গণপ্রজাতন্ত্রী বাংলাদেশ সরকার

Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

NATIONAL GUIDELINE ON

Maternal and Perinatal Death Surveillance and Response (MPDSR)

World Health Organization
Country Office for Bangladesh

UNFPA

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NATIONAL GUIDELINE ON

MATERNAL PERINATAL DEATH SURVEILLANCE AND RESPONSE (MPDSR)

Preface

Bangladesh has made substantial improvement in reducing maternal, neonatal and under five morality in the last decades. The country has been rewarded by global community for achieving Millennium Development Goal 4. Bangladesh shown commendable progress in reducing maternal mortality. A new sustainable development goal (SDG) has been set by United Nations to achieve by 2030 which urge member countries to reduce maternal deaths to 70 or less per 100,000 live births and Neonatal deaths 12 or less per 1000 live births, respectively. Maternal and Perinatal Death Review (MPDR) has been piloted in 2010 in Thakurgaon through existing health system by DGHS & UNICEF. Findings of the death reviews triggered health system and community response that improved the availability and quality of maternal and neonatal health services. Based on the findings MPDR has been scaled up gradually in 10 districts of Bangladesh by 2013. The death review system for maternal and perinatal deaths is able to identify the medical and social causes of deaths and factors associated to deaths that create evidences for taking action plan at local level to intervene to reduce the mortality. The country has been considered the global Maternal Death Surveillance and Response model developed by World Health Organization for preparing death review system for Bangladesh.

Government has considered Maternal and Perinatal Death Review as one of the key approach for quality improvement in maternal and newborn health Therefore, maternal and perinatal death review scaling up by 2021 has been incorporated in the draft result framework of 4th Health, Population and nutrition sector development program.

MPDR has been renamed as Maternal and Perinatal Death Surveillance and Response (MPDSR) to emphasize the surveillance and response as well as to keep consistency with WHO nomenclature. MPDSR is an evidence based approach building on a rigorous process of implementation maternal and perinatal deaths death review system for the last six years in Bangladesh.

This national guideline on MPDSR is a useful document for the health and family planning managers, planners, development partners, professionals, health care providers and field level health and family planning staffs to understand and know about MPDSR implementation in Bangladesh. This document emphasizes on different components of MPDSR including death notification, verbal autopsy, social autopsy, facility death review, data entry and analysis, monitoring and supervision system.

Health Minister, MOHFW

Mohammed Nasim, MP
Minister
Ministry of Health & Family Welfare
Govt. of the People's Republic of Bangladesh

মোহাম্মদ নাসিম, এমপি
মন্ত্রী
স্বাস্থ্য ও পরিবার কল্যান মন্ত্রণালয়
গনপ্রজাতন্ত্রী বাংলাদেশ সরকার

Message

Bangladesh has achieved remarkable success in improvement of maternal and child health and attained the MDG target for child mortality. Our Honorable Prime Minister has received the award from the United Nations for outstanding performance in reducing child mortality. Government of Bangladesh is investing in the health sector for its sustainable improvement with key focus on improving of maternal and child health.

Sustainable Development Goal (SDG) has set up target to reduce global maternal mortality ratio to less than 70 per 100,000 live births and new born mortality at 12 per 1000 live births globally. Bangladesh is committed to put best effort to reach the sustainable goal in time.

MOHFW has developed and been implementing Maternal and Prenatal deaths Surveillance and Response (MPDSR) to capture catch of the maternal, neonatal and stillbirths to identify and to response to the social causes of the death, Findings of the MPDSR helps the health system for improvement of maternal and neonatal health and will ultimately reduce the maternal and neonatal deaths in Bangladesh.

I am delighted that National Guideline on MPDSR has been developed. The Guideline is expected to be highly effective for the health managers and health care providers of Health and Family Planning Directorates for better implementation.

I appreciate Health Economics Unit of MOH&FW for leading the work of developing and implementing the guideline. I also thank UNICEF and others concerned who were involved with the development process of National Guideline. I hope that by acquiring knowledge from this Guideline, health professionals will play an important role in improving of maternal and neonatal health and reducing deaths in Bangladesh.

Joy Bangla, Joy Bangabandhu
Long live Bangladesh.

Mohammed Nasim

Health Secretary, Health Division

MD. SIRAZUL ISLAM
Secretary; HE & FP
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

মো: সিরাজুল ইসলাম
সচিব, এইচ ই এবং এফ পি
স্বাস্থ্য ও পরিবার কল্যান মন্ত্রণালয়
গনপ্রজাতন্ত্রী বাংলাদেশ সরকার

Message

The Government of Bangladesh is committed to ensure quality health care to all citizens in the country, especially in the area of maternal and neonatal health care as it is one of the priority areas for the government. The ministry of Health and Family Welfare has been leading the development and implementation of various programs and activities for improving maternal and child health. As a result of the concentrated efforts, the country has achieved impressive gains in this area which has been recognized globally. The efforts are still going and rising with the remaining challenges of further reducing maternal and neonatal mortality target set for sustainable development goals.

Maternal and Prenatal Death Surveillance and Response (MPDSR) is a mechanism to find out the root causes of maternal and neonatal death with a forward looking way to address it. The ministry has developed National Guideline to use the instrument at all level of service delivery in our country. I think Health Economics Unit for undertaking the initiative in developing the Guideline in consultation with Directorate General of Health Service and Directorate General of Family Planning and different stakeholders including Development Partners.

I hope the National Guideline for MPDSR will be the utilized effectively by the managers and health care providers at different level to ensure identification of causes of death and to find out solutions in preventing future death both in the community and in facility.

Md. Sirazul Islam

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DG, HEU, MOHFW

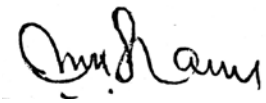
Forward

The Quality improvement Secretariat of Ministry of Health and Family Welfare is putting continuous effort to improve the quality of health care services in Bangladesh to fulfill the commitment of the government of Bangladesh to achieve universal coverage of quality care. Death review system is one of the integrated part of quality improvement in maternal and child health to detect the real causes and to find out ways to address the challenges.

Maternal and Prenatal Death Surveillance and Response (MPDSR) is an evidence based intervention that cross examines the causal factors both medical and social, and follows with appropriate actions to reduce maternal and neonatal deaths. The process is always participatory and follows on non-blaming approach and provides ample scope to the health managers and providers in planning and developing need based strategies and actions plan for improving services.

Health Economics Unit of MoHFW is pleased to be part in developing the MPDSR National Guideline. This is an output of our integrated effort of working together with UNCIEF, UNFPA, WHO, Developmental Partners, Professional Experts and Public Health Specialists. I gratefully acknowledge the support and cooperation of all of the partner organizations and professionals.

This Guideline will help the health managers and health care providers in following and implementing MPDSR process and thus will support in improvement of quality of care for the mothers and newborns in Bangladesh.



Md. Ashadul Islam
Director General
Health Economics Unit
Ministry of Health & Family Welfare
Govt. of the People's Republic of Bangladesh

DG, DGHS Heath

Message

The Government of Bangladesh is committed to improve maternal and neonatal health and kept this as the top priority under the current Health, Population and Nutrition Sector Development Programme (HPNSDP), 2011-2016. Next sector plan also focusing on reduction of maternal and neonatal mortality in Bangladesh. To achieve this, government has taken initiatives to strengthen death notification system for maternal, neonatal death including stillbirths followed by death reviews and response to avert similar maternal and neonatal deaths, over the last decades the management information system for health has been strengthen. Therefore, Bangladesh has been appreciated for its health system globally. The directorate general of health services incorporated the web-based data platform District Health Information Software (DHIS2) to strengthen health system information for every citizen of the country.

Maternal and Prenatal Death Surveillance and Response (MPDSR) in Bangladesh is an excellent initiatives to capture each of the maternal and prenatal deaths and immediately it entered in the web based online system. I am acknowledging the support of UNICEF to pilot and expand MPDSR in 13 districts. Following the death notification, death review will also perform and findings can be monitored upon upload the data in the DHIS-2. This digital innovation will strongly support to the health managers and planners to monitor the maternal and prenatal death situation in the country and identify causes to take appropriate action plan to reduce further death.

This MPDSR guideline has been developed for better understanding of the health and family planning health care providers and managers to righty and timely capture death explore causes of death and intervene accordingly.

I am thankful to Health Economic Unit of MoH&FW and UNICEF to lead this work and to UNFPA, WHO and other partners for their technical support. I sincerely thank and appreciate the hard work been done with the support of professional experts include Pediatricians, Obstetricians & Gynecologists, public health experts, officers from DGHS and DGFP and other development partners who contributed in developing the guideline for MPDSR in Bangladesh.

I strongly believe that this guideline will be useful resources for the providers and planners for scaling up MPDSR in the entire country and effectively undertake health system and community action to reduce the burden of maternal and prenatal deaths in Bangladesh

Prof Dr. Abul Kalam Azad
Director General of Health Service (DG HS)
Ministry of Health and Family Welfare

DG, DGFP-FP

Message

Maternal and perinatal death reduction is the priority area for the government. Directorate General of Family Planning (DGFP) is giving all sorts of efforts for ensuring quality of maternal care, birth planning, safe delivery and post natal care. The Directorate is closely working with Directorate General of health Services (DGHS) in order to reduce maternal and parental deaths. Maternal and Parental Death Surveillance and Response (MPDSR) in an integrated approach of DGHS and DGFP to work to address each of deaths, indentify causes of death and immediate plan for reduction of further deaths.

The national guideline for MPDSR would provide uniform approach for both directorates to notify maternal, prenatal and neonatal death, identity causes of death and take timely and focused initiatives to prevent deaths in near future. It's also a holistic approach to create a single platform for health department and family planning department to work together in MPDSR.

I would like to acknowledge the support and cooperation of all partners and stakeholders who contributed to the development of this important guideline. Health Economic Unit of MOH&FW and UNICEF have been instrumental in developing the Guideline and have ensured that the development process has been both participatory and consultative; I hope that all stakeholders will extend their support in implementing of MPDSR using this national guideline.

Dr. Mohammad Wahid Hossain
Director General of Family Planning (DGFP)
Ministry of Health and Family Welfare

Country Representative, UNICEF Bangladesh

Message

Bangladesh has witnessed significant advancement in past decades in reducing maternal and under five mortalities, achieved MDG4 and was on target to reach the MDG5 mark. In order to touch the Sustainable Development Goal (SDG) in heath sector, the Government of Bangladesh has kept reduction of maternal and neonatal deaths as key priorities and envisioned to achieve this by ensuring universal health coverage with quality health services. UNICEF, Bangladesh designed its country programme to complement government's vision to achieve the benchmark.

In this backdrop, UNICEF Bangladesh had initiated Maternal and Perinatal Death Review (MPDR) in a district of Bangladesh in 2010 with Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Obstetrical and Gynecological Society of Bangladesh (OGSB), Bangladesh Neonatal Forum (BNF), WHO, UNFPA and other partners which was gradually expanded to 13 districts of Bangladesh. MPDR has been used as an effective and evidence-based tool for planning, monitoring and health system strengthening to improve maternal and neonatal health in Bangladesh. A number of good examples already set in the districts using maternal and perinatal death reviews include community death mapping, identifying death-dense areas and intervening accordingly. UNICEF has been advocating with the government to scale up this approach. In order to do this, UNICEF partnered with Health Economics Unit of Ministry of Health and Family Planning (MoH&FW), UNFPA, WHO and other partners to develop this national guideline on Maternal and Perinatal Death Surveillance and Response (MPDSR) based on the previous guideline on maternal and perinatal death review.

I would like to congratulate Health Economics Unit of MOH&FW, DGHS, DGFP, UN agencies and other development partners including professional societies for finalizing this national MPDSR guideline. I wish the national guideline for MPDSR will be useful and effective for planning and review of maternal and perinatal deaths in Bangladesh and contribute to averting future deaths to reach the mark of Sustainable Development Goal by 2030.

Edouard Beigbeder
Representative
UNICEF, Bangladesh

Country Representative, WHO

Message

The World Health Organization is providing technical support to develop and strengthen a global Maternal and Perinatal Death Review (MPDR) system, The MPDR follows the World Health Organization's (WHO) surveillance scheme for maternal death "beyond the numbers" which is designed for reviewing maternal and neonatal deaths and still births. MPDR was first introduced in Bangladesh in 2010 and it has been found to be very effective in reviewing maternal and neonatal deaths and supporting reduction of similar cases of death.

