Photo from VSO 2016 Annual Review

Maternal & Perinatal Death Surveillance and Response (MPDSR):

Overview and Introduction to National Guidance

Learning objectives

By the end of this session, participants will :

- **Understand the purpose of MPDSR**
- **Be familiar with key concepts and definitions**
- **Know the structure of the Ethiopian MPDSR system**
- **Identify how data flows through the system**
- **Be aware of the MPDSR National Guidance**

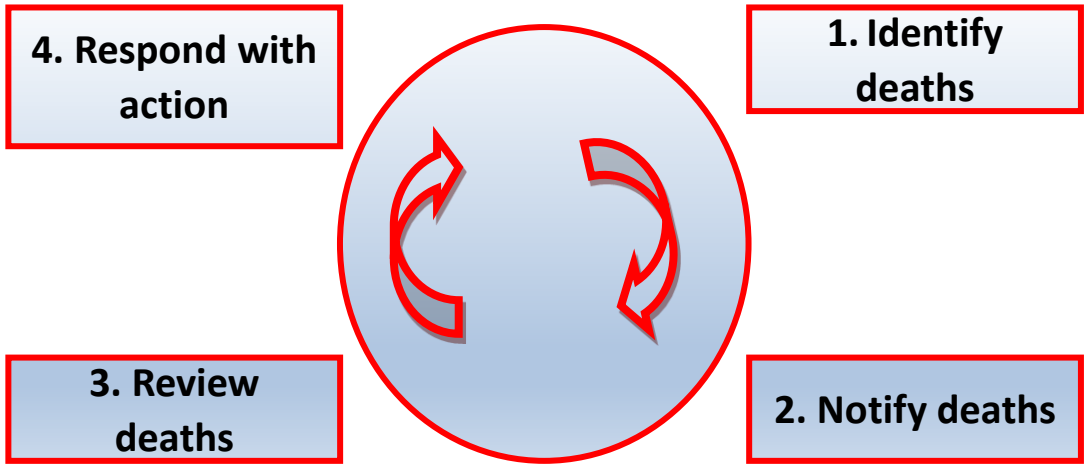
What is MPDSR?

Maternal and Perinatal Death Surveillance and Response **is a key component of the health system that incorporates identification, notification, analysis, and determination of causes and avoidability of maternal and perinatal deaths, with the goal of acting to prevent these in future.**

What is MPDSR?

Community Based & Facility Based

Continuous Cycle



Adding the P to MPDSR

- Ethiopia's MDSR system was established in E.C. 2006
- Public Health Emergency Management (PHEM) has been responsible for MDSR data collection since E.C. 2007
- Now that the MDSR system is established across the country, *perinatal* deaths can be integrated into the process

