Standard Operating Procedures for Maternal Perinatal Death Surveillance and Audit (MPDSR) at Private Health Facilities in Addis Ababa: Pilot implementation in collaboration with AA RHB

Private Health Sector Project (PHSP)

September, 2019

Acronyms

WRA	Women of reproductive age
LBW	Low birth weight
MSB	Macerated Stillbirth
FSB	Fresh stillbirth
ENND	Early neonatal death
FBMDA	Facility based maternal death abstract
FBPDA	Facility Based Perinatal Death Abstract
MPDSR	Maternal Perinatal Death Surveillance and Audit
NICU	Neonatal ICU
PHEM	Public Health Emergency Management
SoP	Scope of Practice

Contents

Introduction

Ethiopia has made impressive progress achieving many of the national and global health indicators as a result of strong leadership of the Federal Ministry of Health (FMOH), coordination of efforts, and intensive investment in the health system by the government, partners and the community at large.

As a result, maternal mortality ratio (MMR) declined from 676 per 100,000 live births in 2011 to 412 in 2016. Also in 2016, contraceptive prevalence rate (CPR) increased from 29% in 2011 to 36%, and total fertility rate (TFR) dropped to 4.6 with a shift to long-acting, reversible contraceptive methods. Births attended by skilled providers reached 28% from 10% in 2011.

However, the Health Sector Transformation Plan set ambitious targets to be attained: MMR of 276/100,000, CPR of 55%, and TFR of 3 at the end of 2020. To achieve these ambitious targets, the FMOH is implementing a set of high-impact interventions – antenatal care (ANC), skilled birth, and postnatal care (PNC) – to improve quality of and access to service delivery in public facilities.

In line with these goals of the FMoH, the Private Health Sector Project (PHSP) designed a family planning (FP) and maternal, neonatal, and child health (MNCH) program to provide a wide range of technical support including trainings, mentorship support and joint supportive supervision (JSS) to 61 private health facilities to address the gap in quality service provision and access in Addis Ababa, Dire Dawa, Harari, Amhara, Oromia, Southern Nations, Nationalities, and Peoples region (SNNPR), and Tigray regions and city administrations to contribute towards the achievement of the aforementioned targets. Moreover, PHSP is supporting to improve the service provision in the 118 facilities by integrating FP into the existing MNCH and public-private mix (PPM) tuberculosis (TB) providing health facilities.

Additionally, PHSP currently in collaboration with AARHB has embarked on pilot implementation of MPDSR in 18 selected high volume private facilities in Addis Ababa.

Though there have been significant reductions in maternal and newborn mortality over the last two decades nationally, when it comes to maternal and perinatal deaths, it was resulting mostly from complications during and following pregnancy and childbirth with approximately 287 000 maternal deaths and 2.6 million stillbirths and neonatal deaths according to 2018 report.

FMoH therefore planned to eliminate preventable maternal and perinatal deaths and thus has been implementing maternal death surveillance and response since 2013, which was integrated within the national public health emergency management (PEHM) system from 2014. Perinatal death surveillance and response (PDSR) was introduced since 2017 by building on this PHEM platform and integrated with the existing MDSR system.

While this being the case for the public sector health facilities, there is no accurate information on how many women/ fetus and newborns died, where they died, and why they died in and private sector facilities in Ethiopia.

Accordingly, in the year four plan, PHSP have started to pilot the implementation of the MPDSR system at 18 health facilities in AA in collaboration with AARHB so as to improve service quality and establish accountability for maternal and perinatal death that happen.

In line with the above plan, PHSP have provided a three days training for focal persons and orientation of the facility RRT with AARHB in June 2019 as part of the initiation support.

Moreover, PHSP found it important to outline the details of the activities to be performed and accomplished by each party be it by individual providers, the review committee, the health faculty, and the RHB.

Therefore as part of the technical support provided for the pilot implementation of MPDSR, PHSP had developed this Standard Operating Procedure (SoP) document for smooth execution of activates.

Intended Users of this SoP

This SoP is intended to be used by health workers at the facility level and the partners involved in the pilot implementation of the MPDSR in private facilities in AA (The RRT, AA RHB MPDSR Team, USAID PHSP).

Goal of the MPDSR pilot implementation:

The goals are to establish a system and contribute towards the elimination of preventable maternal and perinatal mortality in the involved private facilities by obtaining and using information on each maternal and perinatal deaths so as to guide actions to improve the quality of service provision.

Each event of death, be it maternal or perinatal has a story to tell and can provide information that would be used to prevent similar deaths in the future.

Objectives of the pilot implementation

Its main objectives are:

1. To provide information that effectively guides actions to at facility level so as eliminate preventable maternal and perinatal mortality in the involved private facilities.
2. To count every maternal and perinatal deaths, permitting an assessment of the true magnitude and the actions taken to reduce it in the involved private facilities.
3. To establish accountability for every maternal and perinatal death that occur in the respective private health facilities.

Moreover, the MPDSR system to be established in the private facilities shall operate with the following core principles which are absolutely important for all involved parties before and while implementing MPDSR pilot implementation activities.

Core principles of the pilot implementation

- No blame policy - Death reviews focus on health systems not individuals. MPDSR review meetings are designed to be an educational experience for all participants.
- In MPDSR programs, a "zero-reporting" principle is adopted, meaning that reports are made regularly even if no death has occurred.
- Death review data anonymized cannot be used for disciplinary purposes n the staff or the facility.
- The death reviews are incomplete without formulation of a response plan and follow up to prevent avoidable factors in the future.

Purpose:

This SoP defines the process for documenting, reviewing, reporting and developing actions to tackle preventable maternal and perinatal deaths by the respective private facility review and Response Team (RRT).

