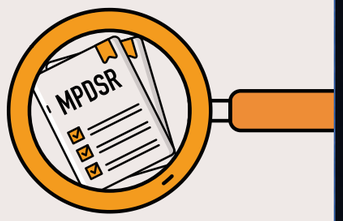
Key findings of the MPDSR assessment



- The MDSR notification system is in place throughout the country, however in some areas is weak and not all maternal deaths are notified to the provincial and national committees;
- The review and response component of the MDSR is not yet well implemented - for every 10 maternal deaths notified, only half are reviewed
- National committees are well-established and with defined TORs, but do not meet frequently to review deaths and ensure implementation of reviews and response plans
- Review meetings are held, but recommendations and follow up plans to implement corrective actions are not implemented consistently. The response component should be systematized
- The role of the sub-national and provincial committees is limited, with most of the key MPDSR processes taking place at national level, rather than locally
- Currently, the Lao National Center for Mother and Children and the Lao National Association of Obstetrics and Gynaecology are responsible for preparing a response plan, however they do not use a standardized approach. Only the Department of Healthcare and Rehabilitation at the Ministry of Health has the authority to put the response plan into action
- Differences exist between data provided by the secretariat and the numbers registered on DHIS2. The number of deaths recorded in the DHIS2 is generally lower due to the fact that the system for registering online is still not fully matured. Reasons for this are inexperience with DHIS2 and delays because of the amount of time it takes to fill in the data. Therefore, the numbers provided by the secretariat are currently the most accurate.
- Underfunding of training and capacity-building activities, both for the MPDSR process but also in general for health workers capacities and professional training affects the effective implementation of MPDSR
- Fear of blame, particularly in provincial level facilities, prevents some health workers and facilities in reporting and notifying all cases of maternal deaths.
- The notification process is not standardized and the system in place is weak.
- Existence of challenges around the use of DHIS2: infrastructure, lack of data culture and supervision

Way forward

MPDSR Programme Capacities

- Formalizing the expected pathways of information management and system response is required, so that all levels of the system are receiving and working on MPDSR information as a quality-of-care improvement activity.
- Explore the linkages between the MPDSR system and HMIS/quality of care improvement committees at facility, district, provincial and national levels.

MPDSR systems and coverage

- Commitment to formalizing the “response” part of MPDSR is required, particularly in ensuring that there is capacity within the system to follow up and monitor recommendations made around maternal deaths prevention and ensuring recommendations are measurable.
- Ensure all sub-national committees are strengthened and trained in implementing the MPDSR process, so that more functions - especially review of deaths and creation of response plans - can be done locally at the subnational level, and then reviewed and monitored by National Committees.

Australian Aid

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Maternal Perinatal Deaths Surveillance and Response system

An overview of guidelines, processes and practices for the implementation of the Maternal Perinatal Deaths Surveillance and Response system

The report, from which this technical brief is based, was conducted in 2022 with support from the Department of Foreign Affairs and Trade (DFAT), Australia, as part of the C-Surge Programme Initiative

Key Takeaways:

In terms of data, differences exist between the two sources of data, due to delays in entering on DHIS2. The MDSR Secretariat data are the numbers that are officially used. The recommendation here is to improve DHIS2 data collection to ensure timeliness and accuracy.

In terms of the review committees, although terms of reference exist, it is unclear what responsibilities each have, and some responsibilities might be better suited to take place at the local level, hence there is a need to strengthen the capacity of the provincial review committee in future to ensure that the response plan can be implemented by them.

The review recommended improving the MPDSR system through building capacity of the secretariat, as well as ensuring clear roles and responsibilities at each level, including the provincial level

Background

Each maternal death or long-term complication (obstetric fistula) represents an individual tragedy for the woman, her partner, her children and her family. It is not enough to know the rates of maternal deaths, which do not give the real reasons why mothers die. We also need to know - who are these women, how could these deaths have been avoided, what preventive factors could have saved them.

This is the essence and rationale behind ensuring a well-functioning Maternal and Perinatal Death Surveillance and Response (MPDSR) system to help us invest in practical aspects, capacity building and medical technologies to reduce maternal death and disability. As ***each maternal death or case of life-threatening complications has a story to tell,*** a well-functional MPDSR can provide indications and recommendations on practical ways of affecting the outcome.

Maternal death reviews (MDR) commenced in Laos in 2010, to determine the causes and events surrounding maternal deaths.

Prior to 2010, reporting occurred in a haphazard fashion as there was no official system in place. Large urban hospitals did report maternal deaths, but reported in a non-systematic manner, with only deaths perceived as important cases being reported. Reviews of deaths did generally not occur.

In October 2010, WHO and UNFPA provided technical and financial support to commence MDR in Laos. The country reached a milestone in 2015 when MDR was officially changed to MDSR (maternal death surveillance and response), as the mechanism for response was introduced.

From 2017, all health centers in the country followed the MDSR protocols. As of 2022, perinatal deaths have been introduced into the system with one province (Luang Prabang) being piloted. Currently perinatal deaths are reported via the pediatric division, however statistics are not readily available nor are they officially approved.

The MPDSR annual meeting is conducted for all stakeholders to:

I. Report and review the previous year work and propose the next steps in analyzing and responding to maternal and Perinatal death.

II. Promote unity and a clearer role in the implementation of MPDSR work of each responsible stakeholder.

Sub-national committees are also present at provincial level. Since 2017, training is frequent and focused at the provincial level, especially at the health centers and mostly catered for midwives and nurses.

