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# MPDSR implementation in the WHO African region

**Maternal and Perinatal Death Surveillance and Response  
WHO/UNFPA/UNICEF joint workshop**

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# Outline

- Overview of Maternal and perinatal health in the African region
- Status of implementation of MPDSR in the Africa Region
- Challenges
- Recommendations -Conclusion



# Brief history on MPDSR-1

- 2010, the 15<sup>th</sup> African Union Summit a historical **decision to make every maternal death a notifiable event.**
- **2011 –Launch of** the UN Commission on Information and Accountability for Women’s and Children’s Health (COIA) was launched -**better information for better health**
- **Maternal death surveillance and response was one of the 10 COIA recommendations with the aim for** *Countries monitor quality of care provided in health services and take steps to make improvements...*



# Brief history on MDSR-2



- In 2011 ,WHO AFRO - revise and include maternal death into the existing Integrated disease surveillance and response (IDSR) reporting
- **In 2013**, during the first African Union international conference on MNCH hosted by South Africa, **a call expand MDSR** was developed by UNFPA and WHO adopted by all Ministers attending the AUC Conference.
- Since 2013, WHO and UNFPA developed and supported dissemination of the WHO guidelines for maternal death surveillance and review **in all countries**
- In 2018, Perinatal death is included in the revised IDSR guideline

**M**aternal  
**D**eath  
**S**urveillance and  
**R**esponse

TECHNICAL GUIDANCE

INFORMATION FOR ACTION  
TO PREVENT MATERNAL DEATH



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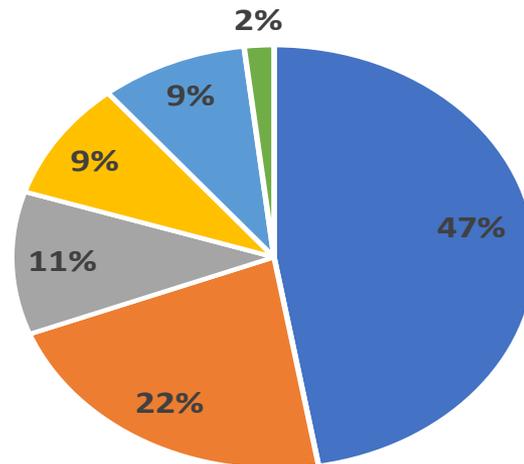
## Status of MPDSR Implementation in the African region

# Methods

Web based survey and questionnaire sent to WHO country focal points and contacts from Ministries of Health, academic and research institutions, development agencies and professional organizations

## Respondent Affiliation (N=55)

- WHO
- Research/Academic Institutions
- Development Organizations
- MOH
- Professional Organizations
- Multiple Affiliations



55 responses from 42 countries

# Methods

- In depth interviews with key informants
- Literature review on Pub Med to identify peer reviewed published papers
- Grey literature search on Google to identify relevant documents
- MDSR Action Network website [<http://mdsr-action.net/>]
- FIGO website as well as websites of professional organizations
- MDSR Country Profiles- [[https://www.who.int/maternal\\_child\\_adolescent/epidemiology/maternal-death-surveillance/country-profiles/en/](https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/country-profiles/en/)]
- A variety of reports were reviewed:
  - ✓ MDSR Country Assessments
  - ✓ National MDSR Annual Reports
  - ✓ CEMD reports
  - ✓ National MDSR tools/guidelines