Scope of the SoP

This SoP covers the procedures of collecting, documenting, reviewing/analyzing, reporting and developing actions to tackle preventable maternal and perinatal deaths by the respective private facility RRT.

Aim of this SoP

The aim of this SoP and the accompanying annexed checklists and forms is to simplify the organization and documentation of the MPDSR activities in the involved private facilities by outlining the procedures of review, roles and responsibilities of individual RRT members and parties using standard definitions and tools.

Roles and responsibilities:

1. **USAID/ PHSP, RMNCH program**
   a. Train one staff from each of the private facilities
   b. Provide orientation for members of the facility RRT
   c. Provide the reporting national formats
   d. Establish three-four review and response team (RRT) which shall be comprised of MPDSR trained staff, pediatrician, Ob/Gyn specialist, Menton /Quality officer of the facility
   e. Provide mentorship support and SS with AA RHB MPDSR team
   f. Organize RM to capture challenges, lessons learned and best practices
   g. Collect data quarterly using standardized and adopted formats to document evidence

2. **AA RHB/MPDSR team**
   a. Collaborate with USAID/PHSP in the pilot implementation of the MPDSR
   b. Avail staffs for training, RM, SS and mentorship visits
   c. Link facilities with the Woreda based PHEM for capturing routine report

3. **Facilities**
   a. Send trainees (Nurse/Midwife/HO/GP) for the MPDSR training
   b. Avail physical space for meetings of the facility RRT

c. Comply with the reporting national standards and recommendations from the RRT based on findings of the review

4. The facility based review and response team (RRT)

a. Ensure that maternal and perinatal depths are collected, reviewed, reported
b. Recommend actions that are indicated on the basis of the MPDR
c. Mobilize resources to implement recommended actions
d. Follow up to ensure that recommended actions are implemented
e. Ensure that maternal and perinatal death reviews are institutionalized

5. Rapid response team (RRT) members

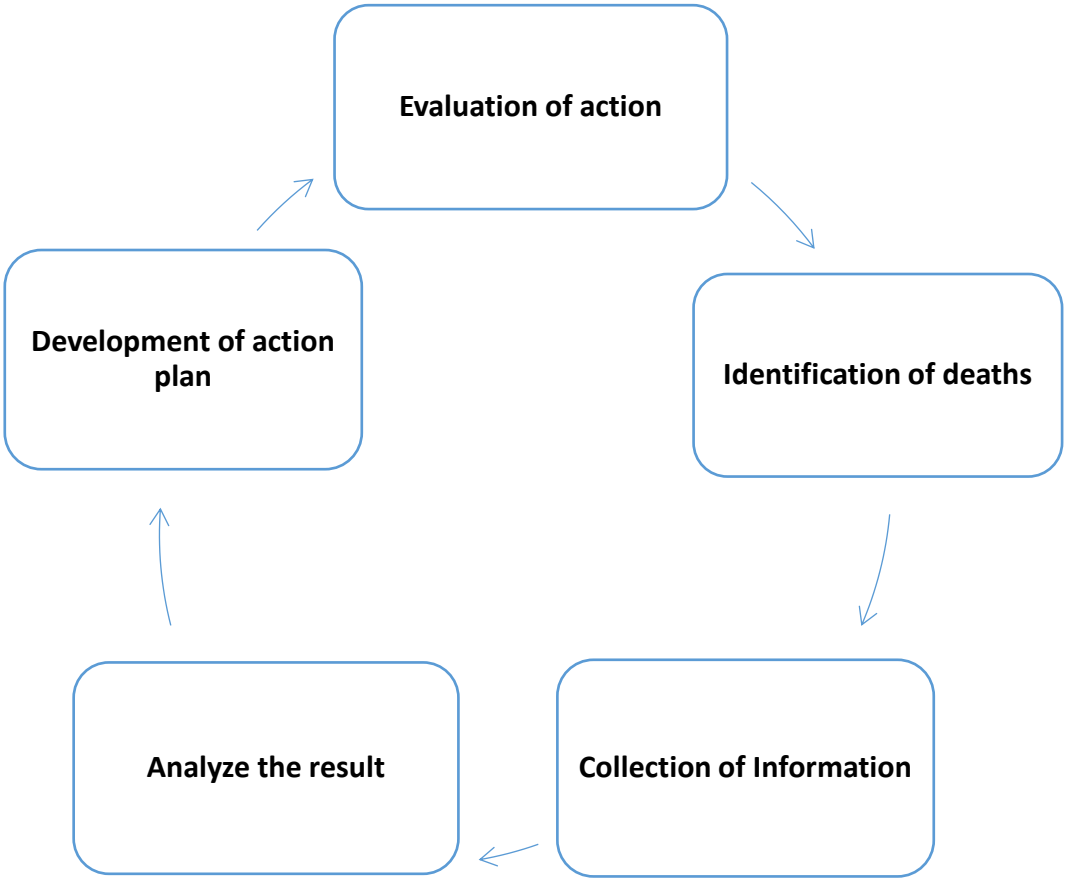
a. Participate in the RRT meetings regularly
b. Be abided by the core principles of the MPDSR
c. Provide technical expertise in the area of maternal and perinatal health for effective interpretation off the causes of deaths
d. Review, discuss and support the team to consider action plan to prevent subsequent similar preventable deaths as per the MPDSR review procedure flow chart
e. Review the progress as per the developed action plan (see annex 5)

