Maternal and Perinatal Death Surveillance and Response (MPDSR) in Bangladesh

Progress and Highlights in 2023

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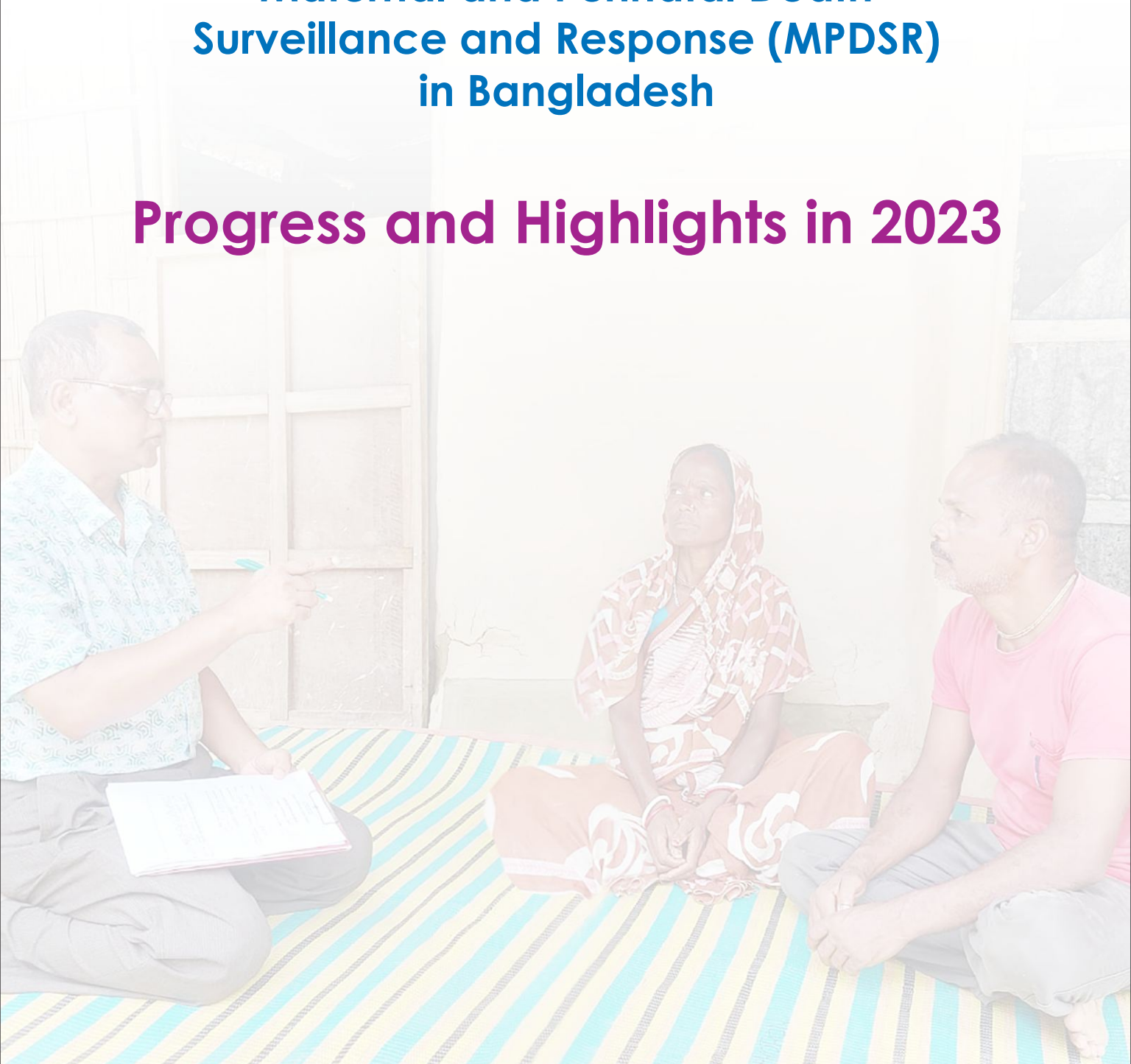

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Content

Abbreviations

AHI	Assistant Health Inspector
ANC	Antenatal Care
CG	Community Group
CHCP	Community Health Care Provider
CSG	Community Support Group
EmONC	Emergency Obstetric and Newborn Care
FDR	Facility Death Review
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HI	Health Inspector
HMIS	Health Management Information System
HNPSP	Health, Nutrition and Population Sector Programme
IMCI	Integrated Management of Childhood Illness
MCWC	Mother and Child Welfare Center
MDGs	Millennium Development Goals
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MNHI	Maternal and Neonatal Health Initiative
MoHFW	Ministry of Health and Family Welfare
MPDR	Maternal and Perinatal Death Review
MPDSR	Maternal and Perinatal Death Surveillance and Response
NGO	Non-Government Organization
NMR	Neonatal Mortality Rate
PNC	Postnatal Care
RCH	Reproductive and Child Health
RMO	Resident Medical Officer
SA	Social Autopsy
SBA	Skilled Birth Attendant
ToT	Training of Trainers
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Center
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VA	Verbal Autopsy
WHO	World Health Organization

Executive Summary

Bangladesh launched the Maternal and Perinatal Death Review (MPDR) system in 2010 with the objective of achieving the Millennium Development Goal targets for reducing maternal mortality by 2015. The MPDR system was piloted from 2010 to 2015, initially covering 10 out of the country's 64 districts. Drawing on implementation lessons and international guidelines, the program was updated and renamed as the Maternal and Perinatal Death Surveillance and Response (MPDSR) system in 2016. It was integrated into the government's routine program and gradually expanded its geographic coverage, reaching all 64 districts by 2023.

UNFPA, UNICEF, and WHO Bangladesh, along with other development and implementing partners, have been significant technical collaborators with the Government and Ministry of Health and Family Planning, supporting the nationwide implementation of MPDSR. Their collaborative efforts include resource allocation, training of health workers, enhancing of existing MPDSR practices and service delivery, and the promotion of quality care at health facilities.

The MPDSR system focuses on reporting and investigating the causes of maternal and perinatal deaths occurring in both the community and health facilities. Verbal autopsies and facility death reviews are conducted to analyze selected cases, with data that is entered into the government's District Health Information System-2 (DHIS-2). The availability of MPDSR data through DHIS-2 facilitates the calculation of maternal mortality ratios, neonatal mortality rates, and the exploration of socio-demographic factors, care-seeking behaviors, and causes of these deaths. The goal is to learn from these cases and develop response and improvement plans to prevent similar incidents in the future.

The MPDSR approach in Bangladesh prioritizes anonymity, non-blaming, and non-punitive actions, encouraging participation at all levels in identifying and reviewing maternal and neonatal deaths and stillbirths. It employs an evidence-based approach that examines health systems and social factors contributing to these deaths through a systematic process. The system has helped identify vulnerable areas with high maternal and neonatal mortality rates, enabling health managers to monitor district-specific maternal mortality ratios (MMR), stillbirth ratios (SBR), and neonatal mortality rates (NMR).

In 2023, the Government of Bangladesh finalized revised national MPDSR guidelines and tools, including a stillbirth review component aligned with global MPDSR implementation guidelines. A technical working group developed a video toolkit, and training sessions were conducted for healthcare providers and district managers on MPDSR performance reviews, cause analysis, and the development of response plans. Monitoring of MPDSR implementation occurred through national-level video conferences, and virtual orientations were provided to district MPDSR focal persons and managers on cause analysis and the development of response plans. Additionally, an operational guideline and implementation plan for near-miss maternal (MNM) studies were developed to enhance maternal healthcare at facilities, with the support of DGHS and development partners.

Background

The Maternal and Perinatal Death Surveillance and Response (MPDSR) in Bangladesh is a comprehensive framework that addresses both community and facility deaths. Notifications of maternal deaths, neonatal deaths or stillbirths are made by the field-level government health care providers in the community and by the senior staff nurses in healthcare facilities. Maternal and Perinatal Death Review is essential for policymakers, healthcare workers, and community members to learn from tragic, often preventable events. Its aim is to improve the quality of safe motherhood programs and prevent future maternal and neonatal morbidity and mortality.

Before 2010, Bangladesh's health system lacked a comprehensive death review system for maternal deaths and also did not possess proper registration and notification processes for deaths. To fill these gaps, Bangladesh adopted the Maternal and Perinatal Death Review (MPDR) approach from WHO's "Beyond the Numbers" initiative, piloting it in one district to assess its effectiveness in reducing maternal and perinatal deaths. Learning from this pilot district, the Directorate General of Health Services (DGHS) gradually expanded the program nationwide in 2016. The Ministry of Health and Family Welfare (MOHFW) developed national guidelines, a National Training of Trainers (ToT) manual, a pocket handbook for health workers, and other tools to strengthen the capacity of stakeholders and key actors involved in the MPDSR implementation.

According to the 2022 report from Bangladesh Sample Vital Statistics, the maternal mortality ratio (MMR) in Bangladesh was estimated to be 156 per 100,000 live births, while the neonatal mortality rate (NMR) was 17 deaths per 1,000 live birth. The new Sustainable Development Goal (SDG) 3 sets ambitious targets, requiring Bangladesh to reduce the MMR to less than 70 per 100,000 live births and neonatal deaths to fewer than 12 per 1,000 live births by 2030.

In Bangladesh, a woman's journey through pregnancy and childbirth is often fraught with suffering and challenges. When a mother dies during childbirth, she misses the chance to witness the beauty of the world and share her story. However, her tragic experience provides critical information that can save countless lives. Understanding where, when, how, and why a mother or newborn died can unlock the key to preventing future deaths. By leveraging this vital information, targeted interventions can be designed and implemented to alleviate the burden of maternal and neonatal mortality.

Aligned with WHO's Maternal Death Surveillance and Response (MDSR) global Technical Guidance published in 2021, efforts have been made to update the MPDR guidelines, placing greater emphasis on surveillance and response, including the review of stillbirths within the existing system. By the end of 2023, the MOHFW has expanded the initiative to all 64 districts with technical support from UNFPA, UNICEF, WHO, and other development and implementation partners.

In 2023, a technical working group was formed to revise the national guidelines, incorporating stillbirth-related information. Despite the challenges posed by the pandemic, this report highlights the progress made in 2023 and acknowledges the key achievements and significant activities carried out under the MPDSR program.

MPDSR at a Glance in Bangladesh

The MPDSR program in Bangladesh functions as a comprehensive system, addressing maternal and perinatal deaths at both community and facility levels. Field-level government healthcare providers in the community, as well as senior staff nurses in healthcare facilities, use datasheets to report any maternal, neonatal deaths, or stillbirths. This data is then uploaded to the DHIS-2 database from community clinics, Upazila Health Complexes (UHCs), and government district hospitals.

