**Pre and Post-Test Questionnaire for MPDSR Hospital Training Package**

For each question, please circle the correct answer:

1. MPDSR stands for …….

a. Maternal and Perinatal Death System and Response

b. Maternal and Perinatal Death Surveillance and Review

**c.** **Maternal and Perinatal Death Surveillance and Response**

d. Maternal and Perinatal Death Systematic Register

2. Which of these is **NOT** a pregnancy related death?

a. A 45 year old woman collapsed and died suddenly. She had missed two periods.

b. A woman with a 35 day old baby, had fever for 3 days before she died.

**c.**  **A 16 year old girl died suddenly after taking some medicine two days after her first sexual intercourse because she thought she was pregnant. She had her period 12 days back.**

d. A woman, known to be HIV positive was 5 months pregnant and died of pneumonia.

3. What is the **FIRST** step of the MPDSR process?

a. Review of the MDR form

b. Develop and implement response actions

c. Analysis of the maternal death

**d.** **Identification of maternal death**

4. Who of the following is **NOT** the member of Hospital MPDSR Review Committee?

a. Hospital Superintendent/Director

b. Obstetrician/Gynecologist/Pediatrician/MDGP

c. Matron/ Nursing Chief

**d.** **Accountant**

5. Which of the following statement is appropriate with regard to Quality of Care affecting maternal deaths?

a. A previous bad experience at a health facility may discourage women from choosing to deliver with skilled birth attendants.

b. Inadequate water supplies in labour wards can increase the risk of maternal death, even if the woman arrived in time

c. The quality of referral systems, admission procedures, and care during recovery should all be considered during MPDSR data analysis

**d.** **All of the above**

6. Which of the following factor decreases the risk of maternal death?

a. Not able to make decision to seek health care for herself

**b**. **Availability of adequate maternity services**

c. Unawareness on high risk conditions during pregnancy and delivery

d. Not using contraceptive methods

7. Which of the following statement is **NOT** true?

a. The MDR form should be filled by a Doctor (preferably) or Nurse, who attend the case, within 24 hours of the maternal death.

b. After reviewing the MDR and PDR forms, the MPDSR Committee needs to analyze the cause of death and develop action plan.

**c.** **Each maternal death should be reviewed within 120 hours after death.**

d. Perinatal deaths should be reviewed monthly.

8. Which of the following statement is **CORRECT** regarding MPDSR Reporting and Data Flow?

a. FCHVs identify and notify to the /Local level health facility about the community deaths.

b. For each facility maternal deaths, on duty doctor/nurse should fill the MDR form and Hospital MPDSR committee should review and develop action plan.

c. For each perinatal mortality, the PDR form should be filled and notified to the MPDSR Committee within 72 hours of the death.

**d. All of the above statements are true**

9. Which of the following is appropriate action that might be taken by the Hospital MPDSR Committee?

a. Close the maternity unit due to poor quality and refer pregnant patients elsewhere.

**b.** **Develop appropriate referral mechanism and orient/reorient the staff.**

c. Punish the doctor who was not present during the time of the death.

d. All of the above.

10. The hospital MPDSR committee is **NOT** responsible for which of the following?

a. Conduct reviews of maternal and perinatal deaths occurring in hospital.

b. Develop action plans following review of the MDR and PDR forms.

c. Synthesize the findings and provide feedback to the hospital.

**d.** **Conduct review meeting for community-level maternal and perinatal dea**ths.

11. Maternal death is defined as:

a. Death of women from direct or indirect maternal causes, more than 42 days, but less than one year after the termination of pregnancy.

b. The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of the death.

c. Near miss-cases resulting from previously existing disease or aggravated by physiological effects of pregnancy.

**d. The death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.**

12. What is the evidence based actions for eclampsia?

a. Diagnosis and treatment of high blood pressure

b. Treatment with Magnesium Sulphate

c. Timely delivery

**d.**  **All of the above**

13. Fetus born dead after completed 28 weeks of gestation or child who is born alive but dies within the first 7 days of life is termed as

**a.** **Perinatal death**

b. Early neonatal death

c. Neonatal death

d. Late neonatal death

14. According to NDHS 2016, MMR of Nepal is ……../100000 live births

a. 330

b. 250

**c.**  **259**

d. 210

15. Which of the following statement is the determinant for maternal death?

a. Socioeconomic and cultural factors

b. Accessibility of health facility

c. Quality of care

**d**. **All of the above**

16. Which of the following is **INCORRECT** statement in the case of maternal death review?

a. Attending service provider should fill the MDR form within 24 hours of death.

b. Maternal death review has to be done by the MPDSR committee within 72 hours of death.

**c.** **The name of staff attending the maternal death case should be published in hospital notice board.**

d. The hospital has to prioritize and implement the recommendations that are within the capacity of the hospital.

17. A young primi gravida delivered in hospital two hours back followed by hemorrhage. She looked very pale (Hb was 5gm%) with un-recordable BP & pulse and she died suddenly. What could be the primary cause of death?

1. **Haemorrhage**
2. Obstructed labour
3. Ruptured uterus
4. Eclampsia

18. Forms used for hospital level MPDSR process includes all **EXCEPT**:

1. Maternal Death Review form
2. Perinatal Death Review form
3. **Verbal Autopsy form**
4. Perinatal Death Summary form

19. Completed MDR and PDR forms should be entered into the web-based reporting system by

1. Family Health Division
2. Palika office
3. **Respective hospital**
4. Regional Health Directorate

20. A nine months pregnant woman was brought to the hospital in the evening unconscious with complains of seizures several times since morning. She did not have history of ANC. Her limbs were swollen and pupils mid-dilated with BP 180/120 mm of Hg. Upon admission she again had seizures. The attending staff at the emergency opened IV line, inserted catheter, sent blood for investigation. But Magnisium Sulphate (MgSO4) was not given in the emergency as it was not available there. The on call doctor came, shifted her to ICU and gave MgSO4. Blood and blood products were also arranged but the patient’s condition deteriorated and the patient died after 2 hours.

What appropriate action can the hospital MPDSR committee implement to improve the quality of care in the hospital:

1. Increase the number of staff in the emergency.
2. Develop protocol to refer all patients coming with eclampsia.
3. Ensure availability of MgSO4 in the emergency also.
4. **All of the above**