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

Progress and Highlights in 2019

unicef

World Health Organization
Bangladesh

UNFPA

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

Progress and Highlights in 2019

unicef

World Health Organization
Bangladesh

UNFPA

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

Progress and Highlights in 2019

Edited By

Dr Animesh Biswas, Technical Officer, Fistula and MPDSR, UNFPA

Published By

Maternal Health Program

Directorate General of Health Services

Government of the People's Republic of Bangladesh

Published

January 2020

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

Forward

Bangladesh can be proud for its success in reducing maternal, neonatal and under five moralities in the last decades. The commendable progress in reducing maternal mortality and thus achieving the target for Millennium Development Goal 4 has resulted in getting award provided by the global community. The United Nations now has set a new target under the Sustainable Development Goal (SDG) to be achieved by 2030 and urges its member countries to reduce maternal mortality ratio to 70 or less per 100,000 live births and neonatal mortality rate to 12 or less per 1000 live births, respectively. Maternal and Perinatal Death Review (MPDR) after its pilot in 2010 in Thakurgoan in the existing health system by DGHS with support from UNICEF, UNFPA and WHO has made a surprising response in the health system and community that improved the availability and quality of maternal and neonatal health services. So the Government scaled it up to 14 districts by 2015.

The country has now adopted the global Maternal Death Surveillance and Response model developed by World Health Organization for preparing death review system for Bangladesh. Therefore, MPDR has been renamed as Maternal and Perinatal Death Surveillance and Response (MPDSR) after the WHO nomenclature. It is one of the key approaches for quality improvement in maternal and newborn health. The system is able to measure the maternal and perinatal mortality in real time, involving the community in the process, does produce information by areas, does give case by case analysis, so enables taking appropriate action as early as possible. MPDSR has been scaled to 48 districts till now by the Ministry of Health and Family Welfare (MoH&FW) with the technical and implementation support from UNFPA, UNICEF, WHO, other development partners and donors. This annual review of 2019 shows progress, opportunities and barriers on different components of MPDSR including death notification, verbal autopsy, social autopsy, facility death review, data entry and analysis, monitoring and supervision system. I am confident with full cooperation of all concerned, the implementation of maternal and perinatal surveillance and response will reduce the maternal and perinatal deaths to a large extent: thus achieving SDG smoothly.

Dr Md. Shamsul Haque
Line Director, MNC&AH
Directorate General of Health Services (DGHS)

Introduction

A woman's journey through pregnancy and childbirth, in Bangladesh is typically a story of suffering and challenges. A mother who dies during childbirth, is unable to see her child and the beautiful world. Moreover, she does not live to tell her own story. However, she leaves critical information which could save thousands of lives in this world. Knowing the answer to where, when, how and why the mother or newborn died could be the key to prevent future deaths. Using such vital information, specific interventions can be designed and addressed to reduce the burden of maternal and neonatal deaths. In this context, the World Health organization (WHO) in 2004 published Beyond the Numbers, which reflected the quest to know in detail, the reason of maternal deaths and the ways to prevent such deaths. Maternal death review has been established for many years globally, specifically in the facility settings to address maternal deaths. Many countries in the past decade started maternal and perinatal death review which was focused on both maternal and perinatal deaths, but did not consider the response towards a death. WHO has launched maternal and perianal death surveillance and response in 2013 which reflected on death reviews followed by response for both the community and facility deaths. In Bangladesh, a comprehensive death review system for maternal death was non-existent in the health system until 2010. In addition, adequate registration and notification of deaths was lacking until 2010. Therefore, Bangladesh has adopted MPDR from Beyond the Numbers and started piloting in one district of the country to investigate if the death surveillance and response can help to reduce maternal and perinatal deaths. Based on the lesson learnt from the piloted district, Directorate General of Health Services (DGHS) gradually scaled up the MPDSR to four districts in 2011 and to ten districts by 2013 with the technical support from UNFPA and UNICEF. This was further scaled up to 14 districts by 2015.

Although the Countdown 2015 report mentioned that Bangladesh is one of the nine countries with good progress in achieving the maternal death target by 2015, the United Nations (UN) report estimated that the maternal mortality ratio (MMR) of Bangladesh in 2015 was 176 per 100,00 livebirths. Moreover, Bangladesh Demographic and Health Survey Report of 2014 stated that the neonatal mortality rate is 28 per 1000 live births. The new Sustainable Development Goal (SDG) 3 has set a universal target, which means Bangladesh should reduce MMR to less than 70 per 100,00 live births and neonatal deaths to <12 per 1000 livebirths by 2030.

Considering the SDG targets, the Ministry of Health and Family Welfare (MoH&FW) of Bangladesh has put forward the maternal and perinatal death review system for national scale up in 2016. The country has revised the maternal and perinatal death review system to make it more action oriented and updated the name to Maternal and Perinatal Death Surveillance and Response (MPDSR). The Ministry of Health and Family Welfare (MoH&FW) took action to roll out MPDSR throughout the country. In line with WHO's Maternal Death Surveillance and Response (MDSR) Technical Guidance, the MPDR system was updated to ensure an increased focus on surveillance and response. MoH&FW developed the national guidelines for MPDSR, National ToT manual, Pocket handbook for the health workers and other MPDSR tools to implement on ground. Government scaled up to 22 districts by 2017 and the ultimate plan is to achieve countrywide scale up, in all 64 districts. By the end of 2019, MoH&FW has completed MPDSR scale up in 46 districts with technical support from UNFPA, UNICEF, WHO and other development and implementation partners. This MPDSR report has emphasized the progress, key achievements, and highlights in 2019.

Maternal and Perinatal Death Surveillance and Response (MPDSR) at a Glance in Bangladesh

MPDSR in Bangladesh is a comprehensive system encompassing both community and facility deaths. Any maternal death, neonatal death or stillbirth is notified by the field level government health care providers at the community level and by the senior staff nurses at the facility level. The death is notified and reported using a slip. Each reported community death is uploaded on the DHIS-2 data base from the community clinic and the facility deaths from the upazila health complex or district hospitals. All maternal deaths and 10% of neonatal deaths are reviewed by the health supervisors at the community level using a verbal autopsy form. Similarly, for all maternal deaths and 10% of neonatal deaths, the health supervisors also perform community based social autopsy as a community response to deaths and to explore social causes and build awareness among the community to prevent future deaths. On the other hand, at the facility level, nurses do the facility death review with the support of doctors and consultants using facility death review forms. Cause assignment from the community verbal autopsy is done at the divisional level under the leadership of MIS of DGHS and the causes are uploaded to DHIS-2. For facility deaths, causes of deaths are uploaded to the DHIS-2 by the nurses. Quality improvement committees at the sub-district, district and divisional levels are responsible to do periodic discussion on the MDPSR findings and progress, prepare action plan as per the death analysis and act at the field level. MPDSR focal persons are assigned at the sub-district, district level for overall management of MDPSR in their working areas. At the facility level, MPDSR sub-committees are functional at the UHC, district hospitals to review facility deaths and prepare action for improvement of facility and quality of care. MPDSR national committee at the national level is the core platform to review, discuss and undertake national action plan for MPDSR implementation in the country. [figure-01]

