

Day 1 Handouts

MPDSR Knowledge Assessment

Pre-Test

Learners Name / Code #: _____

1. Which is the best definition of a maternal death?
 - a. The death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to pregnancy or its management, but not from accidental or incidental causes
 - b. The death of a woman while pregnant or within 42 days of pregnancy, including any accidental or incidental causes
 - c. The death of a woman while pregnant or within 42 days of pregnancy because of limited critical care services
2. How many steps are in the mortality audit cycle?
 - a. 3 steps
 - b. 6 steps
 - c. 9 steps
3. What are the steps of the mortality audit cycle?
 - a. Identify, locate, recommend solutions, implement recommendations, evaluate and refine
 - b. Identify, collect information / notify, analyse information, recommend solutions, implement recommendations, evaluate and refine
 - c. Identify, review, recommend solutions, implement recommendations
4. Standardization of identification of direct and indirect causes of maternal deaths are found in:
 - a. ICD-PM
 - b. ICD-MM
 - c. ICD-20
5. What is the first step of the MDSR process?
 - a. Review of the MDSR form
 - b. Identification of maternal deaths
 - c. Analyse maternal or perinatal death
6. What single term should be written on the death certificate?
 - a. Cause of mortality
 - b. Underlying cause of death
 - c. Morbidity agent
7. Which of the following is a direct cause of maternal death in pregnancy?
 - a. Pre-eclampsia/eclampsia
 - b. Cardiac disorder
 - c. Thyroid disorder
8. Which term is defined as the death of a women from direct or indirect causes more than 42 days but less than 1 year after termination of pregnancy?
 - a. Late maternal death
 - b. Delayed maternal mortality
 - c. Postpartum death

9. What is the underlying cause of death of a woman with HIV who dies of septic shock and renal failure after a spontaneous incomplete abortion?
 - a. Renal failure
 - b. Septic abortion
 - c. Septic shock

10. A 20-year-old woman (30 weeks pregnant), was involved in a traffic accident and died soon after reaching the hospital. What ICD-MM group does this fall into?
 - a. Direct maternal death
 - b. Indirect maternal death
 - c. Coincidental cause of death

11. A 30-year-old woman (38 weeks pregnant), underwent a caesarean section for foetal distress. She had just had a full meal and died on the theatre table because of aspiration following anaesthesia. What ICD-MM group does this fall into?
 - a. Other obstetric complications
 - b. Coincidental causes
 - c. Unanticipated complication of management

12. A 16-year-old girl who was being treated for a high fever died suddenly after reaching the facility. She had taken an herbal medication 2 days earlier, following unprotected intercourse 2 weeks after her last menstrual period. How should the provider document this death?
 - a. Coincidental cause of death
 - b. Indirect maternal death
 - c. Not a pregnancy-related death

13. Pre-eclampsia has been determined to be a leading cause of maternal mortality in Facility X. Which of the options below is an appropriate action that an MPDSR committee could implement to improve the quality of care for women with pre-eclampsia in this facility?
 - a. Take action against the provider who was on duty at the time of the two most recent maternal deaths caused by pre-eclampsia
 - b. Ensure availability of magnesium sulphate in the emergency area at all times
 - c. Immediately refer women who present with pre-eclampsia to another facility

14. What is the primary responsibility of the facility MPDSR committee?
 - a. To review and develop response actions following maternal and perinatal deaths
 - b. To penalize the provider involved in the maternal death
 - c. To complete and send reports on maternal deaths to the district managers

15. How often should the facility MPDSR committee meet?
 - a. When two or more similar maternal deaths are recorded
 - b. Once or twice a year, depending on facility size
 - c. After a maternal death or periodically, even if there is no death

16. Which types of maternal death are included in the ICD-MM classification system?
 - a. Direct, coincidental, unspecified
 - b. Direct, indirect, coincidental
 - c. Direct, unspecified, indirect