6. The facility focal person (trained staff on MPDSR)

a. Serves as a focal point in receiving, aggregating weekly suspected maternal and perinatal death data.
b. Every morning check all in-patient, ICU, NICU, delivery and emergency OPD registers for any death or suspected maternal and perinatal deaths within the previous 24 hours and prepare line listing for the identified deaths
c. If there is any suspected maternal or perinatal deaths in the facility, should screen these using the screening tools to determine whether it was confirmed maternal and perinatal deaths
d. Completes and files a notification form for any confirmed maternal or perinatal death
e. At the end of each week, fill the weekly PHEM reporting formats and report to the respective Woreda PHEM.
f. Writes minutes and keep it achieved as per the annexed meeting minute format (Annex 4)
g. Maintains or keeps all files and documents achieved

h. Co-ordinates activities of the facility RRT committee
i. Ensures members and involved staff are working according to current versions of this SOPs
j. Liaises with the facility managers to implement the recommended actions and follow

The maternal and perinatal death review procedure flow chart



The above flow chart depicts the procedures of the review in a step by step sequence and states clearly the responsible person(s) or position for each activity from identification of deaths to development of action to prevent the occurrence of subsequent preventable maternal and perinatal deaths in the facilities.

Response is the ultimate aim of the surveillance process and shall be based on review of each case based summary and analysis of aggregated data.

Subsequently action plans will be developed to provide responses at facility level to identify institutional responses to improve the quality of service.

Instructions on MPDSR review process at facility

1. **Formation of the committee**

   At the facility level, the MPDR committee will consist of 3-5 multidisciplinary members from relevant departments (Obstetrics/Gynecology, Pediatrics, and anesthesia) and other staffs from quality control office, head midwife and matron representing the facility management.

2. **Orientation of the committee members**

   The members should be sensitized on the aims of MPDR as well as their roles and responsibilities including the following:

   a. How deaths can be identified (for example, discharge register, ward registers, routine records),
   b. Assessing whether written medical records exist and if so, can they be located,
   c. Inspecting the records if they are legible and reasonably complete for key items (such as the woman's address, age, date of admission, gestation, and diagnosis on admission or death?), and
   d. Securing appropriate permissions and co-operation from facility personnel.

3. **Reviewing processes**

   a. Review medical records based on the collected death list from the various registers,
   b. Conduct staff interview for those who performed or were involved on the actual care eg. Delivery, surgery, anesthesia etc., See. Annex V for terminologies and definitions of procedures,
   c. Conduct family interview when it is appropriate and deemed important,
   d. Synthetize the findings on each maternal and perinatal deaths,
   e. Discuss and utilize the findings for developing action plan and ,
   f. Implement action plan to improve maternal and perinatal health.

4. Identifying cases of deaths and sources of data

Deaths may have been noted, for example, in a delivery, ICU, Operation Theater or ward registers. It is important that deaths are not missed and so a full-proof method for detection should be established. The number of maternal and perinatal deaths at the facility needs to be double-checked.

Maternal and perinatal deaths which occur outside the obstetric or gynecology wards, such as in the medical, ICU or pediatric ward, are often missed. One way to avoid this is to list all deaths at the facility among women aged 15 – 49 years old mothers and fetus who were live or stillbirths and newborn death till 28 days and then eliminate those which are not maternal or perinatal deaths after inspection of the medical records. The detailed definition has been given in the Annex 1 and 2.

A facility list of maternal and perinatal deaths needs to be compiled, simply noting the woman's /newborns name and facility/unit number, and the date of death and ward of death. The size of the list will obviously be affected by the type of facility and the delivery and newborn /neonatal case load. However, even one death at, say, a Specialty clinic or MCH center or hospital with only a small number of deliveries can still yield valuable information on preventable/ avoidable factors.

5. Preparation of a short (maternal or perinatal) death summary

The next step is to bring the elements together to create as complete and clear a picture as much as possible of the events surrounding the death. This should involve all members of the facility-specific team.

In preparation for this meeting, the focal person should prepare a short written summary for each death of the events as they see them, incorporating all sources of data. And the summary should highlight:

- Key points from the checklists- When death occurred, What condition and why death occurred
- Avoidable factors and details of their classification
- Delays in seeking and receiving care
- Significant quotations from interviews of care takers and family
- Inconsistencies between the various data sources.

Key points for organizing a successful MPDSR meeting

- Scheduling: - Specify time, place and duration of MPDR meeting
- Have an agenda for MPDR session
- Review previous Action plan
- All members concerned should be in attendance (quorum rules)
- Allow full participation of the committee members
- Avoid blaming and naming
- Identify what was done according to standards
- What was not done according to standards viz a viz resources available and can be improved
- Focus on system issues that they can do something about it
- Keep records of attendance and recommendation
- Develop an action plan

The then RRT should prepare and use summary of the findings as a starting point for their discussions. The end-point for each maternal or perinatal death reviewed is a consensus statement on avoidable factors. This can be arrived at by asking each team member to individually rank factors which they feel were significant, for these rankings to be shared, and then final agreement reached by the team.

In many instances, specific areas for improvement within the facility will emerge from the review process. The team needs to agree on appropriate mechanisms to feed this information back to the senior staff and to stimulate actions.

Attached are thirteen annexes which contain important standard definitions, definition of terms, meeting minute documentation format, action plan template, abstraction and reporting formats for the MPDSR activities that are required to be filled by the facility MPDSR focal person of the respective facilities. For more information please refer to the national technical guideline of the maternal and perinatal surveillance document which was issued in 2017.[1]

[1] Note; please refer to annex 6 regarding the details of what to be reported, by whom, the data source and timing of report submission.