To further investigate these cases, health supervisors at the community level review all maternal deaths and 10% of neonatal deaths using a verbal autopsy form. Additionally, they conduct community-based social autopsies for maternal and neonatal deaths to understand the underlying social causes and raise community awareness to prevent future deaths. At the facility level, nurses and midwives, with support from doctors and consultants, conduct facility death reviews using specific facility death review forms.

Cause assignment based on the community verbal autopsy is conducted at the divisional or district level and then uploaded to DHIS-2. For facility deaths, nurses enter the causes of death into DHIS-2. Quality Improvement Committees are established at the sub-district, district, and divisional levels to regularly discuss MPDSR findings, monitor progress, and develop action plans based on identified issues. These action plans are then implemented in the field. MPDSR focal persons are appointed at the sub-district and district levels to oversee the overall implementation of MPDSR in their respective areas. At the facility level, MPDSR sub-committees operate in UHCs and district hospitals, reviewing facility deaths and devising action plans to improve facility operations and quality of care. MPDSR is routinely discussed in monthly coordination meetings at the district and sub-district levels.

The MPDSR National Committee serves as the central platform for reviewing, discussing, and developing national action plans for MPDSR implementation across the country. The Quality Improvement Secretariat of the Ministry of Health and Family Welfare (MoHFW) ensures the quality aspects of MPDSR, including monitoring. Overall, this structured system ensures that maternal and perinatal deaths are comprehensively reviewed, with actions taken at various levels to improve the quality of care and prevent future deaths.

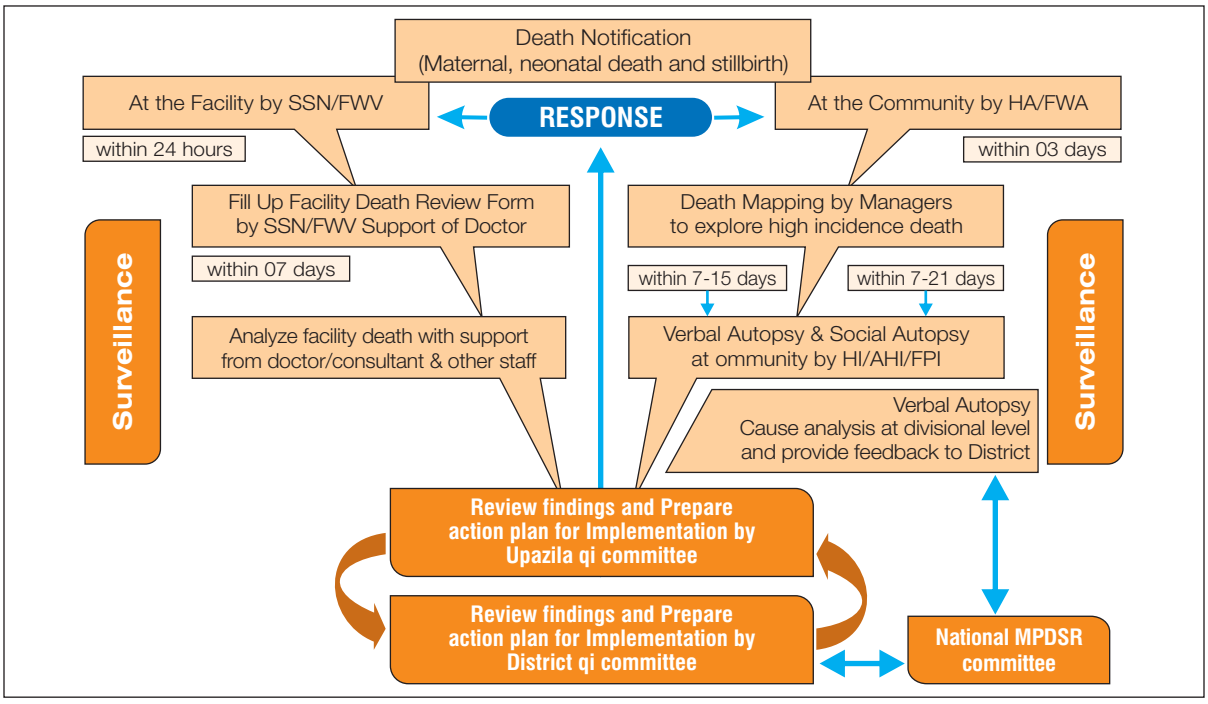

Figure 1: MPDSR Implementation Framework

Scaling-up of MPDSR in Bangladesh: 2023

Since its initial piloting in 2010 in the Thakurgaon district, Bangladesh has progressively scaled up the MPDSR program based on the experiences gained. By 2023, the program had expanded to cover all 64 districts in the country, encompassing over two-thirds of the population. This extensive scale-up was made possible with the support of UNICEF, UNFPA, WHO, and other development partners.

In 2022, the Government of Bangladesh finalized the revised national MPDSR guideline and tools, ensuring a standardized approach across the country. A technical working group was formed to create a video toolkit on MPDSR, providing valuable resources for implementation. Additionally, 12 districts developed their MPDSR action plans in 2022, detailing specific strategies for improving maternal and perinatal health.

To monitor progress and ensure effective implementation, eight national-level video conferences were organized in 2022. These conferences served as platforms for monitoring and discussion. Furthermore, MPDSR focal persons and district managers from 29 districts received virtual orientation on conducting cause analysis for MPDSR cases and developing response plans, enhancing their capacity to address maternal and perinatal deaths.

In terms of support from development partners, UNICEF is currently assisting the MPDSR program in 22 districts, while UNFPA collaborates with UNICEF in 10 of those districts. Additionally, UNFPA is providing technical support to MPDSR in 18 more districts. The combined efforts of these organizations contribute to the successful implementation and continuous improvement of the MPDSR program in Bangladesh.

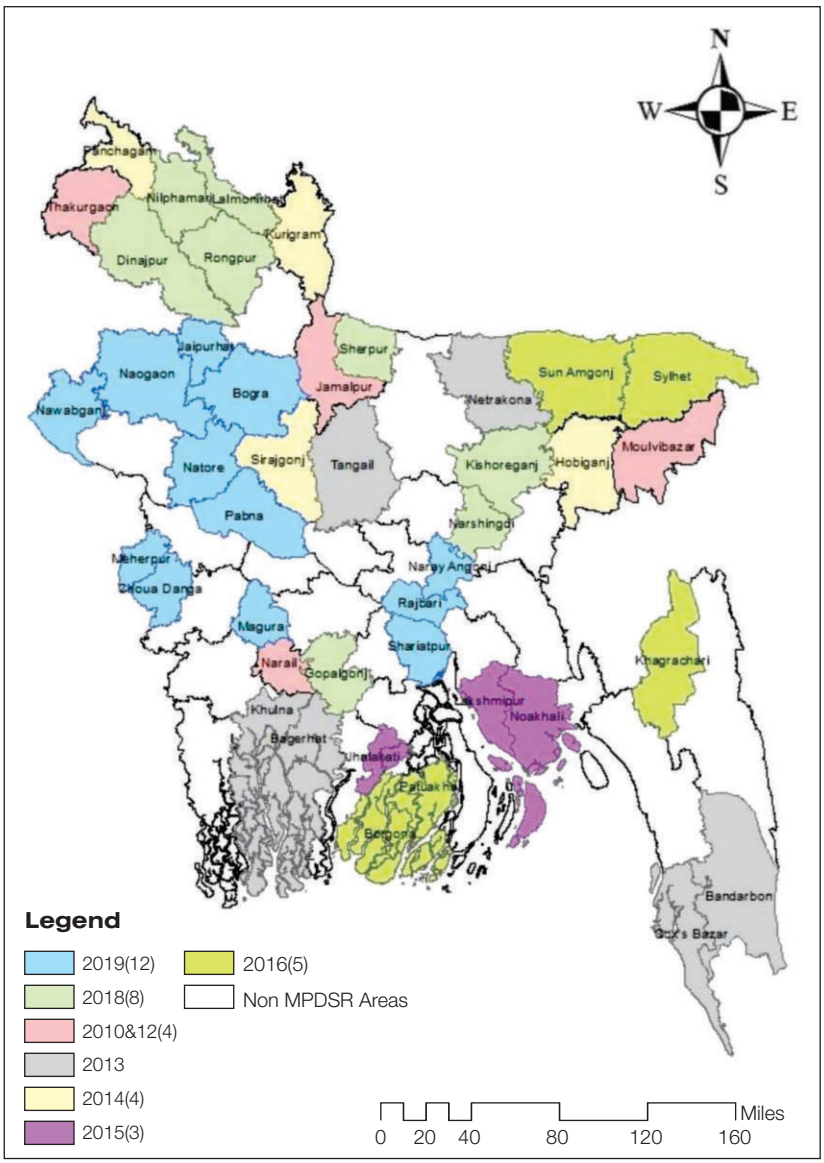

Figure 2: MPDSR Implementation Districts by Year

MPDSR Community Death Review

Field-level healthcare providers, such as health assistants and family welfare assistants, were instrumental in notifying and reporting maternal and perinatal deaths within the community via the DHIS-2 platform.

Maternal death review at the community

Among the reported maternal deaths in 2023, 64 districts reported 1893 maternal deaths, of which 597 deaths were reviewed at community (29% of the notified maternal deaths). As per the below table, in 2023, the highest number of (93) maternal deaths were reported in Chandpur district, 90 deaths were reported in Sunamganj, and 84 deaths were reported in Kurigram [Table 1].

