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சுகாதார அமைச்சு
Ministry of Health

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திகதி 27/08/ 2024.
Date)

All heads of institutions
(National Hospitals, Teaching Hospitals, District General Hospitals and Base Hospitals)

Establishment and Functioning of Maternal and Perinatal Death Surveillance and Response (MPDSR) committees at institutional Level

In view of further reduction of Maternal Mortality in Sri Lanka, Ministry of Health has introduced several new strategies to the existing MPDSR system. In keeping with the MPDSR methodology introduced by the WHO, as a further improvement to the current system, Ministry of Health is introducing the establishment of MPDSR committees at institutional and regional level. Thus, you are kindly requested to establish a MPDSR committee at the respective institution adhering to the guidelines stated below. The terms of references for the establishment and functioning of the MPDSR committee are attached for your reference.

Dr. ASELA GUNAWARDENA
Director General of Health Services
Ministry of Health
"Suwasiripaya"
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

Dr Asela Gunewardana
Director General of Health Services

Cc: DDG PHS II
DDG MS 1
PDHS...
RDHS...
SLCOG
SLCP.

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10. 385, வணக்கத்துக்குரிய பத்தேகம விமலவங்ச தேரோ மாவத்தை, கொழும்பு 10.
385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.

Terms of Reference (ToR) for MPDSR Committee at hospital level

The committees should be established in all hospitals at the level of Base Hospital and above with specialized services for maternity care.

Composition of the committee

Core members
Hospital Director
Senior Obstetrician
Pediatrician
Neonatologist
Anesthetist
Consultant Forensic Pathologist
Special Grade nursing officer
Public Health Medical officer
Medical officer Planning
Medical officer Quality Management unit
MOMCH

Non-Core members
Medical team providing care to the diseased
Field team attending to the care of the diseased

- The committee should be appointed for a fixed period of two years and in the event of a member being transferred out of the institution a new member should be appointed immediately to continue the smooth functioning of the committee
- The head of the institution is responsible and accountable to ensure establishment and implementation of the Maternal and Perinatal Death Review System in the hospital. He / she is responsible for successful implementation of the MPDSR system by ensuring that qualitative, in-depth reviews of the causes and circumstances surrounding maternal and perinatal deaths occur in the hospital, training of relevant staff and for raising awareness among all staff members. The Head of the institution should chair the meeting, in his/her absence, could assign a relevant officer to chair the meeting. The Medical officer Public Health (MOPH) (if available) should be appointed as the Secretary and should assist the Head of the Institution to convene the meeting. In the absence of a MOPH, a suitable officer should be appointed to the position. A rapporteur and presenters should be appointed and minutes of the meeting should be developed after every meeting.
- The committee should maintain strict confidentiality when conducting reviews and a confidentially agreement should be signed before every meeting

Responsibilities of MPDSR Committee at Hospital level

- This committee should be responsible to correctly identify all maternal and perinatal deaths, notify the deaths, plan and conduct the institutional maternal death review meetings (IMDR) and perinatal death review meetings for the deaths occurring at the institution.
- Data collection and preparation of the case summaries should be done prior to the meeting.
- The committee should meet on a fixed date every month or two months even if there no deaths at the institution

- The committee should also be responsible to initiate the implementation of recommendations of the previous reviews and also to follow up the process of implementation and update the status.
- A program of implementation along with the minutes should be sent to the central level and a nil report should be submitted in the event of no deaths for the particular month.
- The report should be made available to the meeting participants and the members before the next meeting
- The committee should be appointed for a fixed period of two years and in the event of a member being transferred out of the institution a new member should be appointed immediately to continue the smooth functioning of the committee
- The chair person should be the Head of the Institution. The secretary, rapporteur and presenters should be appointed and minute of the meeting should be developed after every meeting.
- The analysis of deaths should focus on identifying the cause of death, factors contributing to the death any preventable causes.
- The three-delay model should be considered when the contributory factors for deaths are analyzed.

385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.