Annex

Annex 1. Standard case definitions

1. Confirmed maternal death

The death of a woman while pregnant or within 42 days of the end of pregnancy (irrespective of duration and site of pregnancy), from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

2. **Confirmed perinatal death -extended**

``A death of a fetus born after 28 completed weeks of gestation or neonatal deaths through the first 28 completed days after birth`` Gestational age of 28 weeks as determined by LNMP: GA of 28 weeks or 196 days starting from the first date of the last menstrual period (LNMP) or Fundal height of 28 cm Early or First TM Ultrasound by CRL (9-11 weeks) or GS diameter at 5-6 GA weeks.

Annex 2. Definition of terms

Maternal death: The death of a woman while pregnant or within 42 days of the 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.

Direct obstetric deaths: Maternal deaths resulting from complications of the pregnancy, labour or postpartum or from interventions, omissions or incorrect treatment.

Indirect obstetric deaths: Maternal deaths resulting from previously existing disease or newly developed medical conditions that were aggravated by the physiologic change of pregnancy

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Late maternal death: A maternal death which occurs from 42 to 365 days after the termination of pregnancy (1).

Maternal near-miss: A woman who nearly died but survived a complication that occurred during pregnancy, child birth or within 42 days of termination of pregnancy. In practical terms, women are considered near miss cases when they survive life threatening conditions (i.e. organ dysfunction).

Perinatal death: The death of a fetus after 28 completed weeks and within 7 days after birth.

(**Extended perinatal death:** The death of a fetus after 28 completed weeks and within 28 days after birth.

Live birth: The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Still birth: A fetal death with no signs of life at ≥ 28 completed weeks of gestation.

Ante-partal still birth: A death of a foetus occurring before the onset of labour and after 28 weeks of gestation.

Intra-partal still birth: A death of the foetus occurring after the onset of labour and before delivery of the baby.

Still birth of unknown time: A still birth with un-known timing of death with reference to onset of labour/ lack of evidence to classify as before or after the onset of labour.

Neonatal death: A death of a live born baby within 28 days of birth.

Early neonatal death: A death of a baby within 7 days of birth.

Late neonatal death: A death of a baby after 7 days and before 28 days of birth.

Annex 3.

Many women or neonates who die in pregnancy or after delivery have had multiple procedures. Some are as a result of the medical condition causing the problem, but in some the intervention directly results in the death of the woman, e.g. anaesthesia. It is useful to list all the interventions from early pregnancy through ANC, intra-partum and post-partum. In the comments section state whether the intervention was due to the complication or resulted in the complication.

The interventions have been grouped in the stages of pregnancy to help with the analysis later.

Some definitions:

1. **Evacuation** - The uterus is emptied by using a curette or MVA (manual vacuum aspirator).
2. **Laparotomy** - This is where the abdomen is opened surgically.
3. **Hysterectomy** - This is where the uterus is removed.
4. **Transfusion** - used to mean whether blood or blood products were given to the woman
5. Version - means the baby was turned in the uterus either by manipulating the fetus abdominally or from inside the uterus.
6. Instrumental del. - Was a forceps or vacuum used to assist in delivering the baby
7. **Symphysiotomy** - This is where the ligament holding the symphysis together are cut so that the size of the pelvis is enlarged.
8. **Caesarean section** - The baby is born abdominally through a cut in the abdomen and uterus and not vaginally
9. **Manual removal** - This is where the placenta is removed using a hand or curette after a baby has been born.
10. **Anaesthesia** –

- **General anaesthesia**-where the woman is put to sleep while a procedure is carried out.
- **Epidural anaesthesia** - Where a local anaesthetic agent is injected into the epidural space to provide pain relief during a procedure.
- **Spinal anaesthesia** - Where the local anaesthetic is injected into the cerebrospinal fluid (CSF).
- **Local anaesthesia** – Where local infiltration of each tissue layer was performed

11. Invasive monitoring - Was a central venous pressure (CVP), Swan-Ganz catheter or invasive blood pressure monitoring used?
12. Prolonged ventilation - Did the woman require ventilation other than during an operation? This is usually in an intensive care situation.
13. Others: e.g C/S before 28 weeks
14. Comments: Summary of appropriateness of interventions

Annex 4. Meeting minute documentation template

MPDSR RRT committee meeting minute

Name of the Health facility_____

Date of the meeting_____

Time the meeting was started_____

Members' present_____

Agenda_____

Reports from the Team leader (Trained MPDSR focal person/Quality officer)

_____
_____
_____
_____

Action plan (What, when, by whom, resources needed, and remark, ect.)

_____
_____
_____

Conclusion

_____
_____

Date and time of the next meeting_____

Time the meeting adjourns_____

Signature (from designated minute note taker, focal person) _____

Annex 5:

Recommendations and Action Plan Template

Name of the facility_____

Date of MPDSR review_____

MRN No. _____

Issues Identified	Action Required	People responsible for taking action	Deadline	Person responsible For follow-up	Outcomes achieved	Re-evaluation (Date, reasons why objectives not achieved)	Further actions required

Annex 6. Data collection process, formats to be used, persons responsible for data collection, data source & timing of data collection at facility.

