

Maternal and Perinatal Death Surveillance and Response [MPDSR]

Factsheet
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Nepal aims to achieve the Sustainable Development Goal (SDG) target of MMR 70 per 100,000 live birth by 2030, and MPDSR is a strong proven system which can guide and assist in preventing maternal and perinatal deaths.

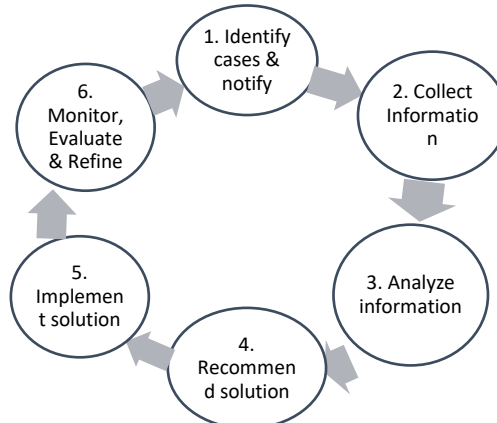
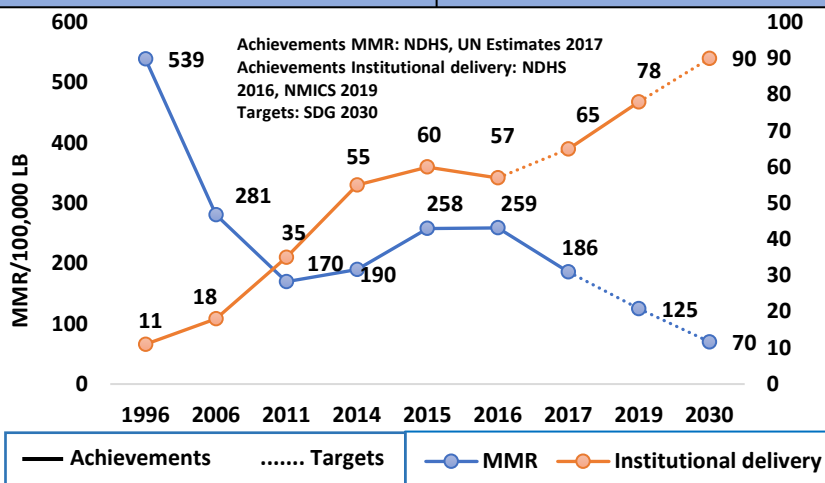
The MPDSR factsheet reflects the situation of maternal and perinatal deaths reported in the MPDSR system which can help in planning the activities to achieve the target.

What is MPDSR?

MPDSR is a surveillance system that counts every maternal and perinatal death and collects information on the causes as well as factors contributing to death.

An important component of MPDSR is the 'Response' part in which the information obtained from the MPDSR review is analyzed to formulate actions to prevent similar deaths in future.

Implementation status: As of May 2022, Facility based MPDSR is implemented in 94 Hospitals and Community MPDSR is implemented in 16 districts.



Objectives:

- ❖ To count every maternal and perinatal death, permitting an assessment of the true magnitude of maternal and perinatal mortality and the impact of actions to reduce it.
- ❖ To provide information that effectively guides immediate as well as long-term actions to reduce maternal mortality at health facilities and community and perinatal mortality at health facilities.

MPDSR Implementation

Province One:

Hospitals: 14 Districts: 3

Madhesh Province:

Hospitals: 9 Districts: 1

Bagmati Province:

Hospitals: 21 Districts: 1

Gandaki Province:

Hospitals: 12 Districts: 2

Lumbini Province:

Hospitals: 19 Districts: 3

Karnali Province:

Hospitals: 7 Districts: 3

Sudurpaschim Province:

Hospitals: 12 Districts: 3

MPDSR Implementing Hospitals and Districts

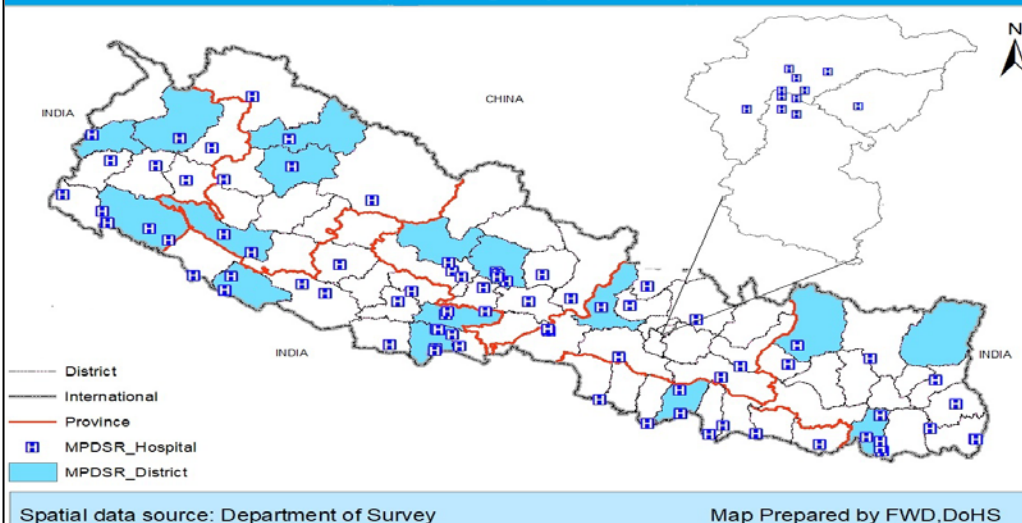


Figure 1:

Majority of maternal deaths have been reported from Province one and Lumbini Province (30% each) followed by Bagmati Province (20%).

Figure 2:

Most of the women who died had delivered in Medical colleges (45%), followed by Government Referral and Government CEONC Hospitals (26% and 15% respectively) and 5% had delivered at home.

Figure 3:

More than half the maternal deaths occurred in Medical colleges (59%). However, 5% died in transit and 3% at home.

Figure 4:

Among the maternal deaths that occurred in hospitals, around one third of deaths occurred within 24 hrs of hospital admission, while a majority (43%) occurred at or after two days of hospital admission.

Figure 1. Distribution of Maternal Deaths by Province (N=111)

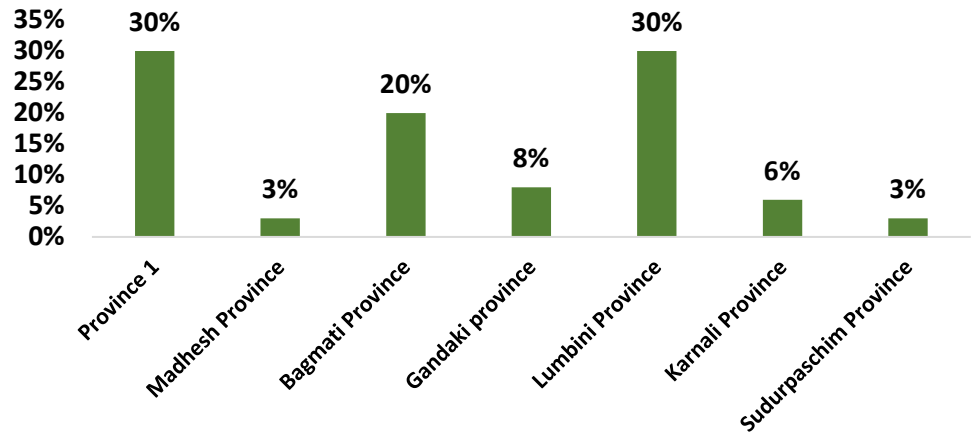


Figure 2. Distribution of Maternal Deaths by Place of Delivery (N=111)

