National Guideline
On
Maternal Perinatal Neonatal Death Surveillance and response (MPDSR)

Ministry of Health and Family Welfare
Government of the People’s Republic of Bangladesh
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Background of MPDSR

Bangladesh has made significant strides in decreasing the maternal mortality ratio (MMR) from 570 in 1990 to 176 in 2015\(^1\). Nonetheless, MMR must be reduced to 143 by 2015 in order to meet millennium development goal (MDG) 5. Although, under five deaths reduced significantly, slower pace in reducing neonatal mortality, which contributes to 60 per cent of all under-five mortality, is considered as a key challenge in achieving the MDG 4 target. These calls for additional effort for achieving MDG as well post 2015 targets, i.e. Sustainable Development Goals by 2030. The post-2015 development agenda SDG has a set of 17 goals and 169 accompanying targets. The Goal 3 of SDG is to ensure healthy lives and promote well-being for all at all ages with the target 3.2 to end preventable deaths of newborns and under-5 children and Target 3.1 to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, which also includes indicator on ‘Skilled Birth Attendance’. Every newborn action plan (ENAP) have been enforced by World Health Assembly in 2014 and sets a goal by 2030, all countries will reach 12 newborn deaths or less per 1000 live births 12 stillbirths or less per 1000 total births.

Maternal Perinatal Neonatal Death surveillance and response (MPDSR) is an evidence based approach that cross examines both health system and social factors through a systematic process. Intervention design, tools and guideline have been approved by government. MPDSR data is being used for death mapping, developing local level planning, monitoring and health system strengthening to reduce maternal and neonatal deaths.

The MPDSR intervention bases on anonymity, non-blaming, non-punitive and participation at all levels for identification of maternal, neonatal deaths and stillbirths, identification of causal relationship especially the social causes including the delay factors. MPDSR system has identified vulnerable area with high maternal and neonatal deaths; calculate MMR and NMR of the districts find out the challenges in the community to address. The trend in causal factors, trend in seeking care by the community for maternal and neonatal emergencies have been explored and presented to policy makers, providers and stakeholders to identify specific action points for improvement. The results from MPDSR are visible which were share jointly by with policy level and senior programme personnel of DGHS and DGF in experience sharing meeting at national level which inform expansion in other districts. Other partners like Save the Children has recently started MPDSR in their projects areas following the same modality. BRAC has some experience to implement verbal autopsy through their own system

Envisioning to sustain the momentum achieved in reducing under five mortality and maternal mortality ratio, Directorate General of Health Services (DGHS) of Bangladesh, in collaboration with the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MOHFW) of Government of the People’s Republic of Bangladesh, initiated Maternal, Neonatal death review through the national health system to notify maternal, neonatal deaths and still births in the Thakurgaon District of Bangladesh in 2010\(^2\) with technical assistance from UNICEF & CIPRB. Obstetric & Gynecological Society of Bangladesh and

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\(^1\) Trends in Maternal Mortality : 1990 to 2015, WHO, UNICEF, UNFPA and WB estimates

Bangladesh Neonatal Forum, UNFPA and WHO were involved in stage of development tools, guideline and implementation of MPDR (the term used then).

Based on the success of MPDR in one district, this approach has gradually scaled up to 10 districts of Bangladesh by 2013. Another three districts added in 2015 making the total of 13 districts in the country. Quantitative data from death notification and verbal autopsies within the communities provide in depth information on cause, time and place of death, health system response in service delivery and role of communities in seeking timely care. The entire intervention has been implemented through existing health system. Front line health workers include health assistants and family welfare assistants both notifying deaths at the community. Subsequently, 1st line supervisor, Health Inspectors, Assistant Health Inspectors or Family Planning Inspectors perform verbal autopsies. Facility based death reviews were undertaken by facility health managers and service providers. Upazila and District MPDR committees review MPDR data and take appropriate local actions. Between 2011 and till date, 1255 maternal deaths, 13,576 newborn deaths were reported and reviewed in four districts. However, in the last twelve months (October 2013 to September 2015), 869 maternal deaths, 8473 newborn deaths have been reported and reviewed in new six districts.

Quality Improvement Secretariat under the MoH&FW has embarked on finalizing a guideline in this regards. In August 2015, Quality Improvement Secretariat facilitated formation of working groups to work on key components of the guideline. The guideline will address the ‘MPDR’ as the ‘MPDSR’ to keep in line with the WHO guideline. This Maternal Perinatal Death Surveillance and Response (MPDSR) guideline was prepared in collaboration with Directorate General of Health Services and Directorate General of Family Planning. It is noteworthy to mention that implementation of MPDSR has been envisaged in the MNCAH Operational Plan 2011-16. Political commitment resulted in incorporation of MPDSR training in the national health sector plan, establishment of knowledge hubs at subnational teaching hospitals serving as centre of excellence and MPDSR data being incorporated in web based Health Management Information System (HMIS) of Directorate General of Health Services.

Henceforth, development of this national guideline based on existing guidelines and training modules which have been used in 13 districts would facilitate scaling up of this evidence based approach throughout the whole country. Moreover, it will facilitate understanding the mechanism, process and steps of implementation of MPDSR including utilization of data for the improvement of maternal and neonatal health services throughout the whole country. This will be used by field level health staff, health Care providers and managers to track real time data on maternal and neonatal death, find out the health system and social bottlenecks and identity corrective actions to avert those unnecessary deaths in future.

**MPDSR Intervention Framework**

The uniqueness of MPDSR is its implementation through the existing health system which ensures ownership and pave the pathway to sustainability. This approach engaged the front line health workers of DGHS (Health Assistant-HA) and DGFP (Family Welfare Assistant-FWA) to collect and notify each maternal death, neonatal deaths and still births from the Community from their respective catchment areas. At the facility level, the Senior Staff Nurses (SSN) or Family Welfare Visitors (FWV) who works in Upazila Health Complex, Maternal and Child Welfare Centre, District Hospital and medical college notify maternal death, neonatal
deaths and still births. After the notification by HA /FWA from community, verbal autopsies and social autopsies are carried out by field level 1st line supervisor of health and family planning department at the household level. However, after facility based death notification, a SSN or FWV with the support of medical doctor will perform facility death review at the facilities.

Verbal autopsies and facility death reviews reveal the specific social and medical causes of maternal and neonatal deaths. Social autopsy is an effective dialogue between community and government frontline workers which is organized in the community level where a maternal and neonatal death has occurred in the recent past. These data are analyzed at upazila and district level. Therefore, MPDSR intervention has effectively contributes to health system strengthening as well as triggering community response to reduce maternal and newborn deaths and enables managers in tracking district specific mortality trends.

**Objectives of MPDSR**

- To identify and notify each maternal, perinatal, neonatal death and still birth at both rural and urban areas
- To determine social and medical causes of maternal, perinatal, neonatal death and still birth in the community.
- To determine medical causes of maternal, perinatal, neonatal death and still birth in the facility and explore the system bottlenecks and corrective actions to avert such deaths in future.
- To identify pockets of death dense areas through death mapping and guide health managers to undertake context specific remedial action.
- To track real time district and upazila specific maternal, neonatal death and still birth through HMIS and monitor the program of MDG and SDG
- To support developing, implementing and monitoring evidence based MNCH plan at local level to reduce maternal and neonatal deaths and morbidity in Bangladesh.

**Operational Definition:**

Deaths notified and reviewed in MPDSR include Maternal, Perinatal death, Neonatal Death and Still Birth. The operational definition for each of the death has noted for assigning death, definition has followed wide range of accepted definition of the World Health Organization.

- **Maternal Death:** Death of mother during pregnancy, delivery or within 42 days of the termination of pregnancy due to maternal complications is considered as Maternal Death.
- **Neonatal Death:** Deaths occurring during the first four weeks after birth
- **Stillbirth:** a baby born with no signs of life at or after 28 weeks' gestation. (did not take any breath/ did not have any movement) is considered as Stillbirth.
- **Perinatal:** includes both deaths in the first week of life and fetal deaths (stillbirths).
Chapter 1: Rural Community based MPDSR

Death notification in rural community

In the community, the Community clinic (CC) platform will be used for notifying deaths. A community clinic is designed to cover approximately 6000 populations. Each CC is supported by 1 community group (CG) and 3 Community Support Group (CSG)s. Also, for every old ward, 1-2 HAs and FWAs are assigned for routine HH visits in the community.

The field staffs (HA & FWA) are responsible to register and notify all maternal, perinatal, neonatal deaths and still births in their assigned catchment areas within the government health system. The NGO workers, volunteers, CG and CSG will be involved in the death notification process.

Steps of community death notification

Step 1: Community Death Identification

Deaths in the community will be detected and reported by Health Assistant (HA) and Family Welfare Assistant (FWA) from his/her assigned areas. Deaths are required to be notified within 3 days after a death occurred. They will use different methods to collect the death news through community networking: such as during field visit in his/her designated areas, from family members, neighbours, caretakers of the graveyard, CHCPs, Community Group and Community Support Groups, volunteers, village representative, imams, village doctors, school teachers, NGO workers, social workers, medicine shop / pharmacists. Different sources of information of death notification in a rural community is mentioned in Figure A.

Fig A: Different sources of information for collection of information by the field workers (HA/FWA)
Step 2: Death notification and reporting
After receiving death news from any sources, HA/FWA will visit the deceased house, verify the death news as per definition and fill out death notification slip. S/he shares this filled out slip to CHCP of the CC located in his/ her assigned catchment area as well as UHFPO. CHCP in turn will enter basic data (registration number, place and date of death etc) of death notification slip in DHIS2 which will generate an automated notification to UHFPO. In case of areas where there is no CC, the HA and FWA will report through the adjacent Community Clinic.

The Upazila statistician will cross check the hard copies of the number of death notification slips with the number of entry by CHCPs thereby confirming the actual number of deaths happened within the upazila.

Fig B: Death notification, verbal autopsy and social autopsy system in community

Verbal Autopsy at Community Level
Verbal Autopsy (VA) in MPDSR is one of the key component to identify medical causes of death, social factors as well as other factors responsible for the death. This also provides scope of getting a unique insight of awareness of the need for care, cultural norms and beliefs, the use of dangerous or inappropriate traditional practices, first and second delays in receiving pregnancy care.