In addition, WHO published a new model of Maternal Death Surveillance and Response (MDSR) system which focuses on the maternal death review findings for the reduction of maternal death at both the community and health facility levels, I am pleased to know that Bangladesh is working on the global MDSR framework by incorporating it in the ongoing death review system in the development of guidelines for Bangladesh, Maternal and Prenatal Death Surveillance and Response (MPDSR).

Bangladesh has made remarkable progress in reducing maternal and neonatal mortality over the past two decades due to its effective policies and practices. The Maternal Mortality Ratio (maternal deaths per 100,000 live births) declined from 322 in 2001 (Bangladesh Maternal Mortality Survey BMMS 2001) to 176 in 2015 World Health Statistics 2016), indicating that the country did remarkably well. The Government is now committed to reaching the Sustainable Development Goal by reducing Maternal Mortality Ratio to 70/100,000 live births and Neonatal Mortality Rate to 12/1000 live births by 2030.

I take this opportunity to congratulate Government of Bangladesh on their continuous effort to improve health status of people. I am hopeful that MPDSR findings will guide the planners and program managers in taking decisions for improvement of the maternal and neonatal health outcomes of Bangladesh.

Dr N. Paranletharan
WHO Representative, Bangladesh

Country Representative a.i., UNFPA

Message

The health of women and their newborns in Bangladesh is constantly improving, with more and more being able to access quality maternal and newborn health care provided by health professionals, such as midwives. Nevertheless, Bangladesh still sees as many as 15 women losing their lives every day due to pregnancy and birth related complications. Fifteen maternal deaths per day is too many. Both maternal and perinatal mortality remain a pressing public health concern.

It is to address this challenge in health care provision that a Maternal and Perinatal Death Surveillance and Response (MPDSR) method has been developed. MPDSR examines gaps in the health system and social factors that contribute to pregnancy or childbirth related deaths. It will thereby strengthen local level planning and monitoring, and guide healthcare systems to avoid these tragic losses of life. The Government of Bangladesh, using a participatory process, developed tools and guidelines for MPDSR, and its implementation has already begun.

Reviewing causes of death and identifying gaps in the healthcare system, as well as examining certain social norms, behaviours and attitudes that may increase the likelihood of maternal or newborn deaths, will be beneficial especially for marginalized women and their babies and those living in remote locations or in poverty. Understanding the circumstances that lead to the death of mothers and newborns will ensure that planning, programming and budgeting is tailored to maximize the impact for saving lives whilst "leaving no one behind" as called for in Agenda 2030 including the Sustainable Development Goals or SDGs.

We in UNFPA feel privileged to have been able to work with the Health Economics Unit, the Directorate-General of Health Services and the Directorate-General of Family Planning of the Ministry of Health and Family Welfare for the establishment of the MPDSR. Through its new Country Programme for Bangladesh 2017-2020, UNFPA is looking forward to continuing our work with the Government of Bangladesh towards overcoming remaining challenges in the health sector, including minimizing maternal and perinatal deaths. UNFPA remains committed to ensuring universal access to information and quality services on sexual and reproductive health and rights for all citizens of Bangladesh.

Iori Kato

Iori Kato
UNFPA Representative a.i.

Editorial

In Bangladesh Reporting and tracking maternal and perinatal death surveillance & response to reduce preventable deaths still remain major challenges regarding quality data management.

The Ministry of Health and Family Welfare (MOHFW) is responsible for planning and management of curative, preventive as well as promotive health services for the people. Maternal and neonatal health is one the priority area for the MOHFW. The progress yet impressive and has been appreciated globally for its sustainable progress. The country still needs further progress to reduce maternal and neonatal deaths which is a mandate of the government.

On behalf of MOHFW , Quality Improvement Secretariat (QIS) of Health Economics Unit has taken the initiative for development of MPDSR national guideline.

Involvement of wide range of stakeholders like DGHS, DGFP, UNICEF, UNFPA, WHO, SCI and DP partners, professional experts includes Pediatricians, Obstetricians & Gynecologists, and public health specialists for development and finalization of the guideline. A National core committee was formed for development and finalization of the guideline by holding series of meeting and national validation workshop.

This guideline will be effective for the health managers and health care providers to know in details on implementation of MPDSR and thus will support in improvement of quality of care for the mother and newborn in Bangladesh.

We hope that National Guideline for MPDSR is being effectively used by the managers and health care providers at different level to ensure identification of causes of death and find out solutions to prevent future deaths both in the community and in facility.

Dr Md Aminul Hasan
Deputy Director HEU
& Member Secretary
MPDSR guideline development committee

Abbreviations

AHI	Assistant Health Inspector
ANC	Antenatal Care
CHCP	Community Health Care Provider
CG	Community Group
CSG	Community Support Group
EmONC	Emergency Obstetric and Newborn Care
FDR	Facility Death Review
FP	Family Planning
FPI	Family Planning Inspector
FWV	Family Welfare Visitor
FWA	Family Welfare Assistant
FWC	Family Welfare Center
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
MNH	Maternal and Neonatal Health
MNHI	Maternal and Neonatal Health Initiative
MoHFW	Ministry of Health And Family Welfare
MO-MCH	Medical Officer- Maternal And Child Health
MPDR	Maternal and Perinatal Death Review
MPDSR	Maternal and Perinatal Death Surveillance and Response
MMR	Maternal Mortality Ratio
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
TOR	Term of References
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UH&FPO	Upazila Health & Family Planning Officer
VA	Verbal Autopsy
WHO	World Health Organization
UN	United Nations
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund

Contents

Background of MPDSR

Bangladesh has made significant stride in decreasing the maternal mortality ratio (MMR) from 569 in 1990 to 176 in 2015[1]. Nonetheless, MMR could not be reduced to 143 per 100,000 live births which was the target meet millennium development goal (MDG) 5 by 2015. Although, under five deaths reduced significantly, slower pace in reducing neonatal mortality, will pose key challenge in achieving the SDG 4 target. These call for additional effort for achieving Sustainable Development Goals by 2030. The Goal 3 of SDG is to ensure healthy lives and promote well-being for all. By 2030, it has set the target to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births. Every Newborn Action Plan (ENAP) also sets a goal by 2030, all countries will reduce newborn deaths to 12 or less per 1000 live births and reduce stillbirths to 12 or less per 1000 total births.

As defined by WHO, 'Maternal death surveillance and response is a continuous cycle of notification, review, analysis and response. It works by involving all stakeholders in the process of identifying maternal deaths, understanding why they happened and taking action to prevent similar deaths occurring in the future'[2].

Envisioning to sustain the momentum achieved in reducing under five mortality and maternal mortality ratio, Directorate General of Health Services (DGHS) in collaboration with the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MOHFW) of Government of the People's Republic of Bangladesh, initiated Maternal and Perinatal Death Review (MPDR) through the national health system to notify maternal, neonatal deaths and still births in the Thakurgaon District of Bangladesh in 2010[3], with technical assistance from UNICEF. Obstetric & Gynecological Society of Bangladesh and Bangladesh Neonatal Forum, UNFPA, WHO and CIPRB were involved in all stages of development tools, guideline and implementation of MPDSR[4]. Intervention design, tools and guideline have been approved by government.

The MPDSR based on anonymity, non-blaming, non-punitive approach and fosters participation at all levels for identifying maternal and neonatal deaths and stillbirths. MPDSR is an evidence based approach that cross examines both health system and social factors through a systematic process. MPDSR system has identified vulnerable pocket areas with high maternal and neonatal deaths and enabled health managers to track district specific MMR and NMR. The trend

1. Trends in Maternal Mortality : 1990 to 2015, WHO, UNICEF, UNFPA and WB estimates
2. WHO, Time to respond. 2016
3. Biswas, A., Rahman, F., Halim, A., Eriksson, C. and Dalal, K. (2014) Maternal and Neonatal Death Review (MNDR): A Useful Approach to Identifying Appropriate and Effective Maternal and Neonatal Health Initiatives in Bangladesh. Health, 6, 1669-1679. http://dx.doi.org/10.4236/health.2014.614198
4. Biswas A . (2015) Maternal and Perinatal Death Review (MPDSR) : Experiences in Bangladesh. WHO. Available from http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/bangladesh-study/en/

in causal factors and care seeking by the community for maternal and neonatal emergencies have been explored and presented to health managers, providers and stakeholders to identify specific action points for improvement. MPDR data is being used for death mapping, developing evidence based local level planning, monitoring and health system strengthening to reduce maternal and neonatal deaths.

The results from MPDR were shared regularly to DGHS and DGFP through experience sharing meeting at national level which has informed expansion in other districts.

Based on the success of MPDR in one district, this approach has gradually scaled up to 22 districts of Bangladesh by 2016. Among these districts, UNICEF has been supporting 14 districts and Save the Children in four districts. UNFPA planned to implement MPDR in five new districts.

Quantitative data from death notification and verbal autopsies within the communities provide in depth information on cause, time and place of death, gaps in health system in service delivery and role of communities in seeking timely care. The entire intervention has been implemented through existing government health system. Front line health workers include health assistants (HA) and family welfare assistants (FWA) both notifying deaths at the community. Subsequently, 1st line supervisor includes health inspectors (HI), assistant health inspectors (AHI) or family planning inspectors (FPI) perform verbal autopsy. Facility based death reviews are undertaken at the facility level by health managers and service providers. Upazila and District MPDR committees review MPDSR data and take appropriate local actions. Based on the MPDSR death notification, in between 2010 to September 2015, 1314 maternal deaths, 14, 381 newborn deaths were reported and reviewed in old four districts (Thakurgan, Jamalpur, Narail, Moulvibazar). However, during October 2013 to September 2015, 869 maternal deaths, 8473 newborn deaths have been reported and reviewed in new six districts (Sirajganj, Panchgarh, Bagerhat, Netrokona, Cox's bazar & Bandarbon). It is noteworthy to mention that implementation of MPDR has been envisaged in the MNC&AH Operational Plan 2011-16. Political commitment resulted in incorporation of MPDSR training in the national health sector plan, establishment of knowledge hubs at subnational teaching hospitals serving as centre of excellence and MPDSR data being incorporated in web based Health Management Information System (HMIS) of Directorate General of Health Services.

In this backdrop Quality Improvement Secretariat (QIS) of Health Economics Unit under the MoH&FW has embarked on developing a national guideline of MPDR to inform national scale up and consistency in interventions in different districts. In August 2015, QIS has formed three working groups to review available project guideline to frame key components of the national guideline in collaboration with Directorate General of Health Services and Directorate General of Family Planning.

MPDR has been renamed as Maternal and Perinatal Death Surveillance and Responce (MPDSR) to put more emphasis on surveillance and response and to keep consistency in WHO nomenclature.

Henceforth, development of MPDSR national guideline would facilitate scaling up of this evidence based approach throughout the whole country. The guideline will facilitate understanding the mechanism, process and steps of implementation of MPDSR including utilization of data for the improvement of maternal and neonatal health services throughout the whole country. This will be used by field level health staff, health Care providers and managers to track real time data on maternal and neonatal death, explore medical and social causes including the health system and social bottlenecks and identity corrective actions to avert those unwanted deaths in future.

MPDSR Implementation Framework

The uniqueness of MPDSR is marked by implementation through existing health system which ensures ownership and pave the pathway to sustainability. This approach engaged the front line health workers (HA and FWA) of DGHS and DGFP to collect and notify each maternal death, neonatal deaths and still births from the Community from their respective catchment areas. After the notification by HA /FWA from community, verbal autopsies and social autopsies are carried out by field level 1st line supervisor of health and family planning department (HI/ AHI/FPI) at the household level.

At the facility level (upazila health complex, maternal and child welfare centre, district hospital and medical college hospital, private clinics), the senior staff nurses (SSN) or family welfare visitors (FWV) notify maternal deaths, neonatal deaths and still births. After death notification at the facility, SSN or FWV with the support of medical doctor or consultant/ specialist perform facility death review at the facilities.