17. Which of the following is NOT one of the guiding principles of the response portion of MPDSR?
 - a. Monitoring the implementation of actions/responses identified during the death review
 - b. Prioritizing actions/responses based on avoidable factors identified during the death review
 - c. Not establishing a timeline for response actions

18. Which of the following options includes examples of the three types of delay in the Three Delay Model?
 - a. Waiting too long to seek care because of the financial implications, the length of time it takes to reach care because of poor roads, and timeliness of care because of understaffed facilities
 - b. Receiving services at a busy facility, the time it takes to properly diagnose the root cause of an illness, and the time it takes medication or treatment to take effect
 - c. The time it takes to find an affordable healthcare provider, the length of time it takes a provider to reach the patient, and the recovery time needed after a surgical procedure

19. What is an important function of a Civil Registration / Vital Statistics (CR/VS) system?
 - a. Registration of only births
 - b. Registration of only deaths
 - c. Registration of births and deaths

20. Monitoring and analysing trends in maternal deaths and the findings of death reviews should be done at the following level:
 - a. Community and facility levels only
 - b. Community, facility, subnational, and national levels
 - c. Subnational level only

Individual Learning Plan

Learner: _____ Facilitator: _____ Date: _____

Instructions: In the form on the following page, for each topic listed, assess your level of competency according to the scale given below.

Level of Competency Scale	
Low	Topic is new or unfamiliar to the learner
Moderate	Learner is aware of the topic. Learner is knowledgeable but will benefit from additional education on the topic.
High	Learner is highly knowledgeable on the topic and may be able to provide additional insight during the workshop

Day/Session #	Learning Objectives	Level of Competence
D1/S3	Describe the goals of Maternal Death Surveillance and Response	Low – Moderate – High
D1/S4	Identify the steps of the Six-Step Mortality Audit Cycle	Low – Moderate – High
D1/S5	Identify maternal deaths	Low – Moderate – High
D1/S5	Differentiate between direct and indirect obstetric deaths	Low – Moderate – High
D2/S2	Create and/or strengthen MPDSR committees	Low – Moderate – High
D2/S2	Describe the key roles and responsibilities of an MPDSR committee	Low – Moderate – High
D2/S3	Complete a Maternal Death Review form	Low – Moderate – High
D2/S4	Assign cause of maternal death using ICD-MM	Low – Moderate – High
D3/S2	Develop an MDSR response plan	Low – Moderate – High
D3/S3	Monitor and analyse trends in maternal deaths and death review findings over time using combined data sources to inform priority responses (HMIS, death review findings, CRVS data when available)	Low – Moderate – High
D3/S3	Analyse trends in maternal death data and findings of audits to inform priority responses at individual facility and regional/district level	Low – Moderate – High

Why Did Mrs. X Die transcript

This is the story of a mother called Mrs. X. Mrs. X could have come from anywhere, but she is most likely to have come from a low-income family in a poor country. Mrs. X represents a universal mother.

Mrs. X died in the small hospital eight months pregnant. The doctor had no doubt about the cause of her death. A haemorrhage. Her placenta had been too low down in her uterus and hadn't been identified in time. The doctor recorded her death, closed her file, and added it to a growing stack of similar cases locked away in a cupboard. Over time, these stacks grew and grew. Some years later, worried about the high numbers of mother's dying in their hospital, the staff reviewed the cases to learn lessons and make the improvements. They reopened and reviewed file after file. One of these was that of Mrs. X. When they read it, they found two striking points.

First, Mrs. X had arrived at the hospital bleeding heavily, yet she only received half a litre of blood. This was all the hospital had available, and it was not enough. Second, Mrs. X and her baby needed a caesarean section, but resources were limited, and the operation took place three hours too late. Both Mrs. X and her unborn baby died. The group then visited Mrs. X's village and spoke with her family, neighbours, and community leaders. They found that there were other reasons for her death. Mrs. X had a history of bleeding early in pregnancy but wasn't aware that this was a danger sign needing attention. She also had had only one antenatal visit.