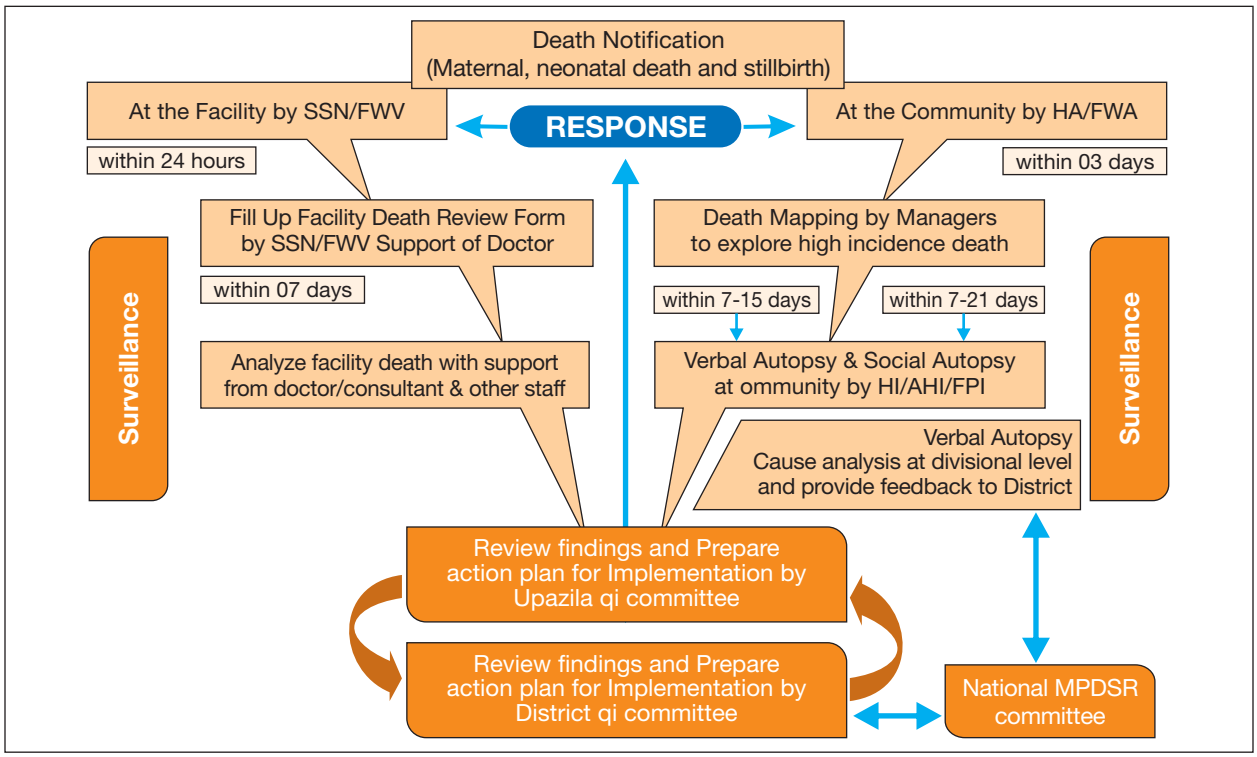

Figure 1: MPDSR Implementation Framework

MPDSR Scale up in Bangladesh: 2019

Bangladesh scaled up MPDSR by phase based on the experiences gathered since piloting and initial implementation since 2010. The piloting starts in Thakurgoan district in 2010 and gradually scaled to 14 districts by 2015. During the national scale up in 2016 and onwards, MPDSR expanded to another 30 districts. In 2019, DGHS has included 16 districts under implementation. By end of 2019, MPDSR is now covering 48 districts and over two third of population of the country. UNICEF, UNFPA, WHO and other development partners are supporting in implementation. UNFPA is currently providing technical support to fifteen districts of its 9th country programme (2016-2020), whereas, UNICEF is supporting to 22 districts. However, some of the district, UNICEF and UNFPA providing joint support to the districts. [figure-02]

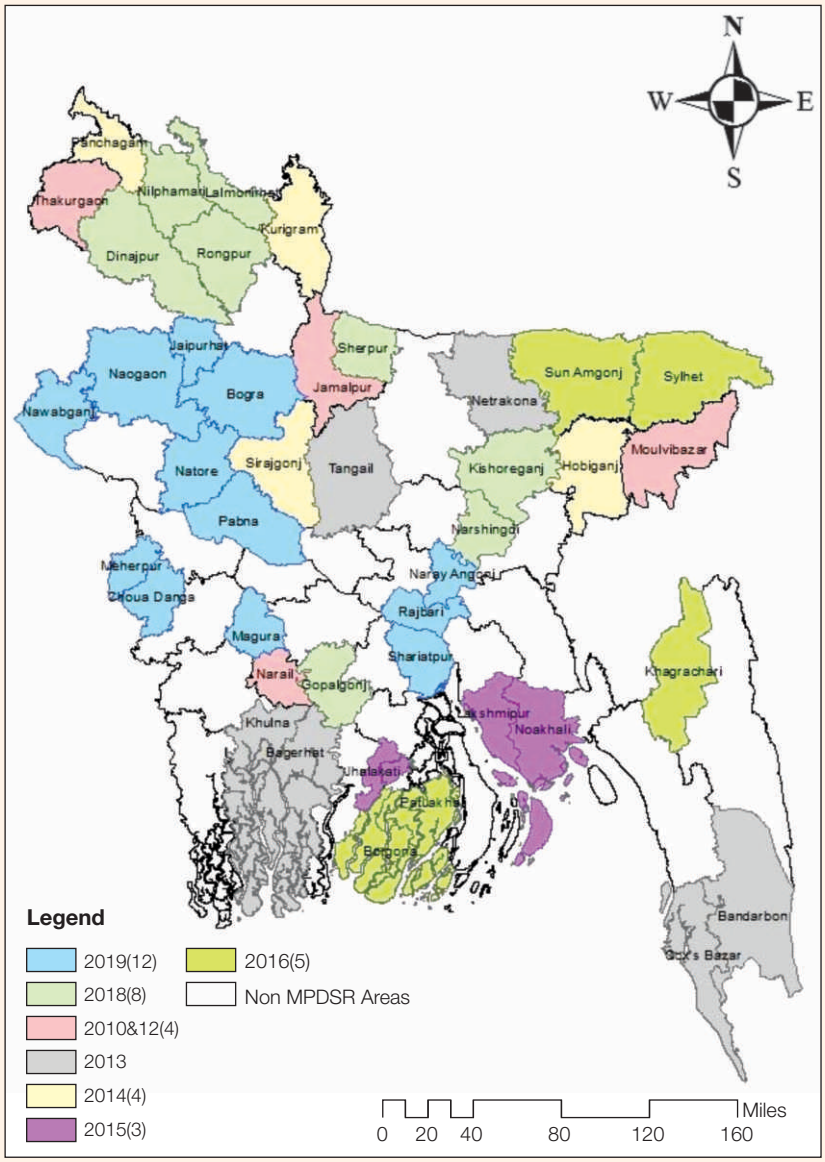

Figure 2: MPDSR Implementation Districts by Year

MPDSR Implementation Status

Capacity Development on MPDSR

In 2019, a total of 12 trainings of trainers (ToT) organized at the national level at the DGHS on MPDSR in where 12 districts were participated. Those include Rajbari, Bogura, Joypuhat, Natore, Naogaon, Chapai Nowabganj, Pabna, Chuadanga Magura, Meherpur, Nayanganj and Sariatpur districts. Over 200 health managers include the Civil Surgeon, Deputy Director Family Planning, Superintendent, consultant Obs-Gyane, Paediatrics, medical officer, senior staff nurses, statisticians received a three days training. Following that, districts planned for district and sub-district level trainings for the health managers and health workers to implement MPDSR at the district level. Till date 39 districts received trainings at the district and sub district level on MPDSR.

In addition to this, in 2019 DGHS organized workshops in Noakhali, Kagrachari and Bandarban districts with technical support of UNFPA and UNICEF. In Noakhali and Bandarban districts, around 100 health staff including health managers, doctors and nurses have received a daylong orientation on MDPSR. Whereas, in Khagrachari district received district level orientation training on MPDSR in where same level of participants was participated. All districts prepared some action plan in the workshop and planned for implementation.

Community Death Notification, Verbal Autopsy and Social Autopsy

Field level health care providers include health assistant and family welfare assistants notify maternal and perinatal deaths and report to the DHIS-2 though community clinic by the Community health care provider (CHCP). In 2019, newly scaled up district started MPDSR at different stage, out of 16 new districts six districts received all level of capacity development training whereas ten districts received ToT. Therefore, their implementation is at the initial stage.

Whereas, the districts who are performing MPDSR in the past years, those are performing the implementation as routine works.

