Government of Pakistan
Ministry of National Health Services,
Regulations & Coordination

Maternal & Perinatal Death Surveillance and Response (MPDSR)

Facilitator's Manual

World Health Organization

Maternal & Perinatal Death Surveillance and Response (MPDSR)

Facilitator's Manual

وزارت صحت، حکومت پاکستان

Government of Pakistan
Ministry Of National Health Services,
Regulation & Coordination

ACKNOWLEDGEMENTS

In order to institutionalize maternal and perinatal death surveillance and response (MPDSR) in Pakistan, the Ministry of National Health Services, Regulations & Coordination (NHSR&C), Government of Pakistan, developed the national guidelines and a training package with the support from World Health Organization, Pakistan in 2018. These technical resources were developed through a thorough consultation process with a broad range of stakeholders and partners including UNFPA and UNICEF.

The Ministry expresses deep appreciation to the technical experts who have led the task including Dr Lubna Hasan & Dr Najma Lalji. The leadership and support from Dr Malik Muhammad Safi and Dr Atiya Aabroo from the Ministry of NHSR&C was pivotal in development of the training package. Gratitude is due to the galaxy of experts, both international and in-country, who played a key role in providing valuable contributions during the development of the training package including the draft review and final consensus building of the package. Special thanks to the technical team from WHO including Dr Karima Gholbzouri, Dr Lamia Mahmoud and Dr Qudsia Uzma from EMRO and Pakistan office.

MESSAGE

Pakistan is committed to achieving the Sustainable Development Goals and the Government of Pakistan is expanding its efforts to address the challenges in achievement of health-related targets. Improving the well-being of mothers, infants, and children is an important public health goal for Pakistan. Their well-being determines the health of the next generation and ensures a healthy and productive citizenry. With an ever-increasing population, at an inter-census annual growth rate of more than 2 percent, the challenge is obvious.

In Pakistan, maternal mortality ratio has decreased from a high of 431 maternal deaths per 100,000 live births in 1990 to a low of 186 maternal deaths per 100,000 live births in 2019 (Pakistan Maternal Mortality Survey).

While infant and Under-5 child mortality indicators have shown reduction, it is clear that we have much to do to reduce neonatal deaths from the current 42 per 1000 live births to the SDG target of 12 per 1000 live births by 2030.

In order to ensure the timely and accurate recording of maternal and perinatal deaths, the Maternal and Perinatal Death Surveillance and Response system is being institutionalised with the support of the World Health Organization in selected districts of Khyber Pakhtunkhwa, Balochistan and Islamabad Capital Territory. This system will ensure that no maternal and perinatal death goes unrecorded and unaccounted for. With WHO support, this system will initially be started at health facility level in selected districts and will later be extended to the community level. Likewise, the focus at the early stage of implementation would be on maternal death reviews while perinatal death reviews would be added along the way.

The training package for implementation of MPDSR is a document that will be an important resource for the trainers and facilitators engaged in the reporting of maternal and perinatal deaths. We are fully committed to operationalize this system and expand the scope both technically and geographically to implement it across the country and at all levels fo reducing preventable maternal and perinatal mortality in Pakistan.

Dr Malik Muhammad Safi
Director (Programs)

ACRONYMS

ANC	Antenatal care
APH	Antepartum Hemorrhage
BHU	Basic Health Unit
CHF	Congestive Heart Failure
CRVS	Civil Registration and Vital Statistics
CS	Caesarean section
ICD	International Classification of Disease
ICD-MM	International Classification of Disease –Maternal Mortality
ICD-PM	International Classification of Disease- perinatal Mortality
MDF	Maternal Death Form
MDR	Maternal Death Review
MMR	Maternal Mortality Ratio
MPDSR	Maternal and Perinatal Death Surveillance and Response
NM	Neonatal Mortality
PDF	Perinatal Death Form
RHC	Rural Health Centre
UNFPA	United Nations Population Fund
WHO	World Health Organization

CONTENTS

BACKGROUND AND INTRODUCTION

Maternal and perinatal mortality remains a challenge worldwide affecting most of the low and middle income countries. Pakistan contributes substantially to regional and global maternal and perinatal mortality figures with an estimated Maternal Mortality Ration (MMR) of 276 per 100,000 live births; the lifetime risk of a maternal death stands at 1 in every 110 women. Neonatal mortality rate is equally high in Pakistan, reported to be 55 per 1,000 births, with stillbirth rate of 47 per 1000 live births. A major proportion of these deaths can be prevented by timely intervention and good quality care during pregnancy and at the time of delivery.

The Government of Pakistan stands committed to globally recommended actions for eliminating preventable maternal and perinatal mortality. This will require establishment of strong monitoring systems that are capable of tracking all maternal and neonatal deaths in real time, allowing for better understanding of the underlying factors contributing to the deaths, and guiding actions to avert similar deaths from occurring.

Maternal and Perinatal Death Surveillance and Response (MPDSR) is a systematic approach that provides required information for guiding public health actions focused on reducing maternal and perinatal deaths. It is a form of continuous surveillance that links the health information system and quality improvement processes from local to national levels. MPDSR includes routine identification, notification, quantification and determination of causes of maternal and perinatal deaths, as well as the use of this information to respond with actions that will prevent future deaths.

NOTES TO THE FACILITATOR

Purpose

This training package is developed for orienting relevant stakeholders on maternal/ perinatal death surveillance and response (MPDSR) and building capacities in conducting facility based reviews of maternal deaths. The training package includes facilitator and participant manuals. Participant manual includes technical details pertaining to the subject, tools required for conducting maternal/ perinatal death reviews and handouts for practicing the process during the training. The training package is designed based on adult learning approach including interactive lectures and problem based learning. Training should focus on active engagement of participants and reviewing maternal death cases in localized context.

Objectives

By the end of this training, participants will:

1. Understand how MPDSR can reduce maternal and perinatal mortality
2. Know the structure and requirements of Pakistan MPDSR system, including roles and responsibilities
3. Understand the process for conducting facility and community based maternal death review
4. Be able to use MPDSR tools

Participant Selection

This module is intended for midlevel health care providers and heads of health facilities. Participants should be selected on the basis of their roles and responsibilities and experience. Following participants are envisioned for undergoing this training.

1. Referral/District/Provincial health facilities – facility based medical officers
2. District health departments – involved in collecting and reporting data from both community and facilities
3. Provincial departments of health and ministry; for advocacy and policy implementation

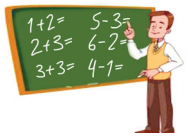
Using the Manual

- This training package has two components, (i) Facilitator Manual and (ii) Participant Manual
- Each manual consists of six modules which are further divided in sessions

- Facilitator Manual contain (i) training process and instructions for facilitator, (ii) presentations, (iii) responses to exercises and case studies, (iv) pre and posttests and (v) training evaluation form
- Participant's Manual contains (i) technical details pertaining to MPDSR, (ii) case studies and exercises for practice, and (iii) Maternal/ perinatal death review tools
- Handout numbers correspond with respective exercise number
- Facilitator should also read the notes shared in presentations

Guide to Symbols

Symbols are assigned for various activities for the ease of facilitator and participants. The symbols used are:

				
Interactive session	**Instruction for trainer**	**Group work**	**Brainstorm session**	**Individual Task**

Preparation for training

Good preparation is required for all training to ensure everything runs smoothly. Below are a few tips for maximizing successful implementation of the MDSR training package.