If she'd gone regularly, her problem may have been picked up. She would have been referred to a specialist, and she and her baby could have survived.

Mrs. X was also severely anaemic, so the loss of even the smallest amount of blood, as little as a cupful, could have tipped the balance between life and death.

The team discovered that it had taken six hours to collect enough money to pay for her transport to the hospital. As a result of these findings, the hospital improved their blood supplies, updated their emergency procedures, and caesarean sections could now be performed as soon as it was necessary.

The local health department provided more midwives in more places to enable more women to have access to good maternity services throughout their pregnancy and birth. Mrs. X's file was closed again.

A year later, a group of visiting health professionals came to the hospital as part of a national inquiry into maternal deaths. They wanted to understand what lay behind the statistics, beyond the numbers, and discover the wider social and economic reasons for the deaths of women like Mrs. X and their babies and what could be done about it. The aim of their work was to recommend changes to the national or regional policies and strategies, to improve women's health, and to save mothers' lives. When they reviewed all that data, common patterns emerged. They found most mothers' stories were similar to that of Mrs. X.

Like many women in developing countries, Mrs. X worked day and night to care and provide for her family. She was illiterate. She lived in poverty in a remote village. She was unable to choose when and if to become pregnant. Mrs. X was also weak and unhealthy. In her society, the male members of the family came first in the queue for food, for education, and for health care. Mrs. X often went without. For women like her, death or complications in pregnancy were, and still are, a real threat.

By uncovering the stories of women like Mrs. X, the national team were able to put pressure on the government to provide more education for girls, more resources and staff for maternity care, and better reproductive health services. They also pushed for raising community awareness about health, nutrition, family planning, and the benefits of skilled maternity care.

Mrs. X started on the pathway of her pregnancy exhausted, with few physical reserves. She hadn't chosen to become pregnant. It was her destiny. The only value she had to her family and community was her ability to produce children. However, Mrs. X had been lucky, in a way. At least she'd had a childhood. In some societies, girls are married off while still children themselves, not physically or mentally prepared for childbirth or motherhood.

If Mrs. X had been treated as an equal to her brothers while she was growing up, she could have been healthier and better educated. If she'd had more control over her adult life, she may have been able to choose when she had children. As Mrs. X continued her walk through pregnancy, her prospects would've been better if she visited a skilled professional health worker, a midwife, or doctor. Even if Mrs. X had known the importance of antenatal care, her midwife was many miles walk away. If only Mrs. X's problems had been recognised and her anaemia treated. If only she'd had specialist care in time.

Because of tradition, poverty, and lack of knowledge many women in Mrs. X's community gave birth at home. Some told stories of being treated harshly and disrespectfully by hospital staff. Some were expected to pay bribes. Mrs. X had also planned to give birth at home, but then she developed a life-threatening complication. She started to bleed.

If Mrs. X been referred and had transport in time to go to a hospital with facilities for providing comprehensive emergency obstetric care, such as equipment, well trained staff, and enough medicines and blood, her life and that of her baby might have been saved.

Mrs. X could have lived to raise her children.

After the long delay in finding transport, Mrs. X was eventually admitted to the hospital where, due to the lack of resources, she and her baby died.

Along the pathway of her pregnancy, Mrs. X faced barriers that prevented her from receiving the care she needed. Each could have been removed. And yet, many or all of these barriers remain along the roads taken by women today.

Mrs. X could be any woman. Your sister, your wife, your mother, your daughter, you. It is up to all of us, no matter where we live, who we are, or what we do, to help remove these barriers for Mrs. X and the millions of pregnant women like her. As individuals, we can lobby for better health care and equal rights for girls and women. As communities, we can make sure our pregnant women are informed and cared for. We can organise local education, support, and transport for our mothers. As health care workers, we can provide quality care in a respectful environment. And we can continue to open the files and learn the lessons from mothers like Mrs. X.