Table 1: Distribution of maternal deaths reported and reviewed by districts in the community

District	Community Maternal Death		
	Death notified	Death reviewed	% of death reviewed
Bagerhat	26	10	38%
Bandarban	9	3	33%
Borguna	22	5	23%
Barisal	44	12	27%
Bhola	29	9	31%
Bogra	33	23	70%
Brahmanbaria	67	2	3%
Chandpur	93	2	2%
Chapai Nababganj	8	1	13%
Chittagong	34	2	6%
Chuadanga	2	0	0%
Comilla	48	37	77%
Coxs Bazar	45	34	76%
Dhaka	48	9	19%
Dinajpur	30	3	10%
Faridpur	7	0	0%
Feni	9	4	44%
Gaibandha	18	10	56%
Gazipur	35	22	63%
Gopalganj	6	1	17%
Habiganj	44	10	23%
Jamalpur	36	11	31%
Jessore	57	4	7%
Jhalokati	9	1	11%
Jhenaidaha	10	2	20%
Joypurhat	7	1	14%
Khagrachhari	8	5	63%

District	Community Maternal Death		
	Death notified	Death reviewed	% of death reviewed
Khulna	25	5	20%
Kishoreganj	61	21	34%
Kurigram	84	19	23%
Kustia	10	0	0%
Laksmipur	19	1	5%
Lalmonirhat	38	23	61%
Madaripur	10	0	0%
Magura	11	2	18%
Manikganj	19	1	5%
Maulavi Bazar	57	18	32%
Meherpur	34	1	3%
Munshiganj	11	5	45%
Mymensingh	64	4	6%
Naogaon	11	0	0%
Narail	5	1	20%
Narayanganj	49	4	8%
Narshingdi	19	9	47%
Natore	4	2	50%
Netrokona	51	13	25%
Nilphamari	22	8	36%
Noakhali	57	37	65%
Pabna	16	10	63%
Panchagarh	16	6	38%
Patuakhali	40	15	38%
Pirojpur	8	3	38%
Rajbari	4	0	0%
Rajshahi	10	1	10%
Rangamati	3	1	33%
Rangpur	22	11	50%
Satkhira	25	8	32%
Shariatpur	13	0	0%
Sherpur	26	9	35%
Sirajganj	54	39	72%
Sunamganj	90	45	50%
Sylhet	69	34	49%
Tangail	41	16	39%
Thakurgaon	11	2	18%
Total	**1893**	**597**	**29%**

Neonatal death review at the community

Among the neonatal deaths reported in 2023 in Bangladesh, 64 districts reported 9318 neonatal deaths, and 1922 of these deaths were reviewed at the community level (19% of the notified neonatal deaths). Among the districts, Thakurgaon reported 669 neonatal deaths, Tangail reported 438 neonatal deaths, Sylhet reported 420 neonatal deaths, and Sunamganj reported 411 neonatal deaths [Table 2].

Table 2: Distribution of neonatal deaths reported and reviewed by districts in the community

District	Community Neonatal Death		
	Death notified	Death reviewed	% of death reviewed
Bagerhat	139	21	15%
Bandarban	15	1	7%
Borguna	54	11	20%
Barisal	118	40	34%
Bhola	68	24	35%
Bogra	80	43	54%
Brahmanbaria	411	3	1%
Chandpur	161	0	0%
Chapai Nababganj	53	2	4%
Chittagong	337	10	3%
Chuadanga	116	0	0%
Comilla	152	83	55%
Coxs Bazar	213	153	72%
Dhaka	333	58	17%
Dinajpur	183	13	7%
Faridpur	36	0	0%
Feni	64	4	6%
Gaibandha	180	17	9%
Gazipur	256	106	41%
Gopalganj	3	1	33%
Habiganj	262	31	12%
Jamalpur	183	26	14%
Jessore	293	7	2%
Jhalokati	29	6	21%
Jhenaidaha	58	2	3%
Joypurhat	47	6	13%
Khagrachhari	22	8	36%
Khulna	179	20	11%

District	Community Neonatal Death		
	Death notified	Death reviewed	% of death reviewed
Kishoreganj	172	55	32%
Kurigram	296	142	48%
Kustia	157	4	3%
Laksmipur	55	8	15%
Lalmonirhat	420	32	8%
Madaripur	11	0	0%
Magura	62	0	0%
Manikganj	66	0	0%
Maulavi Bazar	337	50	15%
Meherpur	84	0	0%
Munshiganj	76	5	7%
Mymensingh	337	0	0%
Naogaon	77	2	3%
Narail	49	6	12%
Narayanganj	24	2	8%
Narshingdi	46	8	17%
Natore	51	2	4%
Netrokona	134	23	17%
Nilphamari	180	10	6%
Noakhali	223	105	47%
Pabna	36	10	28%
Panchagarh	40	14	35%
Patuakhali	164	41	25%
Pirojpur	8	0	0%
Rajbari	135	0	0%
Rajshahi	77	14	18%
Rangamati	5	5	100%
Rangpur	94	37	39%
Satkhira	149	43	29%
Shariatpur	61	0	0%
Sherpur	64	25	39%
Sirajganj	669	381	57%
Sunamganj	438	63	14%
Sylhet	203	86	42%
Tangail	228	43	19%
Thakurgaon	45	10	22%
Total	**9318**	**1922**	**19%**

Review findings of maternal and neonatal deaths

In 2023, among the 1,893 maternal deaths reported across 64 districts in Bangladesh, 597 were reviewed using verbal autopsies at the community level. In contrast, out of 9,318 neonatal deaths reported in the same year, 1,922 were reviewed at the community level. For detailed casual analysis, 397 maternal deaths and 593 neonatal cases from 12 districts were randomly selected for in-depth review.

Cause assignment of maternal death

Out of the 554 maternal deaths reported, 397 cases from 12 districts were reviewed in 2023. These cases which were analyzed to identify underlying causes, location and time of death, gestational week, antenatal care and postnatal care status, mode of delivery, delivery outcome and period of death.

The distribution of the 397 cases reviewed included 42 from Sirajganj, 14 from Moulvibazar, 86 from Sunamganj, 14 from Habiganj, 60 from Sylhet, 36 were from Jamalpur, 24 from Borguna, 33 from and 36 from Noakhali districts.

Cause of maternal death in 64 districts as DHIS-2

According to the 2023 DHIS-2 report, Postpartum Hemorrhage (PPH) was the leading cause of maternal mortality, accounting for 41.8% of cases. Eclampsia was responsible for approximately 16.7% of maternal deaths, while prolonged labor accounted for 7.9%. Other obstetric traumas, such as uterine rupture, caused about 5.2% of the deaths (Figure 3).

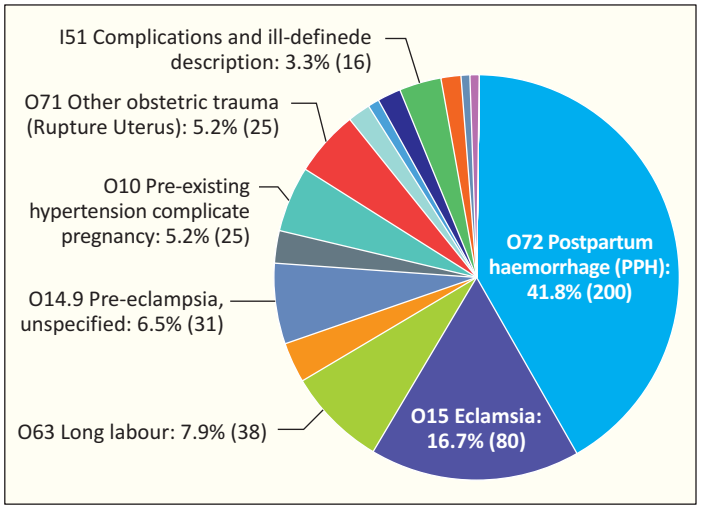

Figure 3: Cause of maternal death in 64 districts

Cause of maternal death in 20 selected districts

In these districts, Postpartum hemorrhage (PPH) was the primary cause of maternal death, representing 51.9% of the cases. Eclampsia caused around 20.1% of maternal deaths and obstructed labor was responsible for 2.1%. Anemia accounted for 10.5% of the deaths, hemorrhage in early pregnancy for 4.2%, puerperal sepsis for 2.9%, and 7.9% due to pre-eclampsia (see Figure 4).

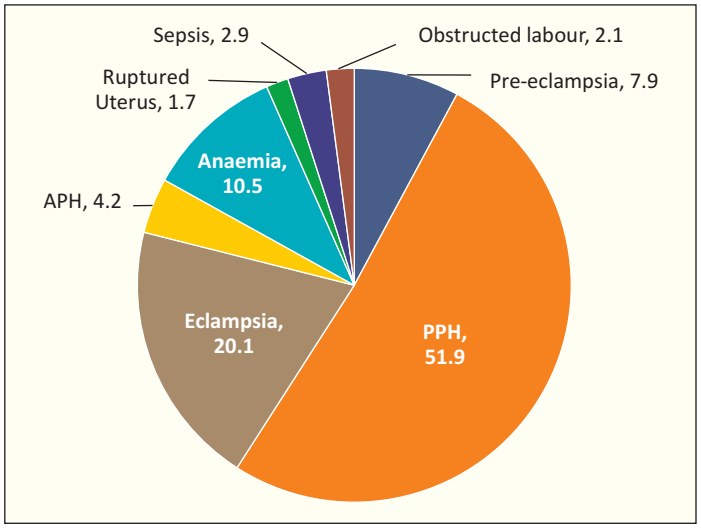

Figure 4: Causes of maternal deaths

Place of death

The chart shows the distribution of maternal deaths by place of occurrence. Approximately 21.4% of maternal deaths happened at home, 22.4% occurred while en route to health facilities, and the remaining deaths took place at various healthcare facilities. Specifically, 32.3% of maternal deaths occurred at medical college hospitals, 16.9% at private facilities, 3.4% at district hospitals, 3.1% at UHCs, and 0.5% at MCWCs. (see Figure 5).

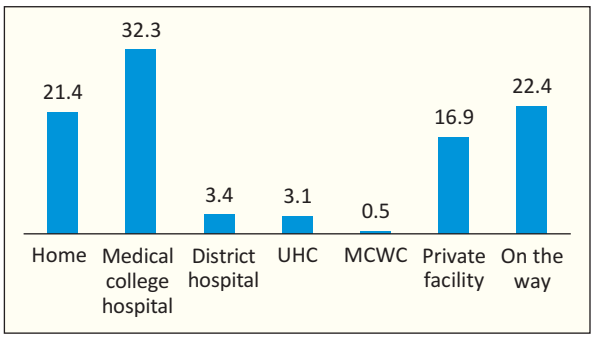

Figure 5: Places of maternal deaths occurred

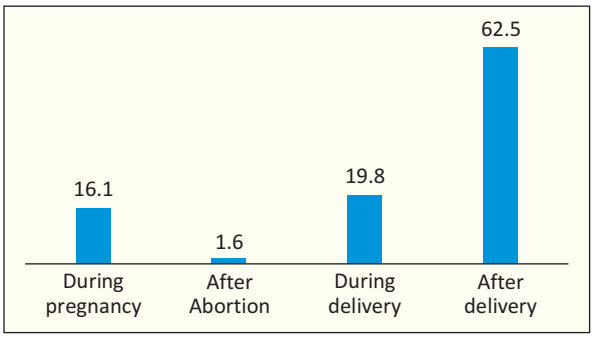

Figure 6: Time of maternal deaths occurred

Time of deaths

The chart illustrates the timing of maternal deaths. Approximately 62.5% of maternal deaths occurred within 42 days after delivery, 19.8% during delivery, and 16.1% during pregnancy. Additionally, 1.6% of maternal deaths happened after abortion (see Figure 6).

Gestational week

The chart depicts the gestational age at which maternal deaths occurred. A significant number of maternal deaths (40%) happened between 37-39 weeks of pregnancy. Additionally, 27.9% of maternal deaths occurred between 33-36 weeks, 13% within 28 weeks of pregnancy, 8.9% between 29-32 weeks, and 10.2% between 40-42 weeks. (see Figure 7).

