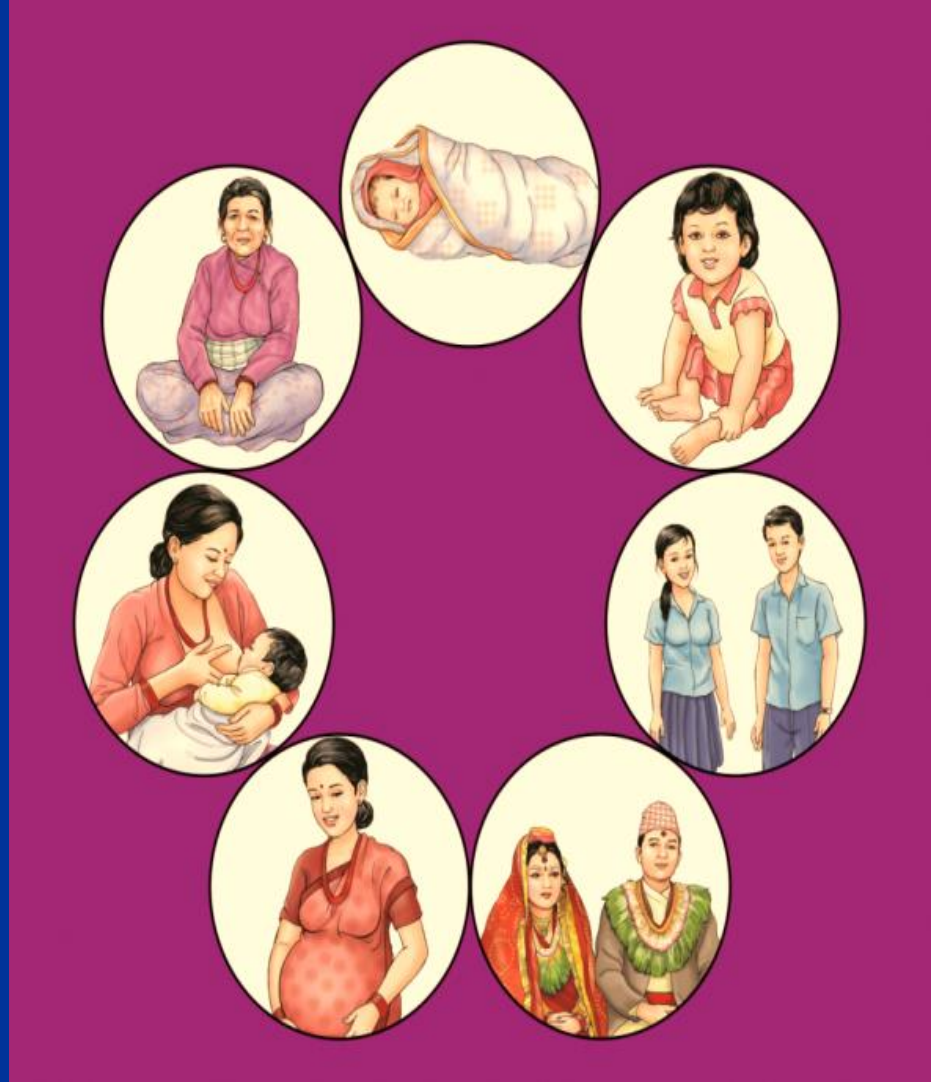
Maternal and Perinatal Death Surveillance and Response [MPDSR]