A verbal autopsy for maternal, neonatal deaths and still births will be done at deceased home in the community. Within the existing Government system, the first line field supervisors (HA/FWA from respective departments) will be responsible to perform the verbal autopsy in the community. This autopsy will be done within 7 to 15 days of the death happened. VA is particularly useful and effective to understand the causes and scenario by the Health and Family Planning Managers / planners who in turn can undertake corrective actions for reduction of maternal and neonatal deaths.

There are three types of form to be used for conducting Verbal Autopsy
• Form 1: Maternal Death Review at Community
• Form 2: Neonatal Death Review at Community
• Form 3: Stillbirth Review at Community

Objectives of verbal autopsy in rural community

• To identify the medical and social causes including delays for maternal, perinatal, neonatal death & still birth in the rural community
• To analyze and disseminate the death findings for preparing the local level action plan and implementation modalities
• To strengthen the health system design for improving the maternal, perinatal, neonatal health services

Verbal autopsy process

Health Inspector (HI) and Assistant Health Inspector (AHI) will be responsible to perform the verbal autopsy in the community. The process of interviewing is very crucial as the skill of the interviewer will determine the quality of data.

Important Issues for consideration

• The interview needs to be conducted at the resident/house of deceased family in the community.
• The interviewer needs to confirm the death case based on the standard definitions
• The interviewee must be carefully selected (considering the presence at the time of death and related events) to gather accurate information
• The interviewer should clearly specify objective of conducting verbal autopsy to the interviewee and must take written consent before the interview session.
• The respondent need to be informed that they will have scope and freedom to escape any question or stop the interview process. The interviewer must assure about the confidentiality of the interviewee’s information and only share the findings to proper authority

Process of Verbal Autopsy

The field level health service providers (Health Assistant/ Family Welfare Assistant) will notify maternal death, perinatal, neonatal deaths and still births from the community. The Upazila manager will then assign first line supervisor (Health Inspector/ Assistant Health Inspector/ Family Planning Inspector) of Health and Family Planning department to conduct the verbal autopsy in the same community. The supervisors will visit the household after at least 7 days of death occurred in the community. Ideally, the verbal autopsy should be performed within 15 days of death notification from the field. The interviewer (HI/AHI/FPI) will perform the verbal autopsy and will fill up the questionnaire properly and submit the original copy of the filled up questionnaire to the statistician in the Upazila Health Complex.
Social Autopsy at community level

Social Autopsy (SA) is a mechanism to examine or scrutinize social factors relevant to an event/ occurrence to determine the reasons as well as findings ways to prevent this in the future. The group collectively determines the root causes and strategies for dealing with the occurrence of similar situations in the future.

Social autopsy cross examines the medical or social factors of a death through a systematic process and follows with appropriate actions to reduce deaths.

Social autopsy is a non-blaming approach in the society which focused on social factors, dilemma related maternal and newborn death occurred at community, discuss with the family members, community groups, community support groups, neighbored about the deaths, digging out the causes which is preventable and find out a solution which could prevent future death in that society. People attended in the meeting get the opportunity to hear mistakes/ errors from the incidence of a maternal and neonatal death, they will feel, realize the causes and understand by seeing the emotional and touchy moment and learn from this sad example.

Objectives of Social Autopsy:

1. To find out the social factors and barriers that caused maternal, perinatal, neonatal deaths and still births in the community
2. To summarize different statement from the community groups and other members of society in preventing such deaths in future through addressing the social factors.
3. To identify solutions from the lessons learnt and address the barriers by community groups
4. To build awareness among community members on death specific preventive measures

Instrument to be used in Social Autopsy:

- Social Behavior change communication (SBCC) materials:
  These materials will be used by the health care providers during conducting the social autopsy at community. The SBCC set consist of a pictorial flipchart containing maternal and neonatal complications and its preventive measure to be taken by the community.
- Semi-structured questionnaire form:
  This form will be filled up at the end of meeting with community

Process of Social Autopsy:

1. Facilitator of Social Autopsy
   Health Inspector/ Assistant Health Inspector /Family Planning Inspector of respective area will conduct Social Autopsy and will act as a facilitator for the social autopsy process through coordination between Health Department and Family Planning Department. Health Assistant/ Family Welfare Assistant/ NGO worker will provide necessary support to HI/AHI/FPI in organizing the community to conduct the event successfully.
2. **Place for Social Autopsy**
   Generally, a place besides the deceased home/ courtyard of a neighbor’s house will be selected as a place to conduct the Social Autopsy. The selected place should have sufficient space for group discussion with 40-50 persons.

3. **Participants for Social Autopsy**
   Around 40-50 participants from adjacent 20-30 households close to the deceased’s home will be the participants of Social Autopsy. Members of respective Community Groups and Community Support Groups must attend the meeting. Local teachers, religious leaders/ Imams, Union Parishad members, health workers and volunteers including both male and female members will join the discussion. Adolescent boys and girls should have scope to join here. Members of the deceased’s family should not join as they would had been passing though shocking memories. Beside this, pregnant mothers or newly married women are highly encouraged to participate.

4. **Time to conduct Social Autopsy**
   A social autopsy shall be organized within 15-30 days after the death occurred.

5. **Duration of Social autopsy**
   The average duration of the Verbal Autopsy session is 30- 45 minutes. However, it could be extended for more than an hour if the participants discuss it rigorously. Generally, during late noon and evening time is the best time for conducting Social Autopsy. Because at that time household head and male participants can join the session. In most of the cases, males are the decision maker in the society. However, it can be organized in the morning hours depending on availability of the participants in the community.

6. **Facilitation of Social Autopsy**
   - At first the facilitator introduces him/herself and specify the objectives of the meeting.
   - The facilitator will seek a verbal consent from the participants and also the members of the deceased family before start the process.
   - At the beginning, anyone from the community or the neighbour describe what happened before the death or how the death has occurred. During presenting the event, the respondents should focus on social factors and barriers of that death.
   - The facilitator will concentrate on finding out the social barriers/ factors of the death without highlighting any blame to any individual or any institution.
   - The facilitator will prompt each of the answers on social barriers and issues raised by the participants to better understand about preventing factors that could be useful to save the lives of mother and newborn in future.
   - The facilitator will also discuss with other participants about the societal barriers and how it could be prevented.
   - The facilitator will show a set of BCC materials (Flip chart) to the participants. If the maternal death occurred, then the provider will show BCC materials on maternal complications and its prevention. If it’s neonatal death, then the facilitator will show the SBCC materials on newborn health. The facilitator will show SBCC materials about usefulness of seeking treatment at health facilities.
   - Finally, the facilitator will seek support and commitment from the society especially from the community groups / community support group on how the society would better plan in near future to prevent any death.
   - After completion the facilitation session, the facilitator will fill up the ‘Social Autopsy Form’ and return it back to the UHFPO.
Issues to be considered

- **Demarcation of the work areas**: Health Assistant/ Family Welfare Assistant will notify all maternal, perinatal, neonatal deaths and stillbirths of his/her working area.
- The first line supervisors (AHI and FPI) will determine the catchment areas under a ward for notifying deaths by the respective Health Assistant/Family Welfare Assistant. This will minimize the overlapping/duplication of death case reporting. Areas in urban setting will be demarcated by municipal or city corporation authority.
- **Proper filling up of the death notification slip by HA/FWA**: The death notification slip needs to be filled up properly to confirm the cases considering the standard definitions of maternal, perinatal, neonatal deaths and stillbirths.
Chapter two: Urban community based MPDSR

The city corporations (Dhaka & Chittagong) are divided in zones and report to chief health office. For other small city corporation like Khulna, Barisal do not have chief health office. District municipality has municipality office and upazila municipality office is available in some of the areas.

Deaths are required to be notified within 3 days after a death occurred in the urban areas.

The steps for death notification in urban setting comprises of the following steps:

**Death identification in urban settings**

In urban setting, deaths will be identified using various network. Various sources of information are shown in the Fig:B. Corporation’s vaccinators, NGO workers will be responsible to collect death information.

Fig C: Death identification and notification in urban settings

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**Step 2: Death notification and reporting in urban setting**

In case of big City Corporations, City Corporation’s vaccinators and NGO workers will notify all maternal, perinatal, neonatal death and stillbirths in the prescribed notification slip to Zonal Health Offices in Dhaka and Chittagong City Corporations. In case of Rajshahi, Khulna, Sylhet, Barisal and other small city corporation, the notification will be sent to Civil Surgeon (CS) offices (Fig C).

District municipalities can directly send death notification to respective civil surgeon office through municipality office. Deaths in the Upazila municipality will be notified by upazila vaccinator and will be sent to upazila health office. Immediate notification can also be done by text message whereas the death notification slip will be the mandatory means of notification.
Verbal Autopsy at Urban Level

A verbal autopsy for maternal, neonatal deaths and still births will be done at deceased home in the urban community. Within the existing Government system, the public health nurse or Sanitary Inspector or NGO workers will be responsible to carry out the verbal autopsy in the urban community.

Verbal Autopsy process

In urban settings, Public Health Nurse / Sanitary Inspector/NGO supervisors perform the verbal autopsy in the urban community. The assigned person will visit the deceased’s home at the urban community and identify the key persons in the family who were present at the time of death or who knows the entire event of death. They will then be interviewed by the assigned persons using the standard death review forms. There are three types of form to be used for conducting Verbal Autopsy: Maternal Death Review Form, Neonatal Death Review and Stillbirth Review form.

Objectives of verbal autopsy in urban community

- To identify the medical and social causes including delays for maternal, perinatal, neonatal death & still birth in the urban community
- To analyze and disseminate the death findings for preparing the local level action plan and implementation modalities
- To strengthen the health system design for improving the maternal, perinatal, neonatal health services
Process of Verbal Autopsy

- Within 7 to 15 days of death notification from urban community the assigned person (Public Health Nurse / Sanitary Inspector/NGO supervisors) will conduct the verbal autopsy in the same urban community. The assigned person will visit the household after at least 7 days of death occurred in the community. Ideally, the verbal autopsy should be performed within 15 days of death notification from the field. The interviewer will perform the verbal autopsy and will fill up the questionnaire properly and submit the original copy of the filled up questionnaire in respective channels (In case of Dhaka and Chittagong city corporations, to Zonal Health Office of City Corporation; for other city corporations, to civil surgeon office/ Zonal Health Office of City Corporation ; For District Municipality, civil surgeon office and health section of the municipality, for upazila municipality, Upazila Health Office and health section of the municipality).