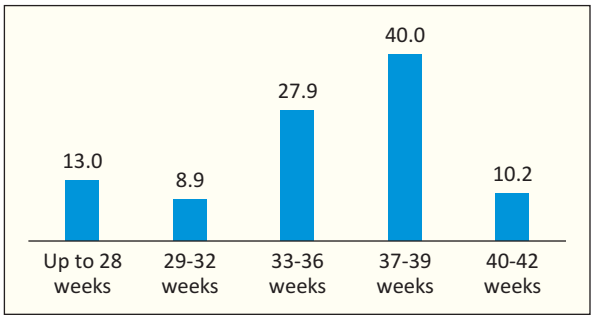

Figure 7: Gestational week of the mothers died

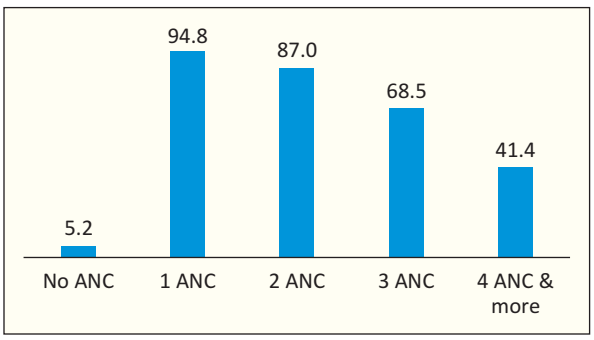

Figure 8: Antenatal care status of deceased mothers

Antenatal care (ANC)

Around 41.4% of the mothers had four or more antenatal care (ANC) visits before death. While 94.8% had at least one ANC visit, 87% had two visits, and 68.5% had three visits. Approximately 5.2% of the mothers did not receive any ANC visit before death (see Figure 8).

Postnatal care (PNC)

Around 35% of the mothers did not receive any postnatal care (PNC) before death. Approximately 65% received only one PNC visit, and 31.2% received two PNC visits before death (see Figure 9).

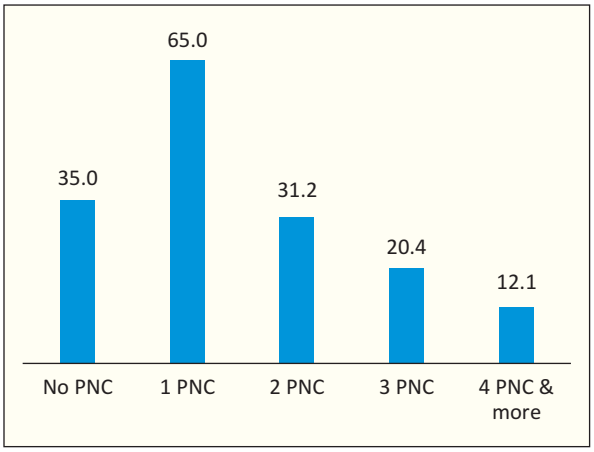

Figure 9: Postnatal care status of deceased mothers

Mode of delivery

Approximately 61.5% of the deliveries were normal vaginal deliveries (NVD), while 38.5% were cesarean section cases (see Figure 10).

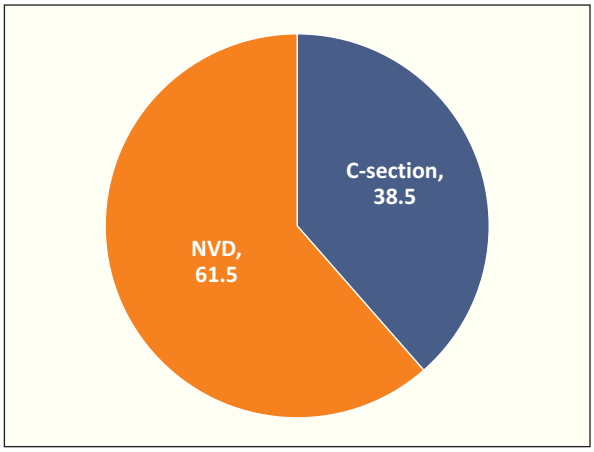

Figure 10: Mode of delivery of deceased mothers

Delivery outcome

Among the maternal death cases, 51.7% of the mothers delivered live births, while 13.7% of them had stillbirths (see Figure 11).

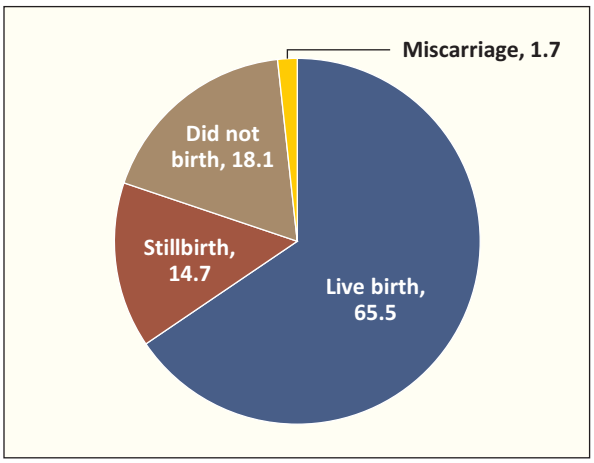

Figure 11: Delivery outcomes of deceased women

Place of delivery

Approximately 38% of the deliveries took place at home, 30.3% at private clinics and hospitals, and 20.4% at medical college hospitals (see Figure 12).

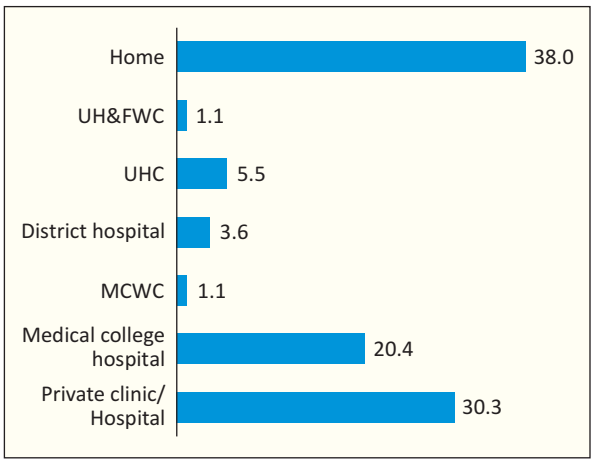

Figure 12: Place of delivery of deceased mothers

Delivery outcome

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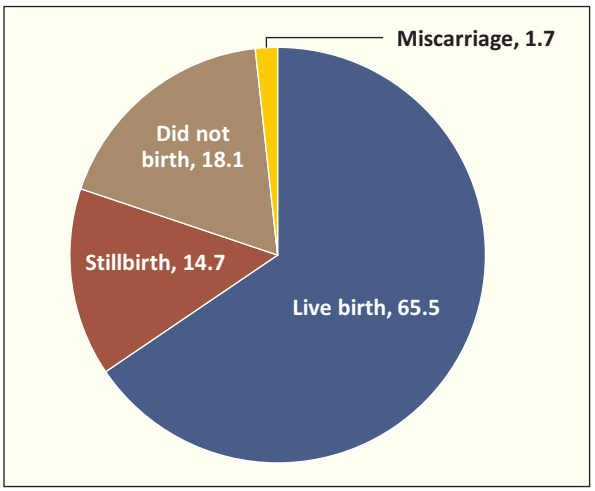

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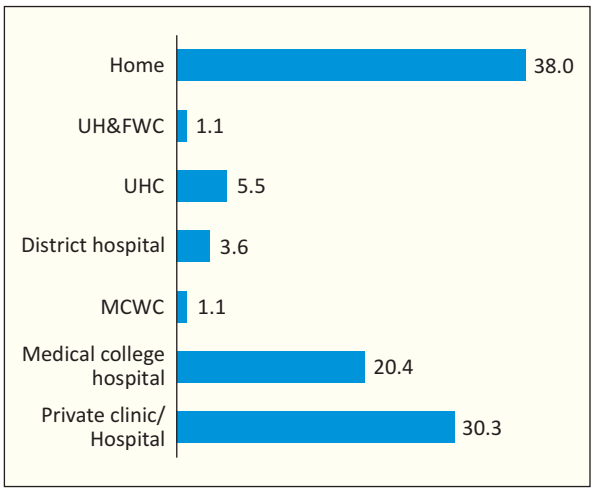


Figure 12: Place of delivery of deceased mothers

Person assisted delivery

Among the maternal deaths post-delivery, 13.9% of deliveries were conducted by Traditional Birth Attendants (TBA), 50.4% by MBBS doctors, and 30% were assisted by nurses and midwives (see Figure 13).

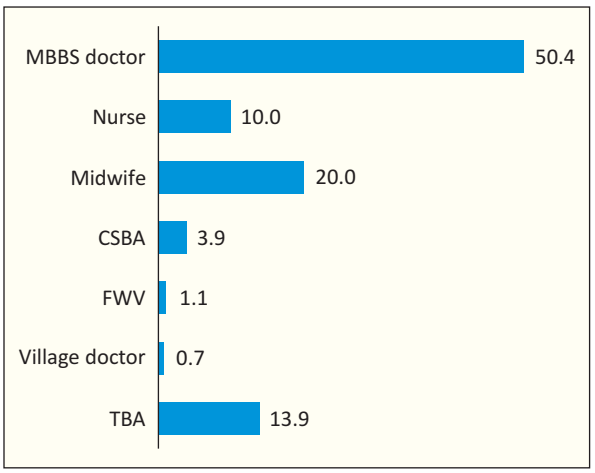


Figure 13: Person assisted delivery of deceased mothers

Maternal age distribution

Approximately 50.8% of the maternal deaths occurred in mothers aged 20-29 years, about 40.3% occurred in the 30-39 years age range and 6.1% of the deaths occurred in adolescents (see Figure 14).

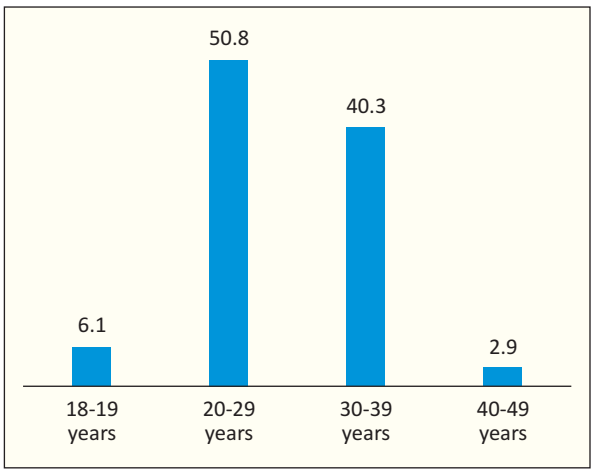


Figure 14: Maternal age distribution of deceased mothers

Time of death after delivery

More than 40.9% of the deaths occurred within 6 hours after delivery, 9.4% occurred between 7-12 hours after delivery and about 83.8% occurred within 7 days after delivery (see Figure 15).