Data collection Process	HMIS form to be used	Who fills the form	Data source	Data collection
Maternal death notification at health facility	Maternal death notification form	Health worker who attended to the deceased	Registers including; Maternity, ANC Operating theatre, OPD, admission, discharge registers	24 hours
Perinatal death notification at health facility	Perinatal death notification form	Health worker who attended to the deceased	Maternity, Operating theatre, Neonatal / Peadiatric ward registers	24 hours
Data collection for maternal death review at health facility	Maternal death review form	Designated HW fills in Maternal death review form during the MPDSR meeting	Patient medical records and relevant registers	Within 7 days
Data collection for perinatal death review at health facility	Perinatal death review form	Designated HW fills in perinatal death review form during the MPDSR committee meeting	Mothers records, New-born's records and relevant registers	Within 7 days

Annex 7. Identification and Notification form for maternal death

To be filled in two copies, one copy kept at HP or reporting ward and the remaining one copy will be documented at health facility surveillance unit)

Section one (Notification)		
1.	Maternal death Notification is reported from	▫ Community & Ward on which death occurred)
2.	Name of the deceased	
3.	Age of the deceased woman (in completed years)	
4.	Name of head of the household:	
5.	Household address	Woreda/Sub-city Kebele Gott HDA team house number:
6.	Date and time of the woman's death	DD/MM/YYY / / Time
7.	Who informed the death of the woman?	1. HDA 2. Religious leader 3. any community member 4. Self (HEW or Surveillance focal person) 5. Other Health care provider 4. Others (specify)
8.	Date of Notification:	DD/MM/YYY / /
9.	Place of death:	1. At Home 2. At Health Post 3. At Clinic 4. At Health Center 5. At Hospital 6. On transit from home to Health facility
Screening of notified Maternal deaths		
8.	Did she die while pregnant?	▫Yes ▫ No
9	Did she die with 42 days of termination of pregnancy?	▫Yes ▫No
10	Has she missed her menses before she dies?	▫Yes ▫No ▫Unknown
Section two (Classification and decision for investigation)		
1.	Type of maternal death:	▫Probable ▫ Suspected ▫Confirmed
2	**If suspected or confirmed maternal death, write ID number/code**	

Annex 8. Facility Based Maternal Death Abstraction Form (FBMDAF) (Health Facility)

I. Abstractor related Information		
Name of the abstractor: Telephone		Qualification of the Abstractor
Was the abstractor involved in the management of the case? 1. Yes 2. No		
II. Identification/ Back ground information		
No.	Question	Response
1	Medical Record Number of the deceased	
2	Age of deceased	

3	Date and time of death	Date Time
4	Ethnicity	
5	When did the death occur?	1. In transit 2. While waiting for treatment 3. Following start of treatment
6	Place of usual residence Woreda/subcity_____	Kebele House number_____
7	Religion	1. Orthodox 3 Protestant 2. Muslim 4. Others (specify)----
8	Educational status of the deceased	1.Illiterate 2.No formal education, but can read and write 4. Don't know
9	Marital status of the deceased	1. Single 3. Divorced 2. Married 4. Widowed
10	Level of education of the husband	1.Illiterate 2.No formal education, but can read and write 4. Don't know
11	Occupation of the deceased	1. Farmer 5. Unemployed 2. Merchant/tradesperson 6. Public employee 3. House wife 7. Others (specify) 4. Daily labourer
12	Occupation of the husband	1. Farmer 4. Daily labourer 2. Merchant/tradesperson 5. Public employee 3. Unemployed 6. Others
13	Monthly income if possible	birr
III. Obstetric characteristics		
1	Gravidity	
2	Parity	
3	Number of living children	
4	Attended ANC?	Yes No Not known
5	If yes Q4, where is the ANC?	1. Health post 3. Hospital 2. Health center 4. Other (specify)
6	If yes, number of visits	
7	Basic package of services provided in ANC (Tick *ALL* that apply)	RPR BP measurement during the follow up Hgb, Iron folate supplementation Blood group, TT immunization U/A
8	Problems or risk factors in the current pregnancy:	
i	***Pre existing problems*** (Tick *ALL* that apply)	Hypertension Cardiac problem
		Anaemia Tuberculosis Diabetes Hepatitis HIV positive Other (Specify) _____ Malaria

ii	***Antenatal/ intranatal problems/risks*** (Tick *ALL* that apply)		Pre eclampsia / eclampsia Placenta praevia Previous Caesarean Section	Anaemia Malaria UTI/pyelonephritis	
9	State of pregnancy at the time of death	1. Antepartum 2. Intrapartum	3. Postpartum 4. Postabortion	5. Ectopic	
10	If delivered, what is the outcome?		1.Live birth	2. Stillbirth	
11	Date of delivery (DD/MM/YY) in Ethiopian calander				
12	Place of delivery:	1. Health post 2. Health center	3. Hospital 4. Home	5. on transit 6. Other (specify)	
13	If she has delivered, what was the mode of delivery?	1. Spontaneous vaginal delivery 2. Operative vaginal delivery (vacuum or forceps) 3. Destructive vaginal delivery for dead fetal outcome 4. Operative Abdominal delivery (caesarean section or Hysterectomy)			
14	Gestational Age at the time of death in antepartum and /or intrapartum events (specify time period in months & weeks)	GA			
15	If the death was post partum or postabortion, after how many days did the death occur?	Days			
IV. Facility Episode					
1	Date and time of admission	Date	Time		
2	Day of admission	1. Working days	2. Weekends	3. Holiday	
3	Main reason/symptom for admission	-			
4	Is it a referred case?	Yes	No		
5	Referred from (Name of health facility)				
6	Reason for referral				
7	Comment on referral	• Accompanied by HCWs • Appropriate management			
8	Summary of management at hospital				
9	Qualification of the most senior attending health professional(s)				
10	Primary cause of death				
11	Is this preventable death?				
12	If preventable maternal death, specify factors according to the three delay model				
i	Delay in seeking care				
ii	Delay in reaching at right facility				
iii	Delay within the facility (diagnostic and therapeutic)				

Annex 9: Maternal Death Reporting Format (MDRF)(Maternal Death Case Based Report)

To be filled in 5 copies by the Health Centre/hospital. Send the rest of copies to the next level by keeping one copy,