Issues to be considered

- The interview needs to be conducted at the resident /house of deceased family in the urban community.
- The interviewer needs to confirm the death case based on the standard definitions
- The interviewee must be carefully selected (considering the presence at the time of death and related events) to gather accurate information
- The interviewer should clearly specify objective of conducting verbal autopsy to the interviewee and must take written consent before the interview session.
- The respondent need to be informed that they will have scope and freedom to escape any question or stop the interview process The interviewer must assure about the confidentiality of the interviewer’s information and only share the findings to proper authority

Social Autopsy at urban community

Social Autopsy (SA) is a mechanism to examine or scrutinize social factors relevant to an event/ occurrence to determine the reasons as well as findings ways to prevent this in the future. The group collectively determines the root causes and strategies for dealing with the occurrence of similar situations in the future.

Social autopsy in urban community cross examines the medical or social factors of a death through a systematic process and follows with appropriate actions to reduce maternal and perinatal deaths.

Objectives of Social Autopsy in urban community

1. To find out the social factors and barriers that caused maternal, perinatal, neonatal deaths and still births in the urban community
2. To summarize different statement from the community groups and other members of society in preventing such deaths in future through addressing the social factors.
3. To identify solutions from the lessons learnt and address the barriers by urban community
4. To build awareness among urban community members on death specific preventive measures

**Process of Social Autopsy**
In urban settings, Public Health Nurse / Sanitary Inspector/NGO supervisors will perform the social autopsy in the urban community. The assigned person will visit the deceased home at the urban community and identify the key persons in the family who were present at the time of death or who knows the entire event of death. They will then be interviewed by the assigned persons using the standard death review forms.

**Facilitator of Social Autopsy**
Public Health Nurse / Sanitary Inspector/NGO supervisors of respective area will conduct Social Autopsy through coordination between Health Department and Family Planning Department.

**Place for Social Autopsy**
Generally, besides the deceased home a suitable place will be selected as a place to conduct the Social Autopsy. The selected place should have sufficient space for group discussion with 40-50 persons.

**Participants for Social Autopsy**
Around 40-50 participants from adjacent 20-30 households close to the deceased home will be the participants of Social Autopsy. Senior members of respective urban community, teachers, volunteers including both male and female members shall join the discussion. Adolescent boys and girls should have scope to join in this discussion. Members of the deceased family should not join as they would had been passing though shocking memories. Beside this pregnant mothers or newly married women are highly encouraged to participate.

**Time to conduct Social Autopsy**
A social autopsy will be organized within 15-30 days after the death occurred.

**Duration of Social autopsy**
The average duration of the Verbal Autopsy session is 30-45 minutes. However, it could be extended for more than an hour if the participants discuss it rigorously. Generally during late noon and evening time is the best time for conducting Social Autopsy. Because at that time household head and male participants can join the session. In most of the cases male are the decision maker in the society. However, it can be organized in the morning hours depending on availability of the participants in the community.

**Facilitation of Social Autopsy**
- At first the assigned person (Public Health Nurse / Sanitary Inspector/NGO supervisors of respective area) introduce him/herself and specify the objectives of the meeting.
- The assigned person will seek a verbal consent from the participants and also the members of the deceased family before start the process.
- At the beginning anyone from the urban community or neighbor describes what happened before the death or how death had occurred. During presenting the event the respondents should focus on social factors and barriers of that death.
- The assigned person will be keep concentration on find out the social barriers/ factors of the death without highlighting any blame to any individual or any institution.
The assigned person will prompt each of the answers on social barriers and issues raised by the participants to better understand about preventing factors that could be useful to save lives of mother and newborn in future.

The assigned person will also discuss with other participants about the societal barriers and how it could be prevented.

The assigned person will show a set of BCC materials (Flip chart) to the participants. If the maternal death occurred, then the assigned person will show BCC materials on maternal complications and its prevention. If it’s neonatal complication, then the facilitator will show the SBCC materials on newborn health. The assigned person will show SBCC materials about usefulness of seeking treatment at health facilities.

Finally, the assigned person will seek support and commitment from the society on how the society would better plan in near future to prevent any death.

After completion the facilitation session, the assigned person will fill up the ‘Social Autopsy Form’ and return it back to the focal point at respective level (In case of Dhaka and Chittagong city corporations, to Zonal Health Office of City Corporation; for other city corporations, to civil surgeon office/ Zonal Health Office of City Corporation; For District Municipality, civil surgeon office and health section of the municipality, for upazila municipality, Upazila Health Office and health section of the municipality).

**Instrument to be used in Social Autopsy:**

- **Social Behavior change communication (SBCC) materials:** These materials to be used by the health care providers during conducting the social autopsy at community. The SBCC set consist of a pictorial flipchart containing maternal and neonatal complications and its preventive measure to be taken by the community.

- **Semi-structured questionnaire form:** This form to be filled up at the end of meeting with community.
Chapter 3: Facility Death Review (FDR)

Facility-based case review of maternal death, neonatal death and still birth at the facility level is a simpler participatory process established within the health system to identify causes and factors at the facility. Deaths from all levels of facilities including Medical College Hospital, District Hospital, Maternal and Child Welfare Center (MCWC) and Upazila Health Complex (UHC) as well private clinics & hospitals should be notified. The death review process will include three step functions: i) recording and reporting on maternal, neonatal death and stillbirth; ii) collecting information on death using FDR form and iii) finally reviewing analytic findings in periodic MPDSR review meetings. The focal point of the health facility will coordinate all activities and report following the line of reporting.

Objectives:

1. To explore medical causes and factors associated with maternal deaths, neonatal deaths and still births at the facility.
2. To identify gaps and challenges of preventing maternal and newborn death in the facility including logistics, human resources, equipment for providing services.
3. To identify third delays of maternal health care in the health facility.
4. To support in improvement of quality of services of maternal and neonatal health care at health facility.

Levels of facility:

All facilities up to upazila level including Medical College Hospitals (MCH), ICMH, MCHTI (Maternal and child health training institute), MFSTC (Mohammadpur fertility services and training center), specialized hospitals, District Hospitals, MCWCs, Upazila Health Complexes and private health facilities at different levels.

Steps of Facility Death review:

i) Death notification and reporting system
When a maternal death/neonatal death or still birth occurs at any facility level, the death information will be recorded and reported as per level.

At district and upazila level hospitals, the deaths will be recorded by the on-duty nurses of the respective wards/FWVs of the respective MCWCs. They then will notify this death to the respective ward-in-charge/MO clinics of MCWCs as well as the MPDSR sub-committees and the facility managers.

ii) Filling up the facility death review form
The Duty doctor/Senior Staff Nurse in the MCH, district hospital and Upazila health complex, Senior FWV/FWV in the MCWC and nurses in private hospitals will be assigned by the Facility
manager/ MPDSR sub-committee to fill up the facility based death review form after the death notified and reported.

The ward-in-charge/MO clinic in turn will collect the first hand data reviewing the hard records such as death certificate, admission register, patient history records, treatment sheets, emergency/OT register, rosters of on-duty providers). He/She will also discuss with the concerned facility providers and those staffs involved in the care of the deceased (doctors, nurses, ward boy, aya etc) and will fill up the facility death review form.

After filling up the form, he/she will submit to the MPDSR sub-committee/Managers of the facility.

*In tertiary level Hospitals:* once a maternal, neonatal death and stillbirth occur in the Medical College Hospitals, ICMH (Institute of Child & Mother Health), MCHTI (Maternal and child health training institute), MFSTC (Mohammadpur fertility services and training center) and specialized hospitals, the duty doctor/ Senior Staff Nurse will fill up the ‘facility death review forms’ by consulting with the concerned staffs and providers that were involved the care of the deceased. He/she will also notify the MPDSR sub-committee members/facility managers about the death event. However, the basic information of these deaths from different wards will be recorded by the respective on-duty nurses in the register.

All facility deaths will be reviewed in the regular morning sessions/clinical meetings in presence of the departmental heads and other doctors, providers/managers/directors/ MPDSR sub-committees.

**iii) MPDSR review meetings**

The filled up FDR forms will be analyzed and discussed in periodic review meetings to find out causes and system gaps as per objectives and appropriate remedial actions will be identified for improvement of quality of MNH care.

**Issues to be considered**

- The deaths happened only after admission of the patients will be notified
- Address and contact number of the deceased should be written properly
- Information about deaths can be reconciled from death certificate or treatment record of the deceased.
Chapter 4: Data Analysis & Reporting

MPDSR data flow outline

The MPDSR data (Death Notification Slips and VA forms / death review forms) are gathered from both the community and facility. The death notification slip information is uploaded by the CHCP at the community clinic when HA/FWA send the slips to them. It is mandated to capture 100% percent deaths from a specific geographical area. As per standards, VAs to be done for all maternal deaths and at least for 10% neonatal deaths.

At upazila, the statisticians will ensure that the deceased mother or the neonate have been registered in the system from the community clinic. He will preserve the Death Notification slips and VA form / facility death review forms. Furthermore, the verbal autopsy and social autopsy forms will be manually analyzed by the MPDSR sub-committee to identify the related factors and the preliminary cause of death. This review finding will then be shared in the monthly QI meeting of the facility in presence of the facility mangers. The confidentiality of the MPDSR data will be maintained in a way so that the details of the deceased information are not disclosed. Facility managers in the review meeting will provide their feedback and plan for necessary actions for the improvement areas. For the private facilities, the death notification slips/forms will be sent to the respective Civil Surgeon’s office/UHCs.

At district level, the data verification is a crucial step. The district managers will randomly cross-check the death data coming through the MPDSR implementation process. Moreover, evidence-based planning will also be done at this level by the managers and the MPDSR sub-committee. The planning will be done based on death mapping, available data and cause of death.

At divisional level, a review team composed of experts (Gynecologist, paediatrician, trained physician etc.) will further identify the causes of deaths for data arrived from all tiers. MPDSR focal person at divisional level in coordination with the Assistant Chief MIS will ensure the data entry into DHIS-2. Further, the statistical analysis and death mapping will be done through system generated data for periodic scrutiny of deaths including trends, pattern and causes. These detailed investigations on a death event will provide a definite evidence based direction and will be very effective for planning.

Detailed process of data flow

- **Data collection**: The Health Assistant/ Family Welfare Assistant will collect death information from the community & Staff Nurse/ FWV will collect the same in the facility. The verbal and social autopsy will be done by the HI/FPI/AHI. In case of facility deaths, the on-duty nurse/FWVs notifies deaths from the respective wards and the Senior Staff Nurse/duty doctors/FWVs conducts Facility Death review.