Policies, Strategies and Protocols on maternal health

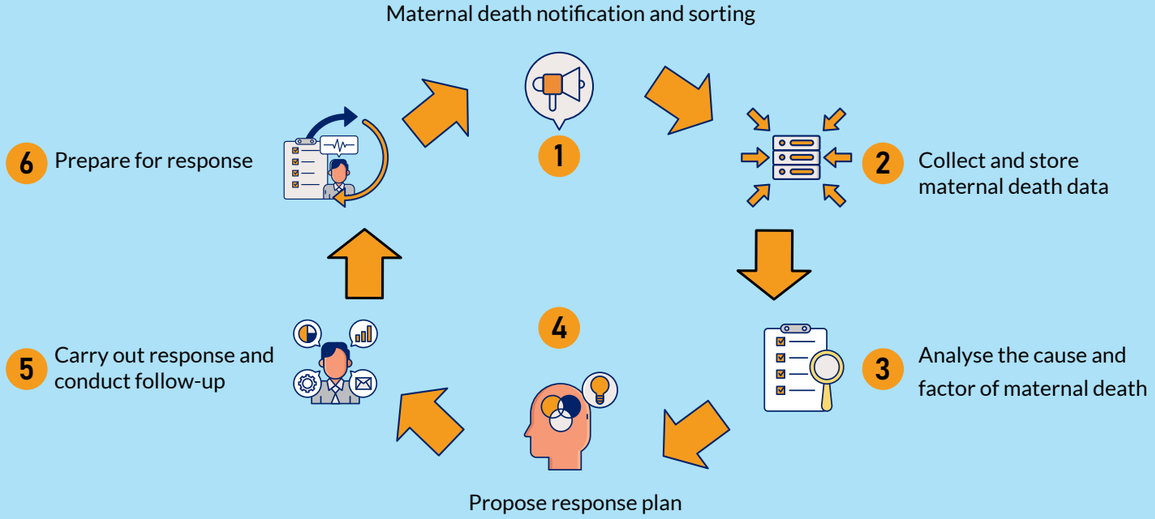
Under the 9th Five Year National Socio-Economic Development Plan (2021-2025), major policy document in Lao PDR, there is a specific program dedicated to MDPSR.

Policies and regulations for MPDSR are based upon the WHO 2021 MPDSR guideline as well as the National Strategy and Action Plan for integrated service on Reproductive, Maternal, Newborn, Child and Adolescent Health 2016-2025. The strategy sets specific objectives to reduce the maternal mortality ratio by 2025 to 110 per 100,000 live births. In addition, Specific Objective 3.2 is about strengthening the MDSR and ensuring action is based on findings. It sets the target of reaching 50% of maternal deaths reviewed by 2025, from 15% in 2014.

The key activities related to MDSR are:

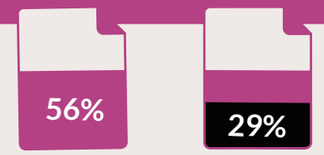
1. Review and develop standard MDSR guidelines
2. Central level monitoring and supervision though maternal mortality reviews conducted twice per year
3. Quarterly meetings of MDSR committee at central and provincial levels
4. Annual maternal mortality review at central level including developing action plans for each level
5. Ongoing training, including Training of Trainers (ToT) on mortality reviews, data analysis, and community and facility data collection

MDSR implementation



MPDSR Data

Based on the estimated numbers of maternal deaths that are likely to happen in the country only around half of the expected maternal deaths were reported to the MDSR Secretariat in 2021, and a lower proportion were reviewed – **56% of those reported, equivalent to about 29% of national estimated maternal deaths.**



There are two main data sources for MPDSR:

1. The numbers collected by and provided directly to the MDSR Secretariat (considered as official data) from the facilities notification process, reviewed and approved by the MDSR Secretariat. It is used during the annual MDSR meeting and as part of the MDSR process, and it is not available publicly.
2. The data collected and uploaded on the DHIS2 system, which is managed and overseen by LSB. The raw data on RMNCAH are hierarchically reported from the facility level until the final level of the Department of Planning and Cooperation (DPC) under the Ministry of Health. DPC verifies and approves the data, and transfers it to the Statistics Bureau.

There are discrepancies between the two sources due to delays or inconsistencies in the process of the notification and recording systems that need to be reconciled.

Organization of the notification, review and response process

The MDSR system covers the whole country. All public health facilities at all levels, from departments at the ministry of health down the grass-root facility of provincial health centers are trained to conduct maternal death notification and report. Perinatal death notifications and reviews are a new component, which has been included into the process in 2022 and has been piloted in a limited geographic area of the country.

According to the 2017 MDSR guideline, the central MDSR Secretariat should be notified of any maternal death no later than 48 hours after the death has occurred. All information regarding the death should be recorded and captured in a dedicated Form. Depending on where the death occurs, there are specific teams responsible for collecting data. For example, should the death occur at a health center, the director of the health center needs to notify the provincial MDSR Committee, who will then pass the information onto the central MDSR secretariat in Vientiane Capital. All collected statistics are to be approved first by the current MDSR Secretariat.

National committees working on the MPDSR programme

Committee	Responsibility	Term of Reference
1. Highest committee (3 members)	National Leadership on MPDSR related matters	National guidance on all MPDSR related matters
2. The management committee (16 members)	National policy guidance on MPDSR related matters	Policy establishment and policy implementation
3. The technical committee (20 members)	Provide national technical guidance on MPDSR related matters	Review and analyze the cause and factors of maternal death
4. MDPSR secretariat (7 members)	Coordinate and communicate between the committees and related stakeholders	Hold an annual meeting, monitor and review documents