- MPDSR Process -



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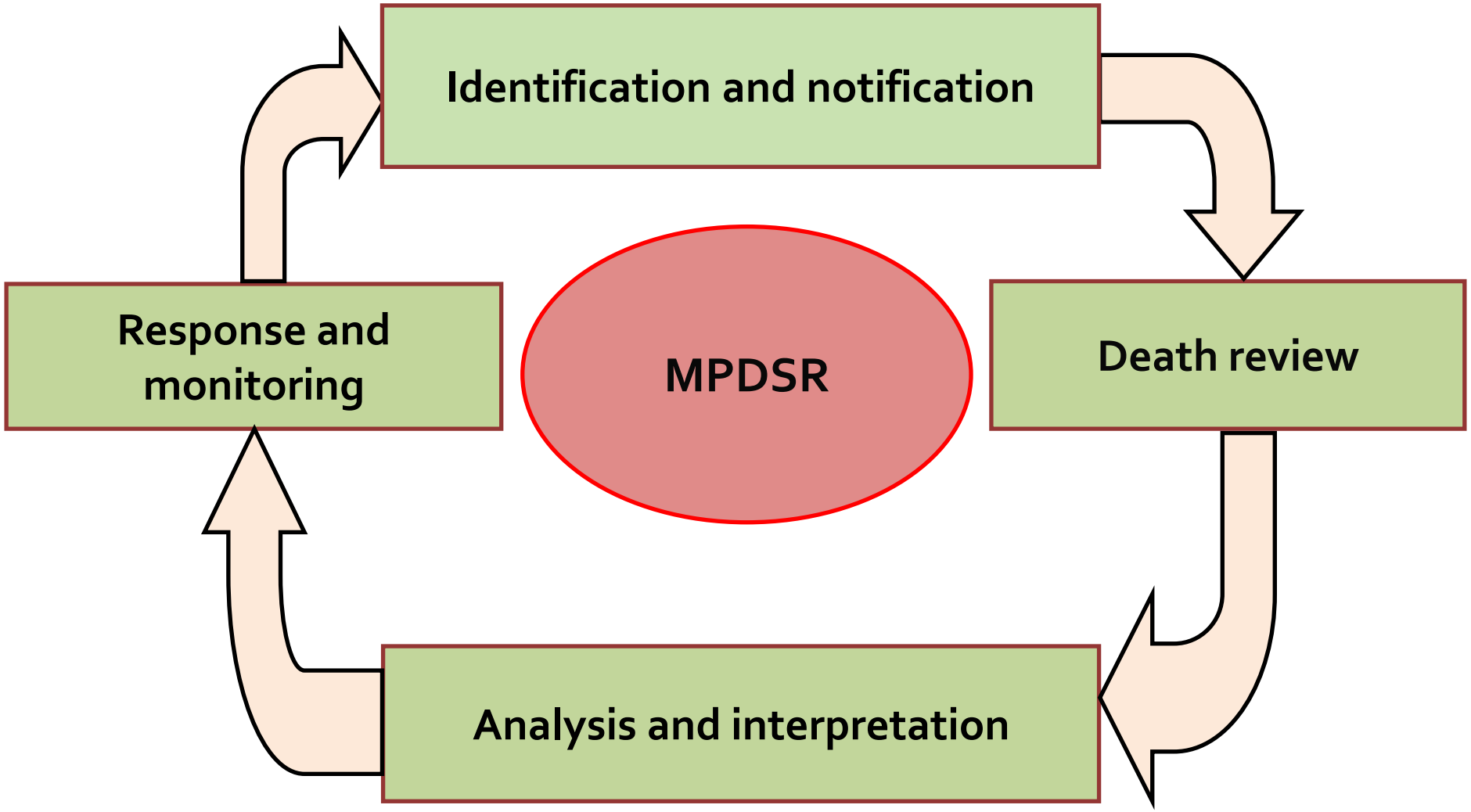
स्वास्थ्य मन्त्रालय
स्वास्थ्य सेवा विभाग
परिवार स्वास्थ्य महाशाखा

