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Understanding the Maternal and Perinatal Death Surveillance and Response (MPDSR) System: Principles and Processes

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Maternal mortality is a key indicator of health and socioeconomic development of any society. Maternal and Perinatal Death Surveillance and Response (MPDSR) is a qualitative in-depth investigation that includes the routine identification, notification, quantification and determination of causes and avoidability of all maternal and perinatal deaths, as well as the use of this information to respond with actions that will prevent future deaths. Hence, it effectively guides actions to eliminate preventable maternal and perinatal mortality and counts maternal and perinatal death to assess the true magnitude of maternal and perinatal mortality, and the impact of actions taken to reduce it.

With UNFPA's support and using a system's focused approach Fiji's Ministry of Health and Medical Services (MHMS) introduced MPDSR in 2022, establishing the Central Division MPDSR Committee with defined Terms of Reference (TOR) and code of conduct. In 2023 work has progressed with the development of National MPDSR Guidelines and national training. It is recommended that that all Pacific Island Countries and Territories (PICT)s are supported to establish an MPDSR system at all levels of health facility, including MPDSR committees, to ensure responsibility and accountability for maternal deaths and that the issues and recommendations surrounding each death are prioritized and addressed promptly at the highest level.

1. BACKGROUND

Maternal mortality is a key indicator of health and socioeconomic development of any society, and mortality of children under 5 specifically in the perinatal period is an important indicator of health status and national prosperity[1]. Hence preventing these deaths is of national priority.

Maternal and Perinatal Death Surveillance and Response (MPDSR) is a qualitative in-depth investigation into the causes of and circumstances surrounding maternal and perinatal deaths. It includes the routine identification, notification, quantification and determination of causes and avoidability of all maternal and perinatal deaths, as well as the use of this information to respond with actions that will prevent future deaths. Hence, it effectively guides actions to eliminate preventable maternal and perinatal mortality at health facilities and in the community; as well as to count every maternal and perinatal death, permitting an assessment of the true magnitude of maternal and perinatal mortality, and the impact of actions taken to reduce it. Its conduct is multi-disciplinary; confidential and the process involves "no-name, no blame." When functional and conducted properly, MPDSR is an effective system strengthening tool, associated with quality improvement practices to facilitate targeted implementation of evidence-based interventions, which ultimately decreases maternal and perinatal mortality and morbidity.

A tentative step was taken by Fiji in October 2022 to orient its National Confidential Enquiry on Maternal Deaths (CEMD) on the principles and processes of MDSR following a 2019 MDSR report that showed counting, reporting and analysing every death through the MDSR process will guide tailored responses that the government at all levels, in collaboration with partners, can take ownership of.

2. PROGRESS AND ACHIEVEMENTS

2011-12: In compliance to WHO's 2004 publication titled "Beyond the Numbers", that all countries establish audit systems, the Fiji Ministry of Health and Medical Services (MHMS) partnered with Human Resources for Health Knowledge Hub, University of New South Wales, Sydney to conduct a Perinatal Medical Audit study in three Divisional Hospitals.[2]

[1] https://www.emro.who.int/emhj-volume-25-2019/volume-25-issue-3/human-development-index-maternal-mortality-rate-and-under-5-years-mortality-rate-in-west-and-south-asian-countries-19802010-an-ecological-study.html
[2] 2015: Improving maternal and child health audits in Fiji through a perinatal mortality audit. International Journal of Gynecology and Obstetrics, 129, 2 https://www.sciencedirect.com/science/article/abs/pii/S0020729215000314

2019: With the support of UNFPA Fiji MHMS established a National Confidential Enquiry into Maternal Deaths (CEMD) Committee to guide and introduce an MDSR system in the country; development, validation and finalization of Fiji's 1st MDSR report in 2019/20; and an attempt at establishing Kiribati, Vanuatu, and Solomon Islands MDSR committees

2022: With UNFPA's support and using a system's focused approach Fiji MHMS introduced MPDSR in the country, with 2 workshop trainings for health workers from National, Divisional and Sub-Divisional levels, during which global MPDSR tools were adapted to Fiji context. As a result, the Central Division MPDSR Committee was established with defined Terms of Reference (TOR) and code of conduct.

2023: Fiji's 1st MPDSR National Guidelines developed and a national MPDSR 'Training of Trainers' (TOT) conducted.

3. CHALLENGES

Non-prioritization of maternal health by governments and donors in the region. It is assumed due to current low global (Maternal Mortality Ratio) MMR estimates that most Pacific Countries and Territories (PICTs) have achieved MMR SDG targets and so little or no attention, capacity development or funding is paid to programmes on maternal health or strengthening health system processes to improve it.

As a result, recent spikes have been reported in maternal mortality i.e. Fiji's 2019/20 MDSR report showed an institutional MMR for Fiji of 86/100,000 live births compared to the estimated 24/100,000 live births previously disseminated. In 2023, Tonga reported 5 maternal deaths within the 1st half of the year, evidence of the need to establish a system of understanding and preventing such mortalities which the MPDSR seeks to address.

4. FUTURE DIRECTIONS

4.1 Recommendations for governments:

4.1.1 Urgently establish MPDSR systems from lower-level health facilities, referral hospitals, divisional/district/provincial health levels to national levels. This ensures that all levels take

responsibility for every maternal death/morbidity; and are held accountable for the implementation of identified recommendations to prevent future occurrences.

4.1.2 In alignment with global best practice, inclusion of maternal and perinatal deaths as significant and notifiable conditions under the Integrated Disease Surveillance and Response (IDSR) reporting.

4.1.3 Establish MPDSR committees at all levels of the health system, including the national MPDSR committee under the Minister for Health or Secretary for Health to ensure the issues and recommendations surrounding each death are prioritized and addressed promptly at the highest level.

4.2 Recommendations for development partners:

4.2.1 Support national governments in the institutionalization of MPDSR in the countries through the establishment and functionality of MPDSR Committees, and capacity building of its members; development of national MPDSR guidelines; validation and dissemination of annual MPDSR reports and monitoring of recommendations to ensure their implementation.

4.2.2 Support integration of MPDSR in pre-service curricula of health workers including for doctors, midwives and nurses.