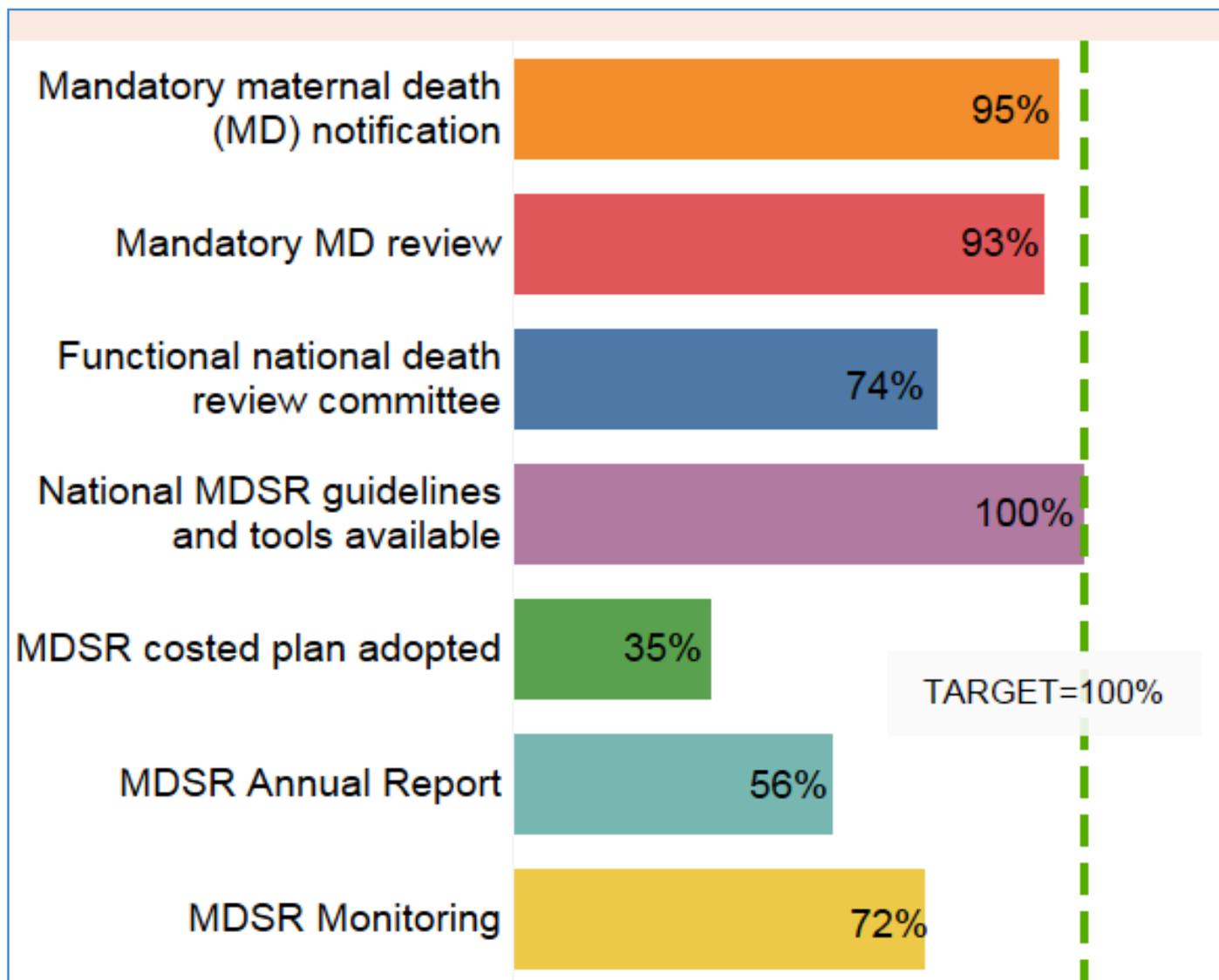




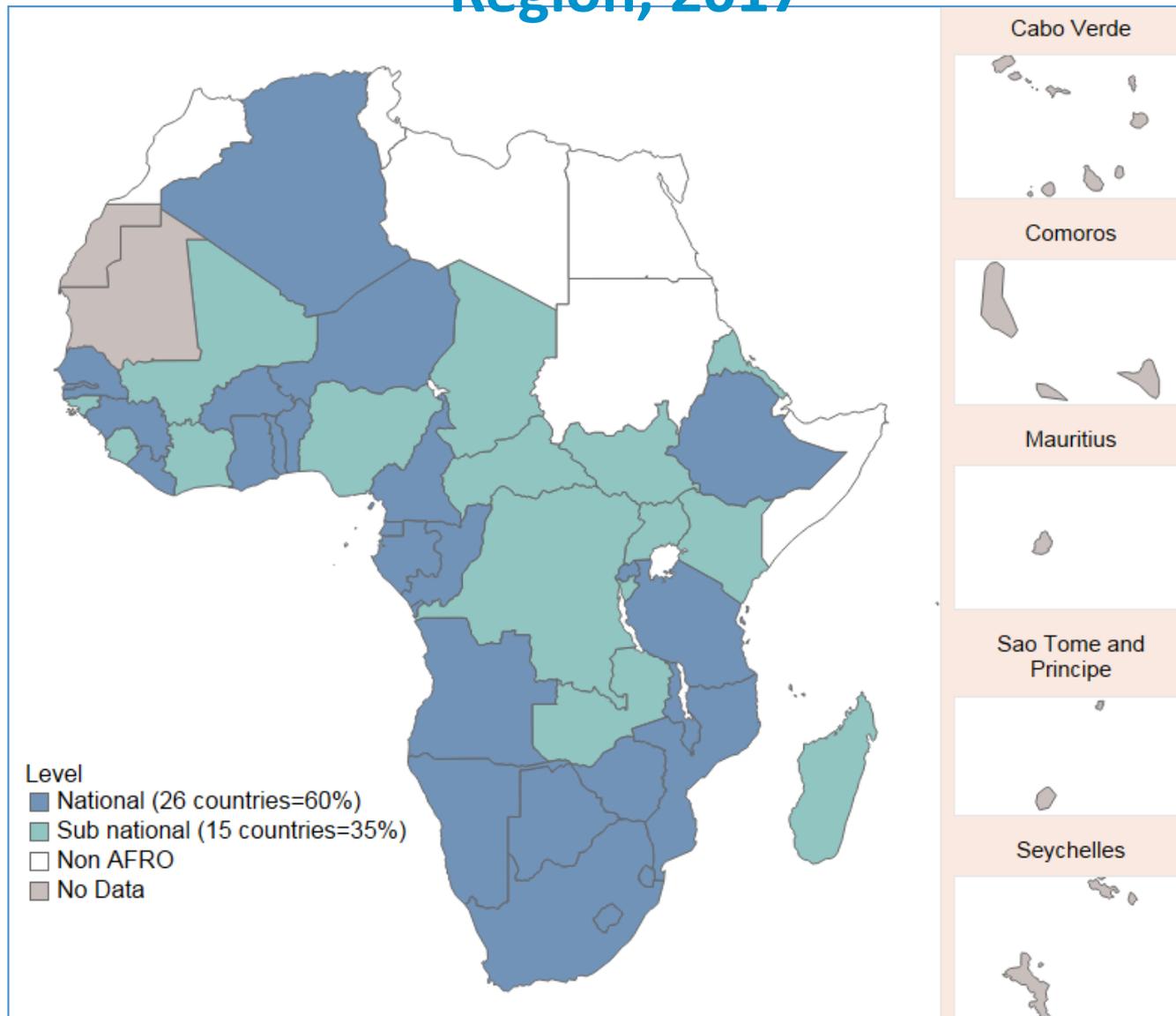
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## MDSR Implementation – key findings