Objectives

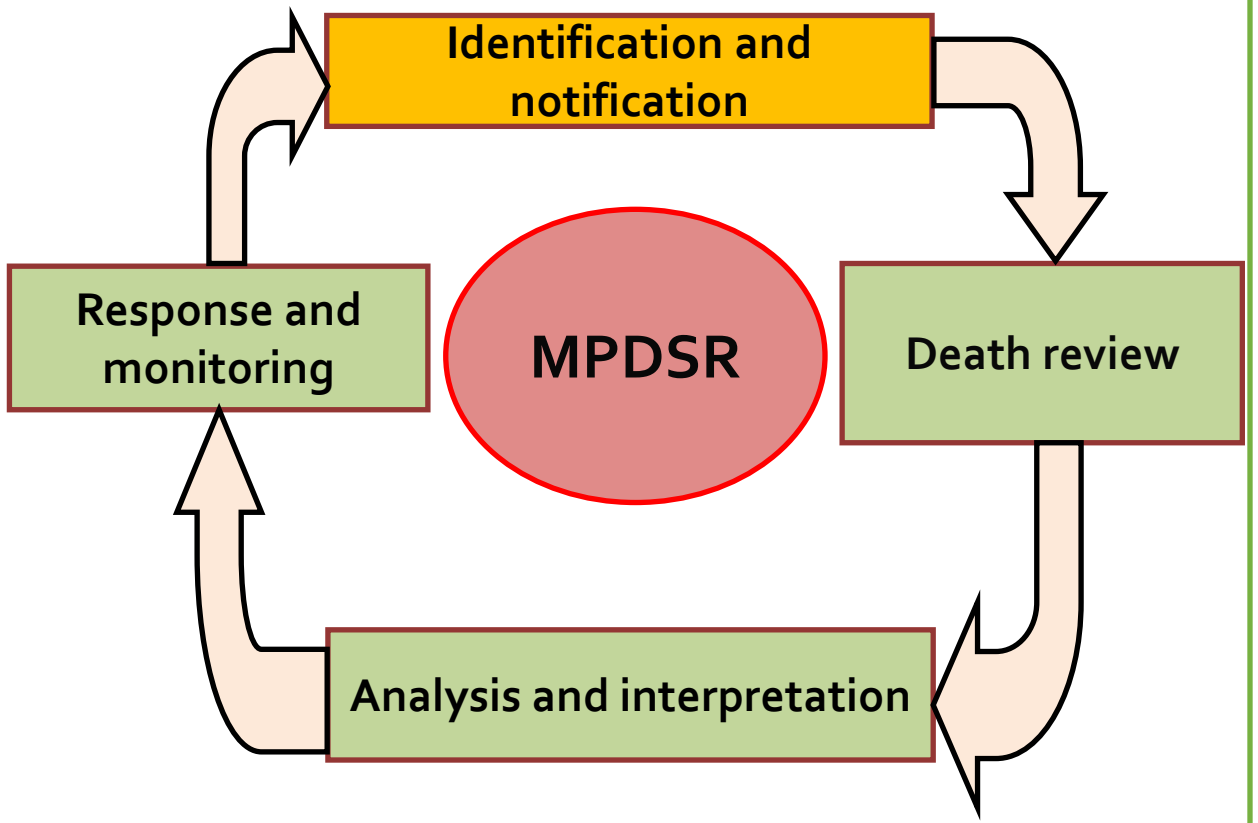
By the end of session, the participants will be able to

- describe the process of MPDSR in the hospitals,
- identify the members of MPDSR Committee in the Hospital, District, Regional and National levels and
- identify the roles and responsibilities of individuals and MPDSR Committee in the Hospital level MPDSR process.