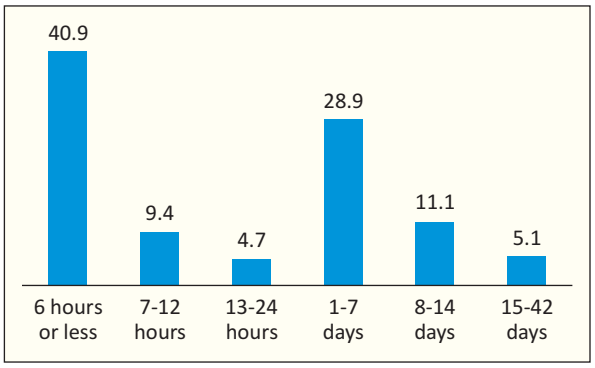


Figure 15: Time of maternal deaths occurred after delivery

Cause assignment of Neonatal deaths

Out of the 3,075 neonatal deaths reported in 2023 from 12 districts, 924 cases were reviewed. Of these, 593 neonatal cases were selected for causal analysis. The breakdown of the 593 reviewed cases includes 176 from Sylhet, 117 from Sunamganj, 76 from Habiganj, 58 from Borguna, 136 from Noakhali, and 30 from Jamalpur. The analysis focused on identifying the cause of death, place of death, antenatal care received, mother's age, neonatal danger signs, and congenital anomalies.

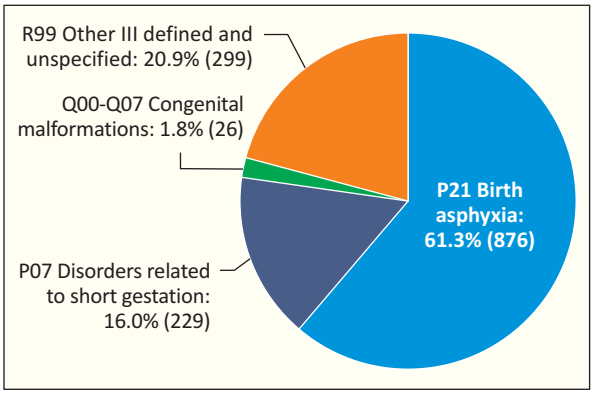


Figure 16: Cause of neonatal death in 64 districts

Cause of neonatal deaths in 64 districts According to DHIS-2

The 2023 DHIS-2 report highlights that Birth Asphyxia was identified as the leading cause of neonatal mortality, accounting for 61.3% of cases. Disorders related to short gestation were responsible for approximately 16% of deaths, congenital malformations caused 1.8% and 20.9% of neonatal deaths were due to other defined and unspecified reasons (Figure 16).

Cause of neonatal death in 12 selected districts

In these districts, Birth asphyxia was identified as the primary cause of neonatal death, constituting 37.1% of the cases. Pneumonia accounted for 27.4% of deaths, and low birth weight was the cause in 24% of cases. (see Figure 17).

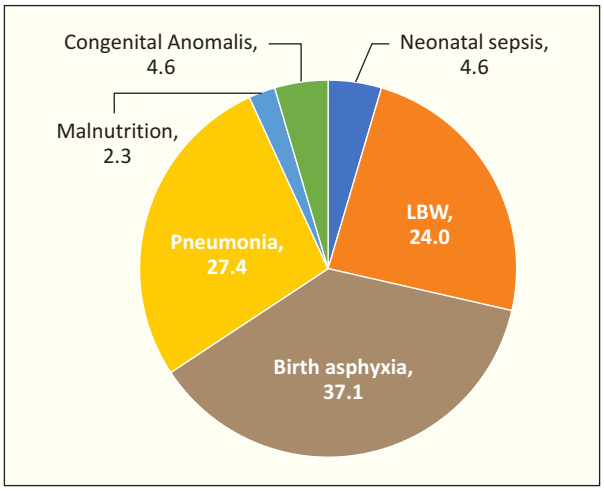


Figure 17: Causes of neonatal deaths

Place of death

Approximately 42.9% of neonatal deaths occurred at home, 29% happened at private clinics/hospitals,4.1% of the deaths took place at medical college hospitals, and 6.3% ensued at district hospitals (see Figure 18).

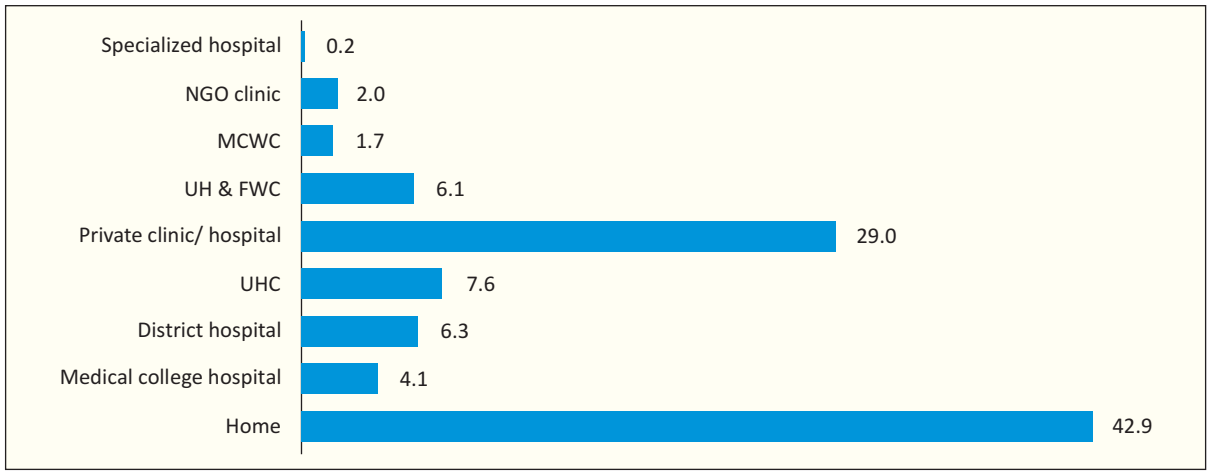


Figure 18: Place of neonatal deaths occurred

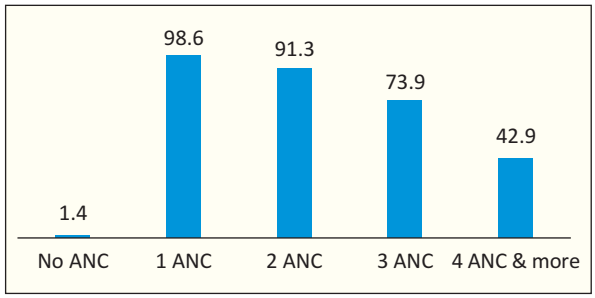


Figure 19: Antenatal care received by mothers of deceased neonates

Antenatal care

Among the mothers of deceased neonates, 42.9% had made four ANC visits, 73.9% made three visits, 91.3% made two visits, and 98.6% made at least one ANC visit. Only 1.4% of the mothers did not receive any ANC (see Figure 19).

Newborn danger sign

Around 26.5% of the newborns showed reluctance to feeding or did not receive food before death. Approximately 13% exhibited a lack of movement or no movement, and 26.4% had rapid breathing (see Figure 20).

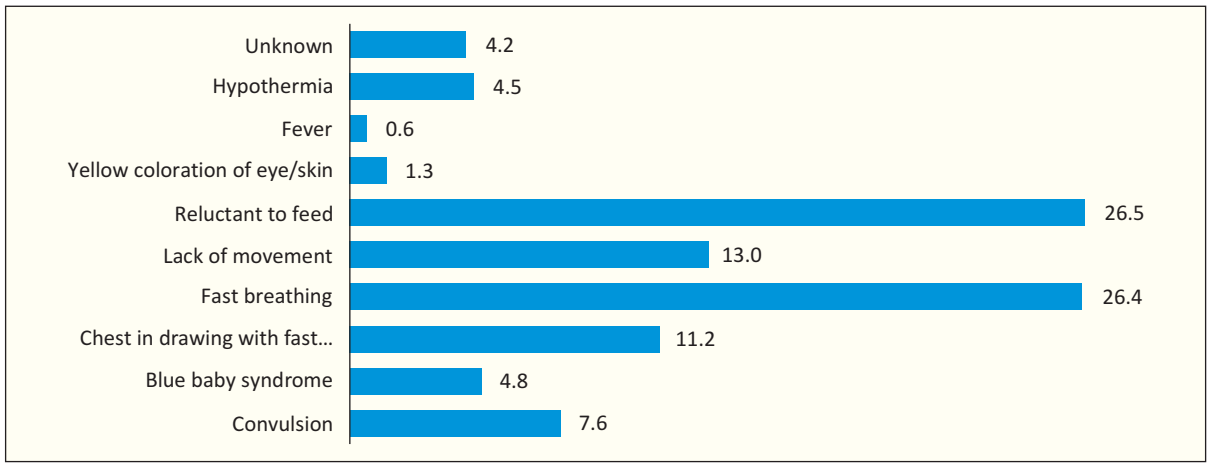
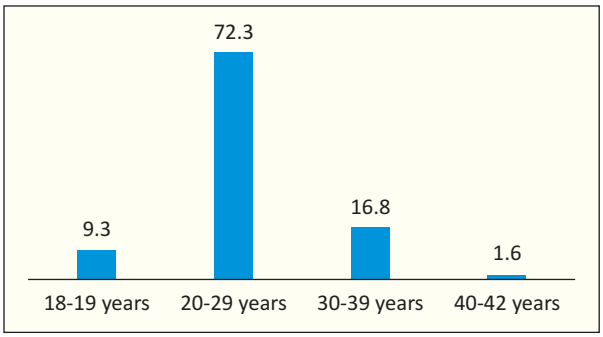


Figure 20: Neonatal danger sign



Mothers' Age

The majority of the mothers of the deceased, 72.3% were aged 20-29 years, while 16.8% were between 30-39 years of age (see Figure 21).

Figure 21: Mothers' age of deceased neonates

Congenital Anomalies

Approximately 83.3% of the newborns were born without congenital anomalies. However, 2.4% had some form of defect in the head, and 0.9% had a defect in either the leg, cleft palate, or anus (see Figure 22).