I. Reporting Facility Information					
Reporting Health Facility name & type(H.C/Cl./Hosp):			W		
Zone :	Region:		Date of Reporting DD/MM/YYYY ____/____/____		
This MDSR is extracted from 1. Verbal autopsy(VA) 2. Facility based maternal death abstraction form					
II. Deceased Information					
Deceased ID(code):_____	Date of Death DD/MM/YYYY ____/_____/__		Age at death: _____ Years		
Residence of deceased Urban Rural	Region	Zone	Woreda	Kebele	
Place of Death	1. At home 2. At health post	3. At health center 4. At Hospital	5. On transit 6. Other specify _____		
Marital status	1. Single	2. Married	3. Divorced	4. Widowed	
Religion: _____	Ethnicity : _____				
Level of Education	1. No formal education 2. No formal education, but can read and write 3. Elementary school	4. High school 5. College and above 6. I do not know			
Gravidity	Parity	Number of living children			
Timing of death in relation to pregnancy	1= Antepartum	2= Intrapartum	3= Postpa		
III. Antenatal Care (ANC)					
Attended ANC?	1. Yes 2. No 3. Not known				
If yes, where is the ANC?	1. Health post 2. Health centre 3. Hospital 4. Other (specify)				
If yes, number of ANC visits					
If delivered, Mode of delivery?	1. Vaginal delivery 2. Abdominal operated delivery (CS or hysterectomy)				
Place of delivery or Abortion?	1 Home 2. On transit 3. H/post 4. H/center 5. Hospital 6. Clinic				
Date of delivery /Abortion	Date _____				
If it was delivery/Abortion, who assisted the delivery/Abortion?	1. Family 2. TBA 3. HEWs 4. HCWs				
Attended PNC/PAC?	1. Yes 2. No 3. Not known 4. Not applicable				
If yes for PNC/PAC, number of visits?					
IV. Cause of death					
Direct obstetric	1= hemorrhage	2= obstructed labor	3= HDP	4=abortion	5= sepsis 6. Others
Indirect obstetric	1=anemia,	2= malaria	3= HIV	4= TB	5. Others
If delivered, what is the outcome?	1. Live birth	2. Stillbirth			
Is the death preventable?	1= Yes	2= No	3= I do not know		
Contributory factors (Thick all that apply)					
Delay 1	Traditional practices Lack of decision to go to health facility Family poverty Delayed referral from home Failure of recognition of the problem				
Delay 2	Delayed arrival to referred facility Lack of transportation Lack of roads No facility within reasonable distance Lack of money for transport				
Delay 3	Delayed arrival to next facility from another facility on referral Delayed or lacking supplies and equipment(specify) Delayed management after admission Human error or mismanagement				

Annex 10. Identification and Notification Form for Perinatal Deaths

To be filled in two copies, one copy kept at HP or reporting ward and the remaining one copy will be documented at health facility surveillance unit)

Notification (section one)		
1.	Perinatal death Notification is reported from	Community Health facility (MRN _____) on which death occurred
3.	Name of the mother	
2.	Name of head of the household:	
3.	Household address:	Woreda/Subcity Kebele team house
4.	Date of birth	DD/MM/YYY
5.	Date of identification of the death	DD/MM/YYY / / Time
6.	Data of notification	DD/MM/YYY / / Time
7.	Who informed the death of the perinatal death	1. HDA 2. Religious leader 3. any community member 4. Self (HEW or Surveillance focal person) 5. Other Health care provider
8.	Place of still birth/Neonatal death:	1. At home 2. On the way to health post 3. At health post 4. On the way to Health facility (HCs, hospitals)
Screening of a notified perinatal death to determine whether it is probable, suspected or confirmed **Ito be filled by Health Extension Worker(community report) or facility surveillance focal person(H.F**		
9.	Was the birth after 7 months of pregnancy?	□ Yes □ No
10.	Was the newborn dead at birth?	□ Yes □ No
11.	Did the Baby die within 28 days after birth?	□ Yes □ No

Section two (Classification and decision for investigation) **I to be filled by Health Extension Worker(community report) or facility surveillance focal**				
1.	Type of perinatal death:	probable	Suspected	Confirmed
2	If suspected or confirmed perinatal death, write ID number/code			

Name of reporting person signature

Annex 11. Facility Based Perinatal Death Abstraction Form (FBPDAF)

I. Abstractor related Information			
Name of the abstractor:			Qualification of the Abstractor
Telephone number of the abstractor:			Date of abstraction:
II. General information Of the deceased:			
1	Unique ID Number		
2	Date and time of birth	DD/MM/YYYY ___/___/	Day ▫ Night ▫ Time
3	Status of the newborn at birth	Alive(live birth) ▫	Dead(stillbirth) ▫
4	Date and time of perinatal death	DD/MM/YYYY	Day ▫ Night ▫ Time
5	Sex of the deceased	Male ▫	Female ▫
6	Place of still birth or	1. Home 2. Health Post	3. Health Centre 4. Hospital 5. On transit from home to facility) 6. During referral from facility to facility
7	Place of residency of deceased/parents	Rural ▫ Urban ▫	Region _____ Zone/sub-city_____ Woreda _ Kebele _____House number_____
General Information of the mother:			
8	Ethnicity of the mothe		
9	Religion of the mothe	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Others (specify)	
10	Marital status of the m	rl. Single 2. Divorced 3. Married 4. Widowed	
11	Age of the mother	(years)	
12	Is the mother of the deceased alive	? Yes ▫	No ▫
13	Educational status of the mother	1.No formal Education 2.No formal education, but can read and write	4. High school 5. College and above 4. Unknown
14	Occupation of the mother	1.Pofessional 2.Clerical 3.Sales and Services	4.Manual Skilled Manual Unskilled 6. Agriculture 7. Unemployed 8. Others (Specify)
15	Occupation of the father	1.Pofessional 2.Clerical 3.Sales and Services	4.Manual Skilled 5. Manual Unskilled 7. Unemployed 8. Others (Specify)_____
III. General Obstetric history Of the mother			
1.	Number of pregnancies: _____ Number of alive children: _____		
2.	Total number of births at ≥ 7 months of pregnancy:	Number of neonatal deaths: Number of still births:	
3.	Number of miscarriages at less than 7 months of pregnancy _____		
4.	• Number of Spontaneous vaginal delivery: • Number of Operative vaginal delivery (vacuum, forceps or destructive): _____ • Number of cesarean delivery:		