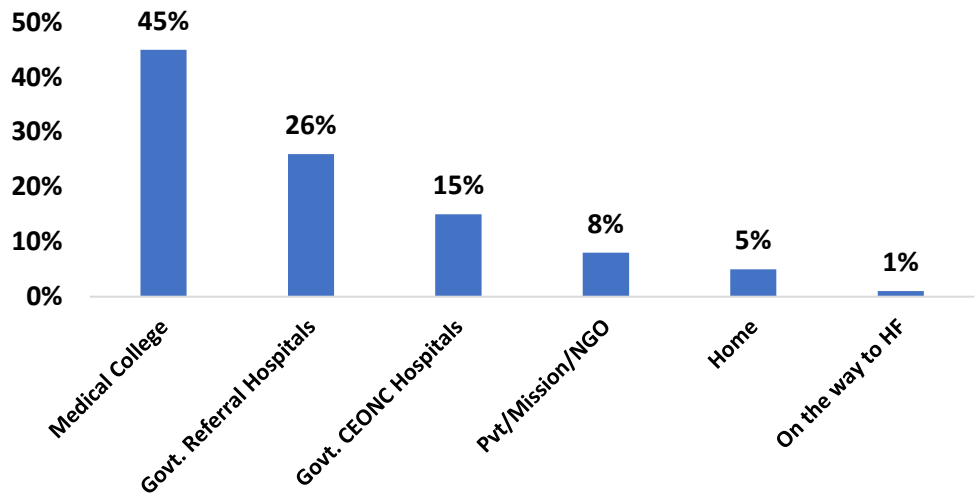


Figure 3. Distribution of Maternal Deaths by Place of Death (N=111)

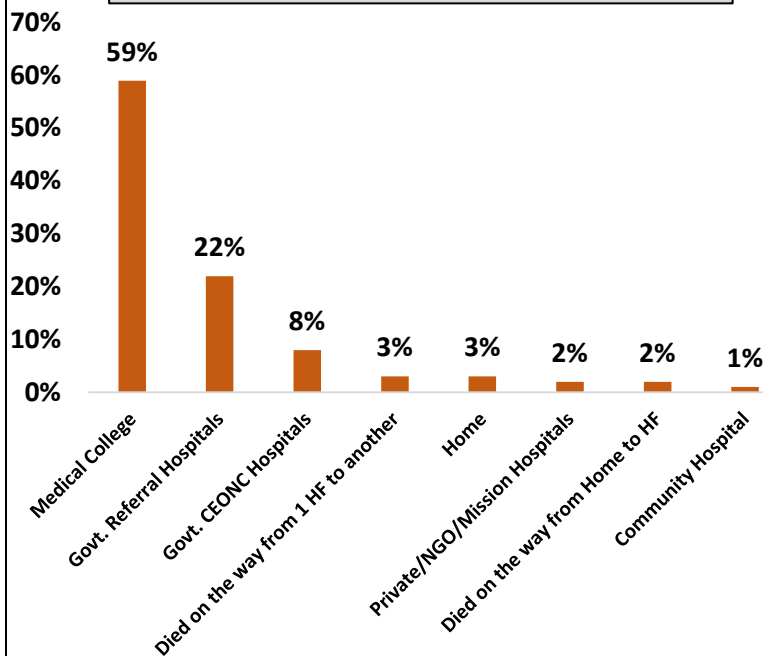


Figure 4. Distribution of Maternal Deaths by Duration of Stay in Hospital (N=102)

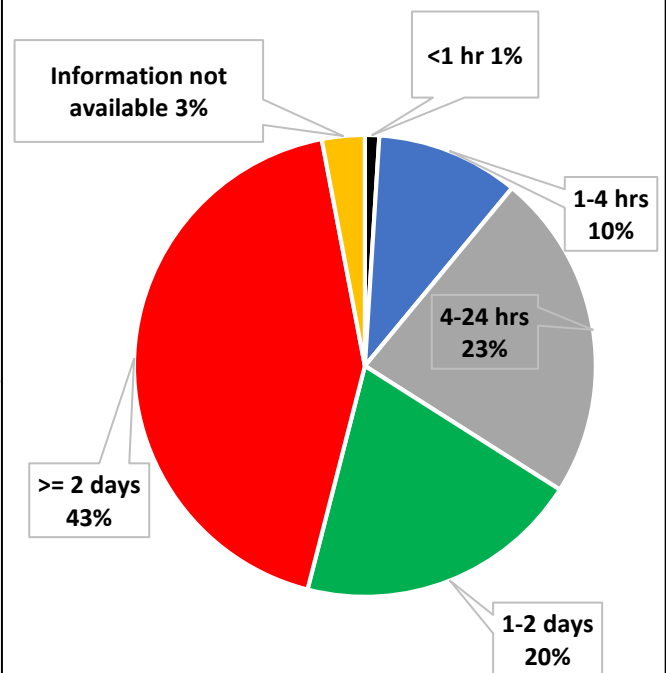


FIGURE 5. DISTRIBUTION OF MATERNAL DEATHS BY PERIOD OF DEATH (N=111)