Process of MPDSR implementation



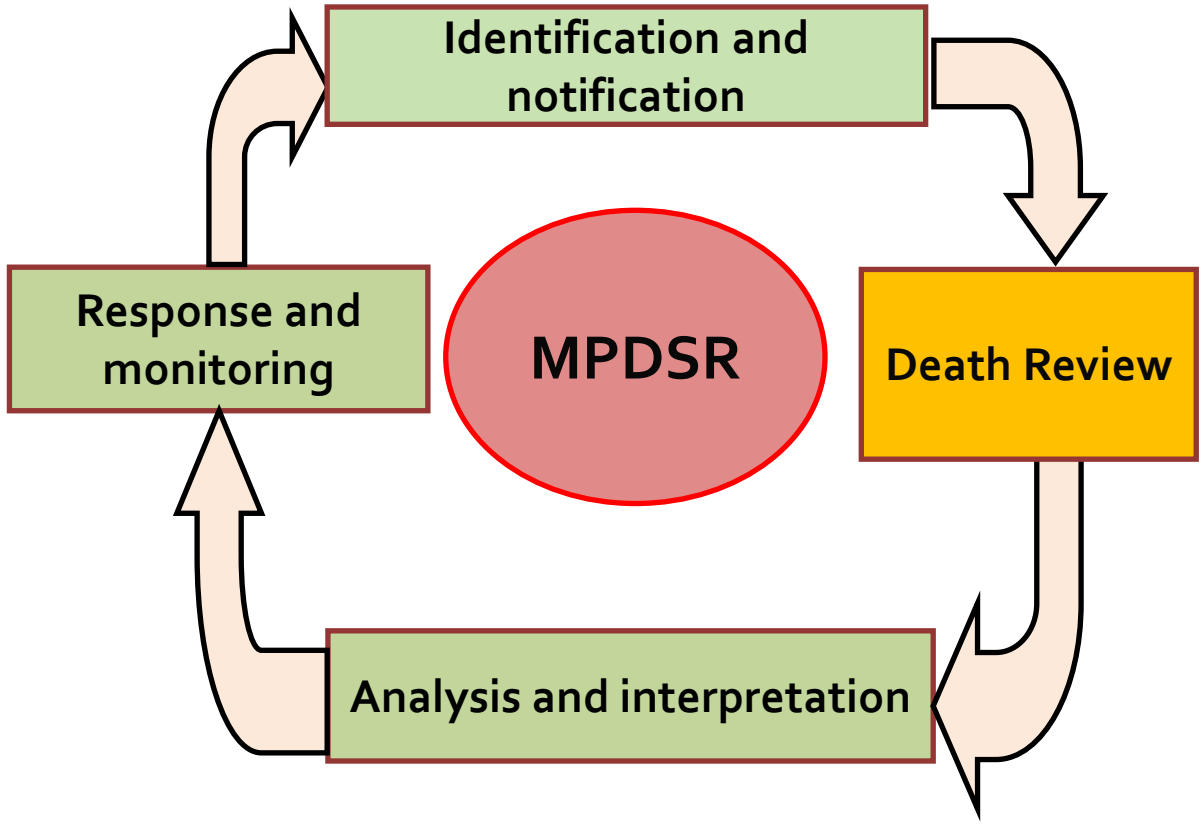
Process of MPDSR implementation



- Deaths of women of 12-55 years in the community must be identified and notified to the respective health facility by FCHVs
- Screening must be done to identify maternal death by respective health facility
- If the death is pregnancy-related then notification should be done to the district team for VA
- Facility deaths should be notified by the on-duty staff to the In-charge