Causes of maternal & neonatal deaths are identified at the divisional level by the professional expert to provide feedback to the district and upazila to undertake appropriate action plan to avert similar death in future. Facility death review organizes by the doctors and nurses to find out the gaps and challenges to improve of quality of care in the facilities. Mapping of community deaths and findings from verbal and social autopsy help the upazila managers to identify the death dense areas as well as medical causes and social factors related to death. Thus, MPDSR intervention effectively contributes to health system strengthening as well as triggering community response to reduce maternal and newborn deaths. It also enables managers in tracking district specific mortality trends .

Overall MPDSR Framework has been sketched in the Figure A below

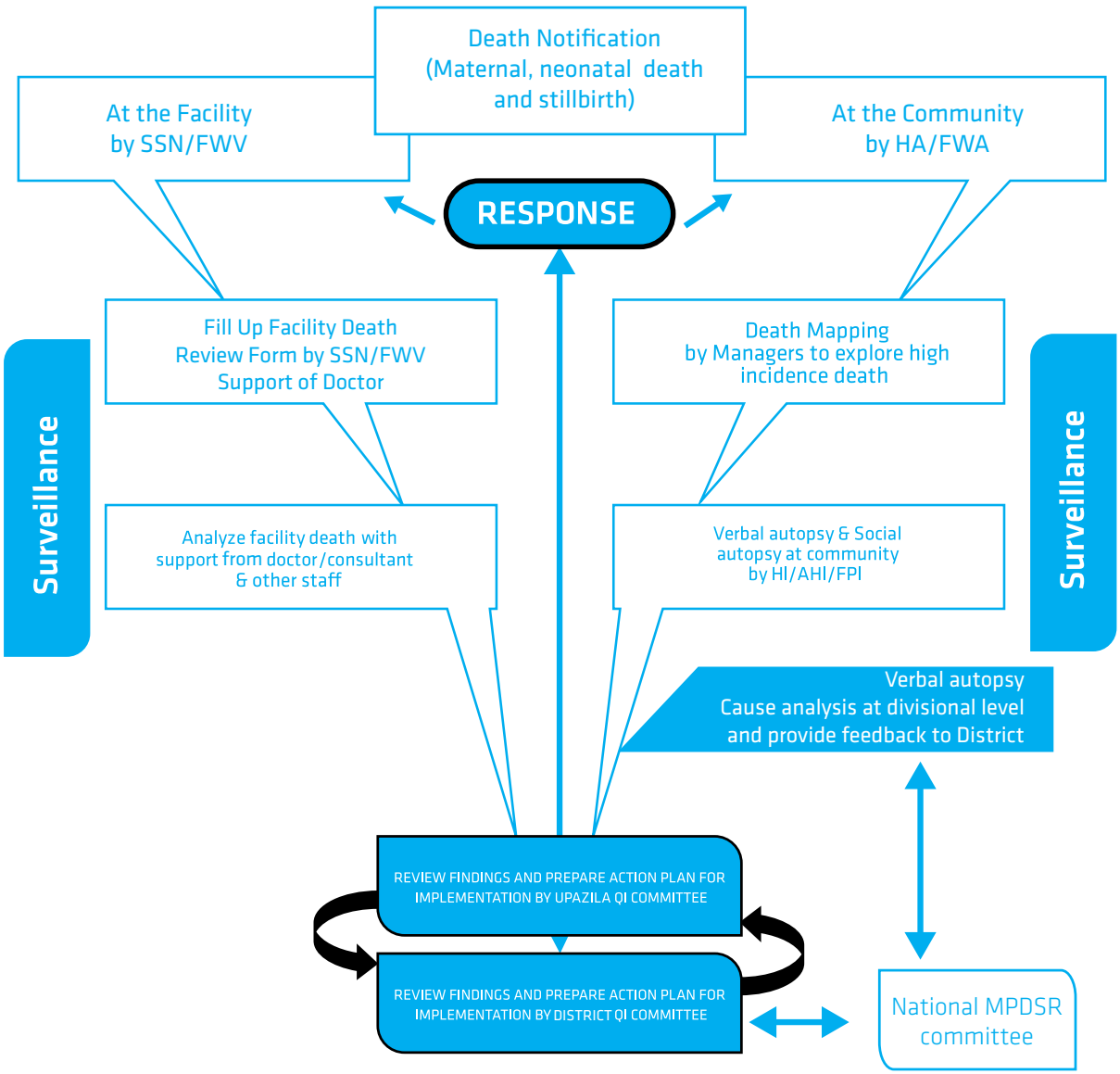


Figure A: MPDSR Implementation Framework

Objectives of MPDSR

1. To identify and notify all maternal and neonatal death and also stillbirth in both rural and urban areas.
2. To determine medical and social causes of maternal and neonatal death and stillbirth in the community.
3. To determine medical causes of maternal and neonatal death and stillbirth in the facility and explore the health system bottlenecks including gaps and challenges and corrective actions to avert such deaths in future.
4. To identify pockets of death dense areas through death mapping and guide health managers to prioritize context specific remedial action.
5. To track real time district and upazila specific maternal, neonatal death and stillbirth through HMIS and monitor the progress to achieve SDG 3.
6. To support developing, implementing and monitoring evidence based MNCH plan at local level to avert maternal and neonatal deaths and morbidity

Operational Definition

Key terminologies under MPDSR including Maternal Death, Neonatal Death & Stillbirths are appended below. Definitions followed the standard definition of World Health Organization (WHO) :

Maternal Death

Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes is considered as Maternal Death.

Neonatal Death

Death occurring during in between birth to 28 days of life is considered as Neonatal Death.

Stillbirth

A baby born with no signs of life at or after 28 weeks' gestation. (did not take any breath/ did not have any movement) is considered as Stillbirth.

Chapter 1
Rural Community Based MPDSR

Death Notification in Rural Community

In the community, the Community clinic (CC) platform will be used for notifying deaths. A community clinic is designed to cover aproximately 6000 populations. Each CC is supported by 1 Community Group (CG) and 3 Community Support Groups (CSG)s. Also, for every old ward, 1-2 HAs and FWAs are assigned for routine HH visits in the community.

The field staffs (HA & FWA) are responsible to register and notify all maternal and neonatal deaths and stillbirths in their assigned catchment areas. The NGO workers, volunteers,CG and CSG will also be involved in the death notification process and will support to the heath workers to formally notify deaths.

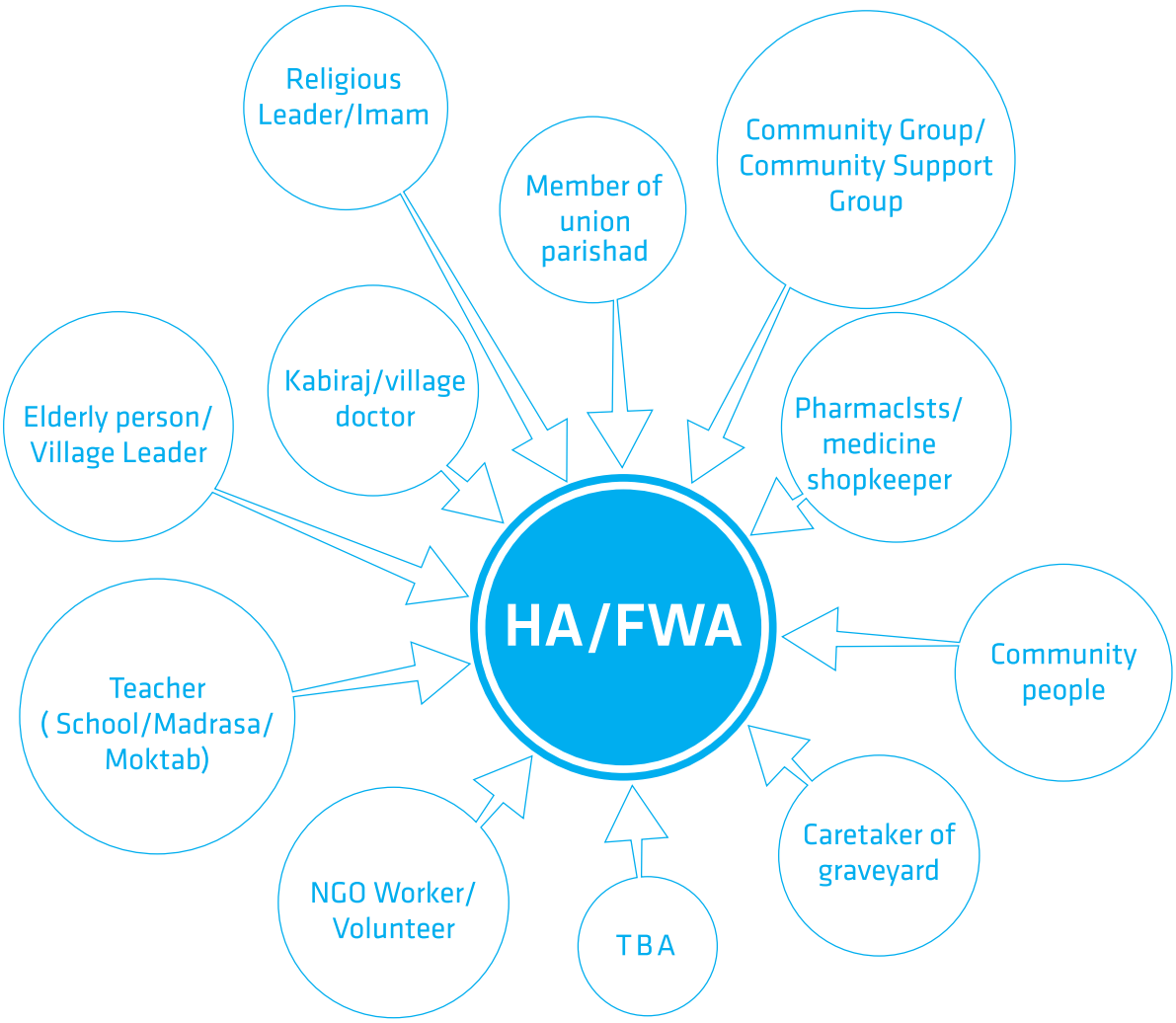
Steps of Community Death Notification

Step 1: Rural Community Death Identification

Deaths in the rural community will be detected and reported by Health Assistant and Family Welfare Assistant from his/her assigned areas. Deaths should be notifed within 3 days.

They will use different means to collect the death news through community networking: such as during field visit in his/her designated areas, from family members, neighbours, caretakers of the graveyard, CHCPs, Communty Group and Community Support Groups, volunteers, village representative, imams, village doctors, school teachers, NGO workers, social workers, medicine shop keepers, pharmacists. The below figure suggest different sources of information of death notification in a rural community [Figure B].

Figure B: Different sources of information for the field workers (HA/FWA) at rural community



Step 2: Rural Community Death Notification and Reporting

After receiving death information from any sources, HA/FWA will visit the deceaser's house, verify the death news following definition and fill out death notification slip and immediately will share a copy of the slip to the Community Health Care Provider (CHCP) of the CC located in his/ her assigned catchment area. Another copy of the notification slip will be submitted to the Upazila Health and Family Planning Officer or MPDSR focal person.

CHCP in turn will enter basic data (registration number, place and date of death etc.) from the death notification slip in District Dealth Information Software-2 (DHIS2) of Management Information System (MIS) of DGHS. It will generate an automated notification to UHFPO. In case of areas where there is no CC, the HA and FWA will report through the adjacent Community Clinic.

The Upazila statistician will cross check the hard copies of the number of death notification slips with the number of entry by CHCPs in DHIS-2 thereby confirming the actual number of deaths happened within the upazila.

Verbal Autopsy at Rural Community

Verbal Autopsy (VA) in MPDSR is one of the key component to identify medical and social causes including factors responsible for a death. This also provides scope of getting a unique insight of awareness about the need for care, cultural norms and beliefs, the use of harmful or inappropriate traditional practices, first and second delays during delivery or complications.

A verbal autopsy for maternal, neonatal deaths and stillbirths will be done at deceased's home in the community. Within the existing Government system, the first line field supervisors (HI/AHI/FPI) will be responsible to perform the verbal autopsy in the community. This autopsy will be done within 7 to 15 days of the death happened.

VA is particularly useful and effective to understand the causes and scenario by the Health and Family Planning Managers who in turn can undertake corrective actions for reduction of maternal and neonatal deaths.