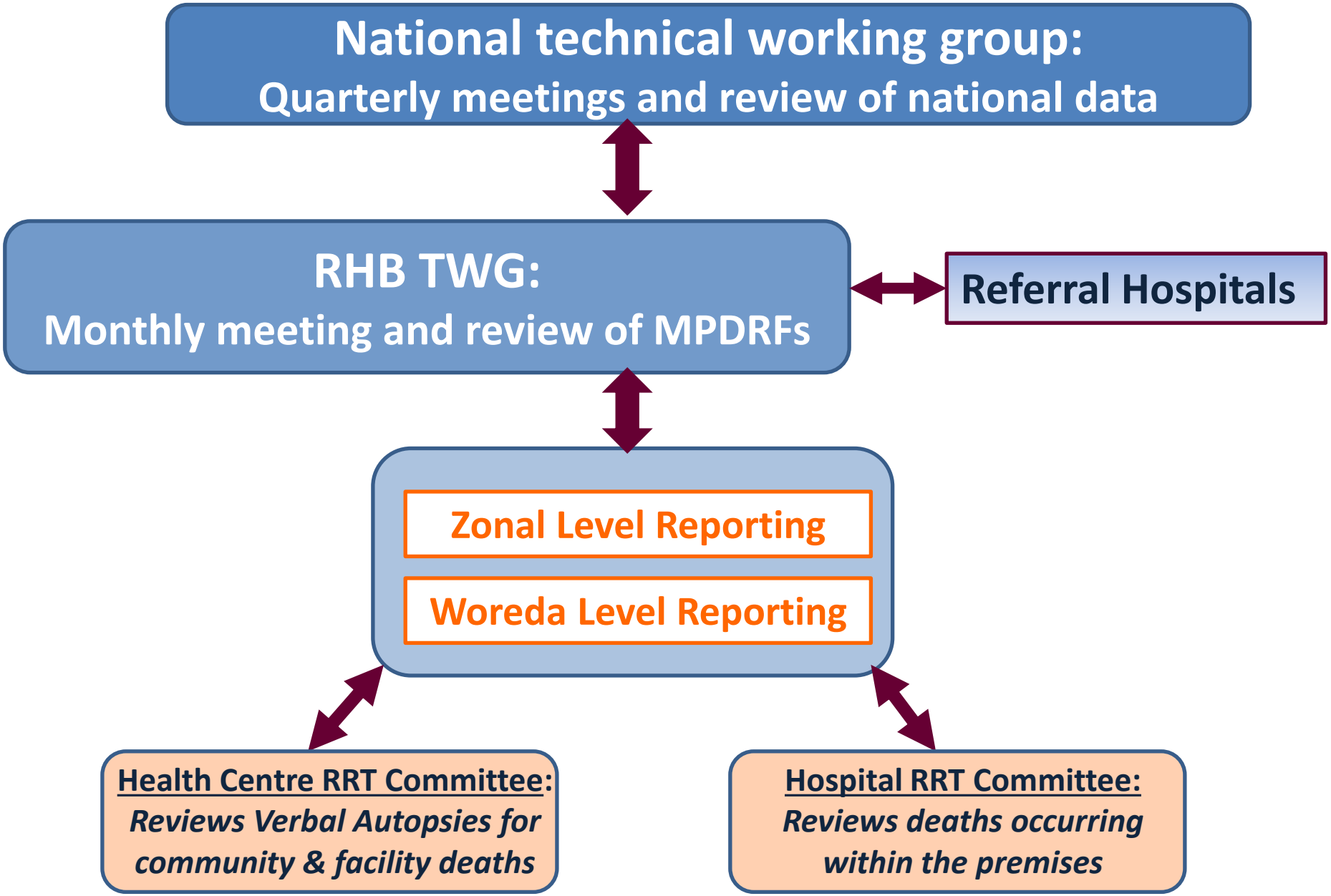
Justification for MPDSR

- **MCH remains a key national health priority**
- **Ethiopia's *maternal mortality rate* is estimated to be 412/100,000 live births = 11,000 deaths per year**
- **The perinatal mortality rates is estimated to be 46/1000 births = 87,000 neonatal deaths & 97,000 still births per year**
- **MPDSR is part of the HSTP as a strategy to reduce avoidable deaths**

PHEM – MCH Integration

- **PHEM leads Ethiopia's *surveillance***
- **Maternal deaths are one of the *weekly reportable conditions***
- **Following reporting and review, case based data are *aggregated and analysed within regional and national databases***
- **The MCH directorate receives analysed data and works to *identify appropriate responses at every level of the health system*.**
- ***Perinatal deaths* will be added to this existing data management platform**

Coordination of MPDSR within PHEM



Goal and Objectives of Guidance

Goal:

To guide effective implementation and scale up of MPDSR in a systematic, standardized and integrated manner

Purpose of the MPDSR Guidance

To facilitate effective functioning of Ethiopia's MPDSR for:

- **Surveillance focal persons**
- **health care managers and providers**
- **policy makers who take action based on MPDSR findings**

To ensure use of emerging information in improving maternal & perinatal health care quality and outcomes

Basics of MPDSR Data Flow

Identify all probable maternal and perinatal deaths occurring in both facilities and the community

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Determine if the death is a suspected maternal or perinatal death

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Notify suspected maternal and perinatal deaths to the focal point at the appropriate level of the health system level

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Verbal autopsy conducted
Review conducted
Case-based report completed
Actions identified

Principles of MPDSR

The following ethical principles are central to MPDSR implementation:

- **Confidentiality**
- **Anonymity**
- **Respect**
- **No Name, Not Blame and No Shame!**

Confidentiality: a Code of conduct

- Local data collectors and involved health care workers are the only staff who see the names of deceased women and babies
- Staff who gather data for MPDSR must commit to never sharing the information
- Review committee members at all levels must sign a non-disclosure confidentiality agreement (kept on record)
- Data cannot be spoken about outside the formal review process

Draft Disclaimer

(Non-disclosure confidentiality agreement)

We, the members of the ---- review committee, agree to maintain anonymity and confidentiality for all the cases discussed at this meeting, held on [DATE]. We pledge not to talk to anyone outside this meeting about details of the events analysed here, and will not disclose the names of any individuals involved, including family members or health care providers.

Anonymity

- Notes and reports protect the patient, friends, family and staff members involved
- Names obscured on case notes used in review
- No names recorded on abstraction forms
- Family informed of the purpose of the investigation and how data will be used

Essentials of no blame

- Acknowledgment throughout system that mistakes do happen
- Constructive approach to learning from every death
- Identifying preventive measures for the future remains the priority
- Results of MDSR to be used as a learning experience and not for any legal process

The purpose of reviewing a maternal or perinatal death is to give value to that life and collectively learn from the experience NOT to blame individuals or institutions

Culture of no blame

The man in the boat needs help managing his appetite, a reminder of good nutrition, and assistance to stop sinking, but NOT a lecture on his poor eating habits!

- **Healthcare providers are vulnerable to self blame, which does not improve care**
- **Support and training are better solutions for preventing future deaths**
- **“No blame” is NOT “no accountability”**

Summary

- **MPDSR system captures *maternal* and *perinatal* deaths in *communities* and *facilities***
- **MPDSR surveillance is managed by *PHEM* but *MCH* is involved in review and response**
- **The ultimate aim of MPDSR is to *identify feasible action* to prevent avoidable maternal and perinatal deaths**
- **MPDSR follows key principles of *confidentiality*, *anonymity* and *no blame***