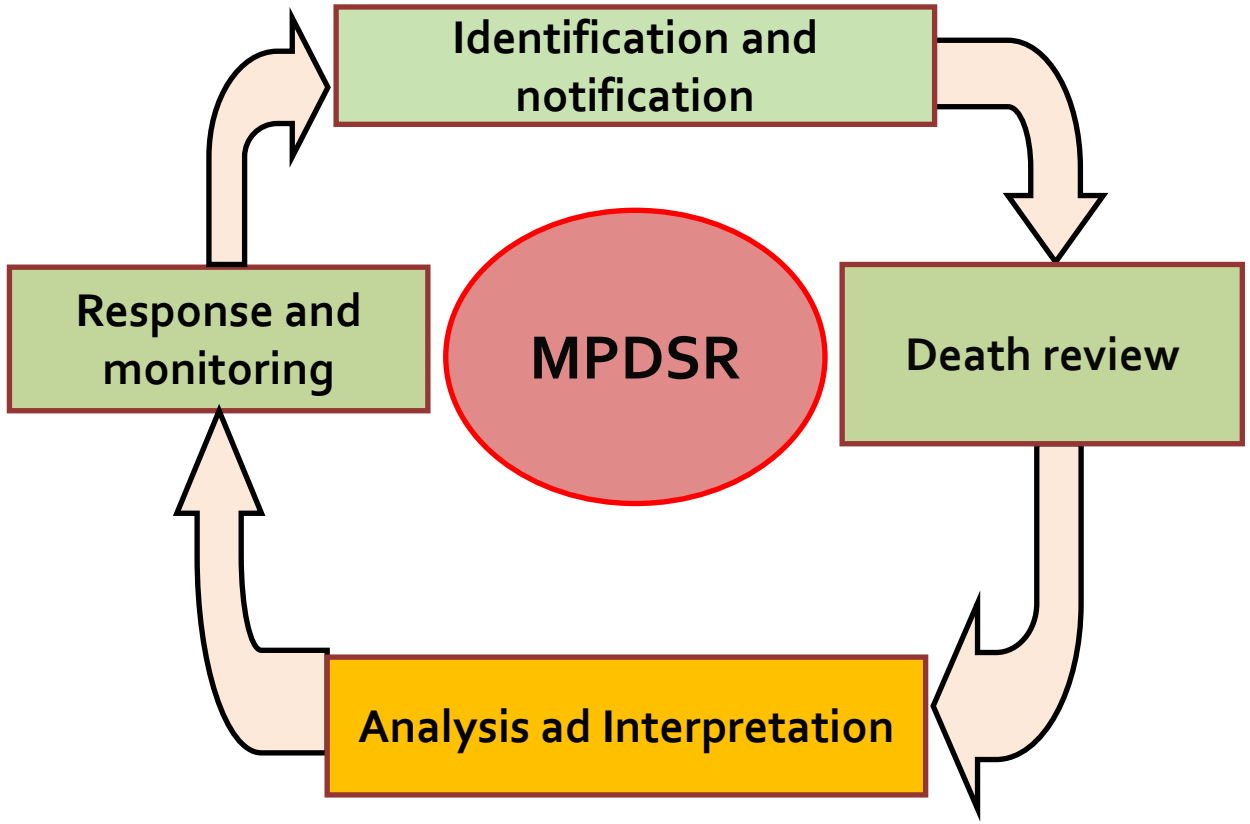
Maternal deaths in the community (home or transit) and hospitals must be informed to the D(P)HO and FHD within 24 hours

Process of MPDSR implementation



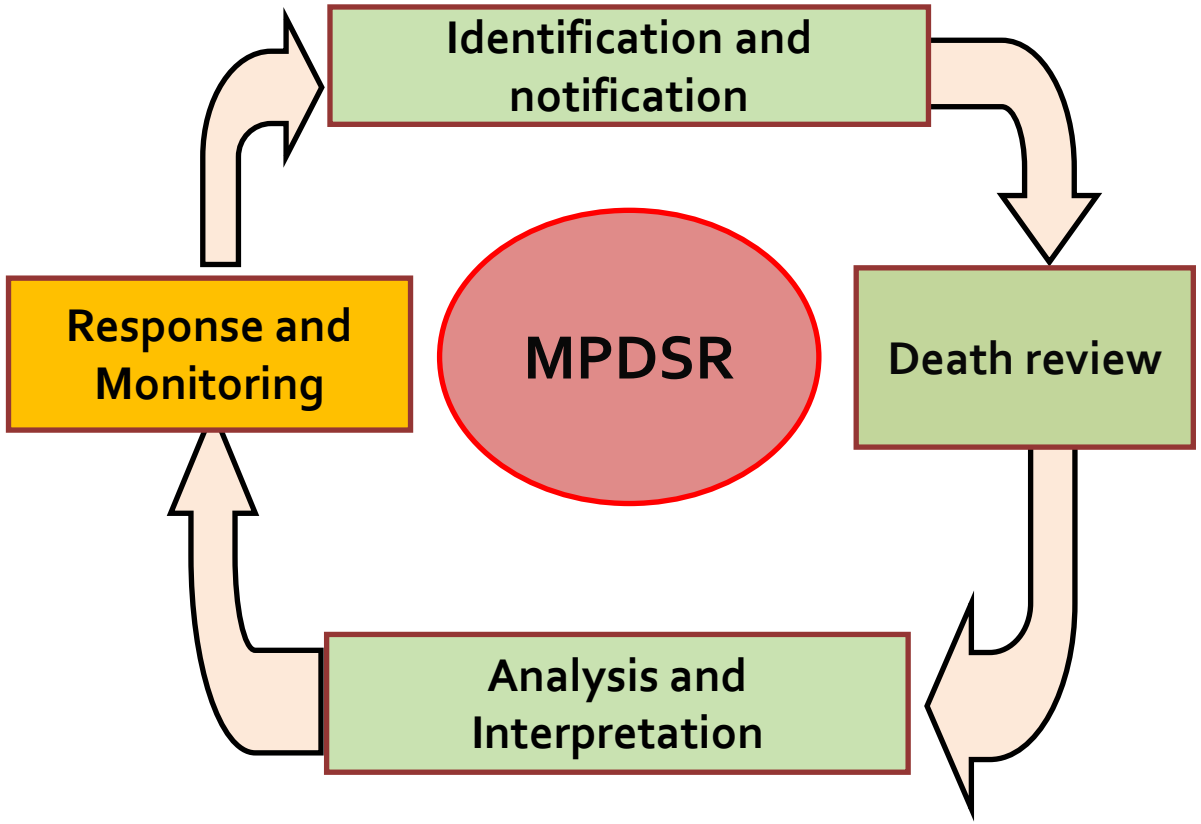
- MPDSR Committee ensures the MPDSR forms are filled-out and maternal and perinatal deaths are reviewed
- Identify the medical and non-medical causes of the deaths & avoidable factors
- Develop action plan & response mechanism to prevent deaths due to same cause in the future
- The action plans which cannot be implemented from hospital and community levels should be implemented in coordination with D(P)HO, RHD and FHD/DoHS