Objectives of Verbal Autopsy in Rural Community

1. To identify the medical and social causes including delays for maternal, neonatal death & stillbirth in the rural community.
2. To analyze and disseminate the death findings for preparing the evidence based local level action plan and implementation modalities.
3. To strengthen the health system for improving the maternal and neonatal health services.

Instrument to be used in verbal autopsy

There are three types of form to be used to perform verbal autopsy

- Form 1
  Maternal death review form
- Form 2
  Neonatal death review form
- Form 3
  Stillbirth review form

Process of Verbal Autopsy

a) Conduction of verbal autopsy

After the death notification in the system (DHIS2), the Upazila manager will assign first line supervisor (HI/AHI/FPI) of Health and Family Planning

department to conduct the verbal autopsy in the same community. The supervisors will visit the household within 7 -15 days of death occurred in the rural community. S/he will confirm the death according to operational definition and then identify the main respondent to do the interview. The interviewee must be carefully selected (considering presence at the time of death and related events) to gather accurate information. In case of neonatal death or stillbirth, mother will be given priority as respondent. The interviewer should clearly specify objectives of conducting verbal autopsy to the interviewee and must take written consent before the interview session. Interviewer need to maintain a non-blaming approach and should not force or lead the respondent to get response. The respondent need to be informed that they will have scope and freedom to escape any question or stop the interview process. The interviewer must assure about the confidentiality of the interviewer's information and only share the findings to proper authority.

b) Reporting and cause assignment

The interviewer (HI/AHI/FPI) will perform the verbal autopsy and will fill up the structured questionnaire properly and submit the original copy of the filled up questionnaire to the statistician in the Upazila Health Complex.

A copy of verbal autopsy form will later be sent to district and then to the division. Cause assignment for each of the verbal autopsies will take place at the divisional level by the professional experts team of medical college hospital (obs-gynaecologists, paediatricians and neonatologists). Verbal autopsy findings and causes of death will be entered in DHIS-2 from the divisional level after assigning causes of death.

Social Autopsy at Rural Community

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 level not for seeking timely care and increase response by the community[5]. It's a mechanism to examine or scrutinize social factors relevant to an event/ occurrence; to determine the reasons as well as finding ways to prevent this in the near future. The community people collectively determines the root causes and strategies for dealing with the occurrence of similar situations in the future. Thus, it cross examines the medical or social factors of a death through a systematic process and follows with appropriate community actions to reduce deaths. Social autopsy is a non-blaming approach in the society which focused on social factors, dilemma related maternal and newborn death occurred at community, discuss with the community groups, community support groups, neighbours 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. People attended in the meeting get the opportunity to hear mistakes/ errors from the incidence of a maternal and neonatal death, they will feel, realize the causes and understand by seeing the emotional and touchy moment and learn from this sad example.

Objectives of Social Autopsy in Rural Community

1. To explore the social factors and barriers that caused maternal, neonatal deaths and stillbirths in the community .
2. To summarize different statement from the community groups and other members of society in preventing such deaths in future through addressing the social factors.

5 *Mahmud R. Social autopsy triggers community response for averting maternal and neonatal death in Bangladesh. Accessed online, 3 May 2016. http://www.who.int/maternal_child_adolescent/epidemiology/maternaldeath-surveillance/case-studies/social-autopsy-bangladesh/en/*

3. To identify solutions from the lessons learnt. and address the barriers by community groups.
4. To build awareness among community members on death specific preventive measures.
5. To improve knowledge of the community on maternal and neonatal complications, birth planning, antenatal care, safe delivery, postnatal care etc.
6. To mobilize the community to seek quality of care from the facility.

Instrument to be used in Social Autopsy:

- Social Behavior change communication (SBCC) materials:
  These materials will be used by the health care providers during conducting the social autopsy at community which are available from government supplies. The SBCC set consist of pictorial flipchart, containing maternal and neonatal complications and it's preventive measure to be taken by the community.
- Semi- structured reporting form;
  This form will be filled up at the end of meeting.

Process of Social Autopsy

1.Facilitator of Social Autopsy

Health Inspector/Assistant Health Inspector, Family Planning Inspector of respective area will facilitate the social autopsy session through coordination between Health Department and Family Planning Department. Health Assistant/ Family Welfare Assistant/ NGO worker, Community Group, Community Support Group will provide necessary support to HI/AHI/FPI in organizing the community to conduct the event successfully.

2.Place for Social Autopsy

Generally, a place besides the deceased's home/ courtyard of a neighbour's house will be selected as a place to conduct the social autopsy. The selected place should have sufficient space for group discussion with 40-50 persons.

3.Participants for Social Autopsy

Around 40-50 participants from adjacent 20-30 households close to the deceased's home will be the participants of Social Autopsy. 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 will join the discussion. Adolescent boys and girls should also join here. Members of the deceased's family should not join as they would had been passing though shocking memories. Besides this, pregnant mothers or newly married women are encouraged to participate. It is important to encourage the presence of male participant who are household head or decision maker of the family.

4.Time to conduct Social Autopsy

A social autopsy shall be organized within 15-30 days after the death occurred.

5.Duration of Social Autopsy

The average duration of the social autopsy session is 45 minutes to one hour. However, it could be extended for more than an hour if the participants discuss rigorously. Generally, during late noon and evening time is suitable for conducting social autopsy. Because at that time household head and male participants can join the session. However, it can be organized in the morning hours depending on availability of the participants in the community.

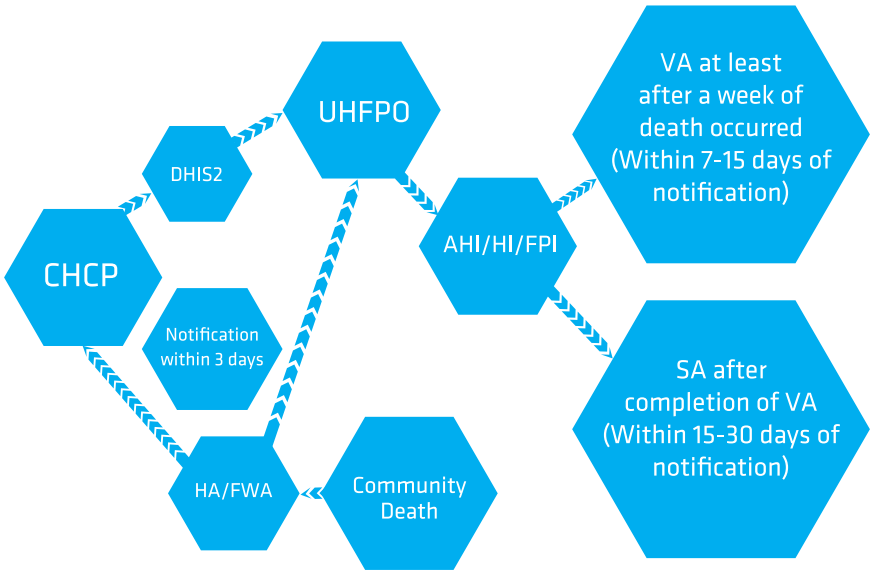
6.Facilitation of Social Autopsy

At first the Health Inspector/Family Planning Inspector (facilitator) introduces him/herself and specify the objectives of the meeting. S/he will seek a verbal consent from the participants before starting the process. At the beginning, the health worker invite anyone from the community or the neighbours to describe what happened before the death or how the death has occurred. The health worker will concentrate on finding out the social barriers/ factors of the death without highlighting any blame to any individual or institution. S/he will prompt each of the answers on social barriers and issues raised by the participants to better understand about preventing factors that could be useful to save the lives of mother and newborn in near future. The health worker will try at best level to identify social factors/barriers related to a death from the description. If any issues related to blaming any health care providers/individuals/ institution come in front during describing the death scenario, the health worker will avoid that issue, rather focus on social factors/ barriers. The health worker will provide room for the participants to speak and ask about their thought and opinion on the death in a positive environment.

The health worker will give floor to the male paticipants to know their views and ensure their participation in preventing such obstacles in coming future.

The facilitator will show a set of social behavioral change communication (SBCC) materials on maternal and neonatal health to the participants. If the maternal death occurrs, then the provider will show SBCC materials on maternal complications and its prevention. If it's neonatal death, then the facilitator will show the SBCC materials on newborn health. The facilitator will show SBCC materials about usefulness of seeking treatment at health facilities. Finally, the facilitator will seek 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 will also request 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. The health worker will ensure that the community should get take home message from the session. 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.

Figure C: Framework for community Death notification, verbal autopsy and social autopsy



Chapter 2
Urban community based MPDSR

The city corporations (Dhaka & Chittagong) are divided in zones and MPDSR report should be sent to Chief Health Officer. For other small city corporations like Khulna, Barisal, Sylhet, Rajshahi and District municipalities should report to respective Civil Surgeon office. Upazila municipalities are available in some of the areas and should report to respective upazila health complex.

Deaths should be notifed within 3 days after a death occured in the urban areas. The steps for death notification in urban setting comprises of the following steps:

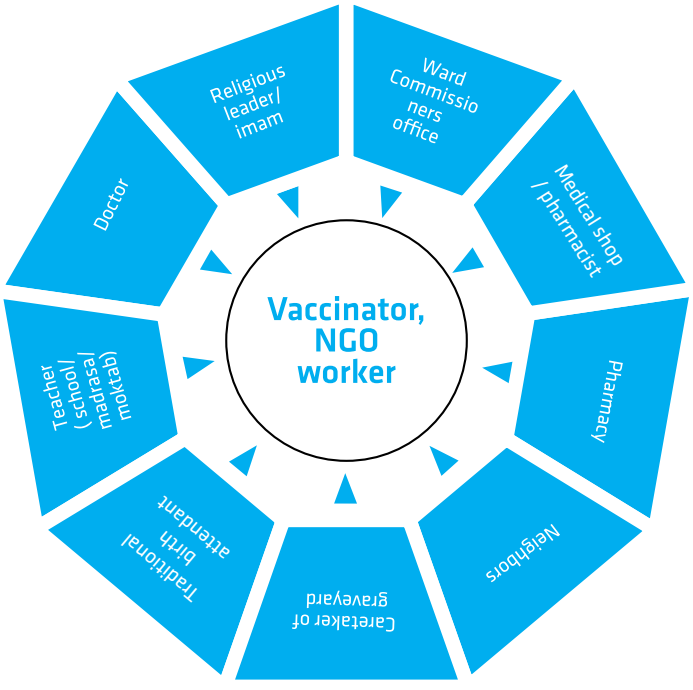
Death Notification in Urban Community

Step 1 : Urban Community Death Identification

Deaths in the urban community will be detected and reported by city corporation's vaccinators, NGO workers from his/her assigned areas. Deaths are required to be notifed within 3 days after a death occured.

They will use different methods to collect the death news through community networking: such as during field visit in his/her designated areas, from family members, neighbors, caretakers of the graveyard, Ward Commissioner's office, private/NGO clinic, religious leaders, school teachers, NGO workers, social workers, traditional birth attendent, medicine shop /pharmacists [Figure -D].

Figure D: Different sources of information for the field workers (Vaccinator/NGO Worker) at urban community



Step 2: Urban community death notification and reporting

In case of large City Corporations, City Corporation's vaccinators and NGO workers will notify all maternal, neonatal deaths and stillbirths in the prescribed notification slip to Zonal Health Offices in Dhaka and Chittagong City Corporations. In case of Rajshahi, Khulna, Sylhet, Barisal and other small city corporation, the notification will be sent to the focal person at Civil Surgeon's offices.

District municipalities can directly send death notification to respective Civil Surgeon office through municipality health office. Deaths in the upazila municipality will be notified by upazila vaccinators and will be sent to the Upazila Health and Family Planning Officer at upazila health complex. Immediate notification can also be done to the focal person in upazila health complex or in municipality or in the city corporation by mobile text message whereas the death notification slip will be the mandatory means of notification.

Designated staff in City Corporation and statistician in the Civil Surgeon Office/upazila health complex in turn will enter basic data (registration number, place and date of death etc.) from death notification slip in District Health Information Software-2 (DHIS2) of Management Information System (MIS) of DGHS. It will generate an automated notification to the CS/ UHFPO.

Verbal Autopsy at Urban Community

Verbal Autopsy (VA) in MPDSR is one of the key component to identify medical and social causes including factors responsible for a death. This also provides scope of getting unique insight of awareness of the need for care, cultural norms and beliefs, the use of dangerous or inappropriate traditional practices, first and second delays during or delivery or in complications.