1. Number of Participants

Given the participatory nature of this training package, it is likely to work best for groups of 15-20. A larger group is more difficult to manage, particularly during the small group work and discussion sessions

2. Number of Trainers

Although presentations can be delivered by a single trainer, it is useful to have two facilitators to share presentations and assist during learning activities

3. Venue

The training requires a room large enough for all participants to fit in comfortably, with an unobstructed view of the power point projector. Enough space is also required for small groups to sit together during the activities, ideally around a table. Alternatively, separate spaces can be made available for groups

4. Seating arrangement

It is recommended to make the participants sit in a round table in groups of 4-5. Preferable participants from same facility should be in same group

5. Materials

Prior to starting the training, it is important to ensure there are enough copies of the National MDSR protocol, the pre (and post) test, handouts and any other documents to be distributed. Flipcharts and marker pens should also be available for group discussions and noting down responses/issues from the activities. Facilitator and participants certificate should be made available

6. Equipment

Power point projector, screen and computer are critical for showing the presentations. A microphone is useful in large venues and is required for the video shown during the training. In case of trainings of trainer adequate number of presentation copies should be available for each potential trainer

7. Opening and closing the training

Training begins with an opening ceremony and ends with a closing ceremony where certificates are given. A relevant local dignitary should be invited to close the training

Training/Learning Methodology

A variety of training learning approaches are suggested in training package; these are:

- Presentations
- Discussion
- Group work
- Role plays
- Individual task

Additional References

- National Guidelines on Maternal & Perinatal Death Surveillance and Response (MPDSR)
- ICD Classification

http://apps.who.int/iris/bitstream/handle/10665/70929/9789241548458_eng.pdf;jsessionid=82CCE6832DDFC76F2E40710560AC5189?sequence=1

DO'S AND DON'TS OF TRAINING

The following "dos and don'ts" should ALWAYS be kept in mind by the facilitator during any learning session.

1. DO's

- Do maintain good eye contact
- Do prepare in advance
- Do involve participants
- Do use visual aids
- Do speak clearly
- Do encourage questions
- Do recap at the end of each session
- Do bridge one topic to the next
- Do encourage participation
- Do write clearly and boldly
- Do summarize
- Do use logical sequencing of topics
- Do use good time management
- Do K.I.S. (Keep It Simple)
- Do give feedback
- Do position visuals so everyone can see them
- Do avoid distracting mannerisms and distractions in the room.
- Do be aware of the participants' body language
- Do keep the group focused on the task
- Do provide clear instructions
- Do check to see if your instructions are understood
- Do evaluate as you go

2. DON'TS

- Don't block the visual aids
- Don't stand in one spot—move around the room
- Don't ignore the participants' comments and feedback
- Don't read from the manual
- Don't shout at the participants

TRAINING AGENDA

DAY 1		
Time	**Duration**	**Activity**
09:00 am	**1 hour**	**MODULE 1: INTRODUCTION**
09:00 am	20 min	1.1 Welcome and introduction
09:20 am	20 min	1.2 Setting course expectations and pre test
09:40 am	10 min	1.3 Goal and Objectives
09:50 am	10 min	1.4 Training Package
10:00 am	**15 min**	**Tea break**
10:15 am	**2 hours**	**MODULE 2: MATERNAL & PERINATAL MORTALITY**
10:15 am	30 min	2.1 Overview on Maternal and Perinatal Mortality
10:45 am	30 min	2.2 Causes and Determinants of Maternal and Perinatal Death
11:15 am	40 min	2.3 Three delays Model Why did Mrs. X die
11:50 pm	20 min	2.4 Standards of Care
12:10 pm	**2 hours 40 min**	**MODULE 3: MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE**
12:10 pm	60 min	3.1 Introduction to MPDSR
01:10 pm	**02:10 pm**	**Lunch Break & Prayers**
02:10 pm	60 min	3.2 MPDSR System
03:10 pm	30 min	3.3 Policy, legal and ethical requirements for MPDSR
03:40	60 min	3.4 Steps for MPDSR implementation
04:40 pm	**20 min**	**Q&A Reflections**
05:00 pm		**Closure**

DAY 2		
Time	**Duration**	**Activity**
09:00 am	15 min	Where we are
09:15 am	**6 hours**	**MODULE 4: FACILITY REVIEW**
09:15 am	2 hrs. 40 min	4.1 Preparing for Maternal Death Review
10:15 am	**15 min**	**Tea break**
12:10 pm	1 hr. 30 min	4.2 Conducting the Review
01:40 pm	**60 min**	**Lunch Break & Prayers**
02:40 pm	90 min	4.3 Response – Action Plan
04:10 pm	20 min	4.4 Dissemination
04:30 pm	**15 min**	**Q&A Reflections**
04:45 pm		**Closure**

DAY 3		
Time	**Duration**	**Activity**
09:00 am	15 min	Where we are
09:15 pm	45 min	4.5 Android Application
10:00 am	**15 min**	**Tea break**
10:30 am	**120 min**	**MODULE 5: COMMUNITY REVIEW**
10:30 am	120 min	5 Community Based Maternal and Perinatal Death Review
12:30 am	**60 min**	**MODULE 6: PERINATAL DEATH REVIEW**
01:30 pm	**60 min**	**Lunch break & Prayers**
02:30 pm	30 min	Post-Test
03:00 pm	15 min	Evaluation Form
03:15 pm	30 min	Certificates Distribution
4:00 pm		**Closure**

MODULE 1: INTRODUCTION OF TRAINING

You are here	**Module 1**	Introduction
	Module 2	Maternal and Perinatal Mortality
	Module 3	Overview of MPDSR
	Module 4	Facility Review
	Module 5	Community Review
	Module 6	Perinatal Death Review

LEARNING OBJECTIVES OF THIS MODULE

By end of this module participants will

- Discuss training expectations
- Get to know each other
- Complete the pre-test

Sessions of Module 1		
Session #	**Session Title**	**Time**
1.1	Welcome and introduction	20 min
1.2	Setting course expectations and pre test	20 min
1.3	Goal and Objectives	10 min
1.4	Training Package	10 min
	Total time	**1hr**

Session 1.1: Welcome and Introduction

Interactive Session

Show presentation 1

Greet participants and introduce yourself

Explain that basic purpose of the workshop is to learn about MPDSR and its implementation

Establishing Norms and Housekeeping

Ask participants to brainstorm norms for the course. These should include

- Times for breaks
- Lunch
- Starting and ending times

Write a list of norms like respecting others' opinions, active participation, etc.