A total number of 402 maternal deaths, 1479 neonatal deaths and 979 still births were reported from selected 11 districts in 2019. According to figure 1, in 2019, Sirajganj reported 69 maternal deaths, whereas Moulvibazar reported 62 deaths. On the other hand, Khagrachari reported three maternal deaths. In case of neonatal deaths Sirajganj captured 391deaths, Moulvibazar was reported 296. While, Rangamati district reported only eight neonatal deaths. In case of stillbirth, Sylhet reported 483 deaths in 11 months. [figure 3]

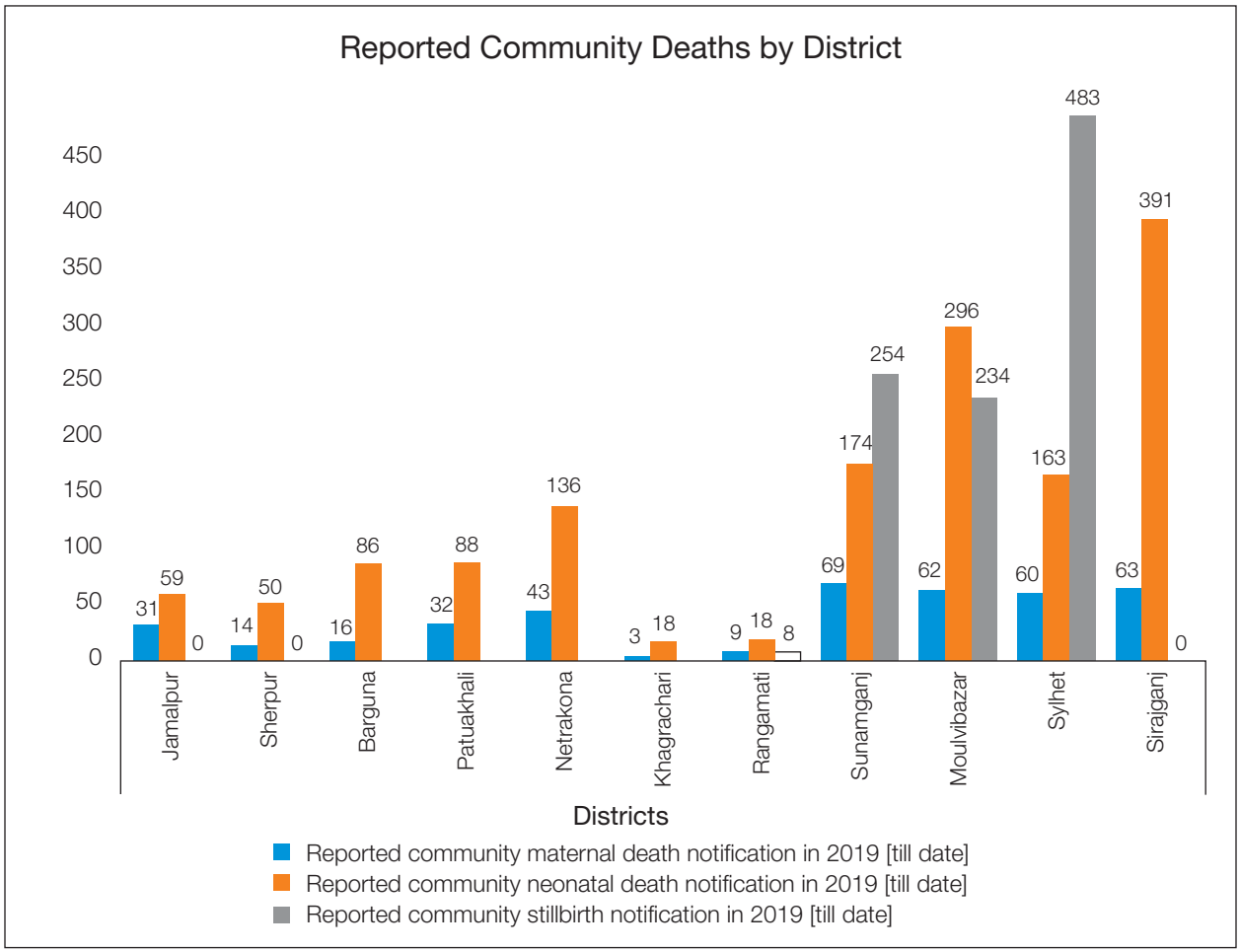

Figure 3: Community death notiifcaiton in selected districts

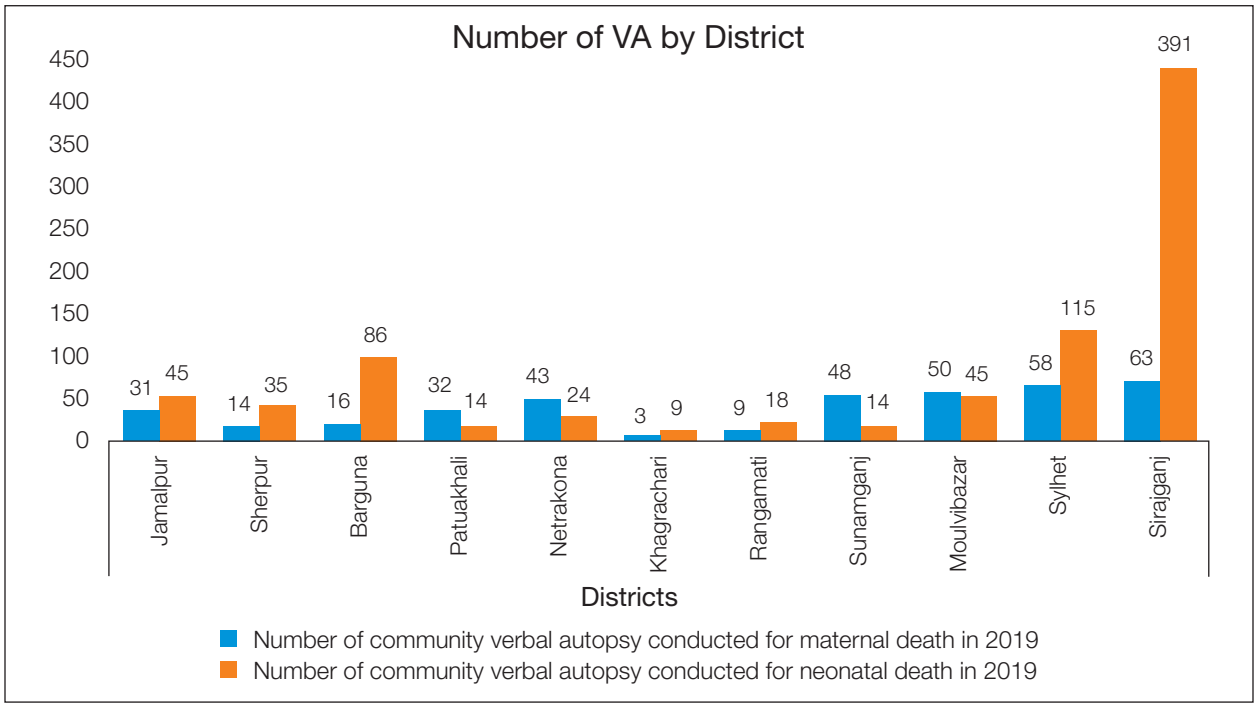

Figure 4: Community verbal atuopsy conduction in the selected districts

Accoding to figure 4, Among 402 maternal deaths 367 (91.3%) verbal autopsies and out of 1479 neonatal deaths 796 (53.8%) verbal autopsies were conducted. Except Moulivbazar, Sylhet and Sirganjganj, all toher eight districts perfomred 100% verbal autopies for maternal deaths. Whereas, Signajganj reported 391 verabl atuopsies for neontal deaths. [figure- 4]