As local health planners, we can provide high quality maternity and family planning services that reach out to more women. And as politicians and policymakers, we can strengthen human rights. We can improve education for girls and women. And we can provide the resources for better, more effective health care services across the world, wherever they're needed, now.

1: Septic abortion

2: Ectopic pregnancy

3: Postpartum haemorrhage

4: Pregnancy with bus accident

5: Severe preeclampsia

6: Pregnancy with severe anemia due to malaria

7: 10 days postpartum with severe pneumonia

8: Pregnancy with breast cancer

9: Pregnancy with anaesthetic complication

**I 0: 5 days postpartum and
cause of death not known**

**I 1: Pregnancy with severe
mitral stenosis**

**I 2: Pregnancy with severe
cervical tear**

I 3: 30 weeks gestation, cause of death not known

I 4: Retained placenta

I 5: Aspiration pneumonitis due to anaesthesia during delivery

Day 2 Handouts

Handout: Completed Case Summaries

Scenario 1: PPH

Summary of the case, to be presented to the team:

A gravida 5 para 4, 35-year-old came to the hospital in the early hours of the morning. She attended 3 ANC visits during the pregnancy, and everything was normal except for mild anaemia. On examination, she was found to be in labour and was admitted into the labour room. Her vital signs and laboratory tests were collected and registered: blood pressure was 110/70, Hb 9 gm/dl, temperature 37.0 C. Her pains intensified after one hour and she delivered a live baby at 9:00am, weighing 2200 grams. She was transferred to the ward and was planned to be discharged after two hours. However, the patient informed the midwife in the ward that she was feeling drowsy. When she examined the patient, the midwife found that her BP was 90/60 and she was bleeding profusely on the bed. A new IV line was inserted, and infusion of 1000 ml of normal saline solution was started. The midwife re-examined her and found that her uterus was soft and added 20 IU of oxytocin. The bleeding, however, did not stop. She was transferred to the labour room for proper examination. On examination, there was no cervical tears that can be seen. She was returned to the ward and placed on constant monitoring of her vital signs. The doctor was called, and he ordered that two pints of blood be transfused immediately; however, there was no blood available. She went into hypovolemic shock and died three hours later.

Scenario 2: Uterine Rupture

Summary of the case, to be presented to the team:

A 39-year old female gravida 8 para 7 presented with severe labour pains at the main hospital after a referral from a local health centre. She had attended two antenatal care visits. She reported no previous medical or surgical history. Her blood pressure and HB were normal. After more than 20 hours, she developed severe abdominal pain and vaginal bleeding. The midwife at the health centre decided to refer her to the hospital when the labour did not progress. The relatives rented a pickup truck to transport her since the health facility ambulance had no fuel. At the hospital, she was found to have a pulse rate of 110 per minute, respiratory rate 50 per minute and BP 90/50mmHg. No temperature was recorded. She appeared clinically dehydrated, with concentrated urine. On examination, foetal heart sounds were not heard and there was generalized abdominal tenderness. The woman was given IV antibiotics, 2 litres of IV normal saline. An ultrasound scan showed a foetus in the abdominal cavity and significant free fluid in the peritoneum. The senior doctor was called but did not arrive. A decision was made for exploratory laparotomy by a junior doctor. A posterior uterine rupture in a transverse direction was found, with blood-stained fluids visible on the intra-abdominal organs. A non-viable male foetus weighing 2900 grams was delivered through the abdomen and a sub-total hysterectomy was performed. The abdomen was washed-out and closed. The woman's condition deteriorated, and she died after 2 hours.