IV. Antenatal history of the mother during pregnancy of the index perinatal death					
1	Number of ANC visits in relation to index perinatal death (report "0" if no ANC visits) _____				
2	Place ANC attended (Tick all that apply)	▫ Health Post ▫Public Hospital Others (specify) ▫ Public HC ▫Private clinic or hospital			
3	Did the mother receive any of the following during preconception and pregnancy	▫Iron folate tablet for more than 3 months ▫ TT injection at least 2 in this pregnancy ▫Multivitamin and mineral tablets for the first 2 months ▫ Other drugs specify			
4	Maternal disease ancondition identified during Pregnancy (Tick all that apply)	d/or ▫Pre-eclampsia o Eclampsia ▫Heart Disease ▫	▫Anemia ▫APH ▫Malaria s ▫HIV	▫ Tuberculosis ▫ Syphilis ▫UTI/pyelonephriti▫ Multiple gestation	▫Abnormal lie/presentation ▫Unknown s Other (specify)

V. Intrapartum history of the mother of the index perinatal death					
1	Estimated Gestational age at delivery in weeks				
2	Was Parthograph used?	yes▫ No▫			
3	Status of the fetal heartbeat during la	or ▫120-160 BPM ▫ <120 or >160 BPM ▫Absent			
4	Mode of del	vey 1. Spontaneous vaginal delivery 2. Vacuum 3. Forceps			
5	Place of birth of the index perinatal death	1. Home 2. On transit 3. Health post 4. Health center 5. Hospital 6 Clinic 7. On transit from facility to facility 8. Other			
6	Total duration of labor	Hours			
7	Total duration of rupture of membrane	Hours			
8	APGAR score of the baby at 1st minute:	APGAR score of the baby a minute:			
9	Weight of Baby (in grams): ___, Head Circumference of the baby (cm):____, Length of the baby (cm):_				
10	Who assisted the delivery?	1. Family member 2. Elderly in the	3. TBA 4. HE	5. HCWs (Midwife, nurses , IESO, obstetrician, GP) 6. Unattended	
11	Did any of the following problems experienced during delivery?	1. Obstructed labor 2. Ruptured uterus 3. APH	4. Pre-eclampsis /eclapsia 5. Anemia 6. Congestive heart failure	7. Cord prolapse 8. Mal-presentation 6.Other	

VI. Post-natal history of the index perinatal death				
1	Did the baby receive any of these care lised (Tick all that apply)	1. Dry and stimulate the baby 2. Keep the baby warm by skin skin 3. Appropriate Cord care	4. Initiate breast feeding within 1 hr of birth 5. Vitamin K injection	
2	Did the baby have athe following? (Tick that apply)	1. Sepsis y 2. Meningitis	4. Birth Asphyxia 5. Lethal congenital malfor 6. Complication of Prematu	7. Meconium aspiration Syndro matn 8. Hyaline membrane Disease ity 9. Others _____

VII. Cause and timing of death					
1	Primary cause of death				
2	Timing of the death	1. Before labo 2. During Lab	r 3. In the first 24 after birth o 4 Between 1st day and 7	5. Between 8 day and 28 days	

VIII. Contributory factors according to the three delay model

1	Delay one : Delay in seeking care	1. Family poverty 2. Did not recognize the danger signs of newborn infants 3. Unaware of the warning signs of problems during pregnancy	4. Did not know where to go 5. Had no one to take care of other children 6. Reliant on traditional practice/medicine 7. Lack of decision to go to the health facility
2	Delay two: Delay in reaching care	1. Transport was not available 2. Transport was too expensive	3. .No facility within reasonable distance 4. Lack of road access 5. Others
3	Delay three: Delay in receiving care	1. Delayed arrival to next facility from another referring facility 2. Family lacked money for health care 3. delayed management after admission	5. Human error or mismanagement' and 6. Delay in first evaluation by care giver after admission 7. Lack of supplies or equipment,

Annex 12. Perinatal Death Reporting Form (PDRF) (Perinatal Death Case Based Report)

To be filled in 5 copies by the Health Centre/hospital. Send the rest of copies to the next level by keeping one copy)