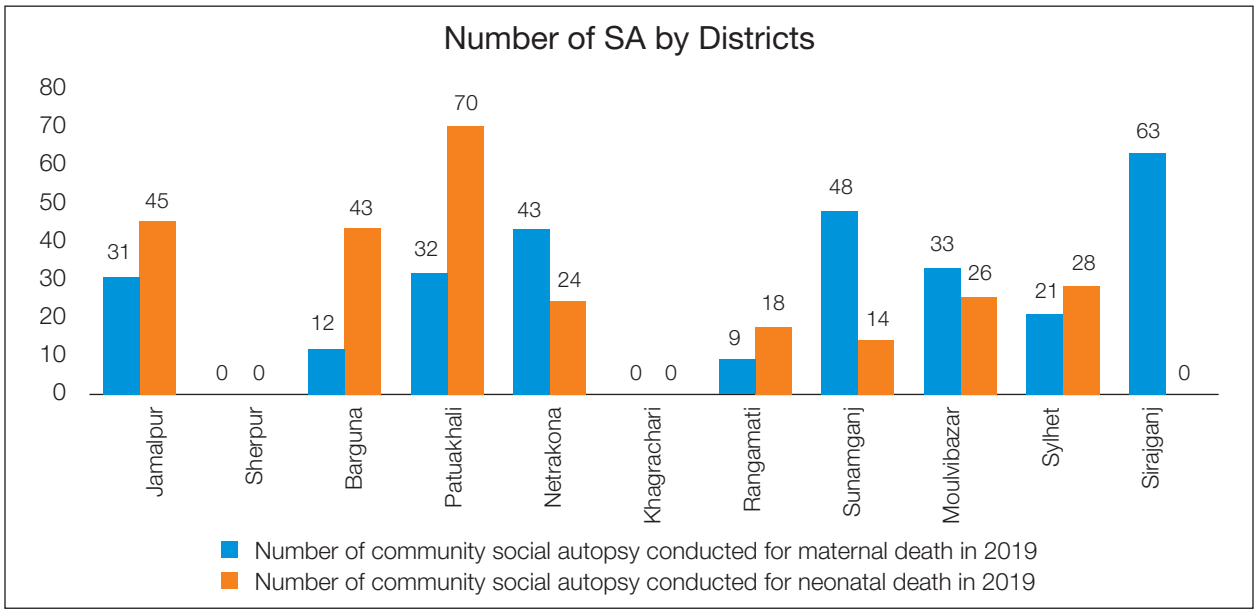

Figure 5: Community social atuopsy conduction in the selected districts

Figure 5 Among 402 maternal deaths 292 (72.6%) social autopsies and out of 1479 neonatal deaths 268(18.1%) social autopsies were conducted shown that Rangamati and Sirajganj continued performed all social autopsies for repored maternal and neonatal deaths in 2019.Moreover, Jamalpur, Patuakhali and Netrokona districts performed social autopsies of all reported maternal deaths. [figure-5]

MPDSR: Cause Analysis

Assigning the Cause of Death

Mortality data at the upazila and district level are analyzed manually to identify important factors associated with the deaths. At the upazila level, the MPDSR focal person, usually the Junior Consultant/ medical officer designated by UHFPO, provide technical support and advice to the upazila MPDSR sub-committees to review and analyze the cause of deaths. The same district-level function is performed by the MPDSR focal person, usually the Medical Officer- Civil Surgeon (MO-CS) Office or the Resident Medical Officer (RMO) assigned by the Civil Surgeon. The statistician at the upazila/ district level prepares a monthly summary on all the deaths in the upazila/ district and the system automatically generates a death map. At the divisional level, the cause analysis and review workshops reveal the actual causes of death of mother and newborn. The participants also calculate the MMR, NMR during the workshop to compare their status and progress with the national level. They jointly develop an action plan to reduce further deaths based on the findings. Major decisions like accountability of the private sectors, quality improvement initiatives, developing skills and ways to motivate human resource are taken during these workshops. The cause of death information is entered quarterly at the divisional level following the death review meeting.

Divisional Cause-Analysis Workshop

At the divisional level, the cause analysis and review workshops reveal the actual causes of death of mother and newborn. The participants also calculate the MMR, NMR during the workshop to compare their status and progress with the national level. They jointly develop an action plan to reduce further deaths based on the findings. Major decisions like accountability of the private sectors, quality improvement initiatives, developing skills and ways to motivate HR are taken during these workshops. The cause of death information is entered quarterly into health management information system (HMIS) at the divisional level following the death review meeting.

An example of a successful Divisional MPDSR Cause of Death Analysis took place at the conference room of Sylhet MAG Osmani Medical College and Hospital (SOMCH), in May 2019. The director, SOMCH, Sylhet chaired he workshop and the Divisional Director, Sylhet was present as a special resource person. The participants included additional directors, civil surgeons, medical officer to civil surgeon, gynae and pediatric consultants and statisticians from Habiganj, Moulvibazar, Sunamganj and Sylhet. The participants were divided into 4 groups to review the maternal death (MD) and neonatal death (ND) forms of 2018, analyzed the cause of death and ICD coding of all deaths. After analyzing the data, majority of maternal deaths were found to be due to PPH (39%), followed by Eclampsia (23%).

Causes of Maternal and Neonatal Deaths

500 maternal deaths verbal autopsy data were analyzed in the divisional level cause analysis workshops. The graph below shows the causes of maternal death in 2019, on a national scale. Eclampsia was found to be the major cause of death (19.4%), followed by PPH (17.8%). Noteworthy, is that there was a decline in the number of deaths due to PPH from about 40% in 2018. [figure-06]

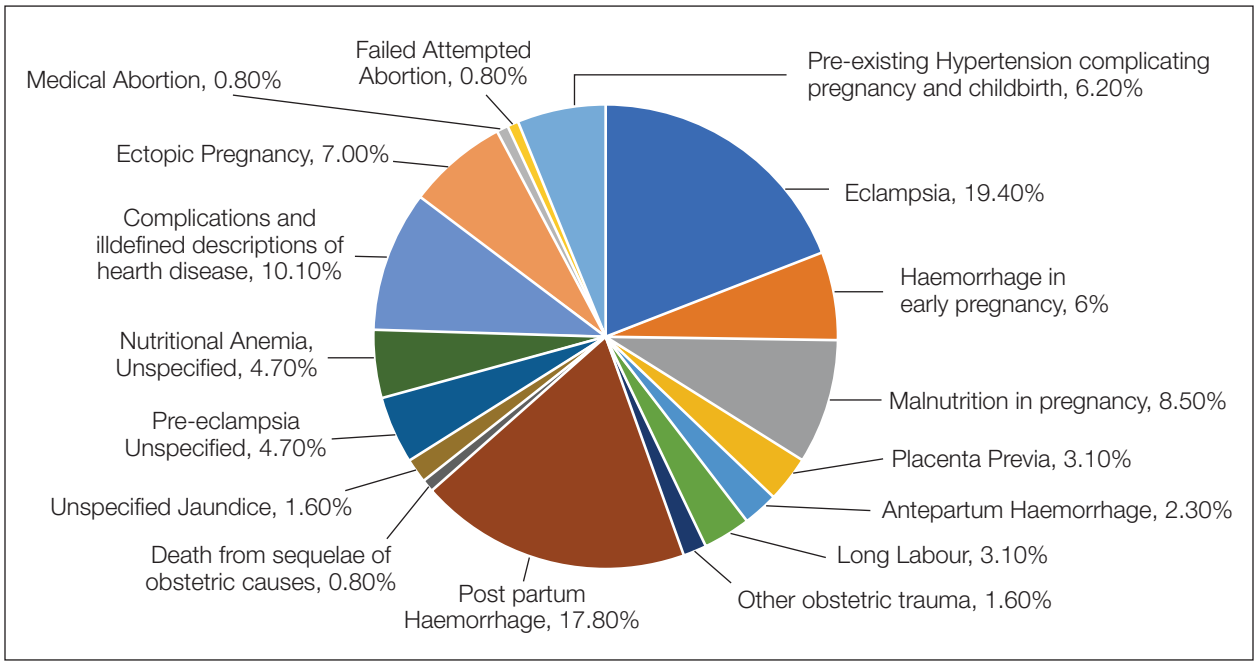

Figure 6: Causes of maternal death in Bangladesh in 2019

In 2019, 500 neonatal deaths verbal autopsy data were analyzed in the divisional level cause analysis workshops. as shown in the figure below, the major cause of neonatal death was found to be Birth Asphyxia (35%), followed by Other ill-defined and unspecified causes of mortality and Disorders related to gestation and low birth weight, both around 24%. [figure-7]