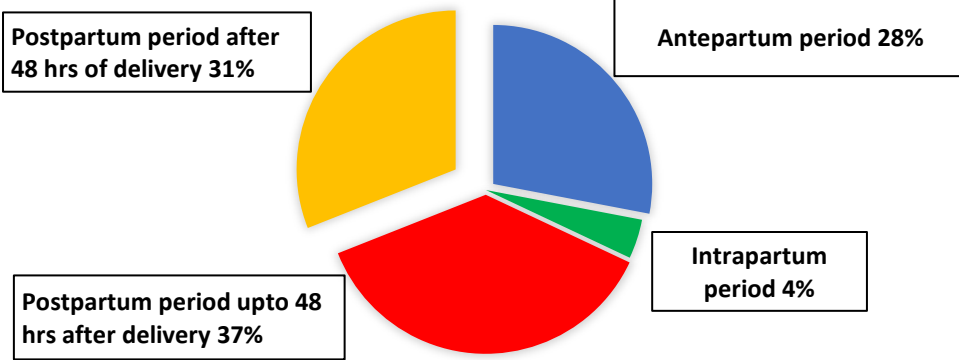


Figure 5: About two third (68%) of deaths occurred in postpartum period, of which 37% had occurred within 48 hours of delivery and 31% after 48 hours of delivery.

Figure 6: Distribution of Maternal Deaths by Cause of Death (N=111)

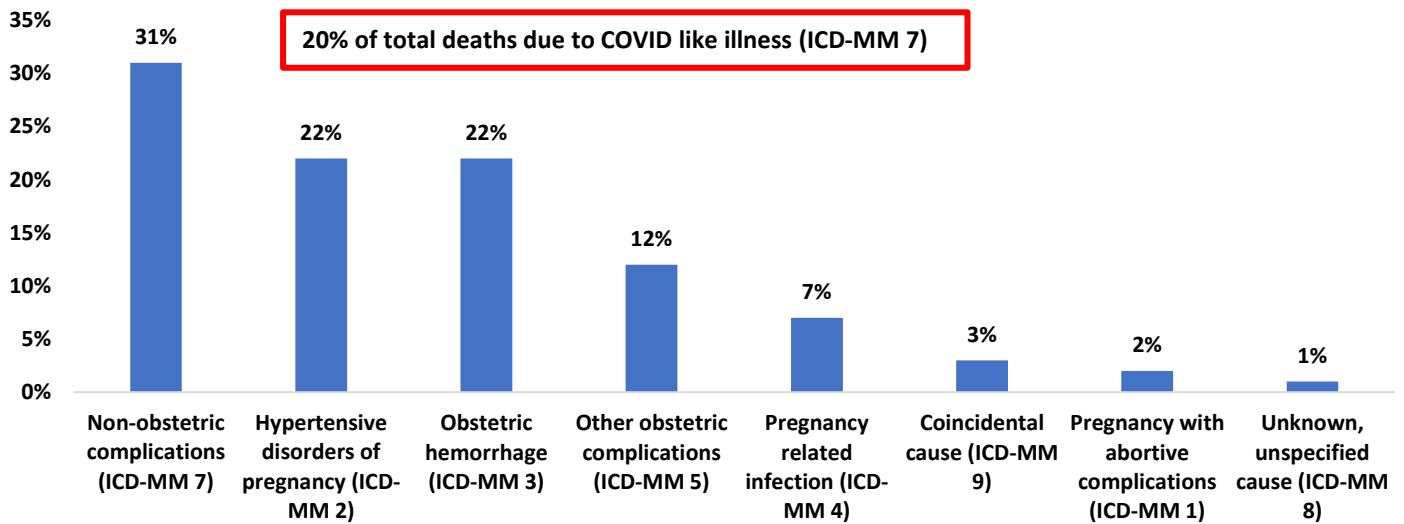


Figure 6: Leading cause of death was non-obstetric complications (31%, 35 cases), of which the cause of death in 63% (22 cases) was due to COVID like illness. This was followed by Hypertensive disorders of pregnancy (22%) and Obstetric hemorrhage (22%).

Figure 7: Of 94 MPDSR implementing Health Facilities (HFs), 27 HFs reported perinatal deaths. Of the 27 reporting HFs, all 7 from Karnali Province (100% reporting) reported, while none of the health facilities from Madhesh Province (0% reporting) reported perinatal deaths in the specified period.