  ![Data Collection Process Diagram]

  **Fig: E Data collection process**

  - **Death Notification**: HA/FWA (community)
    - On-duty nurse (facility)
  - **Verbal autopsy/social autopsy**: AHI/FPI/HI (community)
  - **Facility Death Review**: Staff Nurse/ FWV (facility)
• **Data Transfer:** HA/FWA transfers death notification slips to CHCP of the CC and to Upazila managers of the UHC. All data from the verbal and social autopsy, facility death review data will also be submitted to the Upazila managers. Facility death review data at the district or divisional level will be submitted to the respective managers.

• **Data Storage:** All hard copies of death notification slips, verbal autopsy, social autopsy forms and facility death review forms will be kept with the statistician. However, another set of the same data will be sent at district and divisional level on a quarterly basis.

• **Data entry:** The basic data from the community will be uploaded by the CHCP using information from the death notification slips. At upazila and district level there will be cross checking of information of the deceased mother and the child in the system after every VA. The cause of death information will be entered quarterly at divisional level following the death review meeting.

• **Data analysis:** Data at upazila and district level will be analyzed and reviewed manually to identify important associated factors for the death. The statistician will prepare a monthly summary on all deaths in the Upazila/district. The system will automatically generate the death maps. The hard copies of the VAs will be sent to the national level for documentation and research purposes.
Chapter 5: Review, reporting and monitoring of MPDSR

Committee Structure

Monitoring & Evaluation of MPDSR activities will be conducted by Quality Improvement (QI) committees of different facility levels from National to Upazila level formed by QIS. The QI committee will develop a small subcommittee of at least 5 members (consists of a Gynecologist, a Pediatrician, a Medical officer and two support staffs). This subcommittee will work under the guidance of QI committee with specific TOR.

In addition to above mentioned QI committees, a national technical committee will be formed. Also, a MPDSR focal person will be selected by organizational level QI committee at different levels. They will be responsible for coordination with local committees, national technical committee and with QIS.

MPDSR focal person will compile all reports from the below tiers including the public and private facilities. For example, the divisional MPDSR focal person at the organizational level will compile reports from all facilities from divisions, the district MPDSR focal person at the organizational level will compile reports from all facilities from districts and so on. Also, the focal person will ensure appropriate feedback to the facilities for necessary and needful actions to be taken.

<table>
<thead>
<tr>
<th>SI</th>
<th>Name of committees</th>
<th>Organizational level</th>
<th>Facility level</th>
</tr>
</thead>
</table>
| 1  | National technical MPDSR Committee  
    MPDSR focal person in QIS | | |
| 2  | Divisional QI committees  
    MPDSR focal person (Co-opted in the QI Committee) | MPDSR Sub-committees | |
| 3  | District QI committee  
    MPDSR focal person (Co-opted in the QI Committee) | MPDSR Sub-committees | |
| 4  | Upazila QI committees  
    MPDSR focal person (Co-opted in the QI Committee) | MPDSR Sub-committees | |

The major activities of MPDSR implementation are described below including different committees and its TORs.

A. National level

The national technical MPDSR committee will be formed from representatives of the DGHS, QIS, Development partners, professionals, public health experts and so on. Their main role is at the policy and planning level as well as to oversee the monitoring and supervision of the MPDSR implementation nationwide.
### Composition of the National Technical MPDSR committee

<table>
<thead>
<tr>
<th>SL</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director, PHC and Line Director-MNCAH, DGHS</td>
<td>Chairperson</td>
</tr>
<tr>
<td>2</td>
<td>Programme Manager, MIS</td>
<td>Member secretary</td>
</tr>
<tr>
<td>3</td>
<td>Deputy Director, Health Economics Unit</td>
<td>MPDSR focal person</td>
</tr>
<tr>
<td>4</td>
<td>Director MCH and LD-MCRAH, DGFP</td>
<td>Co-Chairperson</td>
</tr>
<tr>
<td>5</td>
<td>Director, Hospital and Clinics, DGHS</td>
<td>Member</td>
</tr>
<tr>
<td>6</td>
<td>Director, Directorate of Nursing Services</td>
<td>Member</td>
</tr>
<tr>
<td>7</td>
<td>Secretary General, OGSB</td>
<td>Member</td>
</tr>
<tr>
<td>8</td>
<td>Secretary, BPS</td>
<td>Member</td>
</tr>
<tr>
<td>9</td>
<td>Programme coordinator, COIA</td>
<td>Member</td>
</tr>
<tr>
<td>10</td>
<td>Deputy Director, MIS, DGFP</td>
<td>Member</td>
</tr>
<tr>
<td>11</td>
<td>Deputy Director, MCH, DGFP</td>
<td>member</td>
</tr>
<tr>
<td>12</td>
<td>Secretary General, Bangladesh Neonatal Forum</td>
<td>Member</td>
</tr>
<tr>
<td>13</td>
<td>Professor of Neonatology, BSMMU</td>
<td>Member</td>
</tr>
<tr>
<td>14</td>
<td>Programme Manager, EPI, DGHS</td>
<td>Member</td>
</tr>
<tr>
<td>15</td>
<td>Programme Manager, IMCI, DGHS</td>
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<tr>
<td>16</td>
<td>Program Manager, MNH, DGHS</td>
<td>Member</td>
</tr>
<tr>
<td>17</td>
<td>Program Manager, MIS</td>
<td>Member</td>
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<tr>
<td>18</td>
<td>Deputy Director (MCH), DGFP</td>
<td>Member</td>
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<td>19</td>
<td>Deputy Program Manager- EmOC, MNH unit, DGHS</td>
<td>Member</td>
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<tr>
<td>20</td>
<td>Deputy Program Manager- MNH, MNH unit, DGHS</td>
<td>Member</td>
</tr>
<tr>
<td>21</td>
<td>Representatives from WHO</td>
<td>Member</td>
</tr>
<tr>
<td>22</td>
<td>Representatives from CIPRB</td>
<td>Member</td>
</tr>
<tr>
<td>23</td>
<td>Representatives from icddrb</td>
<td>Member</td>
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<tr>
<td>24</td>
<td>Representatives from UNICEF</td>
<td>Member</td>
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<td>25</td>
<td>Representatives from UNFPA</td>
<td>Member</td>
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<tr>
<td>26</td>
<td>Representatives from SCI</td>
<td>Member</td>
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<td>27</td>
<td>Representatives from JICA</td>
<td>Member</td>
</tr>
<tr>
<td>28</td>
<td>Representatives from JICA</td>
<td>Member</td>
</tr>
</tbody>
</table>

### Terms of Reference of National Technical MPDSR Committee

- Monitor overall progress and provide necessary direction and guidance
- Review and endorse National Guidelines, modules and tools for MPDSR implementation
- Facilitate incorporation of the approved National MPDSR guidelines in the Operation Plan of the HPNSDP
- Provide technical support for upholding the quality issues of MPDSR
- Develop an action plan for the implementation of MPDSR in the PIP or relevant operational plan in the next sector programme
- Provide technical support for developing a joint monitoring system development by QIS, respective line directors and the development partners
- Develop a plan for necessary coordination mechanism between two directorates for verbal autopsy hospital death audits and reporting
- Develop and plan for a structured reporting system under DHIS 2
- Develop and plan for the capacity development of service providers for MPDSR implementation
- Provide technical assistance for necessary budget adjustment and allocation for the MPDSR in relevant operational Plans in the current and next health sector program implementation.
- Will meet twice in a year.

The committee can co-opt any member as required

**Terms of reference for the MPDSR focal person of the QIS**

- Act as a guiding body to make functionalize all committees
- Monitor overall MPDSR implementation and provide necessary direction and guidance
- Monitor the functionality and performance of the MPDSR committees/ MPDSR focal person in line with guideline and the QI committees at various tiers
- Support institutionalization of the MPDSR system in Bangladesh
- Support and follow up necessary coordination between DGHS and DGFP for MPDSR implementations
- Review the data quality and follow up activities at various tiers
- Arrange yearly review workshop at national level
- Oversee these monitoring activities and provide necessary directives.
- Provide decision in technical and implementation challenges

**B. Divisional level**

**Divisional MPDSR Focal person**

At the division, there will be a MPDSR focal person from within the divisional QI committee level to look after the overall MPDSR implementation in all districts of that particular division. He will be responsible to provide technical guidance, undertake supervision and monitoring to ensure quality implementation of MPDSR.

In case of division, AD/DD designated by Divisional Director(Health) who in turn will monitor the compilation/analysis in coordination with Assistant chief MIS. **Divisional Director FP will also coordinate at this level to summarize the information from FP facilities across the division.**

**TOR of the MPDSR focal person at divisional level:**

- Coordinate with Divisional/ Regional Medical College Hospitals to review and analyses the verbal autopsy forms to assign cause of death
- Co-ordinate the report compilation from all facilities from divisions and below
- Provide technical support and advice to the divisional/district/upazila MPDSR sub-committees to review and analysis the cause of deaths
- Conduct quarterly co-ordination meeting at divisional level for MPDSR implementation at all levels
- Validate data on a random basis
- Conduct supervision and and monitoring in conjunction with the national team to oversee the progress of MPDSR intervention
- Conduct field visit to observe the MPDSR implementation activities with appropriate feedback
- Provide support for ensuring quality data generated from the autopsies and reviews
Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda
Prepare Death mapping

**Divisional MPDSR sub-committee**

At each facility of the division, public or private a MPDSR sub-committee will be formed which is also a part of the QI committee of that facility. This committee will be overall responsible for oversee the MPDSR implementation in that facility.