Process of MPDSR implementation



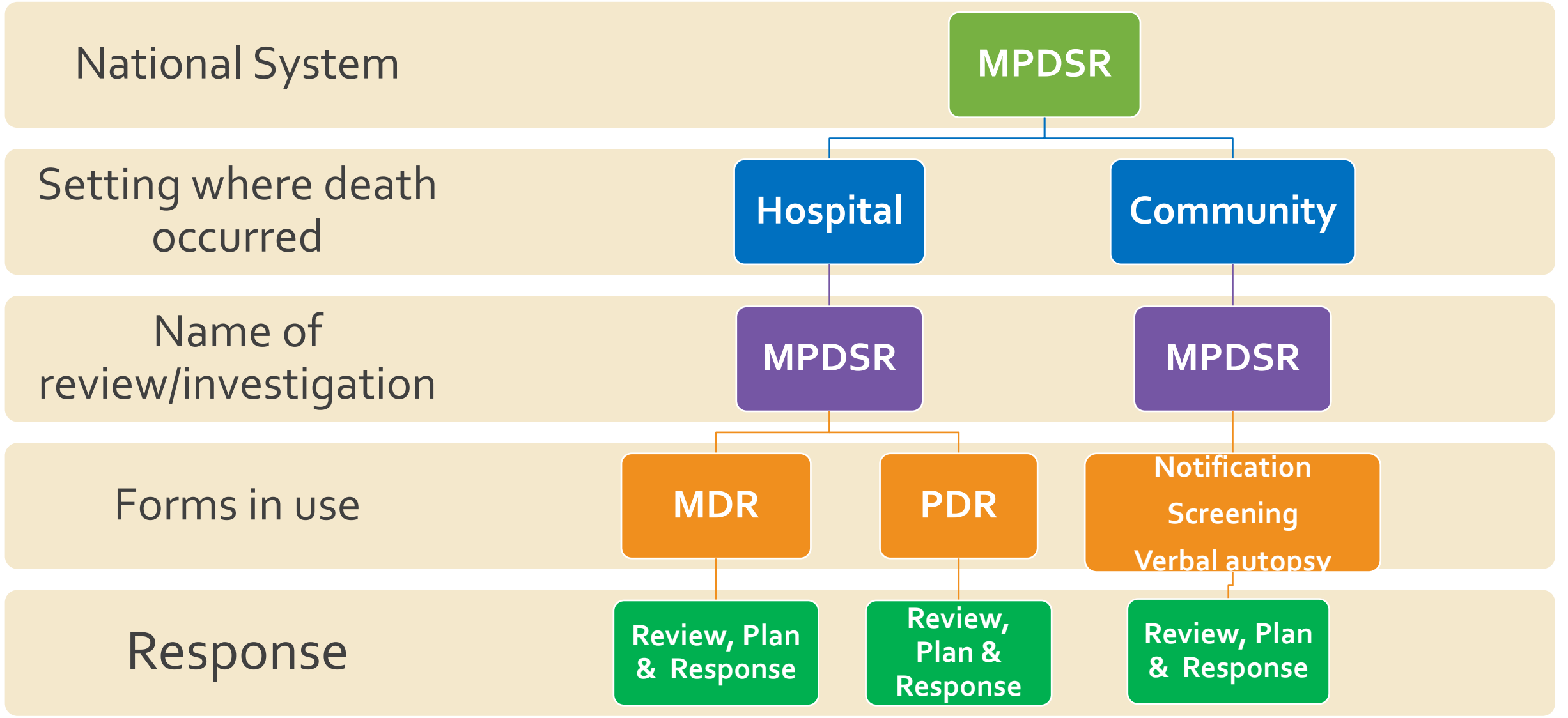
- After each maternal death and once a month for perinatal deaths, overall ***analysis and interpretation*** should be done at the district level
- Prioritized action plans should be implemented.
- The result of the analysis and interpretation should be shared with the region and center with impression and suggestions.
- Analysis is focused on
  - Who is dying?
  - Where are women dying
  - When are women dying
  - What is main cause