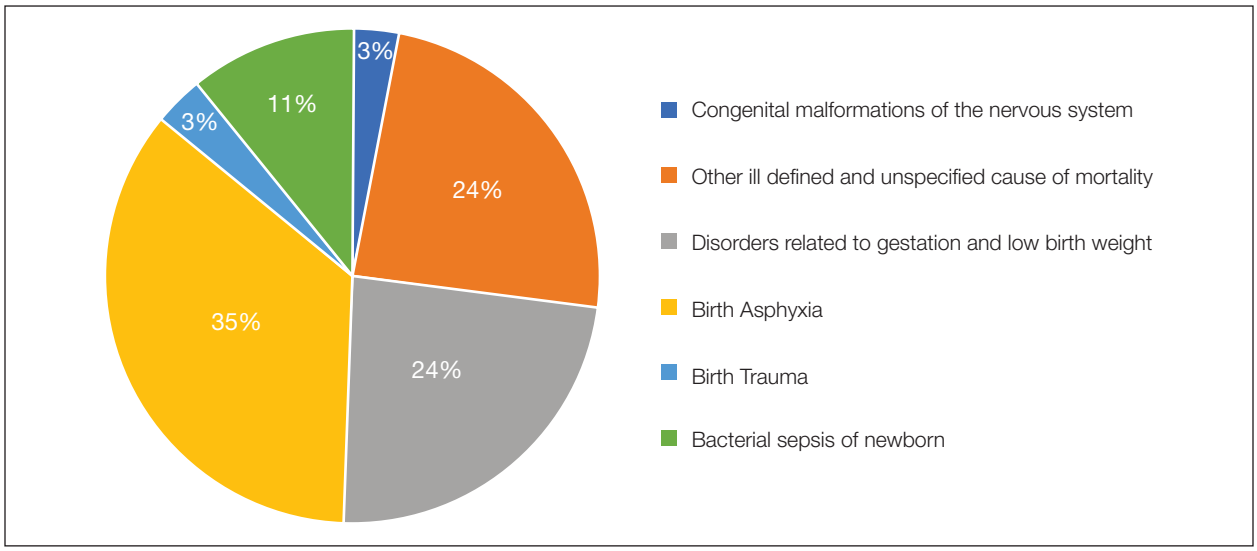

Figure 7: Causes of neonatal death in Bangladesh in 2019

Based on the divisional cause analysis workshops, institutional neonatal mortality rates were calculated for each of the 8 divisions, as shown in the figures below. Chittagong division had the highest institutional NMR (21.35 per 1000 deliveries), in total there were 2416 neonatal deaths in 2019. The lowest NMR was calculated for Khulna division (0.62 per 1000 deliveries) and the total number of neonatal deaths were only 69 in 2019. [figure 8 & 9]

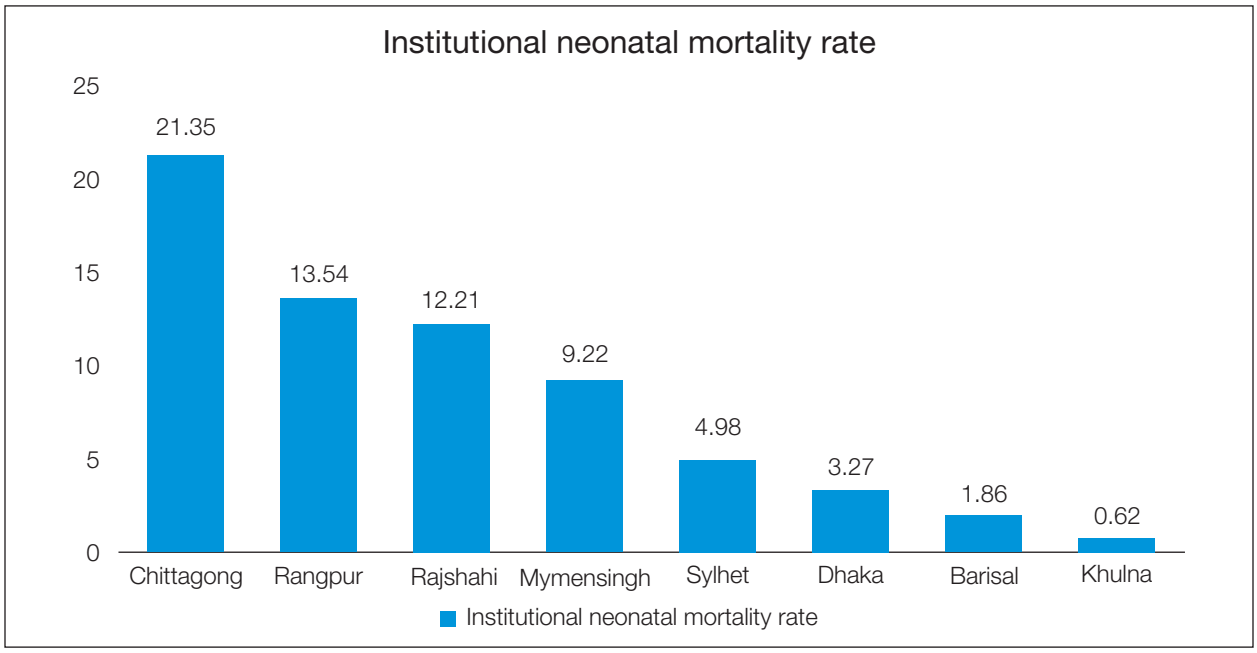

Figure 8: Institutional neonatal mortality rate by division (per 1000 deliveries)

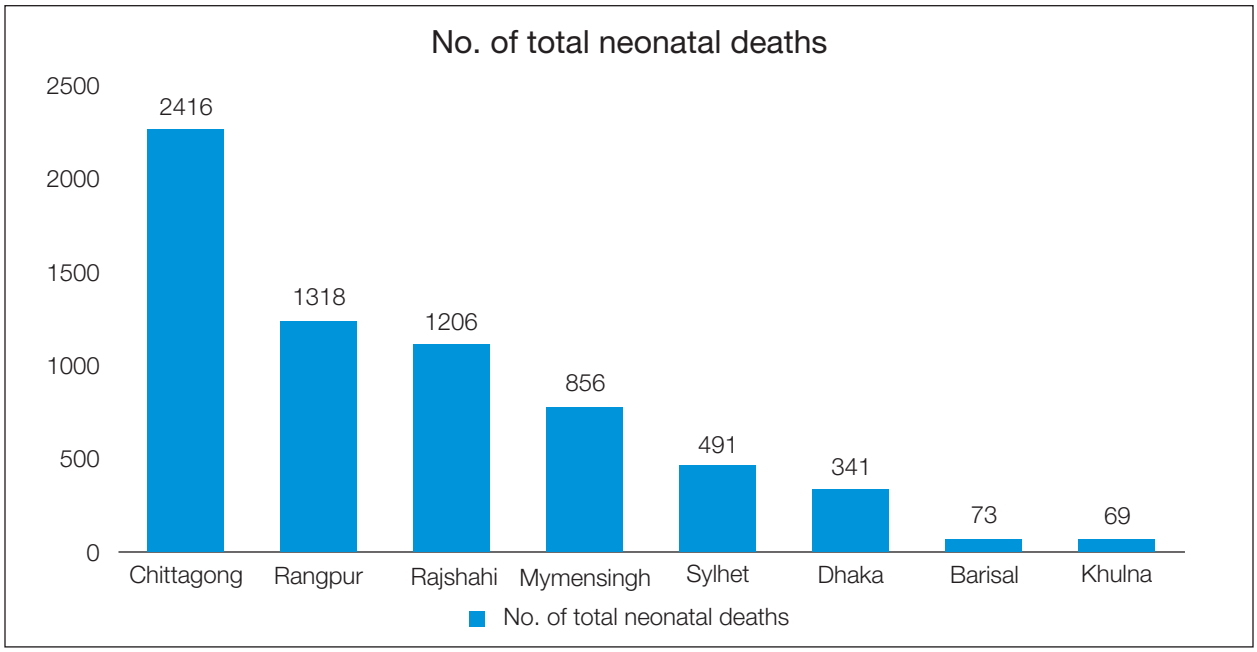

Figure 9: Total number of neonatal deaths by division

Facility Death Notification and Review

At the facility level, each of the maternal and neonatal deaths are notified and reviewed by the senior staff nurses and midwives with the support from the doctors or consultant. 2019 facility death review findings have been compared with previous two years and it has been observed that there is a decline in insititutional MMR from 85.92 to 68.82. Institutional neonatal MMR was 5.77 per 1000 livebirths in comparison to 4.58 in 2017. Institutional stillbirths changed from 17.8 to 16.9