**Composition of the Divisional MPDSR Sub Committee**

1. Head of the department/senior consultant (Obs and gynae)
2. Head of the department/senior consultant (paediatrics)
3. Head of the department/senior consultant (anesthesia)
4. Head of the department/senior consultant (blood transfusion))
5. RP /RS /RMO
6. Register (Obs and gynae)
7. Register( paediatrics)
8. Register(anesthesia)
9. Register(blood transfusion))
10. Assistant register/IMO(Obs and gynae)
11. Assistant register/IMO( paediatrics)
12. Assistant register/IMO(anesthesia)
13. Assistant register/IMO(blood transfusion))
14. Consultant(Pediatric)
15. Consultant(Obs and gynae)
16. Consultant (Anesthesiologist)
17. Medical officer/RMO-1
18. Nursing supervisor
19. Ward master
20. Statisticians

**Chair Person:** Head of Department/ Senior Consultant (Obs & Gynae or paediatric)
**Member Secretary:** Two registrars- (1 Obs & Gynae, 1 Paed/neonatology)
**Adviser:** Director Hospital and/or Principal of MCH

**TOR of Divisional MPDSR Sub committee**

- Review the death notification forms weekly
- Compile death information and report to MPDSR focal person of the divisional QI committee (organizational level) on a monthly basis
- Conduct Internal review meeting fortnightly for resolving issues related to MPDSR implementation process
- Follow up and close supervision of the regular data entry of the forms
- Notify the facility managers on MPDSR implementation update weekly
- Present death review findings in the QI monthly meeting as routine agenda
- Quarterly conduction of internal assessment of MPDSR implementation
- Assign causes for death cause through analysis
- Data entry (cause of death)
- Monitoring and documentation

The committee can co-opt any member as required.
C. District Level

At the district level, there will be a MPDSR focal person from within the district QI committee level to look after the overall MPDSR implementation in all upazilas of that particular district. He will be responsible to provide technical guidance, undertake supervision and monitoring to ensure quality implementation of MPDSR.

District MPDSR focal person: In case of district, the focal person will be the Mo-CS/RMO designated by Civil Surgeon who in turn will monitor the compilation/analysis in coordination with District statistician. Deputy Director Family Planning (DDFP) will also coordinate at this level to summarize the information collected from FP facilities across the district.

TOR of the MPDSR focal person at district level:

- Provide technical support and advice to all District MPDSR sub-committees to review and analyse the cause of each death
- Provide necessary support to the upazila hospital sub-committees and below level as required
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda
- As required will provide technical support and advice to the district/upazila MPDSR sub-committees to review and analysis the cause of deaths
- Co-ordinate the report compilation from all facilities from district and below
- Develop Local action plan (In consultation with the facility managers)
- Validate data on a random basis
- Prepare Death mapping

For the MCWC, Medical Officer (Clinic) from MCWC and Family Welfare Visitor will work as a MPDSR sub-committee at district level

TOR of District MPDSR Subcommittee

- Review the forms weekly
- Compile death information and report to MPDSR focal person of the district QI committee (organizational level) on a monthly basis
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process
- Follow up and close supervision of the regular data entry of the forms
- Notify the facility managers on MPDSR implementation update
- Present death review findings in the QI monthly meeting as routine agenda

The committee can co-opt any member as required

D. Upazila level

**Upazila MPDSR focal person:** In case of upazila, the focal person will be the Junior Consultant/MO designated by UHFPO who in turn will monitor the compilation/analysis in coordination with Upazila statistician. Upazila Family Planning Officer (UFPO) will also coordinate at this level to summarize the information from the FP facilities across the upazila.

**TOR of the MPDSR focal person at upazila level:**
- Ensure the MPDSR agenda in the monthly meeting as an integral part of the QI agenda
- As required will provide technical support and advice to the district/upazila MPDSR sub-committees to review and analysis the cause of deaths
- Co-ordinate the report compilation from all facilities from upazila and below
- Provide necessary support to the union and below level for MPDSR implementation
- Prepare Death mapping

**Composition of the Upazila MPDSR Sub committee**
1. Consultant (Obs and Gynae)
2. Consultant (Pediatric)
3. Medical officer/RMO - 1
4. SSN/Nurse - 1
5. Statisticians - 1

**Chair Person:** Head of Department/ Senior Consultant Obs & Gynae or paediatrics
**Member Secretary:** Indoor Medical Officer Obs & Gynae or paediatrics / RMO
**Advisor:** UHFPO

For the MCWC at upazila, Medical Officer (MCH-FP) assigned by DDFP and Assistant Family Welfare Officer (MCH-FP) assigned by MO will work as a MPDSR sub-committee.

**TOR of Upazila MPDSR Sub committee**
- Review the forms weekly
- Compile death information and report to MPDSR focal person of the upazila QI committee (organizational level) on a monthly basis
- Assign for social and verbal autopsy (In consultation with the facility managers) and follow up to ensure timely data collection
- Conduct Internal review meeting monthly for resolving issues related to MPDSR implementation process
- Follow up and close supervision of the regular data entry of the forms
- Notify the facility managers on MPDSR implementation update
- Present death review findings in the QI monthly meeting as routine agenda
- Develop Local action plan (in consultation with the facility managers)

The committee can co-opt any member as required

**Review Meeting**

The committees at different tiers will conduct routine review meetings for the effective use of the collected MPDSR data.

At National level, all data on death will be preserved for better analysis and remedial action. At divisions, divisional QI committee (MPDSR focal person) will compile the VA forms from districts and below and coordinate with divisional/ regional medical college hospitals and assign definitive causes of death on a quarterly basis through reviewing by an expert team. The Deputy Chief MIS, will be responsible for coordinating data entry for the causes of death in DHIS2.

The district QI committee (MPDSR focal person) will be responsible to overall review and analyses the death findings and prepare local level remedial action plan for MPDSR implementation in the district. The MPDSR focal person will also provide recommendation at different level for further improvement and refinement. The confidentially of data at any level will be maintained. Deaths occurred in the district and the findings from the meetings shall utilize for the improvement of health services. This is the prior most platforms to share findings, best utilization of MPDSR data at the local level.

**Objectives:**

1. To meet periodically and review the findings of maternal death, perinatal, neonatal deaths and still births.
2. To ensure identification, notification and data entry of all death in DHIS2
3. To prepare action plan for the Upazila/ district to address findings of MPDSR.
4. To monitor and supervise the progress and quality of MPDSR implementation and continuous feedback.
5. To prepare recommendations for the district and national level to undertake corrective actions to prevent maternal death, perinatal, newborn death and still birth.

**Process of the MPDSR review meetings:**

*Co-ordination meetings:*

Every quarterly, a co-ordination meeting on MPDSR implementation activities will take place at the divisional, district and the upazila level. For the Divisional level, MPDSR focal person from the divisional QI committee will arrange the meeting at divisional director’s office. The district QI committee and the upazila QI committee will arrange the same co-ordination meeting at the district Civil Surgeon conference room and the upazila health complex respectively for this meeting. All these review meetings will be held at a quarterly interval.

The co-ordination meeting is a platform where the MPDSR focal person will brief on the progress of MPDSR implementation including previous meeting decisions. The MPDSR sub-committee from each facility of that particular tier(division/district/upazila) will also review last 3 months data on death notification (both community and facility deaths), verbal autopsies, social autopsies and facility death review findings of last three months. In the meetings, there will be discussion on the medical and social causes of deaths including related associated factors thus enabling the managers to take immediate need based action for improvement of health services within their areas. Finally, the chairperson of the committee
will summarize the findings and take decisions for corrective actions and necessary planning based on those findings. At the end of the meeting, the meeting minutes will be signed jointly by the chairperson and co-chair of the committee and circulated among the members and to the higher authorities.

**Internal review meetings**

All committees and sub-committees will conduct the internal review meeting at a monthly interval for internal progress monitoring. National MPDSR committee will have their internal meeting twice a year. The nation-wide MPDSR implementation and challenges will be discussed in this meeting and necessary guidance will be chalked out for the improvement areas of implementation. At divisional, district and upazila levels, the MPDSR sub-committees present their MPDSR review findings at QI committee meetings held in the facility once a month. Moreover, they will have their internal review meeting every month.

![Fig: Reporting channel](image)
Monitoring and supervision

The MPDSR intervention will be monitored and supervised periodically to ensure quality of the intervention and continuous feedback and improvement. Monitoring will be performed from the national level to local level. At the national level, under the MOHFW, the DGHS and DGFP will directly monitor the implementation progress. The higher officials from both directorates will be updated on the progress in technical and monitoring meeting at the national level. Moreover, they will visit the field activities at the district level. At the district level, the Civil Surgeon from health department and DDFP from family planning department will be responsible for overall monitoring and supervision. At the local level in upazila, UHFPO from the health department and UFPO from family planning department will be responsible to monitor the progress and provide continuous feedback.

The National Technical MPDSR committee will form an assessor team from within the committee for MNDSR monitoring supervision for regular monitoring. The team will regularly (on a quarterly basis) monitor the MPDSR intervention areas. Quality Improvement secretary as a guiding body will be responsible for overseeing these monitoring activities and provide necessary directives as required.
Annex 1

Government of the People's Republic of Bangladesh
Ministry of Health and Family Planning

Maternal, Neonatal Death and Stillbirth Review & Surveillance

Maternal Death Review Form

Community Form

Implementation

Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

<table>
<thead>
<tr>
<th>Death review number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year serial:</td>
</tr>
<tr>
<td>Month serial:</td>
</tr>
</tbody>
</table>

Technical support: UNICEF, UNFPA, WHO, COIA, CIPRB

Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU, BPA, Save the Children
Verbal consent

Hello, my name is ........................................ I am working in Health Department/ Family Planning Department as .................................. Contact number.................................................You will be happy to know that Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) working together to identify and review maternal and still birth neonatal death which helps to improve health status in Bangladesh. As a part of this I would like to ask some questions and discuss with you about maternal death. This interview will take around 30-45 minutes. You may not answer all questions and all the information in this interview will be kept as confidential. Before give your consent you may ask any questions and know about the subject of interview. You don’t have any risk to participate in the interview. You can quit anytime from the interview. Your name will not mention in the report. Ministry of Health and Family Planning will be benefited from your given information and that will help to improve maternal and neonatal health status.

Thanks to you.

From above consideration, if you want to participate in interview, then I will start the session.

Respondent has given consent to participate in the interview.

Name of the respondent: ........................................................................................................

Signature of the respondent:.................................................................

Date of interview: ........................................................................

Day / Month / Year
**Respondent’s Information**

**Household contact number: Mobile:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation with deceased</th>
<th>Was s/he present during death of neonate (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal respondent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate respondent -1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate respondent -2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General Information

District........................ Upazila....................... Union/pouroshova.................................

Ward................................. Village: .........................

Community Clinic Name: ________________________________

Community Clinic Code:

uję

Mother’s Name: __________________________________________________________

Mother’s online Registration (DHIS-2) code no:

uję

Age of mother: ________________________________ (in years)

Mother’s Education: ______________________________________________________

Education duration: (01. 02. 03............ 10............ 12 etc. and if no education then write code 99)

Socioeconomic condition of HH: □ very poor □ Poor □ Middle class □ Rich

Husband’s name: ...............................................

