MPDSR: Global and Regional Progress, Best Practices for Implementation

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Agenda

- Global reflections on MPDSR implementation
- Common challenges
- Cambodia’s experience as part of TUSIP regional programme
- Best Practices and Examples for expanding progress

MPDSR: (More than) A Decade of Progress

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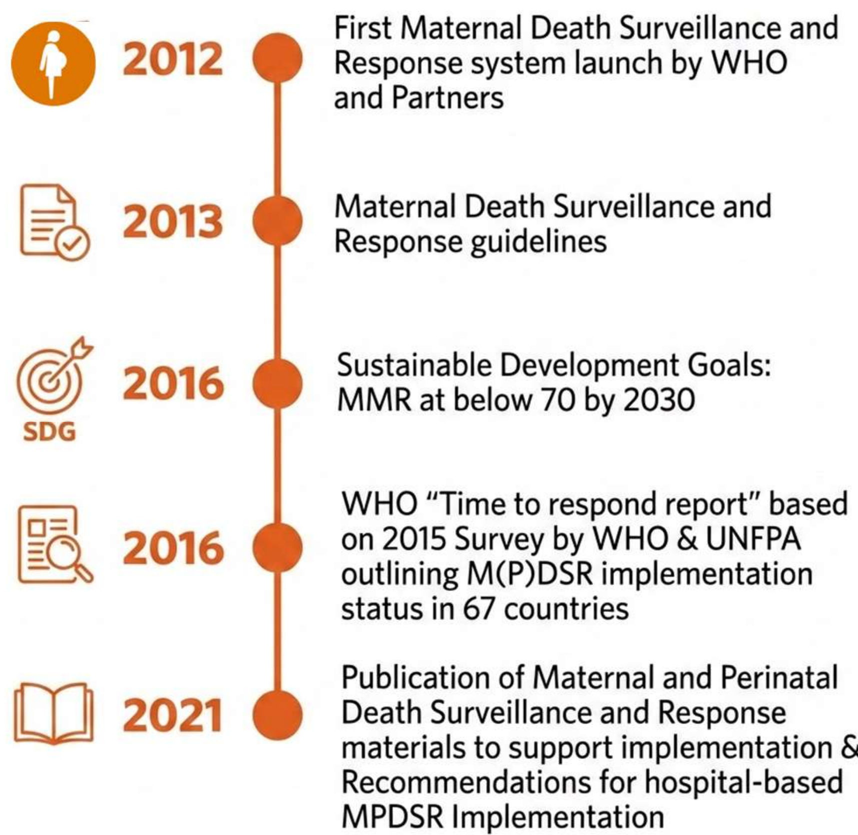
2012
First Maternal Death Surveillance and Response system launch by WHO and Partners
2013
Maternal Death Surveillance and Response guidelines
SDG
2016
Sustainable Development Goals: MMR at below 70 by 2030
2016
WHO "Time to respond report" based on 2015 Survey by WHO & UNFPA outlining M(P)DSR implementation status in 67 countries
2021
Publication of Maternal and Perinatal Death Surveillance and Response materials to support implementation & Recommendations for hospital-based MPDSR Implementation

MPDSR: Increased Accountability

Key Findings from periodic global WHO/UNFPA Surveys

- ★ By 2023, **79%** of countries had adopted MPDSR policies or laws that mandate death reviews for **all** maternal and perinatal deaths, compared to 67% or less in 2018
- ★ 67% of countries had a National MPDSR Committee in 2018; this increased to **83%** by 2023
- ★ 73% of countries in 2018 had policies requiring development of response plans based on death reviews; in 2023, **75%** of countries had guidelines for developing response plans
- ★ By 2023, 67% of countries required issuing a Medical Certificate with Cause of Death including for deaths outside the health facilities

Across countries, most commonly reported challenges include:

Data Quality

How to enhance data quality for reported cases, causes, and underlying causes of death.

Death Reviews

How to boost the effectiveness of death review meetings to foster a learning culture among health workers.

Service Delivery

How to execute recommendations to improve quality of care, strengthening service delivery and patient experience.

Community

How to strengthen community involvement and engagement for holistic maternal and perinatal support.

Cambodia’s Experience: Leading MPDSR implementation

- Cambodia is one of four countries targeting MPDSR implementation with UNFPA support, as part of the “Towards Universal SRHR in Indo-Pacific” (TUSIP) Programme supported by DFAT Australia
- Other countries in the programme: Lao PDR, Nepal, Timor-Leste
- Cambodia’s successful model of MPDSR Training roll-out from National to Provincial level is being followed by other countries
- Network of “allied” hospitals supporting each other in MPDSR & Response Plans – a positive model for replication
- Excellent example of fostering “No Name, No Blame” culture

Next Steps for Cambodia's MPDSR system

- How to strengthen provincial and sub-national level implementation, and track MPDSR implementation at the facility level?
- How to use the evidence from response plans to inform changes in practices and improve service delivery?
- How to effectively engage communities and non-health stakeholders for community MPDSR processes?