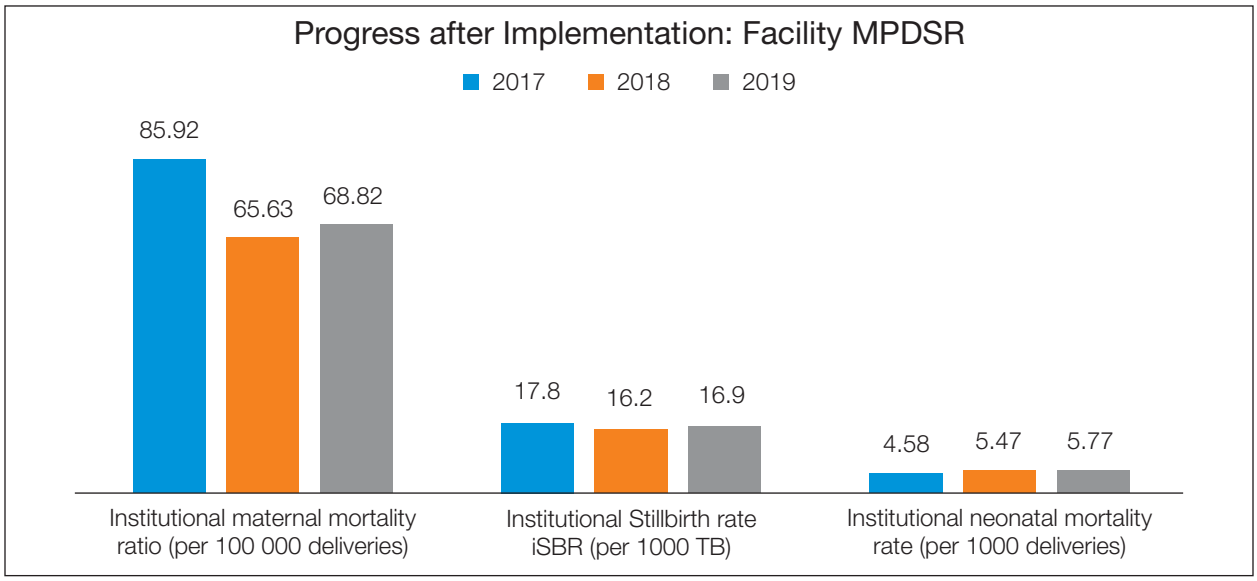

Figure 10: Institutional deaths comparison

Proportion of facility death reivew findings of 2019 shown that more than 80% of the maternal deaths were reviewed in the facilities in 19 districts. Whereas, neontal death review is restrict to only 10% in 12 districts. [figure-10 & 11]

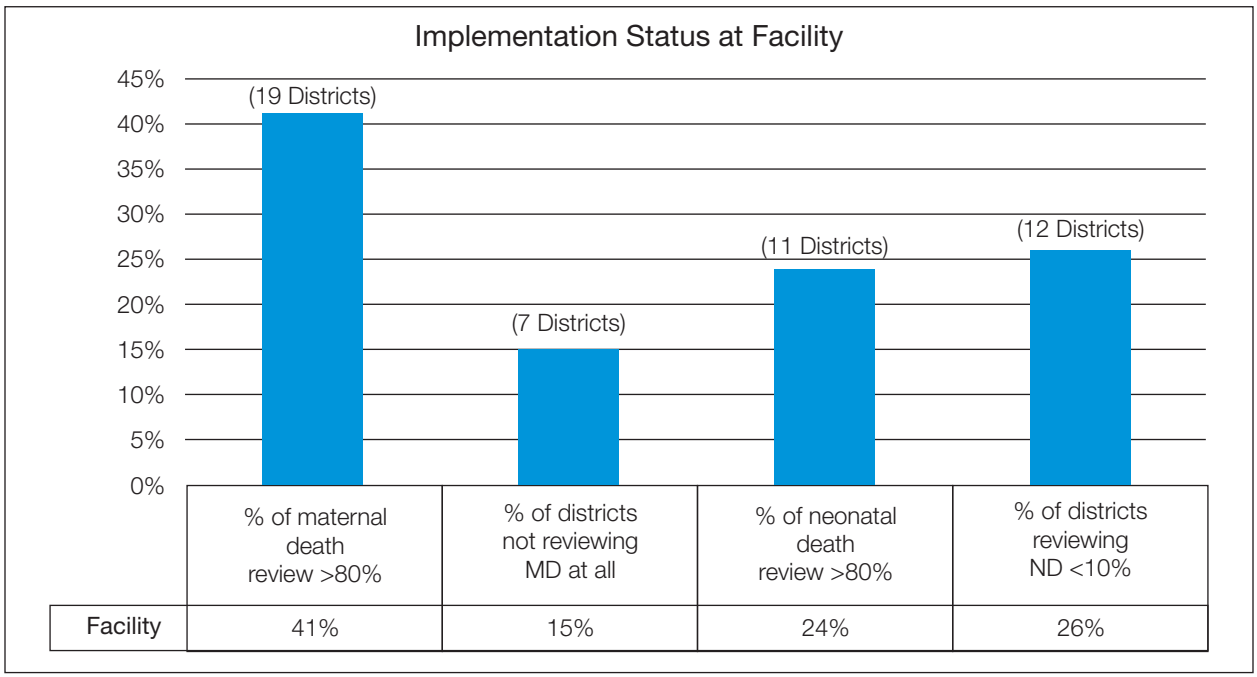

Figure 11: Current status of facility death reviews

Responding to MPDSR Findings

MPDSR findings share in the district monthly coordination meetings and in the upazila monthly coordination meetings including in the quality improvement committee meetings. Action plan are taken by the committees and implement. In 2019, the districts used the data for planning their routine programme and monitoring the overall maternal and newborn health interventions.

The health managers use the death mapping of the district to understand the burden of deaths in a specific focused area where intervention is needed. Previously the death mapping was performed manually by plotting coloured pin in the map, currently DHIS-2 is producing online live district death map help the managers to understand the current context at any point of time.

Social Autopsy

Social Autopsy (SA) is a unique innovation of MPDSR which is an effective dialogue between community and government frontline workers to identify bottlenecks in the family and community to seek timely care and increase response by the community. SA is a non-blaming approach in the society which focusses on social factors, dilemma related maternal and newborn death occurred at community, discuss with the community groups, community support groups, neighbors and often with deceased's family members about the death, digging out the causes which is preventable and find out a solution which could prevent future death in that society.

Health Inspector/Assistant Health Inspector, Family Planning Inspector of respective area facilitate the SA session through coordination between Health Department and Family Planning Department. Around 40-50 participants from adjacent 20-30 households close to the deceased's home are the participants of SA.

Members of respective community groups and community support groups must attend the meeting. Local teachers, religious leaders/Imams, union parishad members, health workers and volunteers including both male and female members join the discussion. Adolescent boys and girls and pregnant mothers or newly married women are encouraged to participate. SA is organized within 15-30 days after the death occurred. The average duration of the social autopsy session is 45 minutes to one hour. The health worker concentrates on finding out the social barriers/ factors of the death without highlighting any blame to any individual or institution. The health worker tries at his/her best to identify social factors/barriers related to a death from the description. The facilitator shows a set of social behavioral change communication (SBCC) materials on maternal and neonatal health to the participants. Finally, the facilitator seeks support and commitment from the society especially from the Community Groups / Community Support Group on how the society would better plan in

near future to prevent any death. The health worker also requests the local leader/ member/ elite person to show their commitment for the society and how they may play role in overall improvement of the system. After completion of facilitation session, the facilitator will fill up the 'social autopsy reporting form and return it back to the statistician or MPDSR focal person at upazila health complex and later enter data and findings of SA in DHIS2 following monthly Health Workers Form. A semi- structured reporting form is filled up at the end of meeting.

Social autopsy in the community is using since 2010 in Bangladesh as a community response and social intervention (Response) towards a maternal or perinatal deaths. In 2019, social autopsies were performed in the districts developed evidence-based action plan based on community on community dialog and decisions making. District like Sunamganj explored the presence of diploma midwives in the social autopsy sessions to open more room for depth discussion on maternal health complications, birth planning, antenatal care, delivery care, postnatal care including postpartum family planning. Midwives also participated in the social autopsies session at the marginalized teagarden community in Moulvibazar districts with an aim no one leaving behind.