Section 1: Basic information

1| Date of Death:          Time (In 24 hours):

   Day / Month / Year    Hour / Minute

2| When the death occurred?

   1. During pregnancy period 2. Post Abortion (Before 28 weeks)
   3. During labour period 4. After the delivery (within 42 days)

3| Where the death occurred?

   01. At home 02. On the way 03. Union health and family welfare centre 04. Upazila Health complex 05. District or sadar hospital 06. Maternal and child welfare centre 07. Medical college hospital 08. NGO clinic 09. Private clinic / Hospital 10. others (specify)............................

4| How many months/ weeks of pregnancy when the mother died?

   Month / week

5| How many times the woman had child birth?

6| How many abortion happened to the mother? (if not known, use code 99)
Section 2: Maternal complications

7 | Was the mother suffering from any disease before pregnancy?
   1. Yes □  2. No □
   
   If yes (put tick marks where applicable):
   1. Hypertension □
   2. Diabetes □
   3. Heart disease □
   4. Convulsion □
   5. Anaemia □
   6. Tuberculosis □
   7. Asthma □
   8. Jaundice □
   9. Others (Specify) __________

8 | What was the result of last pregnancy / delivery? (Multiple response, put tick in box)
   [if this is first pregnancy go to question 9]
   1. Abortion □
   2. Stillbirth □
   3. Live birth □
   4. Pre-term delivery □
   5. Caesarean section □
   6. Delivery conducted by other operation □

9 | What were the complications occurred in mother during the current pregnancy?
   (tick in the box where applicable)

<table>
<thead>
<tr>
<th>Complications</th>
<th>Antenatal</th>
<th>Delivery</th>
<th>Postnatal</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Hypertension</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Abortion</td>
<td></td>
<td>..</td>
<td>..</td>
<td></td>
</tr>
<tr>
<td>4. Haemorrhage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. High fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Swelling of face, leg &amp; hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Convulsion/eclampsia/unconsciousness</td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Jaundice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Anaemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Blurring of vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Labour pain more than 12 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Lack of foetal movement or no movement for longer duration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Raptured uterus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Presentation other than head</td>
<td>....</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Retained placenta</td>
<td>....</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Foul smelling discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Abnormal abdominal pain (intense)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Other, specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Antenatal care

10| How many times received antenatal care? (Mention number) [ if ANC not received, put “00”, if not know, put “99” in the box and skip question 11, 12]

11| From where antenatal care was received? (Multiple response –tick in box)

01. At home 02. Community clinic 03. Union health and family welfare centre 04. Upazila Health complex 05 Maternal and child welfare centre 06 District or sadar hospital 07. Medical college hospital 09. Private hospital/clinic 10. NGO clinic 11. Chamber/health provider’s home 12. others (specify) ...........................................

12| Who provide antenatal care? (Multiple response- tick in box)


13| Did the family have a birth planning for the mother?

1. Where the delivery would conduct (Home/facility etc.)?

2. Who would deliver?

3. How would go to Health Care Centre? (Transport facility)

4. Where would go if any complications arise?

5. Did save money for treatment/transportation

6. Who would attend with the mother or take care of home

7. Arrange any donor for blood transfusion (Blood grouping)

8. Supplies available for essential newborn care (Sterile blade, cloth etc.)
Section 4: Delivery information

14| What was the place of delivery?

01. At home  02. Community clinic  03. Union health and family welfare centre 04. Upazila Health complex 05 Maternal and child welfare centere 06 District or sadar hospital 07. Medical college hospital 08. Private hospital/clinic 09. NGO clinic 10. Chamber/ health provider’s home 11. others (specify )..............................

15| Who conducted the delivery?


16 | What was the mode of delivery?

1. Vaginal (spontaneous) 2. Caesarean Section 3. Instrumental vaginal (vacuum/forceps)

4. Destructive operations.

17 | Pregnancy outcome of current pregnancy (tick the appropriate box):

Section 5: Treatment seeking before death

18 | Did receive any treatment before death of the mother: 1. Yes ☐  2. No ☐

19 | If yes, received treatment from where? (Multiple response- tick in box )

01. At home  02. Community clinic  03. Union health and family welfare centre  04. Upazila Health complex  05. Maternal and child welfare centre  06. District or sadar hospital  07. Medical college hospital  08. Private hospital/clinic  09. NGO clinic  10. Chamber/ health provider’s home  11. others (specify ).............................  1st  2nd  3rd

20 | Who provided the treatment?


21 | If answer is “no” then ask why any treatment/ management was not sought?
(Multiple response)

a. Thought unnecessary  
b. Did not understand that service is required  
c. High Cost  
d. Lack of money  
e. Too far  
f. Lack of Transport  
g. No one to accompany  
h. Poor service quality  
i. Family did not allow  
j. Better care at home  
k. Not known how to go  
l. No time to go for services  
m. Not know where to go  
n. For fear service  
o. Natural disaster/bad weather/night  
p. Other (specify ____________)  
q. Other (specify ____________)
Applicable at the community
If the mother died during pregnancy or during delivery skip section 6

Section 6: Post-natal period

26 | What was the duration from delivery to death?

□ □ □ □

Days / Hours / Minutes

27 | How many number of PNC received ? □ □

[ if PNC not received, put “00” , if not know, put “99” in the box and skip question 29-31]

29 | If received, how long it took to receive 1st PNC after delivery? □ □ □ □

Days / Hours

30 | From where post natal care was received? (Multiple response –tick in box)

01. At home 02. Community clinic 03. Union health and family welfare centre

04. Upazila Health complex 05 Maternal and child welfare centre 06 District or sadar hospital 07. Medical college hospital 08. Private hospital/clinic 09. NGO clinic 10. Chamber/ health provider’s home 11. others (specify ).................................

31 | Who provide post natal care? (Multiple response- tick in box )

01. Doctor (MBBS) 02. Nurse 03. Family Welfare Visitor (FWV) 04. Community Skill Birth Attended (CSBA) 05. MA/ SACMO

06. Health Assistant (HA) 07. Family Welfare Assistant (FWA)

08. Traditional Birth Attendent-Dai 09. Village doctor 10. NGO worker

11. others (specify ).................................
Applicable at the community

32 | Please provide a note on what happened to the mother just before she died [State all events/consequences during complications occurred, how treatment was initiated or not initiated / any factors involved in the society which related with the death of mother] – Please consider important points which not mentioned in the questionnaire

Name of the interviewer: ..............................................

Designation: ......................................................................

Institute name: ..............................................................

Signature: ..................................................................

Date: ........................................................................
# Community maternal death cause assignment form

[Must be filled by the consultant / expert professional]

| Insert ICD 10 table of cause assignment |

| Disease name: |
| ICD code |
| Name of the reviewer: |
| Designation: |
| Institute name: |
| Signature: |
| Date: |
Maternal, Neonatal Death and Stillbirth Review & Surveillance

Neonatal Death Review Form

Implementation

Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

<table>
<thead>
<tr>
<th>Death review number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year serial:</td>
</tr>
<tr>
<td>Month serial:</td>
</tr>
</tbody>
</table>

Supported by: UNICEF, UNFPA, WHO, CIPRB

Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU, BPA
Verbal consent

Assalamualaikum/Namasker, my name is …………………………………. I am working in Health Department/ Family Planning Department as …………………………….. I am very sorry to hear the death news of the child. Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) are working together to identify and review neonatal death to take appropriate action which will reduce further neonatal death in Bangladesh. I would like to ask some questions and discuss with you about your child who had died unfortunately. This interview will take around half an hour. You may not answer all questions and all the information in this interview. All the information will be kept as confidential. Before your consent, you may ask any questions about the subject of interview. You do not have any risk to participate in this interview. You can quit anytime during the discussion. Your name will not be mentioned in the report.

From above consideration, if you want to participate in interview, then I will start the session.

Respondent has given consent to participate in the interview.

Name of the respondent: ………………………………………………………

Signature of the respondent: …………………………………………………

Date of interview: [ ] / [ ] / [ ] Day / Month / Year
Respondent’s Information

Household contact number: Mobile:..............................................

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation with deceased</th>
<th>Was s/he present during death of neonate (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal respondent :</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate respondent -1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate respondent -2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Applicable at the community

General Information (Deceased newborn)

District.......................... Upazila.................... Union/pouroshova..............................................

Ward (New).......................... Village: .......................

Community Clinic Name (Catchment): ________________________________

Community Clinic Code:

Mother’s Name: __________________________________________________________

Mother’s online Registration (DHIS-2) code no:

Age of mother: ______________________________(in years)

Mother’s Education: ____________________________________________________ (Years)

Socioeconomic condition of HH (as listed in CC):

☐ Very poor ☐ Poor ☐ Middle class ☐ Rich

Father’s name: ..........................................................

Child’s name: ___________________________________________________________________

Child’s online Registration code no

__________________________________________________________________________
Applicable at the community

Neonatal Information

1| Date of Birth: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] | Time (In 24 hours): [ ] [ ] [ ]
Day / Month / Year | Hour / Minute

2| Date of Death: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] | Time (In 24 hours): [ ] [ ] [ ]
Day / Month / Year | Hour / Minute

3| Where the death occurred?
□ At home
□ Community clinic
□ Union health and family welfare centre
□ Upazila Health complex
□ Maternal and child welfare centre
□ District or sadar hospital
□ Medical college hospital
□ Private hospital/clinic
□ NGO clinic
□ Chamber/ health provider’s home
□ On the Way
□ Others(specify)..........................

4| How long the neonate was ill before death?
(if not known, specify…………………………………………..) [ ] [ ] [ ] [ ]
Day / Hour / Minute

5| Did the neonate die due to any trauma/Injury?
□ Yes (If yes, what type of injury?) Specify:..................................................
□ No
□ Don’t know
Mother’s Information

6| How many months/weeks of pregnancy at the time of delivery?  

7| Was there any obstetric complication occurred during this pregnancy?