Strengthening provincial and sub-national level implementation

Best practices for sub-national implementation:

Continue Mentorship of provincial and district health facilities as part of network of Allied Hospitals

- Continue MPDSR Training roll-out and Mentorship to lower-level facilities

1. In-person Mentorship

2. Virtual Mentorship

3. Mobile-Social Learning

Best practices for sub-national implementation:

MPDSR Progress Monitoring Tool & Scorecard Dashboard

Tool developed by USAID's Maternal and Child Survival Program (MCSP) /Jhpiego MPDSR team in 2019 - aimed at reviewing Facility-Level MPDSR system

Progress markers are defined to track progress at facility level on six stages of MPDSR implementation:

1. Creating awareness,
2. Adopting the concept,
3. Taking Ownership,
4. Evidence of Practice,
5. Evidence of routine integration, and
6. Sustainable practice;

That assigns the facility a score from 0–30. Aim is to use it periodically at the “Baseline”, “Midline” and “Endline” to assess the level of MPDSR implementation of the hospitals

Using the Progress Monitoring Tool in Nepal

Baseline and Midline scores of Hospitals in MPDSR implementation
Koshi Province

35
30
25
20
15
10
5
0

Bhojpur DH*
Mechi Hospital
Dhankuta DH*
Birat Medical College
Panchthar Hospital
Phaplu Hospital
Khotang DH*
Sankhuwasabha DH*
OCH
BPKIHS
Ilam Hospital
Inaruwa DH*
Koshi Hospital
Udaypur DH*
Taplejung DH*
Nobel Medical College
Terathum DH*
AMDA Hospital

Sustainable Practice
Evidence of routine integration
Evidence of Practice
Taking Ownership
Adopting Concept
Creating Awareness

Baseline
Midline1
Midline2
Midline3

Best Practice: Keeping Track of MPDSR Progress through MPDSR Scorecard

- ➢ Developing **MPDSR Scorecard and corresponding dashboards** can be helpful to review compliance of facilities to MPDSR standards, using indicators from the WHO Operational Guidance

- ➢ MPDSR Committees at Provincial level (PHD)can ensure Hospitals complete the MPDSR scorecards routinely, using quality data sources, analyzed, and used for decision-making

- ➢ Scorecards can also be aggregated at District and Provincial Level, when more hospitals complete the facility-based scorecard

Best Practice: Keeping Track of MPDSR Progress through MPDSR Scorecard

Monthly MPDSR Scorecard

Reporting period: Oct 2022-Mar 2023

Indicators	2022						2023					
	October		November		December		January		February		March	
Maternal and perinatal indicators[1]												
1. Number of total births	600		630		510		550		650		450	
2. Number of maternal deaths	2		2		0		0		1		0	
3. Proportion of maternal deaths assigned by cause (ICD-MM)	50		100		NA		NA		100		NA	
4. Number of perinatal deaths	5		4		3		2		0		0	
5. Proportion of perinatal deaths assigned by cause (ICD-PM)	60		75		100		100		NA		NA	
6. Number of stillbirths	Ante	Intra	Ante	Intra	Ante	Intra	Ante	Intra	Ante	Intra	Ante	Intra
	1	3	1	2	1	2	1	1	0	0	0	0
7. Number of early neonatal deaths (1-7 days)	1		1		0		0		0		0	
MPD Reviews[2]												
8. Proportion of steering committee meetings conducted within 72 hrs	50		100		0		100		100		100	
9. Perinatal deaths reviewed at steering committee meetings	Yes		Yes		Yes		Yes		ND		ND	
10. Proportion of maternal deaths notified through MPDSR (web-based system) that are reviewed at steering committee meetings	100		100		100		100		100		100	
Use of evidence--Recommendations[3]												
11. Proportion of recommendations implemented based on Maternal death reviews	50		80		80		100		100		100	
12. Proportion of maternal deaths recommendations followed up in next review meeting	50		100		0		0		0		100	
13. Proportion of recommendations implemented based on Perinatal death reviews	80		100		100		100		NA		NA	
14. Proportion of perinatal deaths recommendations followed up in next review meeting	50		50		100		0		0		0	

References:

[1,2,3]: WHO OG

Ensuring Response plans inform changes in practices and improve service delivery

Best practices: Improving effectiveness of Response Plans and of corrective actions

Key Principles for effective response plans development:

- ➢ Reinforce Trust and culture of “No Name No Blame”
- ➢ All key members and clinical teams representatives should be present and in regular review meetings
- ➢ Assign Specific team members for monitoring, championing or implementing each MPDSR recommendation, as appropriate, with clear timelines
- ➢ Ensure shared responsibility to change practice to prevent deaths, recognising that the quality of team’s work impacts overall quality of care improvements

Best practices: Turning Response Plans into National MH policies and SOPs in Sri Lanka

Sri Lanka: Maternal death review first implemented in 1959, Perinatal death review first implemented in 2006

How did MPDSR Response plans improve quality of care?