A verbal autopsy for maternal, neonatal deaths and still births will be done at deceased's home in the urban community. Within the existing government system, the Public Health Nurse or Sanitary Inspector or NGO workers will be responsible to carry out the verbal autopsy in the urban community. This autopsy will be done within 7 to 15 days of the death happened.

VA is particularly useful and effective to understand the causes and scenario by the Health and Family Planning Managers / planners who in turn can undertake corrective actions for reduction of maternal and neonatal deaths.

Objectives of Verbal Autopsy in Urban Community

1. To identify the medical and social causes including delays in the urban community.
2. To analyze and disseminate the death findings for preparing the local level action plan and implementation modalities.
3. To strengthen the health system design for improving the maternal and neonatal health services.

Instrument to be used in verbal autopsy

There are three types of form to be used to perform verbal autopsy

- Form 1
  Maternal death review form
- Form 2
  Neonatal death review form
- Form 3
  Stillbirth review form

Process of Verbal Autopsy

a)Conduct of verbal autopsy

After the death notify in the system, the focal person at the City Corporation/Civil Surgeon Office/upazila

manager of upazila health complex will assign person (Public Health Nurse/Sanitary Inspector/NGO supervisors) to conduct the verbal autopsy in the same urban community. The assigned person will visit the household after at least 7 days after death occurred in the urban community.

S/he will confirm the death according to operational definition and then identify the main respondent to do the interview. The interviewee must be carefully selected (considering the presence at the time of death or who knows detail of death) to gather accurate information. In case of neonatal death or stillbirth, mother will be given priority as respondent. The interviewer should clearly specify objectives of conducting verbal autopsy to the interviewee and must take written consent before the interview session. Interviewer will maintain a non-blaming approach and doesn't force or lead the respondent to get response. The respondent need to be informed that they will have scope and freedom to escape any question or stop the interview process. The interviewer must assure about the confidentiality of the interviewer's information and only share the findings to proper authority.

b) Reporting and cause asignment

Ideally, the verbal autopsy should be performed within 7-15 days of death notification from the field. The interviewer will perform the verbal autopsy and will fill up the questionnaire properly and submit the original copy of the filled up questionnaire in respective channels (In case of Dhaka and Chittagong city corporations, to Zonal Health Office of City Corporation; for other city corporations, to civil surgeon office/ Zonal Health Office of City Corporation; For District Municipality, civil surgeon office and for upazila municipality, upazila health complex).

Statistician or the CS officer or the UHC will keep all the records of verbal autopsis. The respected health worker may submit the form to the MPDSR focal person or Civil Sugeon Office or UHC.

A copy of Verbal Autopsy form will later be sent from the upazila to respective division. Cause assignment for each of the verbal autopsies will take place at the divisional level by the professional expert team of medical college (obs-gynocologists, peditricians and neonatologists). Verbal autopsy findings and causes of death will be entered in DHIS-2 from the divisional level at divisional health office after assigning causes of death.

Social Autopsy at Urban Community

Social Autopsy (SA) is a mechanism to examine or scrutinize social factors relevant to an event/ occurrence, to determine the reasons as well as finding ways to prevent this in the near future. The group collectively determines the root causes and strategies for dealing with the occurrence of similar situations in the near future.

Social autopsy in urban community cross examines the medical or social factors of a death through a systematic process and follows with appropriate actions to reduce maternal and perinatal deaths.

Objectives of Social Autopsy in Urban Community

1. To find out the social factors and barriers that caused maternal, and neonatal deaths and stillbirths in the urban community.
2. To summarize different statement from the community groups and other members of society in preventing such deaths in future through addressing the social factors.

3. To identify solutions from the lessons learnt and address the barriers by urban community.
4. To build awareness among urban community members on death specific preventive measures.
5. To improve knowledge of the community on maternal and neonatal complications, birth planning, antenatal care, safe delivery, postnatal care etc.
6. To mobilize the community to seek quality of care from the facility.

Instrument to be used in Social Autopsy:

See page 11

Process of Social Autopsy

1. Facilitator of social autopsy

After a verbal autopsy performed of a maternal and neonatal death or still birth then report back to UHC or CS officer or City corporation. The focal person at the respective place will asign again the person (Public Health Nurse/Sanitation Inspector/NGO worker) to conduct the social autopsy in the same urban community. The asigned person will organize the meeting close to the deceased lane, in the courtyard of a neigbors with in 15- 30 days of a death occured & after the completion of verbal autopsy.

2. Place for Social Autopsy

Generally, besides the deceased home a suitable place will be selected as a place to conduct the Social Autopsy. The selected place should have sufficient space for group discussion with 40-50 persons.

3. Participants for Social Autopsy

Around 40-50 participants from adjacent 20-30 households close to the deceased home will be the participants of social autopsy. Senior members of respective urban community, teachers, ward commissioners, volunteers including both male and female members shall join the discussion. Adolescent boys and girls should have scope to join in this discussion. Members of the deceased family should not join as they would had been passing though shocking memories. Beside pregnant mothers or newly married women are highly encouraged to participate. Decision makers of the familly, partcullarly men will be more encouraged to participate.

4. Time to conduct Social Autopsy

A social autopsy will be organized within 15- 30 days after the death occurred.

5. Duration of Social autopsy

The average duration of the social autopsy session is 30- 45 minutes. However, it could be extended for more than an hour, if the participants discuss it rigorously. Generally, during late noon and evening time is suitable for conducting social autopsy. Because at that time household head and male participants can join the session. However, it can be organized in the morning hours depending on availability of the participants in the community.

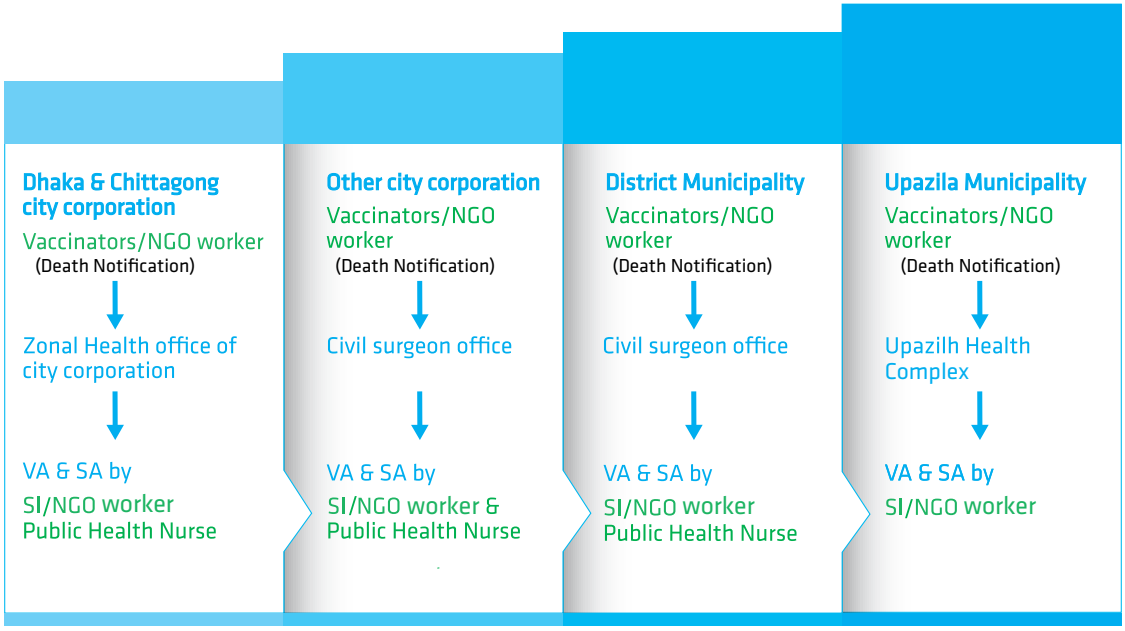
6. Facilitation of Social Autopsy

At first Public Health Nurse/Sanitary Inspector/NGO supervisors (facilitator) introduces him/herself and specify the objectives of the meeting. S/he will seek a verbal consent from the participants before start the process. At the beginning, the health worker invite anyone from the community or the neighbors to describe what happened before the death or how the death was occurred. The health worker will concentrate on finding out the social barriers/ factors of the death without highlighting any blame to any individual or institution. S/he will prompt each of the answers on social barriers and issues raised by the participants to better understand about preventing

factors that could be useful to save the lives of mother and newborn in future. The health worker will try at best level to identify social factors/ barriers related to a death from the description. If any issues related to blaming any health care providers/ individuals/ institution come in front during describing the death scenario, the health worker avoid that issue, rather focus on social factors/ barriers. The health worker will provide room for the participants to speak and tell about their thought and opinion on the death in a positive environment. The health worker give floor to the male persons to know their views and how they could participate in preventing such obstacles in coming future.

The facilitator will show a set of social behavioral change communication (SBCC) materials (Flip chart) to the participants. If the maternal death occurred, then the provider will show SBCC materials on maternal complications and its prevention. If it's neonatal death, then the facilitator will show the SBCC materials on newborn health. The facilitator will show SBCC materials about usefulness of seeking treatment at health facilities. Finally, the facilitator will seek support and commitment from the society on how the society would better plan in near future to prevent any death. The health worker also request the local leader/ member/ elite person to show their commitment for the society and how they play role in overall improvement of the system. The health worker will ensure that the community should get take home message from the session. After completion the facilitation session, the facilitator will fill up the social autopsy reporting form and return it back to the focal point at respective level (In case of Dhaka and Chittagong city corporations, to zonal health office of city corporation; for other city corporations, to civil surgeon office/ zonal health office of city corporation; for district municipality, civil surgeon office for upazila municipality, upazila health complex and health section of the municipality). Later the data and findings of SA will enter in DHIS2 following monthly Health Workers form [Figure E]

Figure E: Framework for urban community death notification, verbal autopsy and social autopsy



Chapter 3
Facility Death Review (FDR)

Facility-based death review of maternal death, neonatal death and stillbirth at the facility level is a simpler participatory process established within the health system to identify causes and factors related to a death at the facility. Deaths from all levels of facilities including medical college hospital, district hospital, maternal and child welfare center (MCWC) and upazila health complex (UHC) as well private clinics & hospitals should be notified. The death review process will include three step functions: i) recording and reporting maternal, neonatal death and stillbirth ii) collecting information on death using facility death review form and iii) finally reviewing analytic findings in periodic facility based MPDSR sub-commitee meetings.

Objectives of Facility Death Review

1. To identify and notify all facility maternal, neonatal deaths and stillbirths
2. To explore medical causes and factors associated with maternal deaths, neonatal deaths and stillbirths at the facility.
3. To identify gaps and challenges of preventing maternal and neonatal death in the facility including logistics, human resources, equipments and supplies for providing services.
4. To support in improvement of quality of services of maternal and neonatal health care at health facility.

Levels of facility

All facilities including Medical College Hospitals (MCH), Specialized Hospitals, District hospitals, MCWCs, Upazila Health Complexes and private health facilities at different levels.

Steps of Facility Death Review

A. Death notification and reporting system

When a maternal death/ neonatal death or still birth occurs at any facility level, the death information will be recorded and reported according to level.

At all level facilities, the deaths will be recorded by the on-duty Senior Staff Nurses of the respective wards and Family Welfare Visitor(FWV)s will report the death in the MCWCs. They will notify this death to the respective Ward-in-Charge/MO clinics of MCWCs as well as to the MPDSR sub-committees and the facility managers. Deaths which are registered in the facility will also be counted for facility death notification.

B. Filling up the facility death review form

Senior staff nurse in the medical college hospital, govt. specialized hospital, district hospital and upazila health complex, FWV in the MCWC and nurses in private hospitals will be assigned by the facility manager/ MPDSR sub-committee to fill up the facility based death review form with the necessary support from the medical doctor/ consultant/ specialist after the death notified and reported.

The SSN/FWV will collect the first hand data reviewing the hard records such as death certificate, admission register, patient history records, treatment sheets, emergency/OT register, rosters of on-duty providers etc. S/he will also discuss with the concerned facility providers and those staff involved in the care of the deceased (doctors, nurses, ward boys, ayas etc.) and will fill up the facility death review forms. It is to be considered that there is no scope to do interview with any of the family members of the deceased immediate after death in the facility. Therefore, recall and records are the only method for data collection. After filling up the form, he/she will submit the form to the MPDSR sub-committee/Managers MPDSR focal person of the facility.