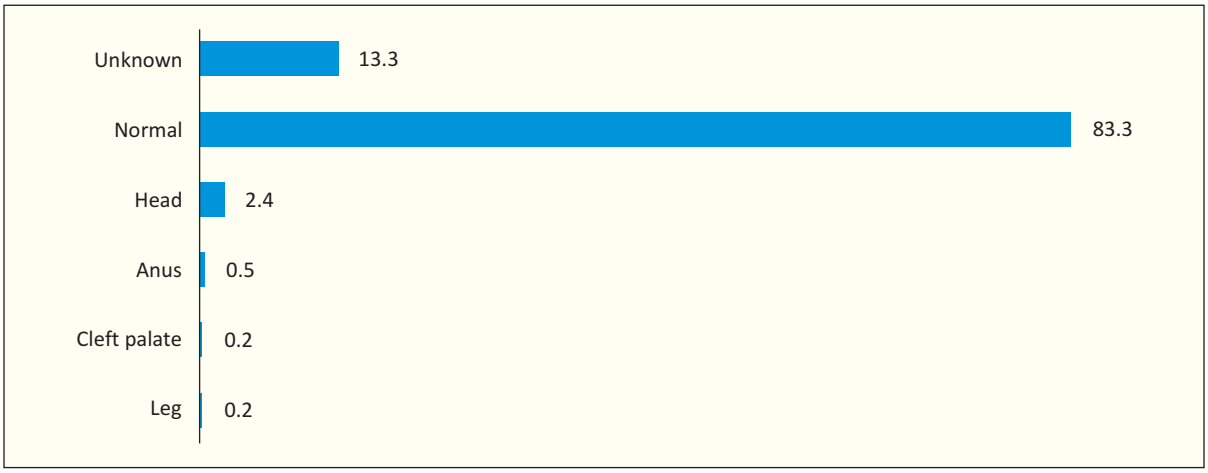


Figure 22: Congenital anomalies of deceased neonates

MPDSR Facility Death Review

The following chapter discusses an overview of maternal and neonatal deaths notifications at the facility level, as reported in DHIS-2 in 2023.

District-wise maternal deaths notified and reviewed at health facilities in 2023

The data reveals that in 2023, 340 maternal deaths were reported and 402 were reviewed at health facilities across 64 districts, 43% of the notified deaths were thoroughly examined [Table 3].

Table 3: Distribution of maternal deaths reported and reviewed by districts at facility.

District	Facility Maternal Death		
	Death notified	Death reviewed	% of death reviewed
Bagerhat	2	1	50%
Bandarban	1	1	100%
Borguna	1	1	100%
Barisal	0	5	0%
Bhola	7	7	100%
Bogra	62	62	100%
Brahmanbaria	4	10	250%
Chandpur	0	0	0%
Chapai Nababganj	0	0	0%
Chittagong	2	2	100%
Chuadanga	0	0	0%
Comilla	16	16	100%
Coxs Bazar	10	12	120%
Dhaka	4	20	500%
Dinajpur	11	11	100%
Faridpur	14	9	64%
Feni	1	1	100%
Gaibandha	2	2	100%
Gazipur	1	0	0%
Gopalganj	5	21	420%
Habiganj	8	9	113%
Jamalpur	5	5	100%
Jessore	19	0	0%
Jhalokati	0	0	0%
Jhenaidaha	1	1	100%
Joypurhat	2	2	100%
Khagrachhari	8	7	88%

District	Facility Maternal Death		
	Death notified	Death reviewed	% of death reviewed
Khulna	0	7	0%
Kishoreganj	0	0	0%
Kurigram	2	10	500%
Kustia	13	10	77%
Laksmipur	0	0	0%
Lalmonirhat	0	0	0%
Madaripur	0	0	0%
Magura	1	0	0%
Manikganj	1	0	0%
Maulavi Bazar	5	5	100%
Meherpur	1	8	800%
Munshiganj	1	1	100%
Mymensingh	0	0	0%
Naogaon	6	18	300%
Narail	4	21	525%
Narayanganj	0	3	0%
Narshingdi	1	4	400%
Natore	1	1	100%
Netrokona	0	0	0%
Nilphamari	0	1	0%
Noakhali	29	20	69%
Pabna	22	26	118%
Panchagarh	3	2	67%
Patuakhali	2	3	150%
Pirojpur	1	1	100%
Rajbari	0	0	0%
Rajshahi	0	0	0%
Rangamati	0	18	0%
Rangpur	29	9	31%
Satkhira	0	0	0%
Shariatpur	2	2	100%
Sherpur	5	5	100%
Sirajganj	2	2	100%
Sunamganj	4	4	100%
Sylhet	0	0	0%
Tangail	13	10	77%
Thakurgaon	6	6	100%
Total	**340**	**402**	

Notification and review of neonatal death at facility by division in 2023

The following data distribution suggests that 3563 neonatal deaths were notified and 4329 deaths were reviewed at facilities reported in 64 districts. [Table 4]

Table 4: Distribution of neonatal deaths reported and reviewed by districts at facility.

District	Facility Neonatal Death		
	Death notified	Death reviewed	% of death reviewed
Bagerhat	2	1	50%
Bandarban	1	2	200%
Borguna	10	9	90%
Barisal	2	35	1750%
Bhola	5	5	100%
Bogra	268	268	100%
Brahmanbaria	0	10	0%
Chandpur	3	3	100%
Chapai Nababganj	5	33	660%
Chittagong	0	2	0%
Chuadanga	0	0	0%
Comilla	5	7	140%
Coxs Bazar	1	1	100%
Dhaka	42	0	0%
Dinajpur	458	341	74%
Faridpur	1	0	0%
Feni	0	0	0%
Gaibandha	68	68	100%
Gazipur	4	1	25%
Gopalganj	106	106	100%
Habiganj	0	37	0%
Jamalpur	367	166	45%
Jessore	4	2	50%
Jhalokati	1	0	0%
Jhenaidaha	2	0	0%
Joypurhat	0	0	0%
Khagrachhari	79	78	99%
Khulna	0	0	0%
Kishoreganj	89	121	136%

District	Facility Neonatal Death		
	Death notified	Death reviewed	% of death reviewed
Kurigram	10	11	110%
Kustia	1	624	62400%
Laksmipur	4	0	0%
Lalmonirhat	2	4	200%
Madaripur	0	2	0%
Magura	0	0	0%
Manikganj	74	0	0%
Maulavi Bazar	131	129	98%
Meherpur	3	0	0%
Munshiganj	0	0	0%
Mymensingh	20	22	110%
Naogaon	1	1	100%
Narail	11	11	100%
Narayanganj	0	0	0%
Narshingdi	0	0	0%
Natore	19	19	100%
Netrokona	4	4	100%
Nilphamari	35	36	103%
Noakhali	260	260	100%
Pabna	235	236	100%
Panchagarh	56	47	84%
Patuakhali	152	158	104%
Pirojpur	25	25	100%
Rajbari	1	2	200%
Rajshahi	0	0	0%
Rangamati	24	67	279%
Rangpur	100	296	296%
Satkhira	10	9	90%
Shariatpur	19	7	37%
Sherpur	103	102	99%
Sirajganj	470	448	95%
Sunamganj	43	33	77%
Sylhet	9	6	67%
Tangail	97	293	302%
Thakurgaon	121	181	150%
Total	**3563**	**4329**	

Monitoring of MPDSR

Monitoring and evaluation are crucial to ensuring the quality and effectiveness of the Maternal and Perinatal Death Surveillance and Response (MPDSR) program. The Ministry of Health and Family Welfare has the responsibility for overseeing the MPDSR program at the national level, ensuring coordination and effective linkage with Quality Improvement (QI) committees established by the ministry. These committees include upazila QI, district QI, divisional QI, and the national MPDSR committee.

MPDSR focal persons and committees are established at various levels to facilitate coordination and monitoring. At the facility level, subcommittees exist, and the MPDSR focal person at each tier is integrated into the QI committee. These subcommittees conduct monthly coordination meetings, while the national core committee meets biannually.

At the district level, the Civil Surgeon and Deputy Director of Family Planning play vital roles in monitoring and evaluating MPDSR progress. At the upazila level, the focal persons are the UHFPOs (Upazila Health and Family Planning Officer) and UFPOs (Union Family Planning Officer). They are crucial in implementing local action plans, validating deaths, ensuring data quality in verbal autopsy and facility death reviews, and evaluating feedback and responses from Social Autopsy (SA) sessions at the community level.

Ensuring the quality of death data and validating deaths according to the International Classification of Diseases, 10th Revision (ICD-10) coding is essential. This involves validating the actual number of deaths and the information obtained from Verbal Autopsies (VAs) and Social Autopsies (SAs).

The monitoring efforts focus on specific areas to ensure the effectiveness of the MPDSR program. Key monitoring areas include validating community death notifications, monitoring the quality of verbal and social autopsy processes, reviewing the facility-level death reviews, and overseeing the implementation of responses and action plans based on the findings. By closely monitoring these areas and ensuring data quality, the MPDSR program can identify gaps, address challenges, and improve maternal and perinatal health outcomes.

MPDSR Monitoring at the National Level by the Video Conference

The Quality Improvement Secretariat (QIS) of the Ministry of Health and Family Welfare (MoH&FW) plays a crucial role in monitoring and evaluating the progress of MPDSR implementation. The QIS organizes routine online video conferences with districts to discuss the quarterly progress of MPDSR implementation. Each session lasts approximately three hours and includes participation from four to five districts.

During these sessions, district Civil Surgeons, MPDSR committees, and focal persons present their findings based on a quarterly monitoring checklist.

The Programme Manager of the QIS chairs the national-level video conference, ensuring effective coordination and oversight. The conference is led by the Director of Hospitals and Clinics and/or the Line Director of Maternal, Neonatal, Child, and Adolescent Health (MNC&AH) from the Directorate General of Health Services (DGHS). Programme Managers from maternal health services under DGHS collaborate with organizations such as UNFPA, UNICEF, and other development partners.

Conference discussions lead to the identification of action points for further improvement in the MPDSR program. These include increasing maternal and perinatal death reporting, strengthening the referral system, establishing blood bank centers in every facility, enhancing verbal and social autopsy processes, improving community-level reporting systems, promoting active participation in data entry in the District Health Information System 2 (DHIS 2), organizing regular MPDSR subcommittee meetings, and monitoring performance data from 2023.

The conferences also highlight gaps and challenges in implementing MPDSR. Identified challenges include frequent changes in MPDSR focal persons and district/sub-district health managers, significant gaps in grassroots-level healthcare development, lack of human resources, some areas remaining uncovered, coordination issues between DGHS and DGFP (Directorate General of Family Planning) in uniform death reporting review and response, lack of prepared actions and monitoring (response), and inconsistency in reporting to the monitoring checklist and DHIS-2.

Districts provide quarterly monitoring reports that offer an overview of the MPDSR implementation status and overall program performance. In 2023, monitoring reports from 19 selected districts showed that all districts reported facility-based maternal and perinatal deaths to the system within the first 24 hours. Most deaths were reviewed within seven days at the facilities. However, at the community level, the overall reporting of maternal and neonatal deaths and stillbirths was 70% compared to the total number of deaths in a year. These reports discuss the district-wise status of reporting, reviewing, and the overall performance of MPDSR responses.