Ask participants to volunteer for following activities for each day of training

- Get participants back from breaks and lunch on time
- Collect feedback from participants
- Prepare energizers for after lunch
- Conduct the "Where are We" exercise at the beginning of each day
- Conduct the "Reflections" exercise at the end of the day
- Other responsibilities the group suggests

Session 1.2: Setting course expectations and pre-test

GROUP WORK 1.2: Training Expectations

Distribute one red and one green card to each participant
Ask participants to spend 5 minutes thinking about the 5 questions

- Ask each person to state one positive thing (on green cards) that will happen during the course
- Ask each person to also recount one negative (on red card) thing about something they hope will not happen during the workshop
- Put the "Positive" and "Negative" in separate columns on the flip chart/board

Summarize their expectations according to the objectives of the workshop

PRE-TEST

Explain that before we begin the workshop, we would like to collect some data using a pre-test so we can assess the effectiveness of the training when it is finished

- Give participants sufficient time to complete the pre-test, then collect it.
- Remind participants to put their names at the top of the paper.
- Ask them to circle "Pre"
- Let participants know that the pre-test is a set of multiple-choice questions
- They should circle one answer only

Now share participants DO and Don'ts presentation 1

DO

- Do ask a question when you have one
- Do request an example if a point is not clear
- Do search for ways in which you can apply a general principle or idea to your work
- Do think of ways you can pass on ideas to your subordinates and coworkers
- Be skeptical—don't automatically accept everything you hear
- Respect the ideas of other participants

DON'T

- Don't close your mind by saying, "This is all fine in theory, but…"
- Don't assume that all topics covered will be equally relevant to your needs
- Don't take extensive notes; the handouts will satisfy most of your needs
- Don't try to show how much you know by monopolizing class time
- Don't engage in side talk
- Don't interrupt others

Session 1.3: Goal and Objectives of the training

Show presentation 1

Goal: Train the participants on conducting MPDSR at facility level

Objectives

By the end of this training, participants will:

1. Understand how MPDSR can reduce maternal and perinatal mortality
2. Know the structure and requirements of Pakistan MPDSR system, including roles and responsibilities
3. Understand the process for conducting facility and community based maternal death review
4. Be able to use MPDSR tools

Session 1.4: Training Package

Interactive Session

- Training should be as interactive as possible and responsive to the needs of the group. To do this, we will review what went well or didn't go well at the end of each day in an exercise called "Reflections." Also, to make sure we are on track, we use an exercise called "Where are We?"

"Where are We" exercise

- Each morning one participant will review the highlights from the day before
- The exercise is not a review of the previous day, but is used to identify the highlights and main points of each day's experiences
- The participant conducting the review should use it as an opportunity to share insights, clarify issues, resolve problems, or review important material.
- Problems identified will be resolved before continuing.

MODULE 2: MATERNAL AND PERINATAL MORTALITY

	Module 1	Introduction
You are here	**Module 2**	Maternal and Perinatal Mortality
	Module 3	Overview of MPDSR
	Module 4	Facility Review
	Module 5	Community Review
	Module 6	Perinatal Death Review

LEARNING OBJECTIVES OF THIS MODULE

By end of this module participants will learn

- Causes, situation and determinants of maternal and perinatal mortality
- Definitions of relevant terms
- ICD classification for maternal mortality
- Standards of care in preventing maternal and perinatal mortality

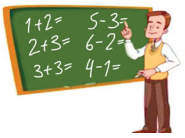
Sessions of Module 2		
Session #	**Session Title**	**Time**
2.1	Overview on maternal and perinatal mortality	30 min
2.2	Causes and determinants of maternal and perinatal death	30 min
2.3	Three delays Model Why did Mrs. X die	40 min
2.4	Standards of Care	20 min
	Total Time	**2hrs**

Session 2.1: Overview of Maternal and Perinatal Mortality

Learning objectives of this session

By end of this session participants will learn

- Situation of maternal and perinatal mortality
- Importance of reporting maternal/ perinatal mortality data



Interactive Session

In order to effectively seek participants' attention, share following anecdote with the participants

Ayesha got married a few years ago. She used to be a picture of perfect health. She would run errands in the house, go in the fields to help her husband, look after cattle, cook food for the family and would still be smiling and ever ready to do more. However, after repeated pregnancies with 3 live and 2 still births, she died while giving birth to her sixth still born child. She is no more!

Now discuss following questions

- Why Ayesha and her baby died?
- How many maternal and neonatal deaths occur worldwide and in Pakistan?
- What can be done? How can we prevent these deaths?

Now share global and national situation of maternal and perinatal mortality using presentation 2.1

Now briefly discuss importance of measuring indicators

Share brief overview of MPDSR system presentation 2.1

- Explain that maternal death review is the key component of MPDSR and share various approaches of maternal death review
- Share that MPDSR process details will be learnt in subsequent modules

Session 2.2: Causes and determinants of maternal and perinatal death

Learning objectives of this session

By end of this session participants will

- Learn relevant definition of maternal and perinatal death
- Recognize common causes of maternal and perianal deaths
- Explain the difference between causes and determinants of maternal and perinatal deaths

Explaining relevant definitions, causes and determinants of maternal and perinatal mortality

GROUP WORK: 2.2

Divide the participants into groups of 4-5 and give them 10 minutes to complete following exercise using handout 2.2

1. List 3-5 main causes and determinants of maternal deaths during or immediately after childbirth in Pakistan?
2. List 3-5 main causes and determinants of perinatal deaths (still births and neonatal deaths) in Pakistan?

Once completed summarize using the slides

Handout 2.2	Causes	Determinants
Maternal		
Perinatal		

Session 2.3: Three Delays Model

Learning objectives of this session

By the end of the session the participants will be able to

- Explain three delays model

Brainstorm with the participants using figure 1 Parveen Bibi's journey

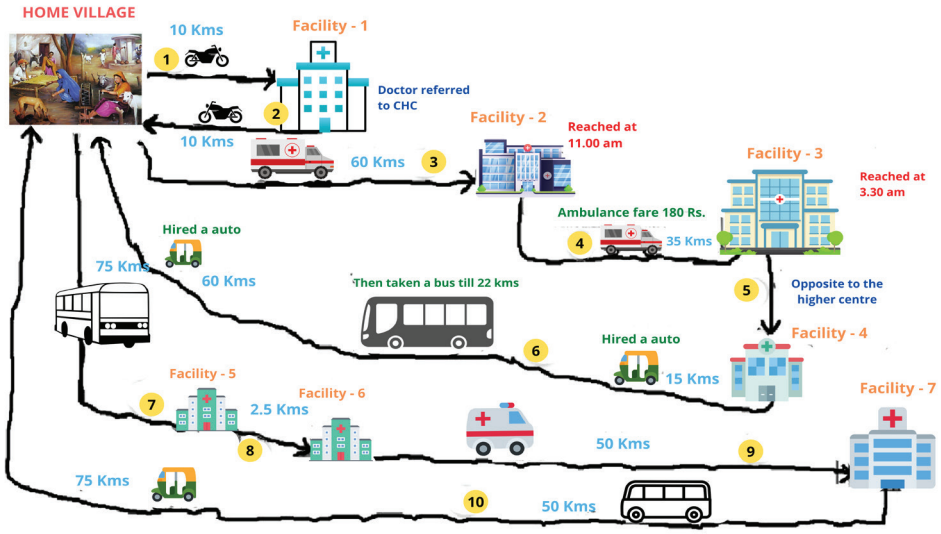


Figure 1: An image to illustrate the different delays[1]. It illustrates the journey of ONE single woman who died.