Process of MPDSR implementation



- Response mechanism developed after prioritization of action plans by reviewing the maternal and perinatal deaths as well as summary of the review should be implemented.
- Response can be target to a specific community, health facility, district, region or national level.
- Ensure that the findings of reviews and recommendations for follow-up action are communicated to front-line staff.
- Continuous follow up for monitoring implementation status of the response.

Nepal MPDSR Process



Hospital Based MPDSR

Maternal and Perinatal Death

Identification

MPD/PDR Form

MPDSR

Cause assignment

Death Review

Response

District MPDSR Committee

- Chief of D(P)HO – Chairperson
- Statistician – Member
- Gynecologist/Obstetrician from public or private hospital – Member*
- Doctor for assigning Cause of Death Member*
- RHCC members – Member*
- Invitee members from line agencies – Members*
- Public Health Nurse (PHN) – Member Secretary
- **To be selected by the Chairperson*

District Hospital MPDSR Committee

Includes for hospitals where different departments for Obstetrics/Gynecology and Pediatrics are not in place.

- Hospital Chief – Chairperson
- Obstetrician/Gynecologist or Concerned Personnel – Member
- Pediatrician or Concerned Personnel – Member
- Nursing Chief/Matron – Member
- Invitee Members *
- Medical Record Section Chief – Member Secretary

** To be selected by Chairperson*

Hospital MPDSR Committee

Includes for hospitals at: Central, Regional, Sub-Regional, Zonal, Private, NGOs, Missionary run, Community and Specialized hospitals where different departments for Obstetrics/Gynecology and Pediatrics are in place.

- Chief of Facility – Chairperson
- Head of Department of Obstetrics/Gynecology – Vice Chairperson
- Head of Department of Pediatrics – Vice Chairperson
- Nursing Chief/Matron – Member
- Invitee Members*
- Medical Record Section Chief – Member Secretary

* To be selected by Chairperson

Responsibilities of Hospital MPDSR Committee

- Conduct reviews of maternal and perinatal deaths occurring in the hospital.
- Ensure that maternal deaths are notified and reviews are conducted properly and adequately
- Ensure data management
- Synthesize the findings and provide feedback to the hospital team
- Recommend actions to district MPDSR committees based on MPDR findings.