Once a maternal neonatal death or stillbirth occur in a facility, Senior Staff Nurse will fill up the 'Facility Death Review Form' by consulting with the doctors, concerned staff and providers that were involved to provide care of the deceased. He/she will also notify the MPDSR sub-committee members/facility managers MPDSR focaal person about the death event.

All facility deaths will be reviewed in the regular morning sessions/clinical meetings in presence of the departmental heads and other doctors, providers/ managers/directors/ MPDSR sub-committees.

C. MPDSR review meetings

The filled up FDR forms will be analyzed and discussed in periodic MPDSR sub-committee meetings/Quality Improving Committee meetings/ monthly health and family planning meetings at the facility to find out causes and system gaps and then appropriate remedial actions will be identified for improvement of quality of MNH care. These information can also be used in monthly health and family planning meeting at upazila and district level to take action to improve the health system in the facility and trigger community actions.

Chapter 4
Data Analysis & Reporting

MPDSR Data Flow Outline

The MPDSR data (Death notification slips and Verbal Autopsy, Spcial Autopsy forms/facility death review forms) are gathered from both the community and facility. Death notification information on maternal and neonatal death and stillbirth is uploaded by the CHCP at the community clinic when HA/FWA send the slips to them. It is mandatory to capture each and every deaths from a specific geographical area. As per standards, verbal autopsies and social autopsies to be done for all maternal deaths and at least ten percent neonatal deaths at community.

At upazila, the statisticians will ensure that the deceased mother or the neonate or still births have been registered in the system from the community clinic. S/he will preserve the death notification slips, VA form and facility death review forms. Furthermore, the verbal autopsy and social autopsy findings can be manually analyzed by the MPDSR sub-committee at local level to identify the related factors and the preliminary cause of death. This review finding will then be shared in the monthly QI meeting of the facility in presence of the facility mangers. The confidentiality of the MPDSR data will be maintained in a way so that the details of the deceased information are not disclosed. Facility managers in the review meeting will provide their feedback and plan for necessary actions for the improvement areas. For the private facilities, the death notification slips/forms will be sent to the respective civil surgeon's office/UHCs / or in the city corporation.

At district level, the district managers will randomly cross-check the death data coming through the MPDSR implementation process. Moreover, evidence-based planning will also be taken at this level by the managers and the MPDSR sub-committee. The planning will be based on death mapping, analysis of verbal autopsies data including causes of deaths.

At divisional level, a review team composed of experts (Oby-gynecologist, paediatrician, neonatologist, trained physician etc.) will further identify the causes of deaths for data arrived from all tiers. MPDSR focal person at divisional level in coordination with the Assistant Chief MIS will ensure the data entry into DHIS-2. Further, the statistical analysis and death mapping will be done through system generated data for periodic scrutiny of deaths including trends, pattern and causes. These detailed investigations on a death event will provide a definite evidence based direction and will be very effective for planning.

Detailed Process of Data Flow

Data collection

The Health Assistant/ Family Welfare Assistant/Vaccinator/NGO worker will collect death information from the community & where as Staff Nurse/ FWV will collect the same in the facility. The verbal and social autopsy will be done by the HI/FPI/AHI/SI/ NGO Worker/Public Health Nurse. In case of facility deaths, the on-duty nurse/FWVs from the respective wards will conduct facility death review with the support of doctors/ consultants.

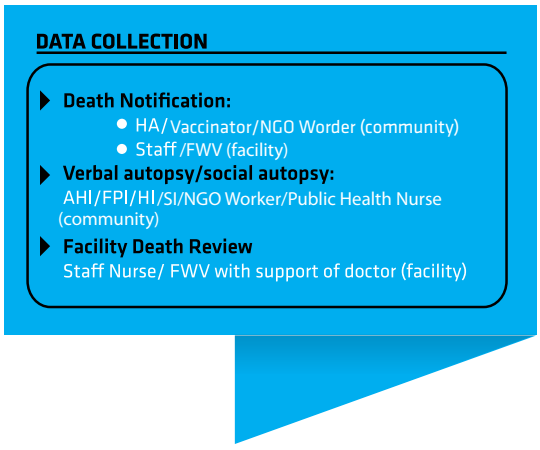


Fig: F: Data collection process

Data Transfer:

HA/FWA transfers death notification slips to CHCP of the CC and to upazila managers of the UHC. All data from the verbal and social autopsy, facility death review data will also be submitted to the Upazila managers. Facility death review data at the upazila, district or divisional level will be submitted to the respective managers.

Data Storage

All hard copies of death notification slips, verbal autopsy, social autopsy forms and facility death review forms will be kept with the statistician. Incase of district hospital, recordkeeper/data entry operator/statistician will keep the record. However, another set of the verbal autopsy data set will be sent at district and divisional level on a quarterly basis.

Data entry

The basic data from the community will be uploaded by the CHCP using information from the death notification slips. At upazila and district level there will be cross checking of information of the deceased mother and the child in the system after every VA. The cause of death information will be entered quarterly at divisional level following the death review meeting.

Data analysis

Data at upazila and district level will be analyzed and reviewed manually to identify important associated factors for the death. The statistician will prepare a monthly summary on all deaths in the Upazila/district. The system will automatically generate the death maps. The hard copies of the VAs will be sent to the national level for documentation and research purposes.

Chapter 5
Review, Response, Monitoring & Evaluation

Outline of MPDSR review, response,monitoring & evaluation

At different tiers, MPDSR focal persons and MPDSR committees will be established for effective coordination of MPDSR implementation and they will have an effective linkage with the QI committees at different tiers formed by the MoHFW. The outline of the functional units for MPDSR implementation are described as follows:

Sl	Name of committees	Organizational level	Facility level
1	National MPDSR Committee	Chairperson of the Committee MPDSR focal person in QIS	MPDSR Sub-committee
2	Divisional QI committee	MPDSR focal person (Co-opted in the QI Committee)	MPDSR Sub-committee
3	District QI committee	MPDSR focal person (Co-opted in the QI Committee)	MPDSR Sub-committee
4	Upazila QI committee	MPDSR focal person (Co-opted in the QI Committee)	MPDSR Sub-committee

MPDSR focal persons at QIS

Overview of the MPDSR focal persons

MPDSR implementation will be facilitated by QI committees at different levels (from National to Upazila) that have been designated by the Ministry of Health and Family Welfare.

MPDSR focal person will compile all reports from the respective tiers including the public and private facilities. For example, the divisional MPDSR focal person at the organizational level will compile reports from all facilities from divisions,

the district MPDSR focal person at the organizational level will compile reports from all facilities from districts and so on. Also, the MPDSR focal persons will ensure appropriate feedback to the facilities for necessary and needful actions to be taken.

Accordingly, at each tier, a MPDSR focal person will be designated at organizational level as follows:

National level
MPDSR focal person at MoHFW (QIS)

Divisional level
Divisional MPDSR Focal Person at divisional office will be AD/DD designated by Divisional Director (Health) who in turn will monitor the compilation/ analysis in coordination with Assistant Chief MIS.

District level
District MPDSR Focal Person at CS office will be MO-CS/RMO designated by Civil Surgeon who in turn will monitor the compilation/analysis in coordination with district statistician.

Upazila level
Upazila MPDSR Focal Person at Upazila health complex junior Consultant/MO designated by UHFPO who in turn will monitor the compilation/analysis in coordination with upazila statistician.

National MPDSR focal person
At national level, there will be a MPDSR focal person within the Quality Improvement Secretariat of the MoHFW to look after the overall MPDSR implementation nationwide. S/he will be responsible to provide technical guidance, undertake monitoring and supervision to ensure quality implementation of MPDSR.

Terms of references for the MPDSR focal person of the QIS

- Act as a guiding body to make functionalize all MPDSR committees.
- Monitor overall MPDSR implementation and provide necessary direction and guidance
- Support institutionalization of the MPDSR system in Bangladesh.
- Support and follow up necessary coordination between DGHS and DGFP for MPDSR implementations.
- Review the data quality and follow up activities at various tiers.
- Arrange MPDSR yearly review workshop at national level.

Divisional MPDSR Focal person

At the division, there will be a MPDSR focal person from within the divisional QI committee to look after the overall MPDSR implementation in all facilities, public or private of that particular division. He will be responsible to provide technical guidance, undertake monitoring and supervision to ensure quality implementation of MPDSR.

In case of division, AD/DD designated by Divisional Director(Health) who in turn will monitor the compilation/analysis in coordination with Assistant Chief MIS. Divisional Director FP will also coordinate at this level to summarize the information from FP facilities across the division.

Terms of references of the Divisional MPDSR focal person

- Coordinate with Divisional/ Regional Medical College Hospitals to review and analyses the verbal autopsy forms to assign causes of death.
- Co-ordinate the report compilation from all facilities in divisions and below and validate data on a random basis.

- Provide technical support and advice to the Divisional MPDSR sub-committees to review and analyse the cause of deaths.
- Monitor submission of VA forms from all districts under the division.
- Conduct quarterly co-ordination meeting at divisional level for MPDSR implementation.
- Conduct supervision and and monitoring in conjunction with the National MPDSR Committee team to oversee the progress of MPDSR intervention.
- Conduct field visit to observe the MPDSR implementation activities with appropriate feedback.
- Provide support for ensuring data quality generated from the autopsies and reviews.
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda.
- Prepare Death Mapping.

District MPDSR focal person

At the district level, there will be a MPDSR focal person from within the district QI committee level to look after the overall MPDSR implementation in all facilities of that particular district. S/he will be responsible to provide technical guidance, undertake supervision and monitoring to ensure quality implementation of MPDSR.

In case of district, the focal person will be the medical officer-Civil Sergeon office/RMO designated by Civil Surgeon who in turn will monitor the compilation/ analysis in coordination with district statistician. Deputy Director Family Planning (DDFP) will also coordinate at this level to summarize the information collected from FP facilities across the district.

Terms of references MPDSR focal person at district level:

- Co-ordinate the report compilation from all facilities in districts and below and validate data on a random basis.
- Provide technical support and advice to the District MPDSR sub-committees to review and analyse the cause of deaths.
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agendas.
- Develop evidence based local action plan (In consultation with the facility managers).
- Prepare Death Mapping .

Upazila MPDSR focal person

At the upazila, there will be a MPDSR focal person from within the upazila QI committee to look after the overall MPDSR implementation in all facilities, public or private of that particular upazila. He will be responsible to provide technical guidance, undertake monitoring and supervision to ensure quality implementation of MPDSR.

In case of upazila, the MPDSR focal person will be the Junior Consultant/MO designated by UHFPO who in turn will monitor the compilation/analysis in coordination with the statistician at UHC. Upazila family planning officer (UFPO) will also coordinate at this level to summarize the information from the FP facilities across the upazila.

Terms of references of MPDSR focal person at upazila level

- Co-ordinate the report compilation from all facilities in upazila and below and validate data on a random basis.
- Provide technical support and advice to the Upazila MPDSR sub-committees to review and analyse the cause of deaths.

- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agendas.
- Provide necessary support to the union and below level for MPDSR implementation
- Prepare Death Mapping.

National MPDSR committee

The National MPDSR Committee will be formed from representatives of the QIS, DGHS, DUFP, UN bodies, professionals and relevant development partners and public health experts. Their main role is at the policy and planning level as well as to oversee the monitoring and supervision of the MPNDSR implementation nationwide.