Explain using presentation

1. Delay 1: Delay in the decision to seek care?
2. Delay 2: Delay in reaching care?
3. Delay 3: Delay in receiving adequate care

1: CSO Dead Women talking initiative in India

Group Exercise: Why did Mrs. X die- Retold ?

Make groups and play the video

https://www.youtube.com/watch?v=gS7fCvCIe1k

Ask the groups to answer and discuss following

1. What was the direct cause of Mrs. X's death? Antepartum Haemorrhage
2. Were there any indirect causes? Anaemia
3. What evidence did the review committees use to make changes in quality of care at the facility?

Staff MDR Review: Conducted a retrospective audit of files, including Mrs. X's, and also interviewed her family members in the community

International Review (National Enquiry): Reviewed aggregated data from across facilities, including social and cultural issues related to access to family planning and gender roles and responsibilities.

4. List 2 actions resulting from the analysis of Mrs. X's death taken at the hospital and nationally Improved blood supply

- Increased availability of emergency services e.g. Caesarean Section
- More trained midwives both for ANC and Delivery

Session 2.4: Standards of Care

Learning objectives of this session

By end of this session participants will learn

- Get familiarize with the definition of Quality of care (QoC)
- Understand the framework of QoC
- Understand the ways to implement QoC

Interactive Session

Share with participants that we will now discuss standard of care and how the causes and determinants of maternal and perinatal mortality can be reduced by improving the standards of care.

Show presentation 2.5

- **Emphasize on reviewing deaths against quality standards**

Module Summary Points

Most of maternal and perinatal deaths are preventable

- Social determinants are the “causes of the causes” of maternal and perinatal deaths, and depend on many social levels
- Addressing maternal and perinatal deaths thus requires action at every level, not just medical or health services
- MPDSR identifies determinants related to the 3-delays from individual to the community and to health facility level
- MPDSR is an important part of quality assessment and improvement

MODULE 3: MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

	Module 1	Introduction
	Module 2	Maternal and Perinatal Mortality
You are here	**Module 3**	Maternal and Perinatal Death Surveillance and Response (MPDSR)
	Module 4	Facility Review
	Module 5	Community Review
	Module 6	Perinatal Death Review

LEARNING OBJECTIVES OF THIS MODULE

By end of this module, participants will learn

- Global experiences and current situation of MPDSR in Pakistan
- Legal and ethical issues involved in MPDSR
- Steps of MPDSR Implementation

Sessions of Module 3		
Session #	**Session Title**	**Time**
3.1	Introduction to MPDSR	60 min
3.2	MPDSR System	60 min
3.3	Policy, legal and ethical requirements for MPDSR	30 min
3.4	Steps for MPDSR implementation	60 min
	Total Time	**2 hrs. 40 min**

Session 3.1: Introduction to MPDSR

Learning objectives of this session

By end of the session participants will

- Be familiar with key concepts and definitions of surveillance and MPDSR
- Understand the objectives of MPDSR

Show presentation 3.1

What is Public Health Surveillance?

Consolidate their concept by giving localized examples such as:

- Dengue surveillance system
- Measles Surveillance system
- Polio surveillance system

Share WHO definition of Surveillance[2] ***(Presentation Module 3-3.1 slide 1)***

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for planning, implementation, and evaluation of public health practice. Such surveillance can:

- Serve as an early warning system for impending public health emergencies
- Document the impact of an intervention, or track progress towards specified goals; and
- Monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.

Ask participants what is Maternal and Perinatal Death Surveillance and Response (MPDSR) and what are its objectives?

2: http://www.who.int/topics/public_health_surveillance/en/

Session 3.2: MPDSR System

Learning objectives of this session

By end of the session participants will

- Get familiar with the objectives and components of MPDSR system
- Gain understanding of global experience of MPDSR
- Understand the current state of MPDSR in Pakistan

Brainstorm steps of MPDSR system, keeping in view public health surveillance system

Show presentation 3.2

Sum up the session by sharing following steps of MPDSR

1. Identification
2. Notification of maternal deaths
3. Maternal death review
4. Analysis – data aggregation and interpretation
5. Recommendation
6. Response
7. Monitoring and Evaluation (M&E)
8. Dissemination of results

GROUP WORK: 3.2

Divide participant in group of 4-5 and ask them to read Handout 3.2 on Global Experience on MPDSR, in 30 minutes.

Give flexibility to participants to add, if they have any additional information

Facilitate discussion to reiterate findings from Global Experience capturing following points:

- MPDSR is a relatively new approach. MPDSR evolved from the established system of Maternal Death Reviews (MDR), which is a core activity in the system.
- Detailed information about the extent and quality of implementation in each country has been largely unavailable due to the recent origins of MDSR and the lack of systematic data collection.
- However, the combined findings of the MDSR baseline survey (conducted in 2015 by UNFPA & WHO and reported in the document "A time to respond") and the WHO-MNCAH policy indicator database provide a good summary of global implementation status in 2015.

Handout 3.2: Global Experience

- **Policy and practice gap in maternal death review**

  85% countries have national policy to review all maternal deaths; whereas 46% countries have national maternal death review committee that meet at least biannually.

- **MDSR evolved from maternal death review**

  Philippines reported a relatively smooth transition to MDSR after 2013, largely due to its established system of maternal death reporting and review (MDRR). A significant change was emphasis on the response element of MDSR.

- **Investigating maternal death creates fear**

  Studies from Moldova, Kenya and Malawi, the previously used system of investigating maternal deaths 'instilled fear' in the country's health professionals, who were afraid of being prosecuted for perceived mistakes.

- **No blame game**

  Malaysia suggested that it is essential for the maternal death review process be non-punitive to avoid "naming, blaming or shaming."

- **MDSR and CRVS strengthen each other**

  MDSR can contribute significantly to a country's culture of accountability where civil registration and vital statistics (CRVS) systems are not well established. Scale of the problem was indicated in Kazakhstan and South Africa; where 29% and 49% more maternal deaths were identified.

- In Malawi MDSR system is expected to strengthen CRVS by collecting data using the International Classification of Diseases (ICD-10) standard for maternal mortality (ICD-MM).

- In Nepal, CRVS and MDSR systems will use same verbal autopsy questionnaires to collect information on suspected maternal death.

- **Training in MDSR techniques specifically death review and response**

- In Ethiopia, Federal Ministry of Health instigated an MDSR training programme following the launch of country's system in May 2013. By the end of 2014, the MDSR system had been introduced in 17 zones, covering about 40 million people in an estimated national population of 95 million.

- Tanzania was in the process of rolling out its system of maternal and perinatal deaths surveillance and response following the compilation of national guidelines and tools in 2015.