Figure 7: Perinatal Death Reporting Status by Province (N=1042)

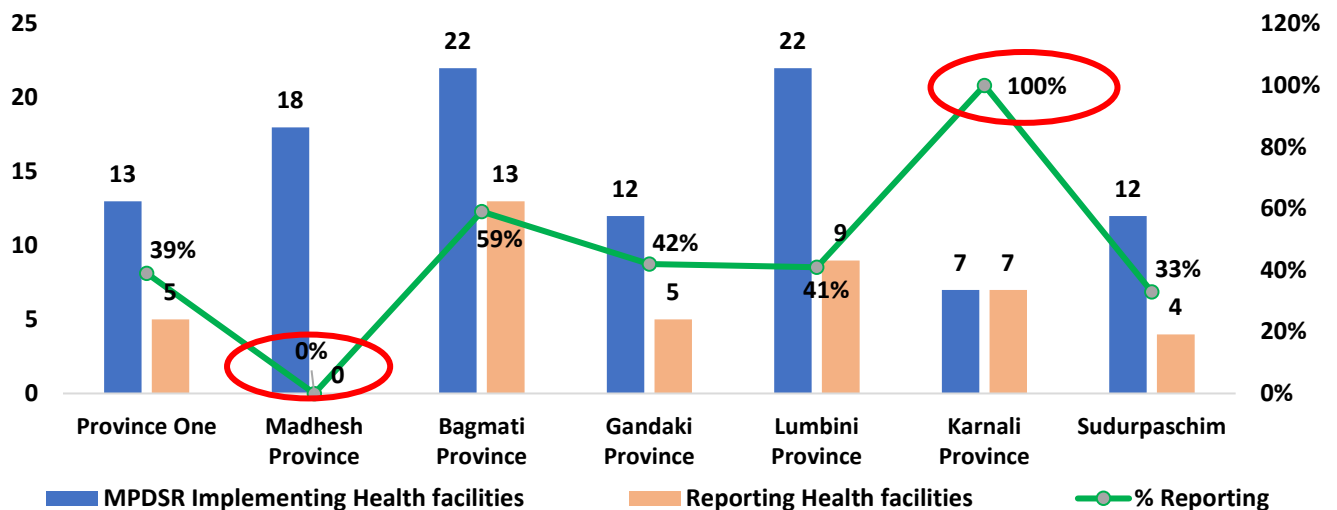


Figure 8: Among the perinatal deaths, 53% were macerated, 18 % each were Fresh stillbirths and ENNDs ≥1 day of life and 11% were ENNDs < 1 day of life.

Figure 8: Distribution of Perinatal Deaths (N=1042)

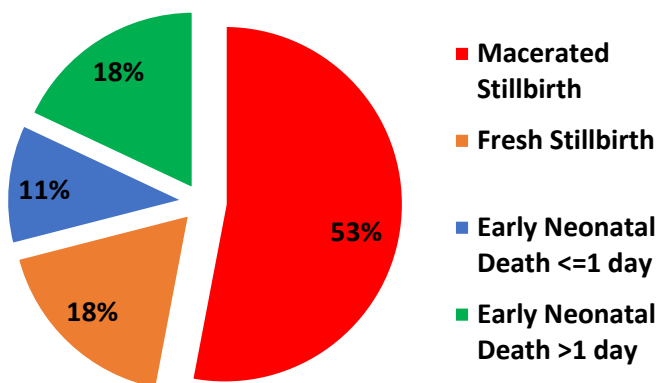


Figure 9: Distribution of Perinatal Deaths by Gestational Age (N=1042)

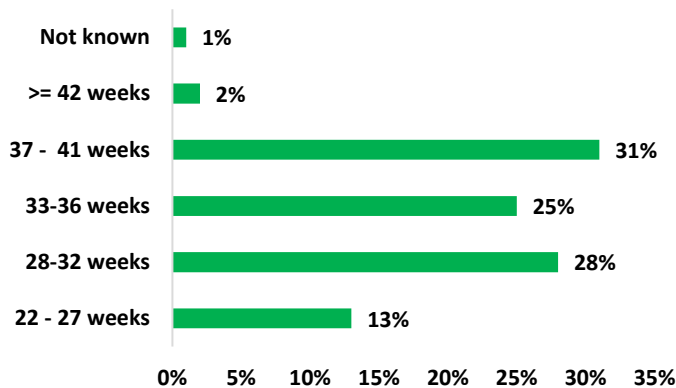


Figure 9: 66% of perinatal deaths were among premature babies (22-36 weeks of gestation), while 2% deaths had occurred in post-dated pregnancy.

