Quality Improvement Secretariat

Health Economics Unit
Ministry of Health & Family Welfare
www.qis.gov.bd

MPDSR district performance review template

MPDSR implementation (Notification and review)				
Sl.	Indicators	Y	N	Remarks
1	Number of projected maternal death in current year in the district / upazila			
2	Reported community maternal death notification in 2019 [till date]			
3	Percentage of captured maternal death against the projected maternal death in the year			
4	Number of maternal death in the facility in 2019 [till date]			
5	Number of projected neonatal death in current year in the district / upazila			
6	Reported community neonatal death notification in 2019 [till date]			
7	Percentage of captured neonatal death against the projected maternal death in the year			
8	Number of neonatal death in the facility in 2019 [till date]			
9	Reported community stillbirth notification in 2019 [till date]			
10	Number of stillbirth in the facility in 2019 [till date]			
11	Number of community verbal autopsy conducted for maternal death in 2019 [mention in % against the reported maternal death]			
12	Major causes of maternal deaths were identified in 2019 till date [in %]			
13	Number of community verbal autopsy conducted for neonatal death in 2019 [mention in % against the reported neonatal death]			
14	Major causes of neonatal deaths were identified in 2019 till date [in %]			
15	Number of community social autopsy conducted for maternal death in 2019 [mention in % against the reported maternal death]			
16	Number of community social autopsy conducted for neonatal death in 2019 [mention in % against the			

	reported neonatal death]			
MPDSR Review and Response				
17	MPDSR subcommittee is functional			
18	MPDSR focal person is assigned and working			
19	Date of the last meeting of MPDSR subcommittee			
20	% of reported community death (maternal / neonatal) validated by district/ MPDSR focal person / committee			
21	If under reported death, they justify [key reasons], what initiatives taken to improve the reporting			
22	Any remedial action taken based number of maternal / neonatal deaths by the district in last month			Based on death mapping
23	% of community verbal autopsy (maternal / neonatal) validated / monitored by district/ MPDSR focal person / committee			
24	If not all verbal autopsy were conducted, they justify [key reasons], what initiatives taken to improve the verbal autopsy conduction. Any gap in verbal autopsy data?			
	Any remedial action taken based on verbal autopsy findings by the district in last month			By analyzing verbal autopsy form
25	% of social autopsy (maternal / neonatal) validated / monitored by district/ MPDSR focal person / committee			
26	If not all social autopsy were conducted, they justify [key reasons], what initiatives taken to improve the social autopsy conduction. Any gaps found in social autopsy conduction			
	Any remedial action taken based on social autopsy findings by the district in last month			Discuss on social autopsy findings from HI/FPI/AHI
27	Any effects of social autopsy recorded in 2019 [follow up monitoring / observation]			
28	% of facility death review (maternal / neonatal) validated / monitored by district/ MPDSR focal person / committee			
29	If not all facility death review were conducted, they justify [key reasons], what initiatives taken to improve the facility death review. Any gaps found in facility death review conduction			
30	Any remedial action taken based on facility death review findings by the district in last month			Analysis of facility death review forms to improve the

				facility
Administrative / Documentation				
31	Performance of focal person a) Arranging meetings b) Coordination c) Facilitating capacity development d) Document review and reporting e) Providing feedback f) Major findings of data validation			
32	Narrate in brief on what type of support is being provided by the DP/responsible person/consultant as a part of technical support (Mention areas)			
33	All Community Death notification form are kept in the CC and UHC			
34	All verbal autopsy form are kept with statistician			
35	All social autopsy report are kept with statistician			
36	All facility death notification and review form are kept with statistician / nurse in charge / MPDSR subcommittee			
Logistical Issues				
37	Community death notification slip are available			
38	Facility death notification slip are available			
39	Community verbal autopsy are available			Maternal/ neonatal
40	Facility death review form are available			Maternal/ neonatal
41	MPDSR guideline are available			For the managers
42	MPDSR pocket book is available to all health workers			Who are implementing
43	All health care providers received training on MPDSR			By tier / responsibility