- **Strong political commitment and participation of a multidisciplinary team**

  Involvement of senior staff members including obstetricians and heads of departments, was associated with greater success in implementation of recommendations for quality improvement in Malawi, Indonesia and Senegal.

- **Various Models of MPDSR**

  Audit and notification of all maternal deaths is mandatory in Uganda. A National Committee on Maternal and Perinatal Death Reviews was established in 2008. An in depth review of a small number of maternal deaths occurring at facilities is conducted and discussed at national level.

- Kenya declared maternal death a notifiable event in 2014 and started reviewing maternal deaths at facility level. Recently it developed comprehensive national MPDSR guidelines. Kenya is taking a phased approach in implementing the "P" in MPDSR.

- **MDSR can generate its own budget line**

  MDSR provides evidence and trends in maternal mortality. This may lead to budget allocation at national and sub national levels.

- **Barrier to acting on recommendations**

  Feedback of MDR recommendations to key stakeholders and health care providers is essential for action to be taken. Most common barriers were lack of involvement from senior staff and heads of department and poor quality of data recorded during the MDR process.

  Other common barriers include shortage of human resources, high turnover of staff, inexperienced staff, lack of standardized guidelines for reviewing maternal deaths.

- **MDSR improves quality of care**

  Quality of care can improve and avoidable mortality can be reduced if recommendations based on MDR findings are implemented.

Share MPDSR situation in Pakistan presentation 3.2

Share key challenges of MPDSR presentation 3.2

Brainstorm on Challenges and Solutions for Rolling out MPDSR in Pakistan
Take responses on flip carts

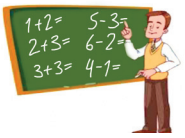
Ask participants to bring case files on maternal deaths

Session 3.3: Policy, Legal and Ethical Requirements for MPDSR

Learning objectives of this session

By end of this session participants will learn

- Policy, legal and ethical requirements of MPDSR



Interactive Lecture

Interactive Lecture

Tell participants that we will now review legal requirements for implementing MPDSR.
Show presentation Module 3-3.3 slides 4-7 on legal requirements

Awareness on Ethical Requirements

- Tell participants that we will now review ethical requirements for implementing MPDSR
- Show presentation 3.3
- Tell the participants to refer to their manual for details on ethical requirements

Conclude by sharing legal and ethical framework

Case Studies

GROUP WORK: 3.3

Divide participants in groups of 4.
Assign each group one case study and give 30 minutes
Ask each group to present. Take feedback from participants.
Show presentation with correct responses on each case study

Case study 1	Maternity team performed a Caesarean section (CS) indication for CS was congestive heart failure (CHF) in pregnancy. MDR revealed that CS was contra-indicated in a woman with CHF. ▪ Back home, a member of MDR committee told his wife and the news soon spread and reached the family of the deceased. ▪ The family sued the doctor who performed the CS. ▪ The hospital director who is member of the MDSR committee gave testimony in court **Questions** 1. What are the legal and ethical issues involved? 2. How could the lawsuit have been prevented?

Case study 1 : Solution			
Legal Issues		**Ethical issues**	
Access to information	No law prohibiting members of MDSR committee from testifying in court if they were part of the review	Autonomy	
Protection of people involved	No law protecting providers from professional liability if information from MDR is used for lawsuit	Privacy	Disclosing information to the public breaches the diseased & family's right to privacy
Use of results	No laws prohibiting the use of MDR data for lawsuits?	Confidentiality	Disclosure of findings of MDR to 3rd party is breach of confidentiality.
		Anonymity	Lack of anonymity during MDR
		Beneficence	Information NOT used for the purpose it was collected. Testimony in court

Case study 2	Madame Y, the wife of a parliamentarian, died of eclampsia. MDR revealed that the doctor who attended to her did not prescribe Magnesium Sulphate which was available in the hospital pharmacy. ▪ A team of policemen arrived the hospital and requested to have the deceased hospital records including MDR report. ▪ The Hospital Director humbly handed over the documents to the police ▪ The next day the doctor who attended to the deceased was arrested **Questions** 1. What are the legal and ethical issues involved? 2. How could the lawsuit have been prevented?

Case study 2 : Solution			
Legal Issues		**Ethical issues**	
Access to information	No legal provisions for health workers to refuse to disclose findings from MDSR	Autonomy	
Protection of people involved	No law protecting providers/hospital from professional liability if information from MDR is used for lawsuit?	Privacy	Disclosing information to the public breaches the diseased & family's right to privacy
Use of results	No laws prohibiting the use of MDR data for lawsuits	Confidentiality	Disclosure of findings of MDR to 3rd party is breach of confidentiality.
		Anonymity	Lack of anonymity during MDR
		Beneficence	Information NOT used for the purpose it was collected

Case study 3	Madame Z died of a ruptured uterus after prolonged labour ▪ MDR revealed that when the doctor on duty was called for the emergency, he has been drinking beer with his friends and did not come immediately until a few hours after the patient had died. ▪ The hospital director suspended the doctor from work **Questions** 1. What are the legal and ethical issues involved? 2. What will you have done if you were the hospital director?

Case study 3 : Solution			
Legal Issues		**Ethical issues**	
Access to information		Autonomy	
Protection of people involved	Malpractice (medical negligence) – failure to protect patient	Privacy	
Use of results		Confidentiality	
		Anonymity	
		Beneficence	The principle of non-maleficence (do not do harm) was not respected

Case study 4	Madame G died of a postpartum hemorrhage before arrival in a health facility. She was delivered by a Traditional Birth Attendant who referred the patient for postpartum hemorrhage. ▪ A community health conducted verbal autopsy by interviewed the sister of the diseased and TBA without taking informed consent. ▪ After analysis of findings, one verbal autopsy committee informed the village head that the TBA had contributed to the death of the woman and that there was urgent need to stop TBAs in the village from conducting deliveries. ▪ The village head informed the police who arrested the TBA and also got VA form from the district hospital **Questions** 1. What are the legal and ethical issues involved? 2. What will you have done if you were the hospital director?

Case study 4 : Solution			
Legal Issues		**Ethical issues**	
Access to information	No legal provisions for health workers to refuse to disclose findings from MDSR?	Autonomy	No informed consent taken before interviews
Protection of people involved	No law protecting TBAs from professional liability if information from VA is used for lawsuit?	Privacy	Digulging information to the public breaches the diseased & family's right to privacy
Use of results	No laws prohibiting the use of VA data for lawsuits?	Confidentiality	Disclosure of findings of VA to 3rd party is breach of confidentiality
		Anonymity	Lack of anonymity during VA analysis
		Beneficence	Information NOT used for the purpose it was collected

Case study 5	The national MDSR committee produced the MDSR report which was disseminated widely. ▪ The MCH Director in the MoH requested that the MDSR committee chair should send him the MDSR database. The database was sent by email. ▪ The secretary of the MCH Director downloaded the file, went through it and then discovered that the sister of one of her friend died due to medical negligence. ▪ The secretary informed her friend who sued the hospital where the woman died. **Questions** 1. What are the legal and ethical issues involved? 2. What will you have done if you were the hospital director?