☐ Yes (If yes, what type of complications? (Multiple response)

<table>
<thead>
<tr>
<th>a. Excessive bleeding</th>
<th>f. Malpresentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. High blood pressure</td>
<td>g. Obstructed labor</td>
</tr>
<tr>
<td>c. Convulsion</td>
<td>h. Twin pregnancy</td>
</tr>
<tr>
<td>d. High fever</td>
<td>i. Trauma related (Injury)</td>
</tr>
<tr>
<td>e. Prolonged labor</td>
<td>j. Others (specify)</td>
</tr>
</tbody>
</table>

☐ No

☐ Don’t know

8| How many times received antenatal care? (Mention number)

☐ Once   ☐ 2 times   ☐ 3 times   ☐ 4 times and above

☐ No

☐ Don’t know (go to quest)
9| From where antenatal care was received? (Multiple response- tick in box)

- At home
- Community clinic
- Union health and family welfare centre
- Upazila Health complex
- Maternal and child welfare center
- District or sadar hospital
- Medical college hospital
- Private hospital/clinic
- NGO clinic
- Private Chamber/ health provider’s home
- Others (specify)

10| Who provided antenatal care? (Multiple response- tick in box)

- Doctor (MBBS)
- Nurse
- Family Welfare Visitor (FWV)
- Community Skill Birth Attenddent
- MA/ SACMO
- Health Assistant (HA)
- Family Welfare Assistant (FWA)
- Traditional Birth Attendent-Dai
- Village doctor
- NGO worker
- Others (specify)

11| How many times the woman had child birth?

12| How many times the mother had an abortion?

13| Place of delivery?

- At home
- Community clinic
- Union health and family welfare centre
- Upazila Health complex
- Maternal and child welfare centre
- District or sadar hospital
- Medical college hospital
- Private hospital/clinic
- Don’t know
Who delivered the baby?

- Doctor (MBBS)
- Nurse/midwives
- Family Welfare Visitor (FWV)
- Community Skilled Birth Attendant
- MA/SACMO
- Health Assistant (HA)
- Family Welfare Assistant (FWA)
- Traditional Birth Attendant-Dai
- Village doctor
- NGO worker
- Others (specify)

What was the mode of delivery?

- Vaginal (spontaneous)
- Instrumental vaginal (vacuum/forceps)
- Caesarean Section

Was there any complications during delivery? What type of complications? (Multiple response - Tick marks)

a) High Blood Pressure/Hypertension
b) Convulsion/eclampsia
c) Bleeding(haemorrhage) during pregnancy/ Ante Partum Hemorrhage(APH)
d) Good contraction (pain) but no progress of labour/ Obstructed labour
e) Labour pain more than 12 hrs/Prolonged labour
f) Premature labour/labour pain before 37 weeks
g) Leakage of fluid before labour/ Ruptured membrane/PROM
h) Less fetal movement/ fetal distress/ meconium stained liquor
i) Abnormal position of the fetus/ mal-presentation
j) Ruptured uterus
k) Placenta not delivered 30 minutes after delivery of the baby/Retained placenta
l) Bleeding(haemorrhage) after/ Post-Partum Hemorrhage (PPH)
m) High fever
n) Fowl smelling vaginal discharge
o) No complication
p) Don’t know
### Information after delivery

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Did the mother deliver twin?</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>18</td>
<td>What was the weight of the baby at the time of delivery?</td>
<td>□ Less than usual (&lt;2.5 kg) □ Usual □ More than usual</td>
</tr>
<tr>
<td>19</td>
<td>Was there any congenital anomaly?</td>
<td>□ Head □ Plate □ Lips □ Upper limb □ Trunk □ Anus □ Foot □ Vaginal canal</td>
</tr>
<tr>
<td></td>
<td>□ Others (specify...) □ No □ Don’t Know</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Did the neonate cry/ breath after live birth?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>01. Yes/took normal breath 02. Week cry or took breath after long interval</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99. Not know</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(If answer is “yes” or “not know” then go to question no. 27)</em></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>If answer was “Week cry or took breath after long interval”, what necessary action was done? (Multiple response)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dried the neonate and wrapped with dry clean cloth</td>
<td>□ Slap forcefully on the back/chest/hip holding both leg up and head below</td>
</tr>
<tr>
<td></td>
<td>□ Stimulation was given at the vertebral column or back</td>
<td>□ Flash warm water in mouth</td>
</tr>
<tr>
<td></td>
<td>□ Mouth to mouth breathing was given</td>
<td>□ Transfer in health care centre</td>
</tr>
<tr>
<td></td>
<td>□ Neonatal resuscitation by ambo bag</td>
<td>□ Nothing was done significantly</td>
</tr>
</tbody>
</table>
|        | □ Others (specify)                                                       | □ Others (specify)...
Was there any danger sign observed in neonate? (Multiple response)

- a. Convulsions
- b. No feed or reluctant to feed
- c. Fast breathing
- d. Chest indrawing with Fast breathing
- e. Hypothermia of hand and feet
- f. Fever
- g. Lack of movement or less movement
- h. Yellow coloration of eyes/ Skin (jaundice)
- i. Reddish umbilicus/ Pus secretion from umbilicus
- j. Pus contained vesicle in the skin
- k. Diarrhea
- l. Others (specify)......................................
- m. Not known

Did the neonate received any treatment before death?

- ☐ Yes (go to question 24)
- ☐ No (go to question 25)

If answer is yes then where treatment was taken? (Multiple tick)

- ☐ At home
- ☐ Community clinic
- ☐ Union health and family welfare centre
- ☐ Upazila Health complex
- ☐ Maternal and child welfare center
- ☐ Medical college hospital
- ☐ Private hospital/clinic
- ☐ NGO clinic
- ☐ Chamber/ health provider’s home
- ☐ Others (specify)..........................

If answer is “no” then ask why any treatment/management was not seeked? (Multiple response)

- Not necessary
- Not understand that service is needed
- Cost too much
- Lack of money
- Too far
- Transport problem
- No one to accompany
- Poor quality service
<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family did not allow</td>
</tr>
<tr>
<td>Better care at home</td>
</tr>
<tr>
<td>Not known how to go</td>
</tr>
<tr>
<td>No time to go for services</td>
</tr>
<tr>
<td>Not know where to go</td>
</tr>
<tr>
<td>For fear</td>
</tr>
<tr>
<td>Natural disaster/bad weather/night</td>
</tr>
<tr>
<td>Other (specify ______________________)</td>
</tr>
</tbody>
</table>
## Community Neonatal death cause assignment form

[Must be filled by the consultant / expert professional]

### Cause of Death

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death</th>
<th>ICD code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ........................................... (Due to or as a consequence of)</td>
<td></td>
</tr>
</tbody>
</table>

### Antecedent causes

<table>
<thead>
<tr>
<th>Morbid conditions, if any, giving rise to the above cause, stating the underlying causes last</th>
<th>ICD code</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) ........................................... (Due to or as a consequence of)</td>
<td></td>
</tr>
</tbody>
</table>

| c) ........................................... (Due to or as a consequence of) |          |
| d) ........................................... (Due to or as a consequence of) |          |

### Other significant conditions contributing to death, but not related to disease or conditions causing it

| ............................................................. |
| ............................................................. |

### Name of the reviewer:

Designation:

Institute name:

Signature:

Date:
Maternal, Neonatal Death and Stillbirth Review & Surveillance

Maternal Death Review Form

Implementation

Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Year serial:</td>
</tr>
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<td>Month serial:</td>
</tr>
</tbody>
</table>

Supported by: UNICEF, UNFPA, WHO, CIPRB

Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU, BPA
General Information

Name of the facility: ________________________________________________________________

Facility Code: 

Mother’s Name: ________________________________________________________________

Age of mother: __________________________ (in years)

Mother’s hospital Registration no:

Hospital ward no: Hospital bed no:

Mother’s Address:

District.......................... Upazila........................ Union/pouroshova..............................

Ward.............................. Village: .........................

Husband’s name: ________________________________

Contact number:

1. Admission information:
Date & time of received at emergency/outdoor:

On [ ] [ ] [ ] at [ ] : [ ] AM/PM or Unrecorded [ ]
Applicable at the facility

Date & time of admission at indoor:
On [__] [__] [__] at [__]:[__] AM/PM or Unrecorded [__]

Date & time of death
On [__] [__] [__] at [__]:[__] AM/PM or Unrecorded [__]

2. Condition of the mother during admission:

2.2 Unconscious [__] 2.4 Not recorded [__]

3. Status of pregnancy at emergency dept./OPD:

3.1 Antenatal [__] 3.4 Others [__]
3.2 In labour pain [__] 3.5 Not recorded [__]
3.3 After delivery [__]

4. Disease diagnosed at the time of admission:

4.1 Ectopic pregnancy [__] 4.11 Postpartum haemorrhage [__]
4.2 Missed abortion [__] 4.12 Retained placenta:
4.3 Spontaneous abortion [__] a. with haemorrhage [__]
4.4 Medical abortion [__] b. without haemorrhage [__]
4.5 Induced abortion [__] 4.13 Prolonged labour [__]
4.6 Threatened abortion [__] 4.14 Obstructed labour [__]
4.7 Placenta previa [__] 4.15 Rupture uterus:
4.8 Abruptio placenta [__] 4.16 Others (Specify):__________________________
4.9 Molar pregnancy [__]
4.10 Intra partum haemorrhage [__]
5. Was the mother referred in? 1. Yes □ 2. No □

If Yes from where:

1. Government facility
2. Private facility
3. Home
4. Other, specify:
5. Unrecorded

6. First visit of doctor/consultant:

Date & time of attendance On □□□□ at □□ : □□ AM/PM

Unrecorded □ or Not available □

7. Diagnosis in indoor:

7.1 Ectopic pregnancy □ 7.10 Intra partum haemorrhage □
7.2 Missed abortion □ 7.11 Post partum haemorrhage □
7.3 Spontaneous abortion □ 7.12 Retained placenta:
7.4 Medical abortion □ 1. With haemorrhage □
7.5 Induced abortion □ 2. Without haemorrhage □
7.6 Threatened abortion □ 7.13 Prolonged labour □
7.7 Placenta previa □ 7.14 Obstructed labour □
7.8 Abruptio placenta □ 7.15 Rupture uterus:
7.9 Molar pregnancy □ 7.16 Others (Specify): ................................

