OTHER SIGNIFICANT CONDITION</b> Contributing to the death, but not related to the disease or condition causing it.				Approximate Interval Between onset and death  a) ..... ..... ..... b) ..... ..... .....
NOTE: For instruction on filing this death certificate please refer to WHO International Classification of Disease.				

Whether Dead body is sent for Medical Autopsy? Yes  No

Body was handed over to \_\_\_\_\_

NIC No. \_\_\_\_\_

Address: House No. \_\_\_\_\_ Street No. \_\_\_\_\_

Town: \_\_\_\_\_ Tehsil / Dist \_\_\_\_\_

Phone No. \_\_\_\_\_

Relationship with the dead person \_\_\_\_\_ Signature of the person receiving the dead body \_\_\_\_\_

Name of the doctor issuing death certificate \_\_\_\_\_

Designation: \_\_\_\_\_

Signature: \_\_\_\_\_

Stamp: \_\_\_\_\_

# B



حکومت پنجاب پاکستان  
THE GOVT OF PUNJAB, PAKISTAN



وزارت صحت

### DEATH CERTIFICATE

CRMS No: D352678-11-0004  
NATURE OF DEATH: NORMAL

FORM No: 104256230

وراثت سے انتقال  
3520113478571  
104256230  
29-3-2011  
30-3-2011

دہشت	دور موت	تاریخ وفات	بیماری	جنس	تاریخ پیدائش	عنوان	منشی کا نام	منشی کا نمبر
شہل	طبی	8-1-2011	سرور	اسلام	1-1-1934	سروسز	محمد	3520152668733

APPLICANT NAME: ADNAN MAJEED

APPLICANT CNC: 3520113478571 RELATION WITH DECEASED: Father

ADDRESS: HOUSE # E/0392, WAZIR ALI ST ALI PARK, BADIAN ROAD,

CITY LAHORE, TEHSIL LAHORE CANTT, DISTRICT LAHORE

DECEASED NAME/ CNC	FATHER NAME/ CNC	DATE OF BIRTH	SEX	RELIGION	PLACE/DATE OF DEATH	DATE OF BURIAL	REASON OF DEATH	SIGNATURE PERIOD
ABDUL MAJEED 3520152668733	FATEH DIN	1-1-1934	MALE	ISLAM	SERVICES HOSPITAL 8-1-2011	8-1-2011	NATURAL	2 Y

BLOOD RELATION  PERSON CAUSING DISPOSAL OF BODY

NAME: ADNAN MAJEED

CNC: 3520113478571

GRAVEYARD NAME: BAGHE REHEBAT

ENTRY DATE: 29-3-2011

ISSUE DATE: 30-3-2011

ADDITIONAL INFORMATION

منشی محمد  
محمد علی  
محمد علی (78)

### Maternal Death\* Information Form

For Maternal Deaths in the community & Primary Health Care Facilities  
It should be filled as soon as possible after receiving information of Maternal Death  
Where choices of answer are given, please circle the applicable response(s)

Name of Health Facility \_\_\_\_\_  
 Identification Number of Health Facility \_\_\_\_\_  
 Name of the Patient \_\_\_\_\_ Wife of \_\_\_\_\_  
 Age \_\_\_\_\_ Address \_\_\_\_\_

Parity: 0 / 1 to 4 / 5 & above

Time & Date of Patient's Death: \_\_\_\_\_ am / pm on \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Information provided by: Husband / Mother / Mother-in-law  
 Other s (specify) \_\_\_\_\_

At the time of death, the woman was: Pregnant / Delivered / had an abortion

Duration of pregnancy: \_\_\_\_\_ months

Time & Date of delivery/abortion: \_\_\_\_\_ am / pm on \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If delivered, delivery conducted by: Doctor/LHV / Midwife /LHW/ Dai  
 Relative (specify): \_\_\_\_\_

Mode of Delivery: Normal /Forceps /Vacuum /Caesarian

Place of delivery: Home / Health Centre (specify) \_\_\_\_\_  
 Name of Health Centre \_\_\_\_\_

Place of death: At Home / on the way to the Health Centre /Health  
 Centre (specify) \_\_\_\_\_  
 Name of Health Centre \_\_\_\_\_

Why was patient in Hospital: For Delivery / due to Bleeding/Fits/Fever/  
 Prolonged Labor\*\*/  
 Other (specify) \_\_\_\_\_

Any antenatal Check up : Yes / No

If Yes, checked by: Doctor/ LHV / Midwife/LHW/ Dai

Reason for Antenatal check up: Routine/Swelling/Bleeding /Headache/  
 Other (specify) \_\_\_\_\_