Through these monitoring and evaluation efforts, the MPDSR program can identify areas for improvement, address gaps and challenges, and enhance the overall quality and effectiveness of maternal and perinatal healthcare.

National MPDSR coordination meeting

During the national-level coordination meeting on MPDSR, several critical discussions and decisions were made. The workshop was chaired by Dr. Mohd. Shahadt Hossain Mahmud, the Director General of the Quality Improvement Secretariat (QIS), Health Economics Unit (HEU), Ministry of Health and Family Welfare (MoH&FW). The meeting was attended by members of the national MPDSR committee.

It was decided to continue conducting video conferences for joint monitoring involving the QIS, Directorate General of Health Services (DGHS), and Management Information System (MIS). This approach allows for regular communication and collaboration among key stakeholders.

The workshop emphasized the need to develop a monthly action plan through coordination meetings involving the district and upazila level MPDSR sub-committee focal persons. This collaborative planning will facilitate the utilization of findings from verbal autopsies and social autopsies, contributing to the improvement of maternal and perinatal healthcare.

The meeting recognized the importance of enhancing coordination among statisticians at the national, divisional, and district levels. To achieve this, it was decided to focus on capacity development for statisticians through the MIS. This would ensure effective data management and analysis, leading to improved monitoring and evaluation of the MPDSR program.

The workshop highlighted the need to strengthen the referral system for obstetrically complicated women across primary, secondary, and tertiary level healthcare facilities. Enhancing the referral pathways and protocols will ensure that women with complications receive timely and appropriate care at the most suitable level of healthcare.

By making these decisions, the national-level coordination meeting aimed to enhance collaboration, improve data utilization, strengthen statistical coordination, and ensure an effective referral system within the MPDSR program. These efforts will contribute to the overall improvement of maternal and perinatal health outcomes.

MPDSR Monitoring at the district Level

The findings from the Maternal and Perinatal Death Surveillance and Response (MPDSR) system are instrumental in improving maternal and newborn health outcomes. These findings are actively shared and discussed in various coordination meetings at the district and upazila levels, as well as in Quality Improvement Committee meetings. This ensures that the data is disseminated to relevant stakeholders and used for evidence-based decision-making.

One significant outcome of these discussions is the development of action plans based on local and national evidence. These action plans help address identified issues and improve the quality of maternal and newborn healthcare interventions in the respective districts. By utilizing the gathered data, program districts can effectively plan and adjust their routine programs to meet the specific needs and challenges of their local populations.

The death mapping process has also been enhanced through the utilization of the DHIS-2 platform. Previously, this process was performed manually by plotting colored pins on a map. However, the DHIS-2 platform now provides an online live district death map, enabling health managers to better understand the prevalence and forms of maternal and neonatal mortality in their region. This real-time information helps them identify potential areas of intervention and make informed decisions to improve maternal and newborn health outcomes.

Overall, the integration of MPDSR findings into coordination meetings, action plans, and the use of technology platforms like DHIS-2 demonstrates a proactive approach by health managers in utilizing data to monitor and enhance maternal and newborn health services in their districts.

Distribution of MPDSR action plan regarding System Strengthening according to the districts

District	Activities	Milestone
Jamalpur	Functionalization of Upazila MPDSR Committee as per ToR outlined in the guidelines.	-No. of the monthly meetings conducted and discussed MPDSR.
	Organize refresher training for the health and family planning staff (HA, AHI, HI, CHCP, FPI, FWA) to ensure quality death review, registration, and data entry in DHIS2.	-No. of training conducted. -No. of staff trained.
	Conduct regular coordination meetings between health and family planning field workers (HI, AHI, FPI, FWA) to ensure 100% death notifications avoiding duplication.	-No. of coordination meeting held.
	Involvement of doctor and Midwife in the Social Autopsy session.	-No. of SA attended by doctor and/or midwife
	Attend and facilitate at least one SA session in a quarter	-No. of SA attended and facilitated session
	Review VA and SA reports and provide feedback to improve the quality of the death review.	-No. of VA and SA forms reviewed.
	Conduct a review of maternal, neonatal and stillbirth following the MPDSR guidelines	-% of all types of death reviews conducted/ (on time).
	Cross-checking of facility death in the community at the Upazila level.	-No. of community death notification and review conducted based on the facility death information.
	Death review information entered in the DHIS2	-No. of death review information entry done.
	Conduct death cause analysis, and assign death causes as per ICD 10 code	-No. of VA forms reviewed and death cause assigned as per ICD 10 code.
	Develop a response plan for the community death by each upazila based on the identified causes and gaps.	-Upazila-based plan readily available for a response.
	Develop a response plan for the facility death based on the identified causes and gaps	-DH and UHC-based response plan readily available.
	Share the response plan with the relevant staff both for community and facility death Assign responsibility to roll out the response plan properly and timely	No. of facilities rolled out their response plan.
	Ensure 100% maternal death, at least 10% neonatal death and stillbirth reviewed.	-% of maternal deaths reviewed. -% of Neonatal and stillbirth reviewed.
	Review and validate at least 20% of VA and provide feedback to improve the quality of the death review.	-% of VA reviewed, validated and provided feedback.
	Review and validate at least 5% of VA and provide feedback to improve the quality of the death review.	-% of VA reviewed, validated and provided feedback
	Review MPDSR activities in the monthly coordination meeting as a priority agenda.	-No. of meetings discussed MPDSR as a priority agenda
Gaibandha	Refresher training for AHI/HI for quality conduction of VA & SA, CHCP group for death registration in DHIS2.	Quality filling of VA forms. All deaths will be registered in DHIS2.
	Joint coordination meeting of HA, FWA, AHI, & FPI at the union level for unified death notification to avoid duplication and missing.	Union-level field workers meetings will be useful for many activities like pregnant women registration, child registration, etc.
	Conduction of social autopsy for maternal death organized by local health managers	All social autopsies will be documented and preserved
	Multi-sectoral collaboration with local community members, local government, and youth platform.	Active participation from the community to identify deaths.
	Functionalization of upazilas QI subcommittee and regular conduction of meetings.	Facility death and community deaths will be the priority agenda of the QI meeting.
	Mother assembly with ANC/PNC	Left-out ANC/PNC mothers will come under
	Community awareness through “Uthan Baithak” by NGO partners.	Mass awareness among women will be raised and social taboo will be reduced.

District	Activities	Milestone
Borguna	MPDSR is on the agenda in monthly meetings at the upazila and district levels. Data triangulation between the HA report and the DHIS2 report	Availability of MPDSR logistics (MPDSR pocketbook, national guidelines, forms, and notification slips). Death mapping & addressing major causes of death.
	Prepare union-wise maternal, neonatal, and stillbirth mapping based on available MPDSR data analysis	All staff related to maternal and neonatal heath management are well informed. Validate MPDSR data every month
	Assign relevant staff according to the planned activities at facility level from emergency to indoor to manage the maternal and neonatal complication.	Make available all facility and community death notification slip and reforms (100% MD and 10% neonatal death) and all data entry in DHIS2
	Triangulate the maternal, neonatal death and stillbirth data and forms between HA report and DHIS2 data	
	Check the community and facility death report with the fill up forms of facility and community MPDSR and find out the gap whether any MPDSR activities skipped.	
	campaign and blood grouping by both health and FP departments	coverage and blood grouping and donors will be identified for an emergency
Patuakhali	Provision of proper ANC Awareness development program Refresher training needed for CHCP. Lack of integrated community awareness system.	Quality ANC/PNC Quality services by health service providers.
	Initial stabilization of PPH & eclampsia cases before referral	All completed verbal and social autopsies for the notified deaths
Sirajgonj	Arrange Local level refresher training for HI, AHI, HA and CHCP with their monthly meeting using the Video tools developed by QIS	Quality information ensure in VA and SA forms. 2. All data will be entry and ensure quality in DHIS2.
	Death mapping (from MD verbal autopsy form, 2023) to identify the most vulnerable pocket areas with in the Upazila and report back to CS office within 2 Months.	Identify the most vulnerable Union and villages and Facilities Identify the person who conducted the home delivery (MD)
	Ensure information about still birth from the community level and facility using the MPDSR notification slip and keep record for future reference	Available still birth data in Upazilla level
	Notify 100% of MD, ND, still birth and Review all MD and 25% of ND at facility	All information is available at facility level
	Mother Assembly with all important information about facility delivery and safe delivery.	Covered all pregnant women and their family members from every union at every upazilla
Bandarban	-Lack of proper communication -Lack of referral fee -Need Community mobilization. -Refresher training for CHCP, HI, AHI, and FWA. -Build awareness community people -Quarterly meetings with community leaders.	-Quality Remote contact services -MPDSR forms & slips availability.
	Proper services ensured by the facility Regular monitoring Tracking properly Ensure Quality services & evidenced-based practices. LSPC training	
	Mother assembly Training CSBA for initial stabilization before any complicated patient referral.	
Noakhali	Lack of Mother assembly Refresher training needed for CHCP Lack of integrated community awareness system Awareness camps Availability of ambulance/referral services for remote, char & island areas	

Distribution of MPDSR actions to reduce maternal and perinatal deaths according to the districts.

District	Activities	Milestone
Jamalpur	Discourage home delivery and promote institutional delivery addressing cultural beliefs and ignorance through targeted awareness campaigns. Increased courtyard sessions to promote the benefits of institutional deliveries in rural areas by HA/AHI/FWA. Effective counselling for facility delivery during ANC visits by midwives. Maintain a register for high-risk mothers and EDD tracking. Follow-up with all mothers over the phone 2 weeks before EDD for facility delivery.	-Facility delivery increased. -Reduced preventable maternal & Neonatal deaths.
	Implement comprehensive health education programs to improve knowledge about the necessity and benefits of minimum 4 Antenatal Care Strengthen ANC services covering its all components including danger signs, birth planning, nutritional education etc. by midwives. Provide effective counselling during the first ANC visit emphasizing the importance of at least 4 ANC visits by midwives.	-Overall ANC visits increased.
	Awareness building among community people and encouraging proper birth planning including transport arrangements through community awareness sessions and during ANC services by the midwives.	-Birth planning increased.
	Awareness building among the community people about the risk of delivery by them.	-Reduced home delivery.
	Awareness building among community people and encouraging proper birth planning including savings for delivery. Explore financial assistance (DSF) options and provide counselling for economically challenged mothers, where possible.	-Increased facility delivery -Govt. support provided for the insolvent mothers.
	Raise awareness about risks, provide counselling on increased ANC visits, and enhance health education to address knowledge gaps	-Reduced death due to pre-eclampsia/ eclampsia and other causes
	Control GDM and address anaemia through regular checkups, and provide counselling during ANC visits for healthcare adherence.	-Reduced death due to Anemia and GDM
	Enhance healthcare service quality by capacity building of service providers.	-Quality of care improved
	Strengthening referral systems promptly and efficiently between community to facility levels and lower-level facilities to higher-level facilities.	-Referral system strengthened
	Establish management system for special cases and emergency care services.	- Special case management capacity improved.
	Mandatory policy required for at least 24 hours post-delivery hospitalization/stay.	-Policy developed & available
	Facilitate timely C/S decisions through facility readiness.	Facility-ready and prompt decision for C/S.
	Reduce workload by optimizing staffing and resource allocation.	Reduced workload and prompt service delivery.
	Ensure 24/7 availability of doctors and emergency C-sections in all facilities	Doctors and 24/7 emergency C-section facility available.
Gaibandha	At least 3 functional UHFWCs will be identified and CHCP, HA and FWA counsel pregnant mothers to select the nearest FWCs for NVDs.	Mds and NDs will be reduced as well as FWCs will also perform 24/7.
	Ensure that minimum arrangements are available for NVDs.	
	DGHS and DGFP will jointly arrange a combined mother assembly with ANC and blood grouping campaign.	ANC coverage will increase and blood grouping of pregnant mothers will be possible with potential donor will be identified.