Figure 10: 13% of women with perinatal deaths were of below 20 years of age and 6% were above 35 years of age. While a majority of women with perinatal deaths were of the age group 20-35 years (78%).

Figure 10. Distribution of Perinatal Deaths by Maternal Deaths (N=1042)

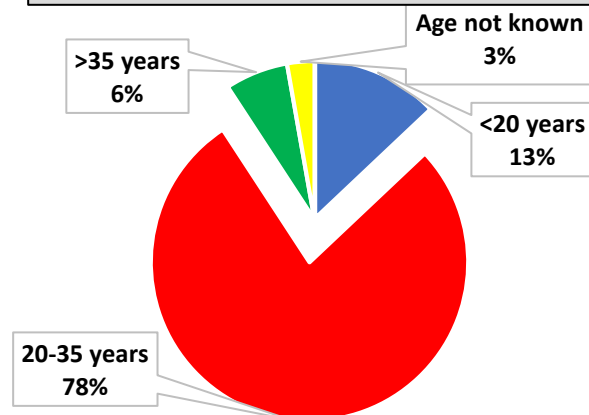
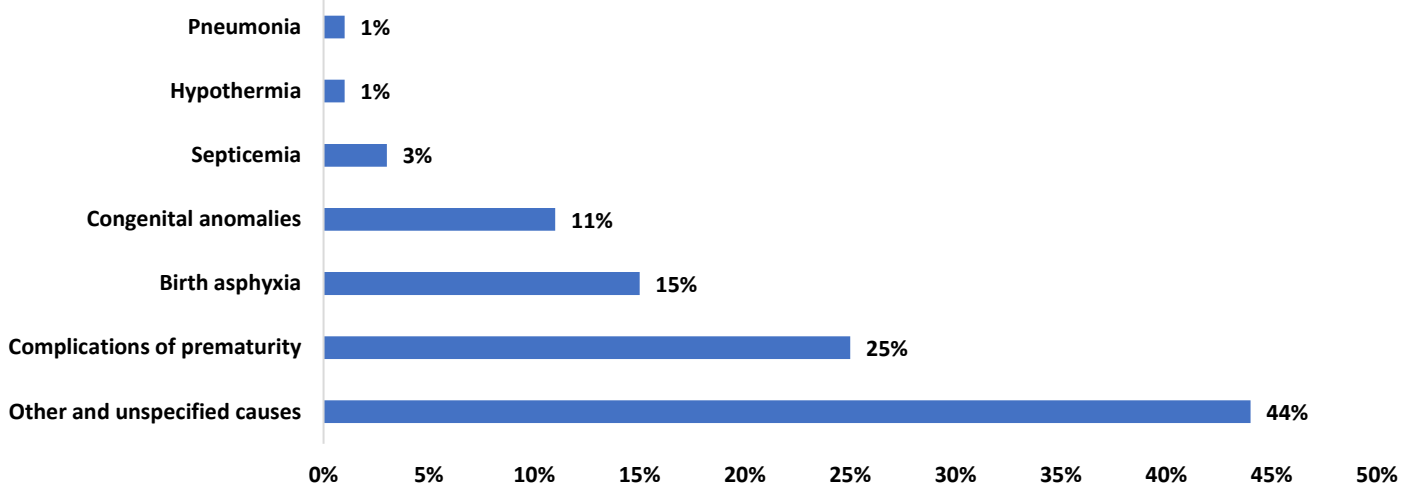


Figure 11: Out of 1042 perinatal deaths, Other and unspecified causes (44%) were the most common final cause of perinatal deaths followed by complications of pre-maturity (25%) then Birth Asphyxia (15%).

Figure 11. Distribution of Perinatal Deaths by Final Cause of Death (N=1042)



Issues and Challenges:

- Gap in timeliness and completeness of reporting
- Rapid change in human resource leading to gap in regular functioning of the MPDSR program
- Challenges in ownership at different levels of service provision

Issues and Challenges:

- Gap in utilization of allocated budget at all levels of service provision
- Weak communication and follow-up
- Inadequate equipment / facilities for efficient recording and reporting