Number of antenatal visits: 1 2 3 4 More than 4

Cause of death:  
 1. Bleeding  
 1.1. Before delivery  
 1.2. After delivery  
 2. Puerperal sepsis  
 3. Hypertension  
 4. Fits  
 5. Prolonged\* \*/obstructed labour  
 6. Abortion (died of bleeding / infection)  
 7. Other causes (Specify) \_\_\_\_\_

Form filled by (name): \_\_\_\_\_ Date \_\_\_\_\_

Designation: Doctor/LHV / Midwife/LHW

\* Death of a woman during pregnancy, childbirth and within 6 weeks of childbirth or abortion  
 \*\* More than 12 hours in labour

NCMH / UNICEF / PAKISTAN

ماں کے مرنے سے پہلے کی وجہ معلوم کرنے کا فارم  
 ان ماؤں کے لئے جن کی موت گھریا پھر برقی میٹرو کیمٹر کے مراکز میں ہوئی ہو۔  
 یہ فارم جلد سے جلد ماں کی موت کی خبر ملنے کے بعد بھرا جائے  
 جہاں کئی جواب دیئے گئے ہیں وہاں صحیح جواب کے گرد (لائٹ) لگائیں

صحت مرکز کا نام \_\_\_\_\_ صحت مرکز کا شناختی نمبر \_\_\_\_\_  
 ریجن کا نام \_\_\_\_\_ شہر کا نام \_\_\_\_\_

- |  |  |
|--|--|
| پچھلے سائے میں                         | : کوئی نہیں ہے یا ۱ سے ۱۰۰ ماں سے زیادہ  |
| ماں کے مرنے کا وقت اور تاریخ           | : _____ بجے _____ دن _____ ماہ _____ (تاریخ) _____ / _____ / _____   |
| مطہرات کنے (فارم) میں                  | : شہر یا ماں ساس، کوئی اور شہر (کہاؤ)  |
| موت کے وقت                             | : موت سے قبل یا بعد جناح ہوا تھا یا نہیں   |
| محل کے ناموں کا نام                    | : _____ ہے   |
| یہ جناح ہونے کا وقت اور تاریخ          | : _____ بجے _____ دن _____ ماہ _____ (تاریخ) _____ / _____ / _____   |
| اگر یہ جناح ہونے کا وقت اور تاریخ      | : ڈاکٹر اور ای۔ ایچ۔ وی۔ اے ڈاکٹر نے کہا ہے یا نہیں۔ _____ (تاریخ اور مکان)  |
| بچہ کی پیدائش کا طریقہ                 | : طبیعی طور پر یا سزارین سے  |
| بچہ کی پیدائش کی جگہ                   | : گھر یا صحت مرکز (م) _____  |
| موت کی موت کہاں ہوئی                   | : گھر یا صحت مرکز کے نام سے صحت مرکز میں (م) _____   |
| اگر موت صحت مرکز کی تو کہیں            | : بچہ کی پیدائش کی جگہ اور موت کی جگہ (م) _____ (موت کی جگہ) _____   |
| محل کے دور میں صحت مرکز کا نام         | : _____ ہے   |
| اگر یہاں تو کسی سے صحت مرکز کا نام     | : ڈاکٹر اور ای۔ ایچ۔ وی۔ اے ڈاکٹر نے کہا ہے یا نہیں۔ _____ (تاریخ اور مکان)  |
| محل میں صحت مرکز کا نام لکھیں          | : _____ (تاریخ اور مکان) _____   |
| محل کے دوران میں قدرتی صحت مرکز کا نام | : ۱ _____ ۲ _____ ۳ _____ ۴ _____ سے زیادہ   |
| موت کی وجہ                             | : ۱. زیادہ خون متعلقہ تھا<br>۲. زچگی سے پہلے خون متعلقہ تھا<br>۳. زچگی کے بعد خون متعلقہ تھا<br>۴. پٹنے کا کار<br>۵. زیادہ قدرتی تھا<br>۶. زچگی سے پہلے ۱۰۰ ماں یا صحت مرکز میں ۱۰۰ سے زیادہ<br>۷. بچہ کی پیدائش میں صحت مرکز یا صحت مرکز سے ۱۰۰ سے زیادہ<br>۸. بچہ متعلقہ تھا (زیادہ خون متعلقہ ہونے سے انہماک سے)<br>۹. کوئی اور وجہ (تفصیل) _____ |
| فارم کے نام لکھیں                      | : (م) _____ تاریخ _____  |
| مہرہ                                   | : ڈاکٹر اور ای۔ ایچ۔ وی۔ اے ڈاکٹر نے کہا ہے یا نہیں۔ _____   |

ہذا محل یا زچگی کے دوران یا زچگی اور بچہ متعلق ہونے کے چھ ہفتے کے اندر عورت کی موت  
 سے ۱۲ سے زیادہ ہفتے میں



