Maternal and Perinatal Deaths Review
Outline:

- Community – Review of suspected Maternal deaths
- Facility – Review of suspected Maternal deaths
- Setting up MPDSR system at facility
- Data quality improvement
  - Confidentiality: a Code of conduct
  - Disclaimer pledge
  - Committee discussion
- Summary Points
- Exercise on MDRF and PDRF
Community–Review of suspected Maternal and perinatal deaths:

• Each completed **verbal autopsy** should be reviewed by the **rapid response team (RRT)** of the respective **health center** within **one week** after Verbal autopsy report is received.

• The **Health Center RRT** should include midwives, MCH nurses and other MCH related health professionals.
Community—Review of suspected Maternal and perinatal deaths:

- For every reviewed verbal autopsy an action plan has to be developed for response based on the identified modifiable factors.

- Following the review of the verbal autopsy the RRT will complete the case based reporting format (maternal/Perinatal death reporting format (MDRF/PDRF)).
Each completed FBAF should be reviewed by the rapid response team (RRT) of the respective health facility within one week.

The health facility RRT should include midwives, NICU Nurses, ESOs, GPs, Health officers, obstetrician, pediatrician and other related health professionals working in obstetrics or neonatal care of that particular facility.
Facility – Review of suspected Maternal and perinatal deaths:

- For every reviewed FBMDA/FPBDPA an action plan has to be developed for response based on the identified modifiable factors.
- Following the review of the FBMDA and FBPDA, the health facility surveillance focal person will complete the case based reporting format (maternal/perinatal death reporting format (MDRF/PDRF))
Reporting flow of case based maternal death reports (MDRF)

National PHEM unit

Regional PHEM unit

Zonal PHEM unit

Woreda PHEM unit

Health center or clinic surveillance focal person

Hospital surveillance focal person
Setting up MPDSR system at facility:

During the “Set Up” phase, facilities should:

- Raise awareness and provide training for all staff
- Schedule regular, routine facility reviews
- Appoint a MPDSR coordinator who relates well to other staff, is supportive and respected
- Invite local experts to join committee from backgrounds other than medical/midwifery
- Engage senior staff and managers
To improve the data quality for FBAF, MDSR committee members and data collectors have their great role

1. **Role of data collector**
   - Ensuring data quality
   - Maximizing data capture
   - Summarizing cases for presentation at review

2. **MPDSR Facility committee**
   Roles and responsibility
   - Constructive discussion and taking key decisions
Data quality improvement:

Data quality improves when...

- All members of staff understand the purpose of the data collection
- There is good coordination across the facility departments for collecting and synthesizing data
- Multiple sources are used (case notes, records from admission, surgery theatre, mortuary e.t.c)
- Notes are legible

Once the process of data collection becomes routine, reporting and quality often improve as staff realize their notes and records will be looked at and used!
Data quality improvement:

Data capture

- Include all sources of information if women/ neonate received care at multiple sites
- Every effort should be made to include information from accompanying family members
- A summary of the chain of events should be generated (description of events leading to the death)
Data quality improvement:

Reminder: Committee Roles

- Multi disciplinary to bring in different perspectives and ideas
- Preserves the anonymity of patients and staff (through non-disclosure pledge)
- Maintains a “No Blame” culture
- Reports objectively on cases
- Identifies actions and provides required feedback to all concerned
- Coordinates with community reviews – essential to build a complete picture
Confidentiality: a Code of conduct:

- Local data collectors and involved health care workers are the only staff who see the names of deceased.
- Knowledge contained within review committees.
- All individuals (including committee members) who access identifying data sign a non-disclosure confidentiality agreement (kept on record).
Disclaimer pledge:

(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 analyzed here, and will not disclose the names of any individuals involved, including family members or health care providers.
Committee discussion:

Five key decisions

1. Cause of death
2. Death classification
   Direct/indirect/incidental
3. Relevant delays
4. Preventability Lessons learnt are applied to prevent further deaths
5. Actions
Summary Points:

• Quality of notes and records are vital to the success of facility based reviews

• Data must be obtained from all relevant sources (departments where woman treated, other health services she attended, family members)

• The whole team should review cases and contribute to taking the key 5 decisions
MPDSR Case based reporting (MDRFs and PDRFs)

• The Health facility RRT (including MCH experts) meets to discuss the case
• The committee agrees on the major delays involved
• The RRT decides on any local actions needed to prevent further similar deaths
• The surveillance focal person is responsible for completing the MDRF and PDRF (case based reporting format) and sending it up the system
• A UNIQUE ID is also given to MDRF/PDRFS

Attention should be given to the Completeness of MDRF and PDRFs

Completed forms should be sent timely within 48 hrs from level to level
Maternal death reporting forms (MPDRF)

Includes five sections

- Reporting Health facility information
- Deceased information
- Antenatal Care (ANC), Delivery and Postnatal care (PNC) / Post abortion care (PAC)
- Causes of death
- Contributory factors
Perinatal death reporting forms (PDRF)

Includes six sections

- Reporting Health facility information
- Deceased information
- General information of the mother
- Obstetric History of the mother in relation to the deceased case
- Perinatal Cause of death
- Contributory factors
Exercise how to fill and review the MDRF or PDRF