



Getting started on facility-based death reviews

Day 1 Session 6

Session Objectives

1. How to get started with perinatal death reviews
2. What are some successful factors from MDSR experiences
3. Composition and functions of the perinatal mortality review team at the facility, district and national levels
4. Describe existing and/ or potential linkages between perinatal mortality review/ MPDSR and quality improvement structures at the facility and the district levels.

Getting started with Perinatal mortality reviews- 1

- The structure and functions of the perinatal mortality committee may vary by country and the specific health system level (e.g. facility, district committee)
- Most facilities may already have in-house mortality reviews and districts may have a focal person
- Review what already exists
- Start small and scale up gradually
- Phased approach: start with one or two facilities and then expand to other locations, moving towards greater coverage
- Involving the right stakeholders is essential to establish the programme and raise awareness & profile.
- An enabling environment will be useful

Getting started with Perinatal mortality reviews-2

- If a quality improvement committee exists , engage with the committee to form a facility level perinatal mortality review committee
- Maternal and perinatal death reviews should be conducted in a collaborative manner rather than in parallel
 - Stillbirths and neonatal deaths are more common occurrences than maternal deaths
 - Can start selecting specific cases for e.g: intrapartum stillbirths or 1st day neonatal deaths
- Who leads the process varies by country context. In some countries obstetricians lead maternal death and stillbirth reviews whereas pediatricians lead newborn death reviews
- Irrespective of who leads the review. They need engagement from all specialties, hospital administration, district level and community members

Getting started with Perinatal mortality reviews-3

- Essential to keep review findings separate from the legal system
- Should focus on ability of health professionals to identify opportunities to improve care rather than assign blame.
- Anonymized process of reporting
- Safe custody of any data collected/ patient case files and destruction of review findings after meetings
- Dedicated person for data collection is needed

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Expertise needed for the review committee:

Diverse range of expertise to identify both the nonmedical and medical problems that contribute to deaths, to prioritize and monitor implementation of recommended actions and to track and analyze trends in audit results and in perinatal deaths, causes and complications.

Success factors identified from the experience with Maternal Death Surveillance and Response (MDSR)

- Committed health committees
- Local champions
- Code of practice for review meetings
- Ensuring confidentiality
- Steering committee should nurture a supportive culture that fosters accountability
- Support from local community leaders, facility directors, or national or state government
- Governments and other key stakeholders need to be involved from the beginning of the facility-based death review process, informed of progress and, as appropriate, invited to attend meetings or sit on steering committees.
- Clear roles and responsibilities
- Adequate resources should be allocated to the programme

Facility-based perinatal mortality audit steering committee

Who

- Those interested in neonatal and maternal health.
- Representatives from the district health office, the facility administration, clinical staff from the departments of neonatology/ paediatrics, obstetrics, midwifery/nursing, anaesthesia, pathology, pharmacy and statistics, as well as community members

Roles and responsibilities:

- Help initiate the case review and mortality audit process and decide on the approach and its scope
- Oversee data collection (identify all facility deaths), perform data analysis and case selection for review meetings
- Develop a schedule for the audit meetings, invite participants and ensure adequate facilitation;
- Develops recommendations (immediate/longer term); oversees and monitors implementation of recommendations
- Assist with dissemination of recommendations and advocate for their implementation.

District level perinatal mortality audit steering committee

Who:

District public health office, hospital directors, community members, representatives from health professional associations, researchers, UN agencies, INGOs, programme managers, civil society.

Roles and responsibilities:

1. Supports formulation, follow-up and monitoring of audit recommendations, including district-level actions
2. Sends summary of data (abstraction tool) to national level for national reporting and aggregated analyses
3. Produce annual report on district perinatal mortality, identify epidemiological trends that need immediate interventions, and share the analysis and actions plans with the facility and national levels

National level perinatal mortality audit steering committee

Who:

Led by the MoH, representatives from health professional associations, epidemiologists, researchers, UN agencies, INGOs, civil society, parents groups and high-level policy-makers.

Roles and responsibilities:

1. Analyse data based on the monthly reporting format, on a semester or annual basis, to profile districts, and identify epidemiological trends that need immediate attention
2. Analyse reports from region/state/district on a semester or annual basis, track actions taken, check report quality, identify areas for improvement and provide feedback to region/state/district
3. Develop a schedule for national level audit meetings, invite participants and ensure adequate facilitation
4. Based on the findings of the analysis, design appropriate responses to improve the situation.
5. Produce annual reports by region/ state/ districts which profiles cause of death, key interventions/actions identified, status of implementation, trend in that year, compared to previous year, priorities for the next year.
6. Develop recommendations (immediate/longer term), oversee and monitor implementation of recommendations
7. Present findings of the perinatal mortality audit at relevant forums
8. Assist with dissemination of recommendations and advocate for their implementation

Illustrative composition of a facility-based committee

- Moderator or Chairperson
- Presenter
- Secretary
- Data manager
- Members

Role of the Moderator or Chairperson

- Convene the perinatal mortality committee at regular intervals
- Facilitate discussion and encourage respectful and open discussion
- Establish ground rules and remind participants of the code of conduct including confidentiality, and no blame principle.
- Lead review of previous meeting's recommendations and status updates

Role of the Presenter

- Identify all perinatal deaths
- Gather all information relevant to the cases to be reviewed
- Conduct the interviews with staff involved with case
- Present summary of clinical cases under review at committee meetings
- Complete relevant forms

Role of the secretary

- Work with the chair to prepare the agenda for the meeting
- In consultation with presenter, ensure relevant documents are available for the review meeting
- Summarize the case analysis
- Sends completed form to appropriate person focal point
- Develop and share report of the review meeting

Role of the Data Manager

- Periodically review data trends
- Monitor data input quality
- Input data into database
- Send data to receiving parties (MoH, etc.)
- Dashboard development and data visualization

Role of the members

- Participate in review of perinatal deaths in the facility
- Recommend and participate in implementation of action plans
- Ensure confidentiality of meeting proceedings
- Ensure linkages with any other ongoing QI/MDSR teams or initiatives, if not a combined MPDSR/QI team