Early on → MPDR reviews findings used to issue Ministry of Health circulars to mandate systemic changes to practices nationwide.

Examples: Ob/gyns to personally examine all cases referred from the provinces (1988); implementing a "red sticker" system for pregnancy appointment cards to identify & notify high-risk pregnancies during ANC (1993); 2500 mopeds given to public health midwives to facilitate MCH home-based care (2006)

AS MMR started to reduce, Response plans became **more specific** to issue recommendations for key maternal health complications

Best practices: Turning Response Plans into National MH policies and SOPs in Sri Lanka

Specific MNH Complications Response and Action Plans:

Obstetric haemorrhage: Response plans turned into: 1) mandated expansion of blood transfusion services, 2) hiring of transfusion specialists in major hospitals, 3) introduction of blood transfusion protocols, 4) strengthening of referral pathways for the management of morbidly adherent placenta

Septic abortions: Response plans contributed to Development of National Guidelines in 2015 on comprehensive high-quality post-abortion care services

Improving management of other maternal morbidities: MPDSR reviews findings led to: 1) development of national guidelines for dengue haemorrhagic fever and pneumonia in pregnancy; 2) fast-track referral protocols for pregnant women with suspected heart disease

Community Engagement for expanded MPDSR and “reaching the last mile”

Best Practice: Community Participation in MPDSR

Community Engagement is crucial for effective MPDSR Implementation:

- ➢ Community members collaborate with health workers to explore and address the factors that contribute to maternal and perinatal deaths;
- ➢ Supported and promoted by global and international policies and guidelines, such as the WHO technical guidelines, Global strategy for women's, children's; the EPMM initiative, etc.
- ➢ Community MPDSR can improve data collection on maternal deaths, addressing issues of underreporting
- ➢ empowering community members to increase accountability for maternal and perinatal mortality prevention.

Best Practice: Community MPDSR System in Bangladesh

- Frontline health workers in Bangladesh are assigned a catchment area, where they are responsible for reporting maternal deaths, neonatal deaths, and stillbirths from the community. Deaths must be reported within **3** days

- Following initial notification, health workers confirm the information about the case at the community clinic

- A community verbal autopsy for all maternal deaths and 10% of neonatal deaths should be conducted within 7–15 days; a social autopsy for all maternal deaths and 10% of neonatal deaths should be conducted within 15–30 days;

- Field-level supervisors from the health and family planning department conduct both the verbal and social autopsies;

- The MPDSR focal person and medical specialists report the cause of death at the upazila (sub-district) and district levels

Best Practice: Community MPDSR System Implementation in Bangladesh

How do Frontline Health Workers Notify and Register Community deaths?

- Frontline health workers learn about community deaths through regular activities like clinics, immunization, and home visits. They utilize networks like community and support groups, as well as local leaders, to ensure all maternal, neonatal deaths, and stillbirths are reported

- Deaths are reported quickly to health workers by a phone call or SMS text; then a health worker visits the household to ask information about the death and fill out a death notification slip

- Within 72 hours of the death, the health worker should report the information to the community clinic / primary health centre and submit the notification slip

- When the death notification slip is submitted, staff in charge of clinic registers enter the information into the HMIS system - DHIS2. A unique number is generated, which is used later for entering the verbal autopsy data

Verbal Autopsy & Social Autopsy

Verbal autopsies are conducted within 7–15 days of a community death. A health supervisor is assigned to verify that the death meets the operational definition and identifies the best respondent for accurate information. Written consent is obtained, and respondents can stop the interview at any time.

Data is collected using a structured form (approx. 30 min), with a no-blame, no-shame approach. Responses are confidential. Completed forms are submitted to the relevant officer or MPDSR focal person at the district level, and followed up by the area health inspector and MPDSR focal person.

Social autopsies focus on social factors relating to maternal and newborn deaths, and aim to identify community-led solutions They are organized 15-30 days after a death; last ~45-60 minutes and 40-50 participants from 20-30 households participate. During the process, the community shares what the complications were, what the family did, and the decision-making dynamics about seeking appropriate care.

Root causes of death are collectively identified and strategies developed to prevent further deaths. The social autopsy process also increases knowledge about danger signs and when to seek care. Social autopsies are conducted for 65-70% of maternal deaths occurring in the community.

For discussion today: How can these examples and best practices be applied in the context of Cambodia?

Thank you!
Main references
Time to respond: a report on the global implementation of maternal death surveillance and response.Geneva: World Health Organization; 2016.
Maternal and perinatal death surveillance and response: global report on decade of implementation. Geneva: World Health Organization; 2024