Monitoring and Evaluation

Monitoring and evaluation are the key to ensure the quality of the intervention and improvement of overall activities. At the national level, the Ministry of Health and Family Welfare is responsible for the oversight of the MPDSR program. At different tiers, MPDSR focal persons and MPDSR committees are established for coordination and to have an effective linkage with the QI committees at different tiers formed by the MoH&FW. The committees include upazila QI, district QI, divisional QI and the national MPDSR committee. At the facility level there are sub-committees and the MPDSR focal person at each tier are co-opted in the QI committee. The MPDSR subcommittees conduct monthly coordination meetings, whereas the national core committee meets biannually.

At the district level, the Civil Surgeon and Deputy Director, Family Planning play an overall role in monitoring and evaluating the progress of MPDSR. At the upazila level, the focal persons are UHFPOs and UFPOs, who take on the most important role in the implementation of local action plan, check for the death validation, quality of data in verbal autopsy and facility death review. Finally, they also evaluate the feedback and responses in the SAs at the community level.

It is important to ensure the quality of the death data and validate the deaths as per definition (ICD-10 coding). This also require ensuring actual number of deaths and information obtained from VAs and SAs.

Key monitoring areas are focused:

- Validate community death notification
- Monitor quality verbal autopsy and social autopsy
- Monitor facility death review
- Monitor the responses and action plans.

MPDSR Monitoring at the National Level by the Video Conference

Directorate general of health services (DGHS) routinely perform online video conference with the districts and talk with the district Civil Surgeon and MPDSR committees include MPDSR focal person to discuss on the quarterly progress of MPDSR implementation of the district. In every video conference, four to five districts are invited to participate a three hours' discussion session. Each district present the findings based on given quarterly monitoring checklist. Each district presents the findings first and then discussion take place. At the national level, Director, Hospital and Clinics and or Line Director, MNC&AH of DGHS lead the conference. Programme Manager of maternal health of DGHS call up the conference and development partners from UNFPA and UNICEF participate. In 2019, eight video conference were organized by the quality improvement secretariat and DGHS jointly.

MPDSR Monitoring Performance Data of 2019

Quarterly monitoring report of the districts give an idea on MPDSR implementation status and overall performance of the programme. Selected 10 districts monitoring report of 2019 has shown that all districts reported facility maternal and perinatal deaths within the first 24 hours and report to the system. Most of them (90%) reviewed the deaths within seven days at the facilities. Whereas in the community level, overall reporting of maternal and neonatal deaths and stillbirths is 70% compare to expected numbers of deaths in a year. [figure-12]

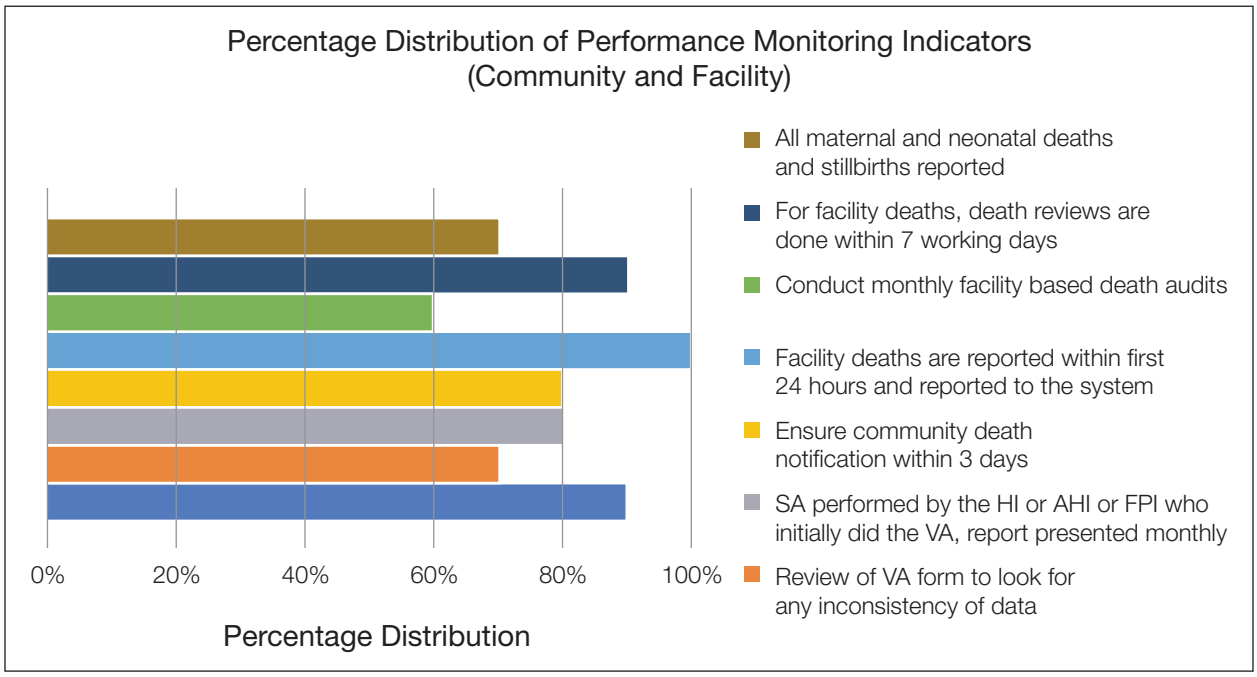

Figure 12: Distribution of Performance Monitoring Indicators

Performance monitoring indicators shown that in all districts shared their death review findings in the monthly meetings and significant percentages of districts have MPDSR manual, guideline and tools etc. Whereas, very few districts able to perform a periodic refreshers course to train their knowledge and skills. It's also reported that all districts are well equipped with MPDSR guideline, manuals and tools. [figure-13]