District	Activities	Milestone
	In the evening and night time no mother will refer to the emergency without knowledge of midwives and initial management of PPH and eclampsia.	The complication management rate will be increased
	All lifesaving drugs should be available in all facilities including UHFWCs.	
	Combined listing of pregnant mothers from unions and mobile phone tracking by midwives from facilities to encourage them to come to hospitals.	Facility deliveries will increase.
Borguna	Increase community awareness for facility delivery during IPC (home visit) by HA/FWA Enhance counselling for facility delivery during ANC visit by midwives. Prepare a EDD register with mobile number and follow up for full	5% increase of facility delivery
	4 ANC Contact all mothers 15 days ahead of EDD for facility delivery. Counselling during 1st 1st ANC for the importance 3rd 3rd and 4th ANC Provide quality ANC by midwife. Awareness building in the community for institutional delivery by HAVFWA during home visit.	5% increase of ANC visit
	Enhance counselling during ANC on danger sign and three delays Provide 'One Stop Service' (make available ticket, checkup, counselling, and medicine from one spot) to pregnant women to motivate them for further checkup in UHC.	5% increase of facility delivery
Patuakhali	Involvement of multi-sectoral departments to make social awareness physically SA/VA which will be applicable.	To identify and reduce the cause of maternal and perinatal deaths. To notify all the maternal and perinatal Death with 100% review.
	Ensured PPH and eclampsia kit box in labour room as well as emergency rooms in each facility.	Regular meeting Meeting minutes present
Sirajganj	Common awareness program as mother assembly and ensure all necessary information distribution (Nutrition, danger sings, Blood grouping, service facilities at UHCs)	Increase number of ANC service and facility deliveries
	Ensure this information in Mother assemblies and arranged tour for the pregnant mother group to the delivery room when they come for ANC service	Increase number of facility deliveries and awareness
	Awareness building and guide during Mother assembly and facility visit	Increase motivation for Facility delivery
	Identify and include them in awareness program and monitoring their activities	Increase Facility delivery
	Increase communication between emergency and labour room	Ensure Initial management of every emergency pregnant woman.
	Meeting with blood bank, asses current status and ensure updated donor list	Ensure blood transfusion
	Identify high risk mothers and track them	Ensure every high-risk delivery in the facility
Bandarban	Networking with UNICEF for involving route level field worker, Parakhormi, Headman karbari. UH&FWC & CC trying to ensure initial stabilization.	-To Identify and reduce the cause of maternal and Neonatal deaths.
	Ensuring initial stabilization before referral. Mw available in SRHR area. Emergency logistics are available in the Labour room and emergency room. -Monthly MPDSR committee in-house meeting in the civil surgeon's office.	Add MPDSR in monthly meeting resolution & meeting minutes.
Noakhali	We have involved multi-sectoral department (youth, education, local Govt, police department, DWA etc.) to make social awareness. A team from CSO will join physically SA/VA which will be applicable.	To Identify and reduce the cause of maternal and perinatal deaths. To Notify all the Maternal and Perinatal Death with 100% review

Distribution of MPDSR common action plan according to the districts.

District	Activities	Milestone
Jamalpur	Increase community awareness for facility delivery during home visits for IPC by HA/AHI/FWA.	
Gaibandha	Training on ANC/PNC for CHCP and FWVs at Upazila level.	Quality ANC will ensure the identification of risk mothers
	Follow up of all facility deaths in the community.	Causes of still births will be focused.
	Review and follow-up of neonatal death and stillbirth review forms	All facility deaths will be covered and with comments and signed with date.
	Response plan development for each maternal death.	
	Well-conducted and structured social autopsy.	
Barguna	Review all maternal deaths, neonatal deaths, and stillbirths in the UHC and 250-bed hospital. -Cumulative data entry of facility death in the DHIS2.	All slips and MPDSR facility review forms for maternal deaths, neonatal deaths and still births are available in the UHC and 250-bed hospital. Entry facility MPDSR cumulative data in DHIS2
Patuakhali	Activation of upazila MPDSR committee Regular meetings of MPDSR committee A team from CSO will join physically SA/VA which will be applicable. Activation of upazila MPDSR committee Ensuring quality services Ensuring practicing evidence-based care LSPC training Monitoring and evaluation need to be increased from Upazila end to field. Regular meeting with internal MPDSR committee	Quality services by health service providers Regular meeting Meeting minutes present Quality services by health service providers
Sirajgonj	Death cause analysis meeting at District and Upazila	All updated data ensure, and all cause identify
	Action plan progress review in every monthly meeting	Achieved all activities as per plan
	Ensure 100% Death and still birth notification and VA, SA ensure as per timeline	All death and still birth notified, VA and SA done in time
	District MPDSR focal person will attend 100% MD verbal autopsy and SA,25% of ND verbal autopsy and SA at community level and share the information in District monthly meeting. District team visit to attend VA and SA	Ensure quality of data in VA and SA form. Increase awareness
	Ensure Quality ANC in Facilities to encourage the pregnant women for facility delivery	Increase number of facility delivery
Bandarban	Functionalized upazila MPDSR subcommittee & continue meeting half yearly. Monthly District Internal meeting with Gynae consultant pediatrics consultant Need monitoring visit with district focal in field	
Noakhali	Activation of upazila MPDSR committee Ensuring quality services Ensuring practicing evidence-based cares LSPC training Monitoring & evaluation need to be increased from Upazilla end to field. Regular meeting with internal MPDSR committee	All completed SA/VA for the notified deaths

Status of MPDSR Implementation and Response

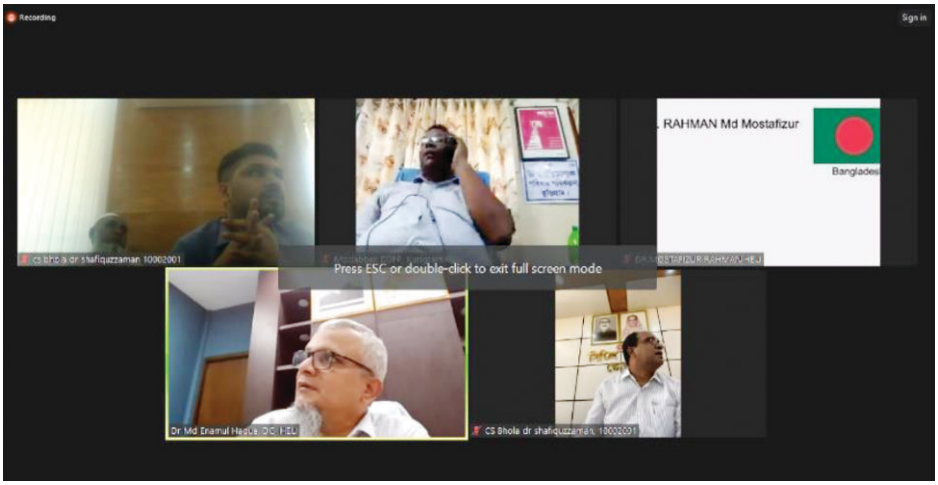
The implementation of the Maternal and Perinatal Death Surveillance and Response (MPDSR) program in Bangladesh has seen significant progress through various capacity- building initiatives. Here are the key highlights:

MPDSR video toolkit development

Experts in Moulvibazar district documented the MPDSR video toolkit, which includes materials on death notification, verbal autopsy, social autopsy, and review meetings. Two technical meetings were held at the QIS Conference Room to finalize the toolkit. It was then uploaded to the QIS website and a formal letter was sent to all the Civil Surgeons and District Family Planning Officers (DDFPs) at the district level for its use.

National-level Video Conferences

Eight video conferences were held at the national level to oversee the MPDSR implementation. These conferences involved 16 districts: Sunamganj, Dhaka, Bandarban, Gaibandha, Borguna, Potuakhali, Sirajgonj, Noakhali, Sylhet, Moulvibazar, Tangail, Kurigram, Habiganj, Bogura, Gazipur, Bhola. They provided a platform for regional stakeholders to share experiences, discuss challenges, and exchange best practices. These sessions also facilitated the dissemination of guidelines and protocols, promoting a cohesive approach to MPDSR across the country. These capacity development efforts aimed to strengthen the knowledge, skills, and abilities of healthcare providers and stakeholders involved in MPDSR implementation. By building their capacity, the program can effectively identify the causes of maternal and perinatal deaths, devise appropriate response plans, and ultimately strive to reduce the burden of these deaths in Bangladesh.



District-level Workshop

Over 200 health managers, MPDSR focal persons, and healthcare providers from various districts received training on MPDSR performance reviews. This training equipped them with the skills and knowledge to conduct thorough reviews of maternal and perinatal deaths within their districts. Participants included MPDSR focal persons, healthcare managers, statisticians, and other relevant stakeholders, with a focus on community and facility-level death notification, review, and response.

MPDSR action plan development at district level

In collaboration with the DGHS, seven district-level workshops were organized for healthcare providers in selected UNFPA districts. Coordinated with UNFPA field officers, SRHR field officers, implementing partners, and local teams these workshops ensured broad participation. Attendees included district and upazila level health and family planning managers, Gynecologists, Pediatricians, RMOs of district hospitals, UHCs, and MPDSR focal persons. The workshops, held in various districts took place at the Conference Room of the Civil Surgeon Office. The districts included Jamalpur (December 19-20, 2023), Gaibandha (December 20, 2023), Borguna (December 31, 2023), Patuakhali (December 21, 2023), Sirajganj (December 28, 2023), Bandarban (December 28, 2023), and Noakhali (December 4, 2023), focused on developing MPDSR action plans with specific milestones and actions tailored to reduce maternal and neonatal deaths in those districts.

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