Reporting Facility Information				
Reporting Health Facility name type(H.C/Cl./Hosp):			Woreda:	
Zone:	Region:		Date of Reporting DD/MM/YYYY / /_____	
This PDRF is extracted from: 1. VA			2. Facility based Perinatal death abstraction form	
Deceased Information				
Deceased ID(code):				
Residence of deceased/parents Urban Rural	Region		Zone	
	Woreda		Kebele	
Date and time of birth	DD/MM/YYYY / / / Day E Night E (hrs/min) /____			
Date and time of death (Not applicable for stillborn)	DD/MM/YYYY / / /			
	Day E Night E Time in (hrs/min) /_____			
Sex of the deceased	1 Male	2. Female		
Estimated gestational age at delivery in weeks	weeks			
Place of Death	1. Home/ Relatives' Home 2. Health Post	3. Health Centre 4. Hospital	5. In Transit 6. During referral (from facility to facility	
General information of the mother				
Is the mother of the deceased perinate alive?	Yes E No E			
Age of the mother (years)	Parity	Number of alive children		
Religion of the mother	1. Orthodox	2. Muslim	3. Protestant	4. Catholic 5. Others (specify)
Educational status Of the mother	1.No formal Education 2.No formal education, but can read and write	3. Elementary school 4. High school	5. College and above 6. Unknown	
Occupation of the mother	1.Pofessional 2.Clerical 3.Sales and Services	4.Manual Skilled 5. Manual Unskilled 6. Agriculture	7. Unemployed 8. Others (Specify)	
Obstetric History of the mother in relation to this deceased case				
Number of ANC visits in relation to the deceased case (report "0" if no ANC visits)				
Number of TT vaccine during the pregnancy of the deceased case: 1. No TT 2. One TT 3. Two and above TT				
Mode of delivery of the deceased baby	1. SVD 2. Operative vaginal delivery 3. Forceps 4. Vacuum 5. C/S			
Status of the baby at birth	Alive/live born E Dead/Still birth E if alive APGAR score at 5th minute			
Where was the deceased baby born?	1. Home 2. On transit 3. H/post 4. H/center 5. Hospital 6.Clinic			
Maternal disease or condition identified				
Perinatal Cause of death				
Neonatal Cause of death	1. Complications Prematurity 2. Asphyxia	3. Sepsis/pneumonia/meningitis 4. Neonatal Tetanus	5. Lethal congenital anomaly 6. Other	

Maternal causes of death	1. Obstructed labor 2. Ruptured Uterus	3. Preeclampsia/ Eclampsia 4. APH (Placenta previa or abruption)	5. Obstetric Sepsis 6.Others
Timing of the death	1. Antepartum stillbirth 2. Intrapartum stillbirth	3. Still birth of un known time 4. Death In the first 24 after birth	5. Death Between 1st day and 7 day 6. Death Between 8 day and 28 days
Is the death preventable?	1= Yes	2= No	3= Unknown

Contributory factors (Thick all that apply)

Delay 1	1. Family poverty 2. Did not recognize the danger signs of newborn infants 3. Unaware of the warning signs of problems during pregnancy	4. Did not know where to go 5. Had no one to take care of other children 6. Reliant on traditional practice/medicine 7. Lack of decision to go to the health facility
Delay 2	1. Transport was not available 2. Transport was too expensive	3. No facility within reasonable distance 4. Lack of road access 5. Others
Delay 3	1. Delayed arrival to next facility from another referring facility 2. Family lacked money for health care 3. delayed management after admission 4. Fear to be scolded or shouted at by the staff	5. Human error or mismanagement' and 6. Delay in first evaluation by care giver after admission 7. Lack of supplies or equipment, specify

Reported by: _____ signature: _____ seal

Annex 13. Weekly Disease Report Form for Outpatient and Inpatient Cases and Deaths.

Health facility name and type		Woreda	
Zone		Region	
Start of week from Monday _____/(day) (month) (Year in Calendar)	to	Sunday _____/(day) (month) (Year in EC)	

3. Record below the total number of cases for each disease/condition for the current week.

Indicator		Put-patient	In patient	
		Cases	Cases	Deaths
Total Malaria (confirmed and clinical)				
Total malaria suspected fever cases examined by RDT or Microscopy				
Number cases positive for malaria parasites (either by RDT or Microscopy)	*P. falciparum*			
	P. vivax			
Meningitis				
Dysentery				
Typhoid fever				
Relapsing fever				
Epidemic Typhus				
Severe Acute Malnutrition /MUAC < 11cm and/or Bilateral Edema in under 5 years children (new cases only)				

RDT = Rapid Diagnostic Test; MUAC = mid upper arm circumference

4. Report timeliness and completeness (to be filled only by Woreda Health Office and Zone/Regional Health Bureaus)

Indicator	Government			NGO	Oth
	H. Post	H. Centre	Hospital	Health Facility	e rs
Number of sites that are supposed to report weekly					
Number of sites that reported on time					

5. Summary for Immediately Reportable Case-based Disease / Conditions: (Total cases and deaths reported on case-based forms or line lists during the reporting week)

DISEASE	C	D	DISEASE	C	D	DISEASE	C	D
AFP/Polio			Maternal Death (confirmed)			Small pox		
Anthrax			Measles			Viral hemorrhagic fever		
Cholera			Neonatal Tetanus			Yellow fever		

Dracunculiais(Guinea worm)			Pandemic Influenza			Deaths of women of reproductive age (15-49)years		
Death of woman of reproductive age(15-49) years			Rabies			Birth of a dead fetus or death of a newborn		
Maternal death(suspected)			SARS			Other (specify):		

C = case; D = death; SARS = severe acute respiratory syndrome NOTE: Official counts of immediately notified cases come only from case forms or line lists.

Look at the trends, abnormal increase in cases, deaths, or case fatality ratios? Improving trends? Actions taken and Recommendations

Date sent by HF/Woreda/Zone/Region: Date received at Woreda/Zone/Region:

Sent by: _____ Received by:_____

Tele: _____ Tel:_____

E-mail: E-mail:

References

This SoP has taken the following documents as reference:

1. MPDSR guideline, Federal Ministry of Health of Ethiopia, 2017 Final Ethiopian 2010 MPDSR report.
2. MPDSR 2010 (2017) annual year report.
3. MPDSR Guidelines, MINISTRY OF HEALTH of Uganda, August 2017.
4. FIGO MPDSR guideline of 2014.