Composition of the National MPDSR committee

Sl	Name	Position
1	Director, PHC and Line Director-MNCAH, DGHS	Chairperson
2	Director MCH and LD-MCRAH, DGFP	Co-Chairperson
3	Programme Manager, MIS, DGHS	Member secretary
4	Deputy Director, Health Economics Unit	MPDSR focal person
5	Director , Hospital and Clinics, DGHS	Member
6	Director, Directorate of Nursing Services	Member
7	Secretary General , OGSB	Member
8	Secretary, BPS	Member
9	Programme coordinator, COIA	Member
10	Deputy Director, MIS, DGFP	Member
11	Deputy Director, MCH, DGFP	member
12	Secretary General, Bangladesh Neonatal Forum	Member
13	Professor of Neonatology, BSMMU	Member
14	Programme Manager, EPI, DGHS	Member
15	Programme Manager, IMCI, DGHS	Member
16	Program Manager, MNH, DGHS	Member
17	Program Manager, MIS	Member
18	Deputy Director (MCH), DGFP	Member
19	Deputy Program Manager- EmOC, MNH unit, DGHS	Member
21	Deputy Program Manager- MNH, MNH unit, DGHS	Member

Sl	Name	Position
22	Representatives from WHO	Member
23	Representatives from CIPRB	Member
24	Representatives from icddrb	Member
25	Representatives from UNICEF	Member
26	Representatives from UNFPA	Member
27	Save the Children International	Member

Terms of Reference of National MPDSR committee

- Monitor overall progress and provide necessary direction and guidance.
- Review and endorse national guidelines, modules and tools for MPDSR implementation.
- Provide technical support for upholding the quality issues of MPDSR.
- Develop an action plan for the implementation of MPDSR in the PIP or relevant operational plan in the next sector programme.
- Provide technical assistance for necessary budget adjustment and allocation for the MPDSR in relevant operational plans in the current and next health sector program implementation.
- Provide technical support for developing a joint monitoring system development by QIS, respective line directors, development partners, UN bodies.
- Develop a plan for necessary coordination mechanism between two directorates for verbal autopsy system, facility death review and reporting social autopsy.
- Develop a plan for structured reporting system under DHIS 2.
- Develop and implement a plan for the capacity development of service providers for MPDSR implementation.
- Conduct review meetings twice a year.

MPDSR sub-committees at QI facility level committees

At each facility, the QI committee will develop a small subcommittee of at least 5 members (consists of a gynecologist, a pediatrician, a medical officer and two support staffs). This subcommittee will work under the guidance of QI committee with specific TOR. In addition to above mentioned MPDSR sub-committees, a National MPDSR Committee will be formed. These sub-committees can co-opt any member as required.

The MPDSR subcommittees are described below for each tier:

Divisional Facility Based MPDSR sub-committees

In each type of facility of the division, public or private, a MPDSR sub-committee will be formed which is also a part of the QI committee of that facility. This committee will be overall responsible for overseeing the MPDSR implementation in that facility.

Composition of Divisional Medical College Hospital MPDSR Sub committee

Chairperson

Head of Department/ Senior Consultant (Obs & Gynae/ paediatric)

Member Secretaries

Two registrars- 1 from Obs & Gynae, 1 from Paed/neonatology

Advisor

Director Hospital and/or Principal of MCH

Members

1. Head of the Deptt/Senior Consultant (Obs and gynae)
2. Head of the Deptt/Senior Consultant (paediatrics)
3. Head of the Deptt/Senior Consultant (anaesthesia).
4. Head of the Deptt/Senior Consultant (Blood Transfusion))
5. RP /RS /RMO
6. Registrar (Obs and gynae)
7. Registrar (paediatrics)
8. Registrar (anaesthesia)
9. Registrar (blood transfusion))
10. Assistant Registrar/IMO (Obs and gynae)
11. Assistant Registrar/IMO (paediatrics)
12. Assistant Registrar/IMO (anaesthesia)
13. Assistant Registrar/IMO (blood transfusion))
14. Consultant (Pediatric)
15. Consultant (Obs and gynae)
16. Consultant (Anaesthesiologist)
17. Medical officer/RMO
18. Nursing supervisor
19. Ward master
20. Statisticians

Notes :

1. Based on the local situation, MCH may form separate MPDSR sub-committee for Obstetrics and Newborn Departments.

2. Following the above mentioned composition, private medical college hospitals / private hospitals / clinics will form their own MPDSR Sub Committees.

Terms of Reference of Divisional Facility Based MPDSR Sub committee

- Review the death notification forms every week.
- Compile death information and send report to Divisional MPDSR focal person on a monthly basis.
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process.
- Assign causes of death through analysis.
- Follow up and close supervision of the regular data entry of the forms (cause of death).
- Notify the facility managers on MPDSR implementation.
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda.

District Facility based MPDSR sub-committees

At each facility of the district, public or private, a MPDSR sub-committee will be formed which is also a part of the QI committee of that facility. This committee will be overall responsible for overseeing the MPDSR implementation in that facility.

Composition of District Hospital MPDSR sub-committees

Chairperson

Head of Department/ Senior Consultant Obs & Gynae or paediatrics

Member Secretary

Indoor Medical Officer Obs & Gynae or paediatrics / RMO

Advisor

Hospital Superintendent

Members:

1. Consultant (Obs and Gynae)
2. Consultant (Paediatric)
3. Consultant (Anaesthesia)
4. Medical officer/RMO
5. Medical officer (Blood bank)
6. Nursing in charge (Paediatric ward)
7. Nursing in charge (Obs & Gynae ward)
8. Ward master
9. Statisticians

Terms of references of Facility Based District MPDSR sub-committees

- Review the death notification forms on a regular basis
- Compile death information and send report to District MPDSR focal person on a monthly basis
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process
- Follow up and close supervision of the regular data entry of the forms
- Notify the facility managers on MPDSR implementation update
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda

MCWC based MPDSR sub-committees

At each of the MCWC, there will be a sub committee. This committee will overall responsible for over seeing the MPDSR sample presentation of MCWC.

Chairperson

MO-Clinic

Member Secretary

MO –MCH (MO-Anaesthesia)

Advisor

Deputy Director- Family Planning

Members

1. ADCC
2. FWV - 3
3. Statistician

NOTE

Following the above mentioned composition, private hospitals / clinics will form their own MPDSR Sub Committee

Upazila MPDSR Sub-committees

At each facility of the upazila, public or private, a MPDSR sub-committee will be formed which is also a part of the QI committee of that facility. This committee will be overall responsible for overseeing the MPDSR implementation in that facility.

Composition of Upazila Health Complex MPDSR sub-committees

Chairperson

Junior Consultant Obs & Gynae /Ppaediatrics

Member Secretary

RMO

Advisor

UHFPO

Members

1. UFPO
2. MO-MCH
3. Consultants (Obs and Gynae)
   Consultants(Paediatric)
4. Medical officers
5. SSN/Nurse
6. Health Inspector
7. Statisticians

NOTE

Following the above mentioned composition, MCWC, private hospitals / clinics at upazila level will form their own MPDSR Sub Committee.
It will be same term of references that of facility based district MPDSR sub- commitee.

TOR of Upazila MPDSR Sub-committee

- Review the death notification forms on a weekly basis.
- Compile death information and send report to Upazila MPDSR focal person on a monthly basis.
- Assign for social and verbal autopsy (In consultation with the facility managers) and follow up to ensure timely data collection.
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process.
- Follow up and close supervision of the regular data entry of the forms.
- Notify the facility managers on MPDSR implementation update.
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda.
- Develop local Action Plan (In consultation with the facility managers).

Composition of Union Health & Family Welfare Centre Sub-committees

Chairperson

Medical Officer/SACMO

Member Secretary

FWV

Members

1. FPI
2. AHI
3. Pharmacist

TOR of Union H&FWC MPDSR Sub-committee

- Review the death notification forms on a monthly basis.
- Compile death information and send report to Upazila MPDSR focal person on a monthly basis.
- Assign for social and verbal autopsy (In consultation with the facility managers) and follow up to ensure timely data collection.
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process.
- Follow up and close supervision of the regular data entry of the forms .
- Develop Local action plan.

Review Meeting and response

The MPDSR sub-committees at different tiers will conduct regular review meetings for the effective use of the collected MPDSR facility data.

QI Committee at different tiers is the key platform to review and analysis over all situation of MPDSR & the area. The QI Committee will meet quarterly and prepare action plan and do responses and follow up.

At national level, all data on death will be preserved for better analysis and remedial action; will be discussed bi-annually in National MPDSR committee for strategic and policy guidance and action. At divisions, Divisional MPDSR focal person (Assistant Chief MIS/as assigned by Divisional Director) will collect the VA forms from districts and below and coordinate with divisional/regional medical college hospitals to organize quarterly meeting to assign definitive causes of death by a thorough reviewing the compiled data by Obstetricians and Pediatricians / Neonatologist. The Assistant Chief MIS at Divisional Director (Health) , will be responsible for coordinating data entry of the causes of death in DHIS2.

The District MPDSR Focal Person will be assigned by respective Civil Surgeon (MO-CS/ DCS assigned by CS) responsible to overall review and analyses the death findings and prepare local level remedial action plan for MPDSR implementation in the district. The District MPDSR focal person will also provide recommendation at different level for further improvement and refinement.

The Upazila MPDSR focal person will be assigned by respective UHFPO (RMO/MO as assigned by UHFPO) responsible to overall review and analyses the death findings and prepare local level remedial action plan for MPDSR implementation in the entire upazila. The Upazila MPDSR focal person will also provide recommendation at different level for further improvement and refinement. Similar actions will be followed in all government and private hospitals/ clinics.

The confidentially of data at all level will be maintained. MPDSR findings will be discussed in regular divisional, district and upazila level monthly Health and Family Planning Coordination meeting to take relevant health system action to improve availability and quality of health services.

Objectives of review meetings

1. To meet periodically and review the findings of maternal deaths, neonatal deaths and still births.
2. To ensure identification, notification and data entry of all death in DHIS2.
3. To monitor and supervise the progress and quality of MPDSR implementation and continuous feedback.
4. To prepare recommendations to undertake corrective actions for preventing maternal, perinatal, neonatal deaths and still births.
5. To prepare action plan and implement at the district/upazila level.

Quarterly Divisional Coordination meeting

- Every quarterly, a co-ordination meeting on MPDSR implementation will take place at divisional level.
- The co-ordination meeting is a platform where the Divisional MPDSR focal person will brief on the progress of MPDSR implementation and follow up the previous meeting decisions.
- In these meetings, there will be discussion on the medical and social causes of death including related associated factors, thus enabling the managers to take immediate need-based action for improvement of health services within their areas.
- The MPDSR sub-committee from each participating facility will share previous 3 (three) months data on death notification (both community and facility deaths), verbal

autopsies, social autopsies and facility death review findings.

- At the end of the meeting, the chairperson of the committee will summarize the findings and take decisions for corrective actions and necessary planning based on those findings.
- The meeting minutes will be signed jointly by the chairperson and co-chair of the committee and circulated among the members and to the higher authorities.

National MPDSR Review Meeting

- National MPDSR committee will have their review meeting twice a year which will be called by the chairperson of the committee. The nation-wide MPDSR implementation and challenges will be discussed in this meeting and necessary guidance will be chalked out for the improvement areas of implementation.

MPDSR sub-committees Meeting

All other MPDSR sub-committees will conduct the internal review meeting at a monthly interval for progress monitoring.

Monitoring and supervision of MPDSR implementation

Monitoring will be performed at all tiers from the national to local

Monitoring from National level

- At the national level, QIS/HEU, MOHFW, DGHS and DGFP will directly monitor the implementation progress. The higher officials from HEU and both directorates will be updated on the progress in review workshops/ meeting at the national level.
- The National MPDSR Committee will form an assessor team for MPDSR monitoring and supervision. The team will regularly (on a quarterly basis) monitor the MPDSR implementation at field.
- Quality Improvement Secretariat will act as a guiding body and will oversee these monitoring activities and provide necessary directives as required.

Monitoring from sub-national/ local level:

- At divisional level, the Divisional Director (Health) and Divisional Director (FP) will be responsible for overall monitoring and supervision. They will regularly (on a bi-monthly basis) monitor the MPDSR implementation at field.
- At district level, the Civil Surgeon (Health) and DDFP (FP) will be responsible for overall monitoring and supervision. They will regularly (on a bi-monthly basis) monitor the MPDSR implementation at field.
- At upazila level, UHFPO and UFPO will be responsible to monitor the progress and provide continuous feedback. The team will regularly (on a bi-monthly basis) monitor the MPDSR implementation at field.
- From all level, the above framework will be applied for overseeing MPDSR activities at private facilities as well.

Annex
Contributors and technical work groups for drafting national guideline

Group A

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12	Dr. Riad Mahmud	UNICEF
13	Dr Rubayet/Dr Nazrul Islam	Save the Children
14	Dr. Shayema Khorshed	QIS

MPDSR Guideline
Development Committee

Committee for development of National guideline for Maternal & Perinatal Death Surveillance and Response (MPDSR) and Terms of Reference.