Case study 5 : Solution			
Legal Issues		**Ethical issues**	
Access to information	No legal provisions for health workers to refuse to disclose findings from MDSR?	Autonomy	
Protection of people involved	No law protecting provider/ hospital from professional liability if information from VA is used for lawsuit?	Privacy	Digulging information to the public breaches the diseased & family's right to privacy
Use of results	No laws prohibiting the use of VA data for lawsuits?	Confidentiality	Disclosure of findings on MDSR database to 3rd party is breach of confidentiality
		Anonymity	Lack of anonymity in MDSR database
		Beneficence	Information NOT used for the purpose it was collected

Session3.4:StepsforMPDSRImplementation

Learning objectives of this session

By the end of the session the participants will be able to

- Identify key steps involved in MPDSR implementation
- Identify review committees and their composition at each level
- Understand the implementation process in Pakistan

Show presentation 3.4

GROUP WORK: 3.4 Committees

Divide participants in groups of 4

Ask participants to read Handout 3.4 on Committees

- Ask each group to fill in information on one type of committee in
- the format given
- Generate discussion on inclusion of workshop participants in any of the committees and their potential role

Before closing this session ask the participants to bring case studies pertinent to maternal death (Facility/hospital based) which will be used in Module 4

Summary Points of the Module

Most of maternal and perinatal deaths are preventable

- MPDSR system captures maternal and perinatal deaths in communities and facilities
- MPDSR surveillance involves community, district, provincial and national levels
- 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
- Implementation of MPDSR will differ according to the provincial context and challenges

MODULE 4: FACILITY REVIEW

	Module 1	Introduction
	Module 2	Maternal and Perinatal Mortality
	Module 3	Overview of MPDSR
You are here	**Module 4**	Facility Review
	Module 5	Community Review
	Module 6	Perinatal Death Review

LEARNING OBJECTIVES MODULE 4

By end of this module participant will learn to conduct facility review for maternal death

Sessions		
Session #	**Session Title**	**Time**
4.1	Preparing for Maternal Death Review	2 hrs.
4.2	Conducting the Review	1.5 hrs.
4.3	Response – Action Plan	1.5 hrs.
4.4	Dissemination	20 min
4.5	Android Application	40 min
	Total Time	**6 hrs.**

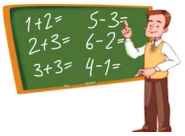
Session 4.1: Preparing for Maternal Death Review

Learning objectives of this session

By end of this session participants will

By end of this session participants will learn

- Learn key steps involved in preparing for Maternal Death Review
- Identify Key members for an MDR committee
- Learn ICD classification for maternal death
- Become familiar with facility notification form MDF1
- Be able to fill data collection form MDF2



Interactive Lecture

Show presentation 4.1

Ask the participants to review the draft disclaimer form attached as handout 4.1

Handout 4.1: Draft Disclaimer form

All individuals (including committee members) who access identifying data sign a non-disclosure confidentiality agreement

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

LIST OF MEMBERS

Sr. no	NAME	DESIGNATION	SIGNATURE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

MDR SESSION NO: **DATE**

FACILITY/DISTRICT

Ask participants to do the following group work

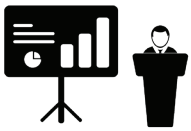
GROUP WORK: 4.1.1 Facility MDR Committee

Divide participants in in groups. All participants from same facility should be in one group

- Draft a TOR for your Review Committee
- Refer to group work 3.4 and complete exercise in handout 4.1.1

Handout 4.1.1: Terms of Reference for Hospital MPDSR Committee	
Chair	
Vice Chair/Coordinator	
Secretary	
Members	
Links to MPDSR SYSTEM	
From whom you will receive information	
to whom will you send information	
Frequency of meetings	

ICD Classification



Interactive Lecture

Share classification of ICD-MM and ICD –PM using presentation

Ask participants to read Direct and indirect categories of ICD-MM classification table in their manuals

GROUP WORK: 4.1.2

Divide participant in group of 4-5 and ask them to read case studies and solve in 30 minutes.
Once completed discuss the answers with the participants one by one
using presentation

INDIVIDUAL TASK: 4.1.3 Case studies

Divide participant in group of 4-5 and ask them to read case studies and solve in 30 minutes.
Once completed discuss the answers with the participants one by one
using presentation

Case study 1

A 24 year old woman delivered a large healthy baby at home. Two hours after delivery she was bleeding heavily with a fast pulse and low blood pressure. She died four hours after delivery.

- CIRCLE AS APPROPRIATE:

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect?

Q3 Should it be reported to the MDSR committee? Yes / No

Case study 2

A 36 year old woman is known to be about 6 months pregnant with her 5th pregnancy. She experiences dizziness and night sweats, shortness of breath and has been coughing blood stained sputum. The Doctor diagnosed tuberculosis and found she was Hep-B positive. She died at 7 months pregnancy of pneumonia.

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect?

Q3 Should it be reported to the MDSR committee? Yes / No

Case study 3

A 31 year old woman is 38 weeks pregnant with her 4th child. She is on her way to the local town walking along the main road with her children when a bus knocks her down. She is unconscious and dies 4 hours after the accident.

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect?

Q3 Should it be reported to the MDSR committee? Yes / No

It should be notified but not reported

Case study 4

A woman dies very soon after arriving at a health facility. The person accompanying her to the facility reported that she delivered two hours ago and has been bleeding since then, but could provide no further details

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect

Q3 Should it be reported to the MDSR committee? Yes / No

Case study 5

A teenage girl is raped and worries she may be pregnant. Two days after the rape she tells her mother, who gets her some herbal medicine. Four hours after swallowing it she collapses and dies

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect?

Q3 Should it be reported to the MDSR committee? Yes / No

It should be notified but not reported

Case study 6

A para 7 has unprotected sex and misses her next period. A Dai gives her some herbal medicine to cause an abortion. Two days later she starts to bleed and five days after taking the medication she becomes feverish and has a very offensive-smelling vaginal discharge. After another two days she collapses and dies.

Q1. Is this a maternal death? Yes / No / don't know

Q2. If yes, can it be classified as Direct / Indirect?