# Overview of the MPDSR core components implementation status, WHO African region

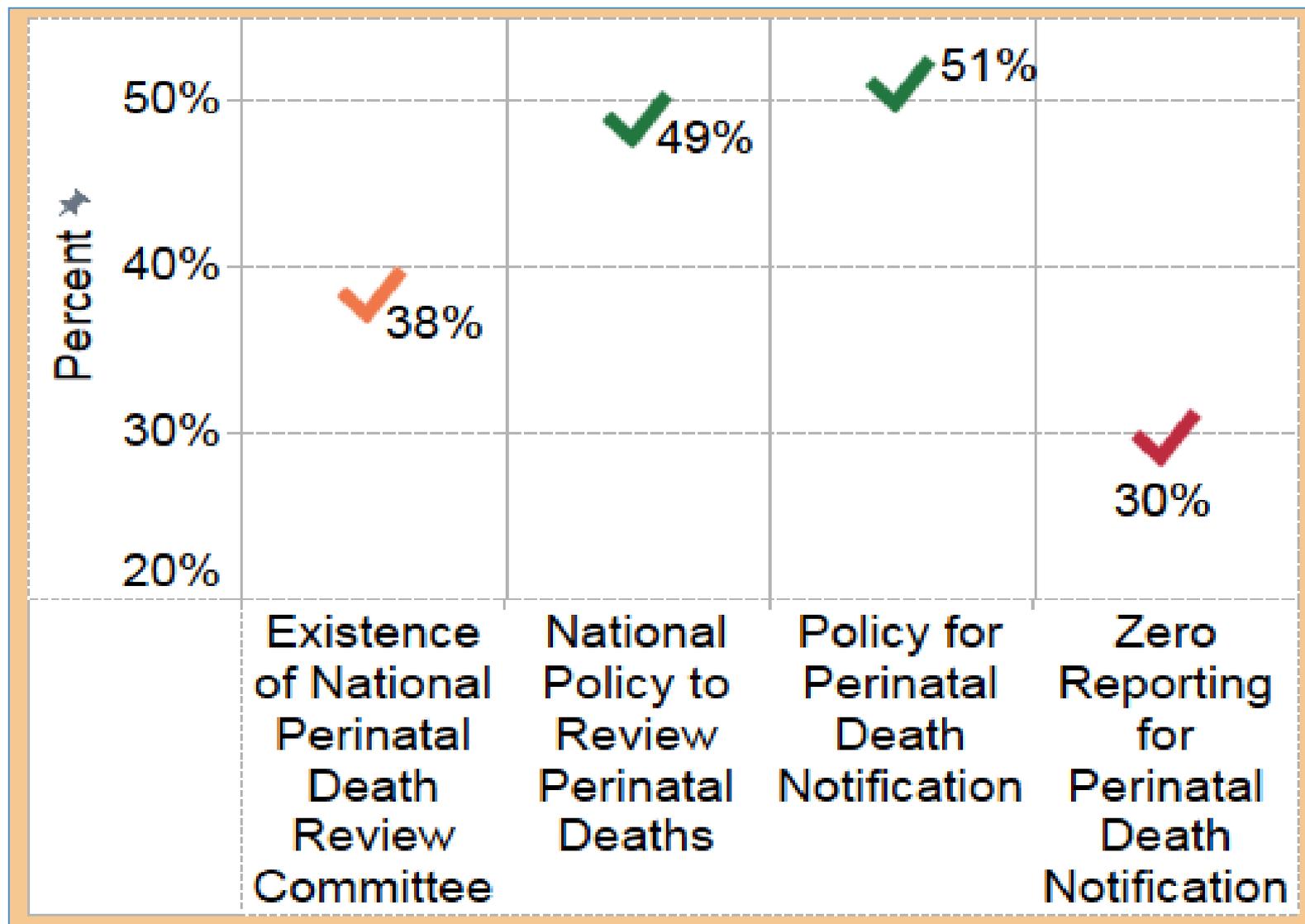


# Level of MDSR implementation status, WHO African Region, 2017



# Perinatal Death Surveillance and Response WHO African Region, 2017

[1]



# How has MPDSR evolved over the last 5 years?

## Country experiences

- Inclusion of perinatal deaths
- Inclusion of near miss
- Improvement in death notification and reporting
- Implementation of review committees both at national and sub national levels
- Implementation of guidelines, mainly at facility levels
- More focus on the “R” response component



# Key actors involved in MPDSR

- **WHO and UNFPA** :Development and adoption of implementation plan, advocacy, technical support, capacity building and funding.
- **Funding organizations included WHO, UNPFA, UNICEF**
- **MOH and professional organizations:** driving the adoption of MPDSR as well as for technical support and capacity building
- **USAID (MCSP) and JPHEIGO** :Adoption of MPDSR in countries.
- **H6 partners, Red Cross, PEPFAR partners, CDC, FHI 360 and Civil Society**





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## MDSR Implementation- challenges

# Step 1: Identify Deaths

- Delays in notification of deaths occur at both community and facility levels
- Death occurring outside of labour & delivery/maternity wards are not reported
- Poor knowledge of definition of maternal death leading to under reporting
- Misunderstanding about the definition of perinatal deaths, specifically confusion around the term stillbirth
- Lack of notification and reporting systems at the community level
- crepancy between deaths reported in routine data (e.g. DHIS) and deaths reported on the surveillance system



## Step 2: Collect Information

- **Survey results shows that all respondents have concerns about the quality of the data collected**
- Medical records and registers are incomplete and inaccurate, making it difficult to assess cause of death and contributing factors
- Lack of standardized forms
- Multiple data sources to collect information
- Quality of data capture varied within countries: incomplete forms or not capturing the data required by the national guidelines
- Coordination between the obstetrics and pediatrics departments