8. Indoor management after admission:

Date & time of initiation of treatment: On □□□□ at □□ : □□ AM/PM

or Unrecorded □
9. Method of delivery:

9.1 Normal Vaginal delivery ☐
9.2 Caesarean section ☐
9.3 Instrumental delivery ☐
9.4 Undelivered ☐

10. Current Pregnancy outcome:

10.1 Live birth ☐
10.2 Still birth ☐
10.3 LBW ☐
10.4 Abortion ☐
10.5 Others (Specify) ............................................
Applicable at the community

11. Weight of the baby after birth: [ ] [ ] [ ] gm

12. Had any congenital abnormality, after birth of the baby: 1. Yes [ ] 2. No [ ]

13. Place of death of the mother:

   1. Emergency [ ]  2. In trolley [ ]
   3. Ward [ ]  4. Labour room [ ]
   5. Operation theatre [ ]  6. ICU [ ]
   7. Others [ ]  8. Post-operative [ ]

14. What is the most probable cause of death?

   (WHO Cause of death form, with separate ICD10 list)

<table>
<thead>
<tr>
<th>CAUSE</th>
<th>ICD CODE</th>
<th>CAUSE</th>
<th>ICD CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH</td>
<td>O 72</td>
<td>APH</td>
<td>O 46</td>
</tr>
<tr>
<td>Peurperial Sepsis</td>
<td>O 85</td>
<td>Ectopic Pregnancy</td>
<td>O 00</td>
</tr>
<tr>
<td>Eclamsia</td>
<td>O 15</td>
<td>Haemorrhage in Early Pregnancy</td>
<td>O 20</td>
</tr>
<tr>
<td>Death from sequel of direct obstetric cause</td>
<td>O 97</td>
<td>Complication of Anaesthesia during Labour &amp; Delivery</td>
<td>O 74</td>
</tr>
<tr>
<td>Obstructed Labour due to Malposition and Malpresentation of foetus</td>
<td>O 64</td>
<td>Failed Attempt abortion</td>
<td>O 07</td>
</tr>
<tr>
<td>Placenta Previa</td>
<td>O 44</td>
<td>Abruptio placentae</td>
<td>O 45</td>
</tr>
<tr>
<td>Medical abortion</td>
<td>O 04</td>
<td>Rupture Uterus</td>
<td></td>
</tr>
<tr>
<td>Complications of anaesthesia during pregnancy</td>
<td>O 29</td>
<td>Obstetric Embolism</td>
<td>O 88</td>
</tr>
<tr>
<td>Malnutrition in pregnancy</td>
<td>O 25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15: Remarks (Please supply a short summary of the events surrounding the death)

...........................................................................................................................................

16. Name of the reviewer:.................................................................

Designation:....................................................................................

Date of information collection: ...............................................

Signature: .........................................................................................
Maternal, Neonatal Death and Stillbirth Review & Surveillance

Neonatal Death Review Form

Facility form

Implementation

Directorate General of Health Services (DGHS) and
Directorate General of Family Planning (DGFP)

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Year serial:</td>
<td></td>
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<tr>
<td>Month serial:</td>
<td></td>
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</tbody>
</table>

Supported by: UNICEF, UNFPA, WHO, CIPRB
Form designed in collaboration with HEU, ICDDR,B, JICA, BRAC, OGSB, BNF, BSMMU, BPA
General Information

Name of the facility: __________________________________________________________

Facility Code: 

__________________________________________

Mother’s Name: ____________________________________________________________

Age of mother: ____________________________________________________________ (in years)

Name of neonate: ____________________________________________________________

Age of Neonate at the time died (in days/ hours/ minutes): ________________________

Mother’s /neonate’s hospital Registration no:

__________________________________________

Hospital ward no: ......................... Hospital bed no: .........................

Mother’s Address:

District................................ Upazila.............................Union/pouroshova..........................

Ward................................ Village: ..........................................................
Applicable at the community

Father’s name: _____________________________________________________________

Contact number: __________________________________________________________

1. Place of delivery of neonate?
   01. At home 02. Community clinic 03. Union health and family welfare centre
   04. Upazila Health complex 05 Maternal and child welfare centre
   06. District or sadar hospital 07. Medical college hospital
   08. Private hospital/clinic 09. NGO clinic 10. Chamber/health provider’s home
   11. Others (specify )....................................

2. What was the type of death of neonate? (Put tick mark in the box)
   a. Neonate born in this hospital and died Q 5
   b. Neonate was born outside and died after admission in this hospital

3. Date & time of received at emergency/outdoor: On __________ at ______ : ______ AM/PM or Unrecorded

4. Date & time of admission at indoor: On __________ at ______ : ______ AM/PM or Unrecorded

5. Date & time of death On __________ at ______ : ______ AM/PM or Unrecorded

6. Condition of the neonate during admission/received:
   2.2 Unconscious □
   2.3 Brought dead □
   2.4 Not recorded □

7. What was the diagnosis of neonate at admission/immediate after born at hospital? (Put tick mark in the box)
   1. Birth Asphyxia
2. Septicemia
3. Low birth weight
4. Severe Pneumonia
5. Meningitis
6. Birth trauma
7. Congenital anomalies
8. Others (specify) _________________________________________________

8. Whether the neonate was referral case? Put tick mark in the box)
   1. Yes
   2. No

8.1 If answer is “Yes” from where the neonate referred? (Put tick mark in the box)
   1. Government facility
   2. Private facility
   3. Home
   4. Other, specify:
   5. Unrecorded

9. When the mother had a First visit of doctor/consultant:
   Date & time of attendance On □□□□ at □□ : □□ AM/ PM
   Unrecorded □ or Not available □

10. Was there any danger sign observed in neonate? (Multiple response, tick in the box where applicable)
### Applicable at the community

<table>
<thead>
<tr>
<th>Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsions</td>
<td></td>
</tr>
<tr>
<td>No feed or reluctant to feed</td>
<td></td>
</tr>
<tr>
<td>Fast breathing</td>
<td></td>
</tr>
<tr>
<td>Chest indrawing with Fast breathing</td>
<td></td>
</tr>
<tr>
<td>Hypothermia of hand and feet</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td>Lack of movement or less movement</td>
<td></td>
</tr>
<tr>
<td>Yellow coloration of eyes/ Skin (jaundice)</td>
<td></td>
</tr>
<tr>
<td>Reddish umbilicus/ Pus secretion from umbilicus</td>
<td></td>
</tr>
<tr>
<td>Pus contained vesicle in the skin</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>Others (specify).....</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

11. What was the diagnosis of neonate at indoor / after seen by the consultants?  
(Put tick mark in the box)

1. Birth Asphyxia
2. Septicemia
3 Low birth weight
4. Severe Pneumonia
5. Meningitis
6. Birth trauma
7. Congenital anomalies
8. Others (specify) ________________________________

12. When the indoor management after admission:

   Date & time of initiation of treatment: On ___ ___ ___ at ___ :

13. Weight of the baby after birth: ___ ___ ___ gm

14. Did the newborn had any congenital abnormality: 1. Yes  2. No
14.1 If answer is “yes”, where was the congenital anomaly?


9. Others (specify…………………………………….)

15. Where was the place of death of neonate?

1. At emergency
2. During transferring the neonate
3. At ward
4. At labour room
5. At operation theater
6. Special care newborn unit (SCANU)
7. Others (specify)

16. What is the most probable cause of death?

(WHO Cause of death form, with separate ICD10 list) Requested to insert from ICD 10

17: Remarks (Please supply a short summary of the events surrounding the death)

............................................................................................................................................................................
............................................................................................................................................................................
............................................................................................................................................................................

Name of the reviewer:..........................................................
Designation:...........................................................................

Date of information collection: ............................................

Signature: ..............................................................................
Government of the People's Republic of Bangladesh

Ministry of Health and Family Planning

Maternal, Perinatal, Neonatal Death and Stillbirth Review & Surveillance

Death Notification Forms
পশ্চিমবঙ্গ সরকার
বাণিজ্য ও পরিবার কল্যাণ মন্ত্রণালয়
মাতৃশূক্ত, নবজাতকের মৃত্যু ও মৃতজ্ঞান (এমপিইআর) অবতীর্ণকরণ প্রিপ
[কমিউনিটি প্যাপারেট]
তারিখঃ
মৃত্যুর ধরনঃ
(1. মাতৃ মৃত্যু 2. মৃতজ্ঞ 3. নবজাতকের মৃত্যু)
থিকঃ
(1. জেলা 2. মোট) মৃত্যুক্ত/মৃত নবজাতকের জন্মকালীন তথ্য
মায়ের নামঃ
মায়ের বয়সঃ
পিতা/মায়ের নামঃ
পাটাঃ
(গ্রাম / ইউনিয়ন / উপজেলা / জেলা)
মৃতের পরিবারের মোবাইল নং (যদি থাকে)ঃ
মৃতার/মৃত্যুকের তারিখঃ
মৃতার সমযঃ (২৪ ঘন্টার মধ্যে)
প্রসবের তারিখঃ
প্রসবের সমযঃ (২৪ ঘন্টার মধ্যে)
মৃতার স্থানঃ
প্রসবের স্থানঃ
1. বাড়িতে 2. কমিউনিটি ক্লিনিক 3. ইউনিয়ন সামাজিক ও পরিবার কল্যাণ কেন্দ্র 4. উপজেলা সামাজিক কমিটি 5. মাতৃসন্তান 6. জেলা হাসপাতালে 7. মেডিকেল কলেজ হাসপাতালে 8. এইচআইটি বা এনিওহাসপাতাল 9. প্রসর হয় নাই 10. অন্যান্ত (উল্লেখ করুন)
কে প্রসব করিয়েছেনঃ
1. ভ্রাতার (MBBS) 2. নার্স 3. পরিবার কল্যাণ পরিদর্শক (FWV) 4. সিভিসিএস (CSBA) 5. এমএ / সামনো (MA/ SACMO) 6. সামাজিক / পরিবার কল্যাণ সহকারী (HA/ FWA) 7. পূর্বী চিকিৎসক 8. এনিওমি কর্মী 9. অন্যান্ত (উল্লেখ করুন)
তথ্য এগাছাইর নামঃ
তথ্য এগাছাইর ব্যাপার

Applicable at the community
<table>
<thead>
<tr>
<th>তথ্য প্রদায়কর</th>
<th>মূখ্যকর</th>
<th>মূখ্য-কর</th>
<th>তথ্য প্রদায়কর</th>
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তথ্য প্রদায়করের নামঃ.................................................................
পদ্ধতিঃ.................................................................
মোবাইল নংঃ.................................................................

তথ্য প্রদায়করের শাখার নামঃ.................................................................