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02. Dr. Md. Aminul Hasan, Deputy Director, HEU, MOHFW – Member Secretary
03. Representative Director, MIS, DGFP, - Member
04. Dr. Shimul Koli, PM, DGFP, - Member
05. Dr. Md. Azizul Alim, DPM, MNH, DGHS – Member
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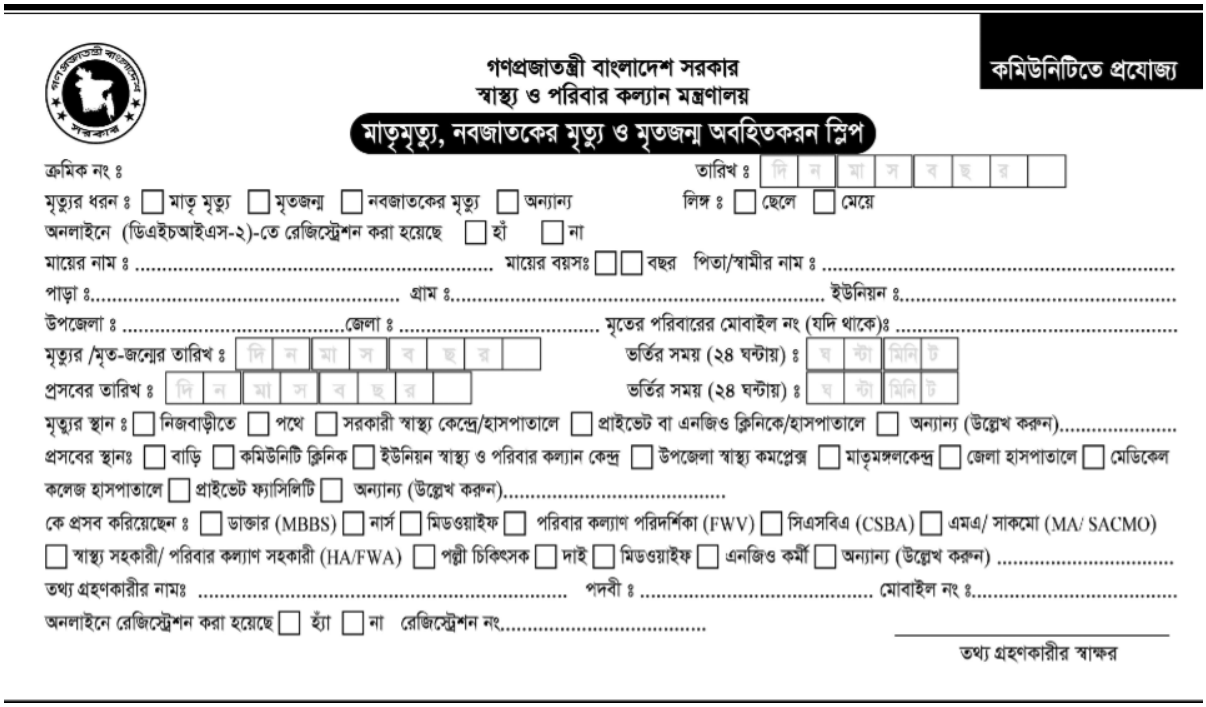
Terms of Reference:

- Provide support for stock taking of the documents / events on MPDSR in Bangladesh
- Review / examine the existing document of MPDSR that are practicing within the govt system or by any development partner / NGO in any part of the country
- Review the best practices on MPDSR in other countries
- Develop a national guideline on MPDSR in a consultative way under the health system strengthening and also focusing the quality
- Co-opt any member in the committee.

MPDSR Death Review Form



কমিউনিটিতে প্রযোজ্য

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যান মন্ত্রণালয়

মাতৃমৃত্যু, নবজাতকের মৃত্যু ও মৃতজন্ম অবহিতকরন স্লিপ

ক্রমিক নং ঃ তারিখ ঃ দি ন মা স ব ছ র

মৃত্যুর ধরন ঃ ☐ মাতৃ মৃত্যু ☐ মৃতজন্ম ☐ নবজাতকের মৃত্যু ☐ অন্যান্য লিঙ্গ ঃ ☐ ছেলে ☐ মেয়ে

অনলাইনে (ডিএইচআইএস-২)-তে রেজিস্ট্রেশন করা হয়েছে ☐ হাঁ ☐ না

মায়ের নাম ঃ ..... মায়ের বয়সঃ ☐☐ বছর পিতা/স্বামীর নাম ঃ .....

পাড়া ঃ..... গ্রাম ঃ..... ইউনিয়ন ঃ.....

উপজেলা ঃ .....জেলা ঃ ..... মৃতের পরিবারের মোবাইল নং (যদি থাকে)ঃ .....

মৃত্যুর /মৃত-জন্মের তারিখ ঃ দি ন মা স ব ছ র ভর্তির সময় (২৪ ঘন্টায়) ঃ ঘ ন্টা মিনি ট

প্রসবের তারিখ ঃ দি ন মা স ব ছ র ভর্তির সময় (২৪ ঘন্টায়) ঃ ঘ ন্টা মিনি ট

মৃত্যুর স্থান ঃ ☐ নিজবাড়ীতে ☐ পথে ☐ সরকারী স্বাস্থ্য কেন্দ্রে/হাসপাতালে ☐ প্রাইভেট বা এনজিও ক্লিনিকে/হাসপাতালে ☐ অন্যান্য (উল্লেখ করুন).....

প্রসবের স্থানঃ ☐ বাড়ি ☐ কমিউনিটি ক্লিনিক ☐ ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যান কেন্দ্র ☐ উপজেলা স্বাস্থ্য কমপ্লেক্স ☐ মাতৃমঙ্গলকেন্দ্র ☐ জেলা হাসপাতালে ☐ মেডিকেল কলেজ হাসপাতালে ☐ প্রাইভেট ফ্যাসিলিটি ☐ অন্যান্য (উল্লেখ করুন).....

কে প্রসব করিয়েছেন ঃ ☐ ডাক্তার (MBBS) ☐ নার্স ☐ মিডওয়াইফ ☐ পরিবার কল্যাণ পরিদর্শিকা (FWV) ☐ সিএসবিএ (CSBA) ☐ এমএ/ সাকমো (MA/ SACMO) ☐ স্বাস্থ্য সহকারী/ পরিবার কল্যাণ সহকারী (HA/FWA) ☐ পল্লী চিকিৎসক ☐ দাই ☐ মিডওয়াইফ ☐ এনজিও কর্মী ☐ অন্যান্য (উল্লেখ করুন) .....

তথ্য গ্রহণকারীর নামঃ ..... পদবী ঃ ..... মোবাইল নং ঃ.....

অনলাইনে রেজিস্ট্রেশন করা হয়েছে ☐ হ্যাঁ ☐ না রেজিস্ট্রেশন নং.....

তথ্য গ্রহণকারীর স্বাক্ষর

কমিউনিটি পর্যায়ে প্রযোজ্য

ফর্ম -১

মাতৃমৃত্যু

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
Government of the People's Republic of Bangladesh
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
Ministry of Health & Family Planning

মাতৃমৃত্যু, নবজাতকের মৃত্যু ও মৃতজন্ম পর্যালোচনা (এমপিডিআর)
Maternal and Perinatal Death Surveillance and Response (MPDSR)

কমিউনিটিতে মাতৃমৃত্যু পর্যালোচনা ফরম
Community Maternal Death Review Form

কমিউনিটি ফর্ম -১

বাস্তবায়নে
Implemented by
স্বাস্থ্য অধিদপ্তর ও পরিবার পরিকল্পনা অধিদপ্তর
Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

কারিগরি সহযোগিতায়ঃ ইউনিসেফ, ইউএনএফপিএ, বিশ্বস্বাস্থ্য সংস্থা, সিওআইএ (কইয়া), সিআইপিআরবি
Technical support: UNICEF, UNFPA, WHO, COIA, CIPRB

ফরম ডিজাইন ও সমন্বয়েঃ এইচইইউ, আইসিডিডিআরবি, জাইকা, ব্র্যাক, ওজিএসবি, বিএনএফ, বিএসএমএমইউ, বিপিএ, সেইভ দ্যা চিলড্রেন
Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU, BPA, Save the Children

অফিসের ব্যবহারের জন্য
ফর্ম জমাদানের তারিখ:
মাতৃমৃত্যুর বাৎসরিক ক্রমিক নং:
ফর্ম গ্রহণকারীর নাম ও স্বাক্ষর:

কমিউনিটি পর্যায়ে প্রযোজ্য

ফর্ম -২

নবজাতক

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
Government of the People's Republic of Bangladesh
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
Ministry of Health & Family Planning

মাতৃমৃত্যু, নবজাতকের মৃত্যু ও মৃতজন্ম পর্যালোচনা (এমপিডিআর)
Maternal and Perinatal Death Surveillance and Response (MPDSR)

কমিউনিটিতে নবজাতকেরমৃত্যুপর্যালোচনা ফরম
Community Neonatal Death Review Form

কমিউনিটি ফর্ম -২

বাস্তবায়নে
Implemented by
স্বাস্থ্য অধিদপ্তর ও পরিবার পরিকল্পনা অধিদপ্তর
Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

কারিগরি সহযোগিতায়ঃ ইউনিসেফ, ইউএনএফপিএ, বিশ্বস্বাস্থ্য সংস্থ, সিওআইএ (কইয়া), সিআইপিআরবি
Technical support: UNICEF, UNFPA, WHO, COIA, CIPRB

ফরম ডিজাইন ও সমন্বয়েঃ এইচইইউ, আইসিডিডিআরবি, জাইকা, ব্রাক, ওজিএসবি, বিএনএফ,
বিএসএমএমইউ, বিপিএ, সেইভ দ্যা চিলড্রেন
Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU,
BPA, Save the Children

অফিসের ব্যবহারের জন্য
ফর্ম জমাদানের তারিখ:
মাতৃমৃত্যুর বাৎসরিক ক্রমিক নং:
ফর্ম গ্রহণকারীর নাম ও স্বাক্ষর:

ফর্ম -৩

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

মাতৃমৃত্যু, নবজাতকের মৃত্যু ও মৃতজন্ম পর্যালোচনা (এমপিডিএসআর)

স্বাস্থ্যকেন্দ্রে মাতৃমৃত্যু পর্যালোচনা ফরম

ফ্যাসিলিটি ফরম -৩

বাস্তবায়নে
স্বাস্থ্য অধিদপ্তর ও পরিবার পরিকল্পনা অধিদপ্তর

অফিসের ব্যবহারের জন্য	
ফর্ম জমাদানের তারিখ:	স্বাক্ষর:
নবজাতকের বাৎসরিক ক্রমিক নং:	
ফর্ম গ্রহণকারীর নাম:	স্বাক্ষর:

হাসপাতালে ব্যবহৃত

ফর্ম -৪

নবজাতক

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
Government of the People's Republic of Bangladesh
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
Ministry of Health & Family Planning

মাতৃমৃত্যু, নবজাতকের মৃত্যু ও মৃতজন্ম পর্যালোচনা (এমপিডিআর)
Maternal and Perinatal Death Surveillance and Response (MPDSR)

সেবাকেন্দ্রে নবজাতক মৃত্যু পর্যালোচনা ফরম
Neonatal Death Review Form

ফ্যাসিলিটি ফরম -৪

বাস্তবায়নে
Implemented by
স্বাস্থ্য অধিদপ্তর ও পরিবার পরিকল্পনা অধিদপ্তর
Directorate General of Health Services (DGHS) and
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Technical support: UNICEF, UNFPA, WHO, COIA, CIPRB

ফরম ডিজাইন ও সমন্বয়েঃ এইচইইউ, আইসিডিডিআরবি, জাইকা, ব্র্যাক, ওজিএসবি, বিএনএফ,
বিএসএমএমইউ, বিপিএ, সেইভ দ্যা চিলড্রেন
Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU,
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ফর্ম গ্রহণকারীর নাম ও স্বাক্ষর:

All forms are available in this link
http://www.dghs.gov.bd/index.php/en/mis-docs/dhis-2-form

www.unicef.org

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