Q3 Should it be reported to the MDSR committee? Yes / No

Ask Participants to go through MDF 1 Notification Form shared in their manual

GROUP WORK: 4.1.4

FILLING MDF 2

From the clinical case brought by the participants ask each group to simulate Facility Review Committee:

- Transfer raw data from clinical notes to MDF2 – handout 4.1.4
- Using the clinical cases provided complete as much of the form as possible
- Discuss how to fill MDF 2
- Once participants have filled MDF 2 discuss key points

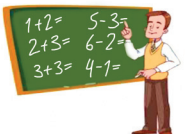
Show presentation for discussing the key points on filling MDF 2

Session 4.2: Conducting MDR

Learning objectives Session 4.2

By end of this session participants will

- Learn the process for conducting MDR
- Get familiar with the GRID for clinical review



Interactive Lecture

Share Presentation 4.2

PROCESS- CONDUCTING MDR

1. Disclaimer form
2. Medical grid for facility review (Handout 4.2.1)
3. Committee worksheet for community review (Handout 4.2.2)

- **Response**
  - Identifying response
  - Prioritizing response
  - Action plan tool
- MDF4 Provincial MDR committee
- Session report Hospital records

Group Work 4.2

Hospital facility MDSR Committee Simulation

Use the case for which you have already filled the MDF2 form

1. 1Divide into groups to simulate a hospital MDSR Committee meeting.
2. Allocate the following roles to group members: Gynaecologist, Lead Midwife, CEO, Medical Director, coordinator, Quality Officer, Anaesthetist.
3. The Medical Director should review the Roles and Responsibilities in the Guidelines
4. The coordinator should present the case to the rest of the committee, which should be followed by committee discussion
5. Ask the participants to fill the Disclaimer Form Handout 4.1
6. As a group, clarify outstanding issues by using the GRID provided (Handout 4.2.1) and complete it
7. Ask each group to present and generate discussion

Session 4.3: Moving to Action Response

Learning objectives Session 4.3

By the end of the session the participants will be able to

- Understand various categories and levels of response
- Identify actions
- Prioritize actions
- Fill the action tool

Share Presentation 4.3

Individual Task 4.3.1 Case work using following case

A 25-year old had her 3rd baby at home. Her first baby died after a difficult delivery. Her second baby was premature and survived. During this pregnancy, she attended antenatal care at the local RHC. She went into labour at term and delivered at home. She started bleeding 1 hour after delivery of a healthy baby. The local LHV came within 1 hour. She found the woman very pale and collapsed and gave her oxytocin and then misoprostol. The LHV suggested moving the woman to the DHQ hospital, an hour away, as the bleeding continued. The husband did not agree and the woman died.

Possible actions

1. 1Ensure iron is available for pregnant women in that Health Centre
2. Increase the number of SBAs in that area
3. Punish the husband
4. Make sure blood transfusion is accessible in that community
5. Commend the SBA for her actions
6. Ensure family planning is available in that community
7. Make sure National guidelines re ANC are available in that health centre
8. Check local EMONC training has been delivered and repeat if necessary
9. Increase community awareness of need for SBA at delivery by supporting delivery of an educational campaign

Exercise 1. Possible Actions

- Work on your own
- Consider the 9 possible actions
- List the 3 possible actions you think would be most effective in this case
- Prepare for discussion

Exercise 2: Once you have identified the actions prioritize them

- Complete the grid (Prioritization)
- Use + to indicate your score for each criteria
- Minimum +
- Maximum +++++
- For each possible action, put a score against the criteria. Be prepared to justify your scores!

Group Work 4.3.2 - Case work

Reshuffle the participants to form different group

A 35-year-old p8 is admitted in a tertiary level hospital. She is full term pregnant and experiencing labour pains for 6 hours. She has received no antenatal care in any of her pregnancies including the current one. On admission at 6am, she was received by the house officer who performed a pelvic examination and thinks the cervix is fully dilated. She asks the nurse to set up an I/V infusion and moves to see another patient. The nurse while setting up the I/V line sends out basic Lab tests. Two hours later the resident TMO takes over the labour ward and on examining the woman diagnosed obstructed labour. A C-section is performed by the TMO, an alive male baby is delivered. Post operatively the patient recovers from anaesthesia but the pulse remains feeble an hour later she is re-examined by the S/R in a routine morning round. She suspects internal bleeding and shifts the patient to the Theatre. She performs a subtotal hysterectomy and requests four units of packed cells. The patient receives one unit of blood and dies 4 hours later. Results of the Investigations sent by the Nurse are received after the death of the patient. All are within normal limits but she is HEP. B positive and her hemoglobin is 7.5

Complete the Action tool 4.3.2

Group Work 4.3.3

- Ask the secretary to fill MDF 4 (Handout 4.3.3) and session report (handout 4.3.4)
- Recap
- MDF4 is to be submitted to provincial MDR committee
- Session report is for hospital record
- One session report is written for each case

Recap MDR Committee meeting

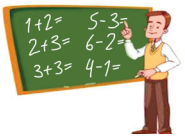
- Chairperson reviews previous case session report and action plan
- Draft disclaimer signatures reminds participants of no name no blame
- Coordinator reads summary
- Participants analyze using medical grid
- Chairperson fills committee worksheet
- Fills action plan
- Secretary fills MDF4 for provincial MDR committee (Handout 4.3.3)
- Secretary fills session report for hospital record (Handout 4.3.4)

Session 4.4: Dissemination of MPDSR Results

Learning objectives of this session

By the end of this session participants will learn

- Factors affecting MDR
- How to disseminate findings of MPDSR
- Format of MPDSR Report



Interactive Lecture

Show presentation 4.4

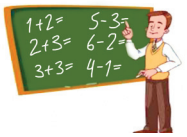
Making Facility MPDSR committees

SUMMARIZE MPDSR using following

Summary of MPDSR

S. No	Steps	Process	Tools to be used/ products developed
1.	Preparing for MDR	Identifying and selecting MDR committee members	– ToRs development for the committee – Disclaimer form to be signed by committee members
		Notification	MDF1
		Data collection	MDF2
2	Conducting MDR	Facility Committee	Grid Analysis MDF4 Session Report
3	Response	Identifying and prioritization followed by action plan	Identifying Prioritization Action tool
4	Way forward	– Secretary fills MDF4 for Provincial MDR committee – Secretary fills session report for Hospital record	MDF4 (Handout 4.4.1) Session report (Handout 4.4.2)
5	Dissemination	Provincial and district	MPDSR Report

Session 4.5: Android Application for Data Collection



Interactive Lecture

Show presentation 4.5

Summary Points Module 4

- MPDSR is a national system, it needs to work as a whole, with close links between each level
- Every province, district, tehsil, hospital, health center and community play an important part in the overall success of MDSR in addressing maternal deaths
- MDSR should improve availability of data, its main purpose is identifying follow-up actions and implementing change
- Better data alone will not reduce maternal deaths

MODULE 5: COMMUNITY REVIEW

Module 1	Introduction
Module 2	Maternal and Perinatal Mortality
Module 3	Overview of MPDSR
Module 4	Facility Review
Module 5	Community Review
Module 6	Perinatal Death Review

You are here

LEARNING OBJECTIVES OF THIS MODULE

By end of this module participants will learn how to conduct community review for maternal death

Sessions		
Session #	**Session Title**	**Time**
5.1	Community Based Maternal and Perinatal Death Review	2 hrs.

SESSION 5.1: COMMUNITY BASED MATERNAL AND PERINATAL DEATH REVIEW

Learning objectives of this session

By end of the session participants will

- Understand how to conduct community bases maternal and perinatal death review

Community based review for maternal and perinatal death

Brainstorming Exercise: 5.1

Ask participants what they understand by community based review for maternal and perinatal death

- **Collect responses and paste on board Read and group their responses**

Recap steps of facility based review of maternal death and share that community based review follows same process

Show presentation 5

Definition

Community-based maternal and perinatal death reviews are also called verbal autopsies. It is a method of determining causes of death that occur outside health facility. It includes identifying two sets of causes that has led to death.