## Step 3: Analyse Results

- infrequent committee meetings
- Review forms are inaccurate or incomplete
- Incorrect assignment of cause of death for both maternal and perinatal deaths in registers, case summaries, and notification forms [e.g preventable deaths classified as unpreventable]
- Variable processes for reconciling differences during reviews
- Lack of ICD-10 use and limited knowledge about ICD-10
- Staff involved in the maternal/perinatal death case are sometimes invited to the review committee, leading to fear of blame and litigation
- Inability to recognize trends



## Step 4: Recommend Solutions

- “R” Response component is perhaps the weakest component in most countries
- Recommendations range from very specific, time-bound, and feasible to broad and long-term
- Lack of prioritization of recommendations
- Responses (action plans) are not clearly linked to contributing factors and cause of death



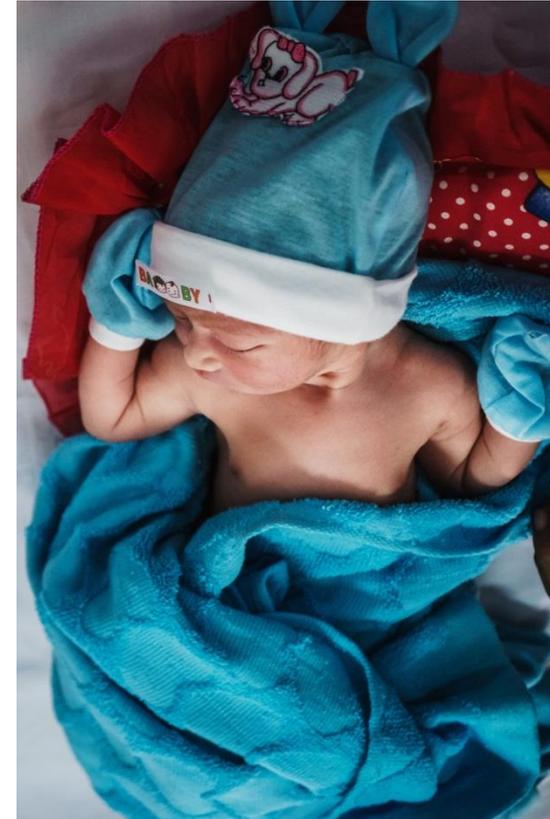
# Step 5: Implement Recommendations

- **Barriers**
- **Implementing recommendations are assigned informally [e.g. verbally rather than in writing]**
- **Staff motivation and workload are consistently cited as barriers**
- **Lack of engagement or difficulty engaging with Quality Improvements programs and initiatives**
- **Lack of MOH leadership**
- **Health systems issues-Limited human resources  
Inadequate funding- lack of a dedicated budget-Lack of commodities-Inadequate referral systems**
- **Lack of community engagement**



## Step 6: Evaluate and Refine

- Challenges
- Focus on “M” monitoring but not “E” evaluation
- Lack of defined feedback mechanism for tracking and evaluating MPDSR implementation in some countries
- Not all countries are sharing success stories
- Lack of feedback to the community



# Overall MPDSR challenges

In many countries, only a small number of deaths are being reviewed

**57%** of respondents felt that there was fear of reprisal or disciplinary action

The overarching challenges for each step in the MPDSR cycle include insufficient technical, human and financial resources to fully institutionalize MPDSR.

Reporting deaths at the community level remains a major challenge

Integration of MDPSR into other data collection systems like HMIS, IDSR and CRVS is in progress in many countries but remain weak at this point.

Response is the weakest component of the cycle with barriers faced in making effective recommendations and implementing them.

- Analyze the performance and sustainability of MPDSR systems in countries where it is integrated with other disease surveillance systems
- Use of MPDSR in humanitarian crises-Are maternal/perinatal deaths considered emergencies? How did this affect training/staffing and capacity building?
- Tracking gender-related factors known to contribute to maternal morbidity and mortality within MPDSR systems may improve an understanding of maternal deaths

# Conclusions

- Maternal Death Surveillance and response is critical for ending preventable maternal and newborn mortality
- Every maternal death should be notified, reviewed and responded to
- There is need to strengthen identification in order to count every maternal and perinatal death, minimise underreporting and accurately calculate the MMR
- Countries also need to integrate perinatal death surveillance and response into the MDSR systems
- Information generated from the MPDSR systems should be utilised for planning and improvement of the quality of MNH services at all levels

**Response is critical to end preventable maternal and newborn mortality!**



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