Responsibilities of Hospital MPDSR Committee

- Mobilize resources to implement recommended actions.
- Follow up to ensure that recommended actions are being implemented.
- Disseminate the review findings and recommendations to district, region and center.
- Co-ordinate with stakeholders for quality of care improvement

Process of Maternal Death Review and Response in Hospitals

At PHCC and other BEONCs, the MPDSR will be conducted with support from D(P)HO.

- Identification of death of pregnancy related death
- Attending doctor/nurse complete MDR form and prepare summary report
- H-MPDR-C reviews every maternal death
- H-MPDR-C identifies and prioritizes the response activities
- H-MPDR-C prepares an action plan and acts
- D-MPDSR-C reviews the death
- D-MPDSR-C identifies and prioritizes the response activities
- D-MPDSR-C prepares an action plan and acts
- Health Facility MPDSR-C prepares an action plan and acts

Process of Perinatal Death Review and Response in Hospitals

At PHCC and other BEONCs, the MPDSR will be conducted with support from D(P)HO.

Identification of perinatal death

Attending doctor/nurse complete PDR form and prepare summary report

H-MPDR-C reviews the death every month

H-MPDR-C identifies and prioritizes the response activities

H-MPDR-C prepares an action plan and acts

D-MPDSR-C reviews the death

D-MPDSR-C identifies and prioritizes the response activities

D-MPDSR-C prepares an action plan and acts

Health Facility MPDSR-C prepares an action plan and acts

Role of Attending Doctor and/or Nurse

- Identify maternal and perinatal deaths within the hospital
- Notify the death to the Doctor In-charge
- Complete the MDR form within 24 hours and PDR form within 72 hours of death in coordination with the attending staff
- Support the hospital based MPDSR-C to review maternal deaths within 72 hours and perinatal deaths every month

Role of Hospital MPDSR Committee

- Review MDR forms within 72 hours of death
- Review summary of PDR forms every month
- Assign cause if death, identify the avoidable factors and prioritizes the activities
- Complete Prioritization and Action Plan forms
- Prepare maternal and perinatal death summaries for D-MPDSR-C meeting
- Implement the action plan in coordination with DHO/DPHO
- Monitor the response

Role of District MDSR Committee

- Review the maternal death review forms from community and facility
- Identify the avoidable factors based on VA and hospital MPDR Forms
- Prioritize the response activities
- Prepare an action plan
- Implement the action plan in collaboration with stakeholders
- Monitor the response
- Acts on the findings

Role of Cause of Death Assignment Team

- Review the community based VA forms
- Identify underlying cause, contributory factors, antecedent cause, immediate cause of death
- Identify avoidable factors
- Recommend the action points for addressing the avoidable factors
- Support the facility and district MPDSR-C in planning and responding

Who are you?

- Metacard with Doctor/Nurse or Hospital MPDSR Committee or District MPDSR Committee or Cause Assignment Team or Medical Recorder.
- Raise hand upon identifying who is responsible for the displayed action.
- Respond according to the metacard provided to you.

Roles of individuals and MPDSR Committee

- Identifies maternal and perinatal deaths within the hospital
  - Doctor/Nurse
- Identifies the final cause of death and contributory factors for community maternal deaths
  - Cause Assignment Team
- Completes the MDR **form within 24 hours** of maternal death
  - Doctor/Nurse
- Enters information in the web-based system
  - Medical Recorder

Roles of individuals and MPDSR Committee

- Prepares an action plan
  - Hospital and District MPDSR Committee
- Reviews the maternal death review and verbal autopsy forms from community and facility
  - District MPDSR Committee
- Monitors the action plan implementation in hospital
  - Hospital MPDSR Committee

Roles of individuals and MPDSR Committee

- Reviews summary of PDR forms every month
  - Hospital MPDSR Committee
- Implements the action plan in collaboration with stakeholders at the community
  - District MPDSR Committee
- Coordinates to call MPDSR committee meetings in hospital
  - Medical Recorder

Any Feedback?

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