GROUP WORK: 5.1

Community Review using MDF 3

Divide participants in groups of 4-5

- Give them case studies or ask them to bring in their own case studies of community based deaths
- Ask them to fill in MDF 3 HANDOUT 5.1.1 and Committee worksheet 5.1.2

MODULE 6: PERINATAL DEATH REVIEW

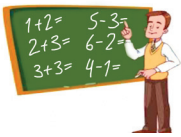
Module 1	Introduction
Module 2	Maternal and Perinatal Mortality
Module 3	Overview of MPDSR
Module 4	Facility Review
Module 5	Community Review
Module 6	Perinatal Death Review

You are here

LEARNING OBJECTIVES OF THIS MODULE

By end of this module participants will learn how to conduct perinatal death review

Sessions		
Session #	**Session Title**	**Time**
6.1	Perinatal Death Review	1 hr. 15 min



Interactive Lecture

Share presentation 6

Perinatal death review

It is a process of collectively reviewing all available information about a stillbirth or a neonatal death and includes trying to arrive at the cause of deaths and analyse the information as to other non-medical factors which could have contributed to the death and if addressed may prevent deaths in the future. Also identify assign and schedule actions to address modifiable factors.

GROUP WORK: 6.1

Perinatal Review using perinatal death review form

Divide participants in groups of 4-5

- Give them case studies or ask them to bring in their own case studies of facility and community based perinatal deaths

Ask them to fill in the form Handout 6.1.1 PDF 1(Notification form) and 6.2.2 PDF 2 (Perinatal Death Revie form facility based) and 6.1.3 PDF 3 (Neonatal Death Data collection form in community

Ask Participants to fill Posttest and training evaluation form

Distribute certificates to the participants

PRE/POST TEST

NAME: **DATE:**

MPDSR Training Pre/Post-Test

For each question, please circle the correct answer

1. MPDSR stands for…?

a. Maternal Perinatal Death System and Response

b. Maternal Perinatal Death Surveillance and Review

c. Maternal Perinatal Death Surveillance and Response

d. Maternal Death Systematic Register

2. What is the most important part of the MPDSR process in order to reduce maternal mortality?

a. Identification

b. The review of the case

c. The analysis of the case

d. The actions

3. Which of these could be a maternal death? Circle ALL those that should be investigated further as potential maternal deaths.

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

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

c. A 16-year-old girl took some medicine two days after her first sexual intercourse because she thought she might be pregnant.

d. A woman, known to be tuberculosis, died of pneumonia. Her family did not know the date of her last period.

4. Reporting a maternal death

a. A maternal death in the Community should be reported to the head of the health center within 24 hours

True False

b. A maternal death in the community should be reported to the head of the health center within 48 hrs.

True False

c. If the death is confirmed to be related to pregnancy a verbal autopsy should be carried out within 3-4 weeks of notification

True False

d. The verbal autopsy should be carried out by the LHW.

True False

5. Facility Level Reviews. Which of the following types of people should be members of a Hospital Review Committee? Circle ALL that apply (1 POINT for each correctly ticked or left blank)

a. Hospital CEO
b. Obstetrician/Gynecologist
c. RMO
d. Ambulance Driver
e. Chief pharmacist
f. Senior Nurse
g. IT in charge
h. Anesthesiologist/Anesthetist
i. Night security guard
j. officer from referring hospital
k. Pediatrician
l. DMS

6. Community level factors affecting maternal deaths. (2.5 points each)

a. Men in Pakistan are traditionally the decision makers in the family. If a husband or other male household head does not believe a pregnant woman is experiencing an emergency, it is likely there will be a delay in seeking care for her

True False

b. Poor understanding of the purpose of antenatal care and its potential to identify health problems reduces appropriate health-seeking behavior during pregnancy

True False

c. Living in the rural areas increases the risk of developing complications during pregnancy

True False

d. If community members who attend delivery are able to correctly recognize danger signs, they can urge the family to seek medical attention quickly

True False

7. Quality of Care factors affecting maternal deaths. (2.5 points each)

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

True False

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

True False

c. As long as a hospital has enough blood, women with PPH will be saved in time

True False

d. The quality of referral systems, admission procedures, and care during recovery should all be considered during MDSR data analysis (in addition to what emergency interventions were provided)

True False

8. Which of the following are social factors that put women at risk of maternal death? (2 points for each correctly ticked or left blank)

a. Fees for public maternity services

b. Dry climate

c. Low use of family planning

d. Ethnic diversity

e. Belief that birth is a natural event that does not require medical intervention

9. Reporting and Data Flow in an MDSR: (2.5 points each)

a. Community deaths will be reviewed by a district committee and death will be notified to the P-MDR-C

True False

b. Hospital deaths will be counted, summarized and sent to the district MDR-C to identify changes that are required at the facility.

True False

c. All review committees should meet monthly and submit a report, even if NO maternal deaths have occurred during that time period.

True False

d. A Facility review committee notices that one OB/UNIT has not reported a single maternal death for over one year. They should celebrate the fact that all maternal deaths have been prevented in that Unit.

True False

10. Which of the following are appropriate actions that might be taken by a Hospital review committee?

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

True False

b. Allocate more staff to the post-obstetric surgery recovery room

True False

c. Appoint a referrals officer to liaise with Health Centers.

True False

d. Punish the house-officer who was on duty during the time of the last death

True False

e. Ensure a partograph is available for every birth and provide refresher training to staff on how to use it

True False

TRAINING EVALUATION FORM

Training Title: MPDSR training _____

Date Attended: _____

Please select the rating for each section based on the following criteria:

5=excellent 4=good 3=average 2=fair 1=poor

Please rate the trainer(s) on the following:

1. Knowledge of the subject matter. ☐5 ☐4 ☐3 ☐2 ☐1
2. Ability to explain and illustrate concepts. ☐5 ☐4 ☐3 ☐2 ☐1
3. Ability to answer questions completely. ☐5 ☐4 ☐3 ☐2 ☐1

Open-ended comments (use the back if you need more space):

4. What specifically did the trainer do well?

5. What recommendations do you have for the trainer to improve?

Please rate the content and structure of the training:

6. The usefulness of the information received in training. ☐5 ☐4 ☐3 ☐2 ☐1
7. The structure of the training session(s). ☐5 ☐4 ☐3 ☐2 ☐1
8. The pace of the training session(s). ☐5 ☐4 ☐3 ☐2 ☐1
9. The convenience of the training schedule. ☐5 ☐4 ☐3 ☐2 ☐1
10. The usefulness of the training materials. ☐5 ☐4 ☐3 ☐2 ☐1

11. Was this training appropriate for your level of experience?

Yes No

If you said "No" to #11, please explain:

Open-ended comments (use the back if you need more space):

12. What did you most like about the training?

13. What can be improved with regard to the structure, format, and/or materials?

Your Name: _____ (Optional)

Your Department: _____ (Optional)

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