Scenario 3: PE/E

Summary of the case, to be presented to the team:

Primigravida, 38 years old, with a history of gestational hypertension admitted at 6 pm with severe headache. She had attended 3 ANC visits at the health facility and her pregnancy was progressing normally. On admission her blood pressure was 180/110, lower limb oedema, uterine fundus height of 30 cm, closed cervix, no uterine contractions, and positive foetal heart sounds were heard. Following assessment, the woman was transferred immediately to the delivery room where she had her first eclamptic fit. The nurses waited for the obstetrician before initiating the loading dose of magnesium sulphate. Once the obstetrician arrived (one hour after the eclamptic fit began), management started. A urinary catheter and intravenous line were placed, loading dose of magnesium sulphate and antihypertensive treatment was then started in the delivery room. The woman was transferred to intensive care unit. Laboratory investigations were requested (WBC, electrolytes, glucose, urea and creatinine) and this was recorded in the patient record, but no results could be found. An ultrasound was requested to assess gestational age and foetal viability. The US revealed a live foetus of 36 weeks and the decision to perform a caesarean section was taken. A caesarean section was performed at 8:00 pm. The obstetrician extracted a live infant weighing 2300g (Apgar 6), who was transferred to the paediatric ward. During the post-operative period, vital signs were hardly monitored at all (BP taken three hours after surgery). The woman went into coma in intensive care unit and died 16 hours after admission.

Scenario 4: Anesthesia

Summary of the case, to be presented to the team:

A 29-year-old gravida 3 para 2 woman with a medical history of asthma presented to the labour room at the health facility in labour and was admitted. She previously had two antenatal care visits at the same facility. On examination, her BP was 120/80 mm Hg, pulse rate 80 beats per minute and the foetal heart sound was 120 per minute. Her Hb and urine exams were normal. On vaginal examinations, the cervix was open 4 cm, the membranes were intact, and no discharge of fluids seen. She was admitted into the labour room and the progress of labour monitored by using a partograph. Four hours later, the membranes broke, which was meconium stained and the foetal heart sound was 90 beats per minute, the cervix was 8 cm dilated but the head was still high. A decision was made to perform an emergency caesarean section due to foetal distress. The woman was taken to the theatre and operated under general anaesthesia, after a first attempt at spinal anaesthesia failed. Anaesthesia was administered by an anaesthetic assistant with limited experience. A live baby weighing 2800 grams was delivered. When the operation was done, the woman did not wake up and experienced respiratory distress. Her vital signs dropped: she had blood pressure at 90/50 mmHg and was unable to breathe on her own. She was assisted with bag and mask ventilation and was put on IV fluids and taken to the ICU, where she died after a few hours.

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Day 3 Handouts

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MPDSR Capacity Building Workshop Evaluation Form

Instructions: Please rate the MPDSR workshop using the following scale:

1-Agree 2-No Opinion 3-Disagree

Course Component	Course rating
The workshop objectives were clearly presented	1-----2-----3
The training was presented in a helpful sequence	1-----2-----3
The workshop was well-balanced between presentations and practice exercises	1-----2-----3
The length and timing of sessions was appropriate for the workshop	1-----2-----3
The workshop enhanced my understanding of the goals of MDSR	1-----2-----3
The workshop enhanced my understanding of the Six-Step Mortality Audit Cycle	1-----2-----3
I feel confident about my skills in identifying maternal deaths	1-----2-----3
The workshop improved my ability to differentiate between direct and indirect obstetric deaths	1-----2-----3
The workshop improved my ability to complete maternal death review forms accurately	1-----2-----3
The workshop improved my ability to prepare a case summary	1-----2-----3
After the workshop, I feel confident assigning the cause of maternal death using the ICD-MM	1-----2-----3
The workshop enhanced my understanding of creating/strengthening an MDSR/MPDSR team	1-----2-----3
I feel confident about my ability to develop MDSR/MPDSR action plans	1-----2-----3
I feel confident about my ability develop a process for tracking an MDSR action plan	1-----2-----3
After the workshop, I am comfortable identifying trends and commonalities within a collection of maternal death data	1-----2-----3

Please provide any additional feedback on the structure and content of the workshop.