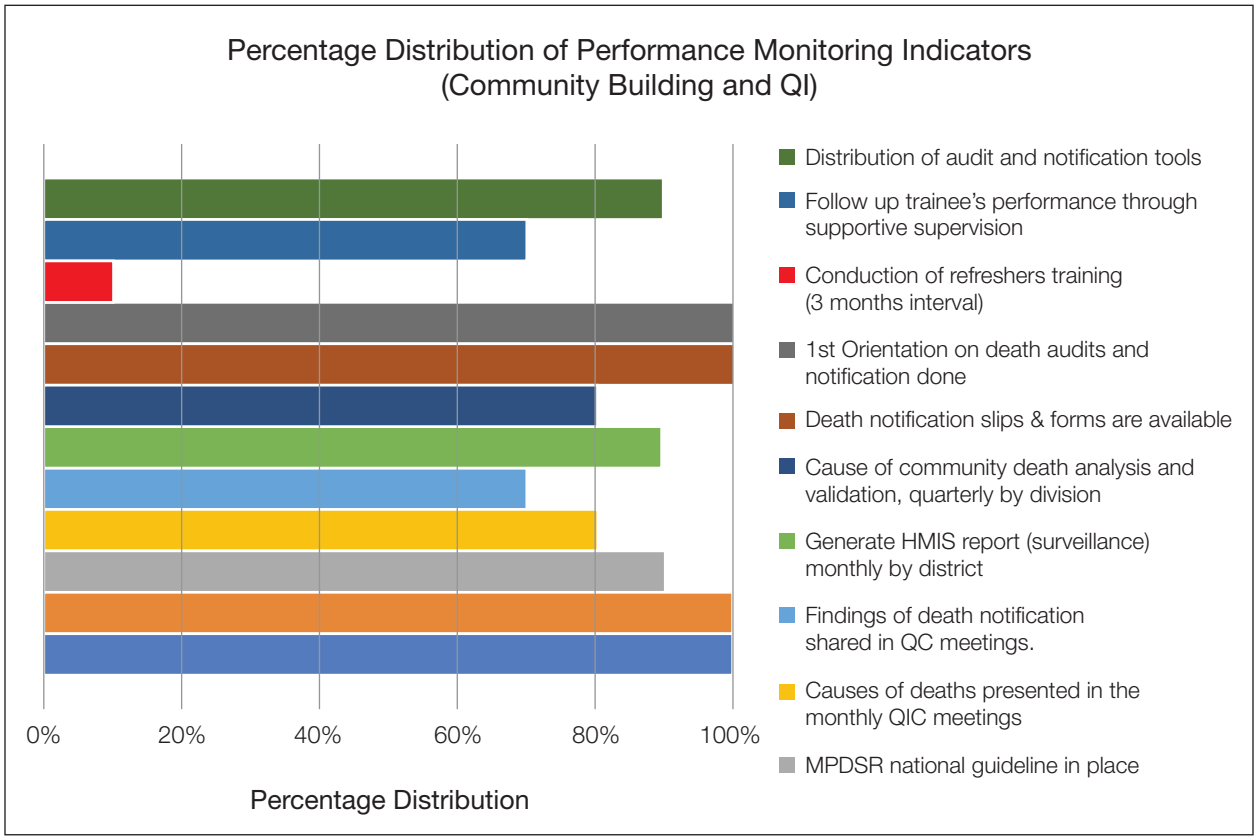

Figure 13: Distribution of Performance Monitoring Indicators

MPDSR Case Studies

Inclusion of Midwives

Inclusion of midwives in the process of MPDSR has proven to be very effective. Usually, the Health Inspector or Family Planning Inspector has limited knowledge on the types and causes of maternal and neonatal deaths. They usually fill up the Verbal Autopsy form as described by the relevant community and relatives, which may not reveal the actual cause of death. Since Midwives are solely deal with reproductive health issues like ANC, deliveries, PNC, family planning, newborn care and reproductive rights, their knowledge will help to identify and assess the causes of deaths in greater depth.

In the teagarden areas of Moulvibazar district, Sylhet division in 2019, 12 midwives were recruited under DGFP to ensure safe delivery conduction, to create awareness about conducting safe deliveries at the facility through home visits and leading Social Autopsies. Midwife-led Social Autopsies helped to create greater awareness and sensitization and ultimately, and motivate the community to ensure safe delivery. Whereas in Sunamganj, government midweives are working at the upazila health complex engagged in the community social autopsy sessions.

Thus, also help in the identification of causes and also helps in the reduction of Maternal, neonatal mortality and morbidity.

Active Engagement of MPDSR-Focal Persons

In Patuakhali, there was a high prevalence of maternal and perinatal morbidity and mortality. Moreover, the MPDSR system was not structured and functional. There were very few VAs conducted due to lack of verbal autopsy forms available and lack of knowledge at the end of the health care providers on how to conduct the VAs. With the active engagement of the civil surgeon, VA forms were obtained, and refresher trainings were conducted at the district level. Following the training, all deaths were notified, and all VAs were completed; half of the SAs were conducted. Moreover, Upazila level subcommittee are now reviewing the causes of deaths and the reports are being shared with the district focal person.

Engaged Community Support Groups

In the 35 intervention teagarden areas of Sylhet Division, total 06 maternal deaths occurred, in the year 2019. 100% SAs were conducted, successfully, where 232 participants (105 male and 127 female) participated. The Panchayat members, teachers, UP members, community leaders, community elder peoples, guardians, pregnant women and eligible couples participated in these social autopsies. They discussed the social causes of deaths and prepared an action plan to prevent future preventable maternal and neonatal deaths in their community. Due to active involvement of the community support groups, it was possible to get commitment form the local leaders to take steps in maternal and neonatal mortality reduction.

Evidence-Based Action Plan and Implementation

Formulating and implementing evidence-based action plan has proved to be the key to successful implementation. In the teagarden areas, 15 awareness meetings were arranged in December 2019. Several important decisions were made such as ensuring facility delivery with the goal of eliminating home delivery. Additionally, awareness was created about an effective referral process and availing at least 4 ANC visits for all mothers. The decision to involve midwives in the MPDSR process was also incorporated within the action plan.

Continued Support of Development Partners

Verbal autopsies and social autopsies had not taken place at Khagrachari even after the orientation. With the technical support of UNICEF and UNFPA, a 2-days-long TOT on MPDSR took place at the district level. Several important decisions were made such as- VA and SA will take place in a timely manner and at all levels VA and SA forms will be available. Soon, a evidence-based action plan will be developed with the support of both UNICEF and UNFPA.

Capacity Development on MPDSR in Noakhali

The Noakhali district Civil Surgeon office organized a day long orientation meeting on MPDSR with the support of UNFPA. District and upazila health and family planning managers participated in the orientation. Current approach to MPDSR in Bangladesh and the status of Noakhali district in the implementation were discussed during the session. Each upazila did a group exercise to identify key actions to be taken in the district. Key action points taken by the district are:

- Nominate MPDSR focal person in all upazilas.
- Ensure supplies of MPDSR tools and guidelines at all levels.
- Ensure timely notification and review of maternal and perinatal deaths.
- Include MPDSR agenda in the upazila and district coordination meetings.
- MPDSR focal persons will monitor the MPDSR implementation and report back to the respective managers.

Bandarban District Prepared an Action Plan Based on MPDSR Findings

A day long technical workshop on maternal perinatal death surveillance and response (MPDSR) was organized by Civil Surgeon Office Bandarban district. The workshop was planned to develop the capacity of the upazila managers and health care providers to identify MPDSR progress, challenges and way forward. Brief presentations and following group works were performed in the workshop. Each of the upazila presented their findings and future plan. More than 55 participants from all upazilas participated. The workshop was supported by UNFPA. Some of the key action plans were identified to further implementation of MPDSR in the district.

- Assign MPDR focal person in the upazilas and activate them.
- Ensure each upazila has sufficient logistics/ tools to perform MPDSR.
- MPDSR will be prioritized in the next monthly coordination meeting with the field level health care providers and update them about implementation.
- Ensure that quality verbal autopsy data is collected.
- QI committee meetings will ensure discussion on MDPSR.

Urban MPDSR has been Initiated in Dhaka City Corporation

Considering the need of MPDSR in urban settings, Dhaka north city corporation organized two workshops in the City Corporation on MPDSR to build the capacity of health managers working in the government and private facilities located in the Dhaka North City corporation. The workshop was funded by UNICEF and UNFPA provided technical support. Over 60 health managers were oriented on MPDSR national programme, and a brief on facility death review for maternal and perinatal deaths in the urban facilities was given during the session.

Technical Workshop on MPDSR Organized by Quality Improvement Secretariat for Dhaka North and South City Corporation

2-3 October 2019: Quality improvement secretariat of Ministry of Health and Family Welfare organized two national level workshops at the Health Bhaban with the Dhaka North and South City corporation on urban MPDSR. The urban health care providers including doctors, constants, health managers, professors of Obs-Gynae, Paediatrics participated in the session. Urban MPDSR implementation modalities were presented and a group discussion took place to identify challenges in implementing urban MPDSR in Dhaka and identify some recommendations to way forward at the workshop. Funded by UNICEF, UNFPA provided technical support to the workshop. Some actions points came up for way forward include-

- A facility mapping of government and private facilities is needed.
- Increasing facility death notification and reviews could be a good starting point.
- MPDSR tools and guidelines can be provided to all facilities in Dhaka North and South City Corporation after mapping exercise.
- Each private and NGO facility shall send the monthly MPDSR data to the City Corporation monthly basis.

Acknowledgement

- Ministry of Health and Family Welfare (MoH&FW), Bangladesh.
- Maternal and Neonatal Health Programme office, Directorate General of Health Services (DGHS)
- Directorate General of Family Planning (DGFP)
- Directorate General of Nursing and Midwifery (DGNM)
- Quality Improvement Secretariat (QIS), MoH&FW
- Obstetric and Gynaecological Society of Bangladesh (OGSB)
- Centre for Injury Prevention and Research (CIPRB) for technical support in report printing.
- All other development partners & agencies, implementing partners, donors are supporting and contributing to MPDSR implementation in Bangladesh.
- UNICEF, Bangladesh for technical review and support in providing cause-specific analyzed data
- WHO, Bangladesh for technical review of the annual report, and
- UNFPA, Bangladesh for providing technical support to the DGHS in the MPDSR annual report publication.


unicef


World Health
Organization
Bangladesh


UNFPA