Welcome

Welcome to the second edition of the Action Network Newsletter for professionals, policy-makers, academics and advocates committed to making every maternal death count.

In our first edition, we had said there was a huge potential to improve survival and quality of care from the learning that maternal death reviews can offer. The missing ingredient has been the response and action step, and a large focus of the recent activities in this area, including that of our Action Network, has been on **how to translate the learning from death reviews into meaningful improvements in quality**.

In this newsletter we bring to you updates from the workshops, technical guidelines, and some recent publications and news.

We hear from Dr Ravichandran Jeganathan, National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia, who shares the inspirational story of Malaysia's efforts to make every death count through maternal death surveillance and response and his lessons from this experience.

In his words:

> "The Malaysian journey has been far from being a bed of roses. We have stumbled, fallen, halted and even rejected along the way. But have picked up the pieces, dusted off the dirt and have moved forward. Success, as you can see, has followed."

Take heart!

NEWSLETTER

THE ACTION NETWORK

TO MAKE EVERY MATERNAL DEATH COUNT

October 2013

Connect | Discuss

WHO workshop in London

The WHO hosted an MDSR workshop that took place from 9 - 11 September in London, which was very well received. It brought together 30 participants from across 23 countries and engaged them in interesting dialogues around new as well as understood aspects about keeping track of maternal deaths, reviewing them and responding to the situations appropriately.

Health professionals, representatives from the Ministries of Health from various countries, and representatives from international organisations were given an update on MDSR implementation, accompanied by clarifications and discussions about MDSR. Several participants shared their own experiences and expertise, as well as the challenges faced in implementing MDSR in their specific contexts. With the wealth of experience that was already in the room, discussions were very participant-led with a significant amount of peer-exchange and learning taking place. **We will share with you the rich learning and case studies from this workshop,** beginning with the case of Malaysia.

One of the central aims of this workshop was to catalyse the development of a global network of experts who can support the WHO and partners in responding to requests for technical assistance for country implementation. By the end of the workshop, it became eminently clear that a step towards this had been taken. Participants established more direct connections amidst themselves and also joined the Action Network. The role of the Action Network and its ambitions were presented to the participants for feedback, and we at the Action Network secretariat will be working on supporting and sharing the encouraging ideas that emerged.

Where is MDR in MDSR? "Everywhere"

The WHO workshop in London included several presentations that touched upon defining and understanding MDSR and the components that it contains within it, and many others presented their own country level experiences of how they have accounted for and reviewed maternal deaths. The discussions were rich. Whilst most of us understood the definition of MDSR, the question that was asked was "**how was it different from MDRs?**

Isabella Danel's presentation defined MDSR as

> "a form of **continuous surveillance** linking the health information system and quality improvement processes from local to national levels. It includes the routine identification, notification, quantification, and determination of causes and avoidability of **all maternal deaths**, as well as the use of this information to **respond** with actions that will prevent future deaths."

MDSR is therefore simply the overarching system that brings together several components in a coherent way so that they all function in tandem and support the '**response**'.

MDSR as a process would, therefore, include identifying deaths to all women of reproductive age, and then ascertain whether it is a maternal death or not. All deaths would be notified and reviewed using an appropriate form of maternal death review, e.g. a facility-based review or a community review with verbal autopsy, to identify medical cause(s) of death and other contributing factors including quality of care.

The response component for each maternal death would then recommend and implement actions to prevent similar future deaths. The aggregated information on the deaths would help with further recommendations. Sharing these findings and related recommendations would happen at the facility as well as the district levels and above. Annual assessments of whether recommendations have been implemented and a monitoring and evaluation of the MDSR system itself would help providing information which would feedback into the system.

Inspire

Case study | Malaysia

Dr. Ravichandran Jeganathan, who is the National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia, shared experiences from Malaysia at the recent WHO London workshop. He identified some of the specific actions and responses that were introduced as a result of the Malaysia Confidential Enquiry System (the most developed form of MDSR) contributing to improvements in quality of care. The case study evoked much interest from the participants.

Malaysia's Experience with Maternal Deaths

By Dr Ravichandran Jeganathan

Malaysia, currently a "middle income" nation striving to become a "high income" nation by the year 2020, is a place where 28 million people from multiple religions, cultures, languages and ethnicities reside. Despite competing demands of this diverse and aspiring population, Malaysia is well known as the country which has made significant strides in maternal health.

Confidential Enquiry into Maternal Deaths (CEMD) was known to be implemented only in the UK and Australia/NZ when Malaysia embarked on it in 1991. Over these last two decades, the maternal mortality ratio has declined from 44 to 27 per 100,000 live births in 2011. Malaysia's MDG target, however, is 11.

Over these last 22 years Malaysia has released five reports based on CEMD and the sixth one is in progress. The reports have been followed by various training manuals, case illustrations, guidelines and consensus statements. Policy changes at the national level, improved facility-based services, as well as enhanced home-based and primary maternal care were a result of these efforts. For example, pharmacological agents e.g. prostaglandin F2a, Novo 7, Tractocile, Duratocin and others, were introduced into managing postpartum haemorrhage, as a result of the CEMD findings. Certain drugs (e.g. Dexamethsone, MgSO4) were downgraded to allow the midwives to initiate therapy in case of preterm labour and severe preeclampsia/eclampsia from the moment of contact with the patients. Similarly, patient referral and feedback mechanism were improved, and maternal and foetal surveillance equipment was updated when it was found that targeted CTG as well as Doppler Ultrasound could allow us to better manage and optimise outcomes in high-risk pregnancies.

In order to ensure that some of these changes would be sustainable and the skills were passed on, Malaysia also introduced the Advance Diploma in Midwifery. This was in response to the findings of the CEMD and MDSR that the then midwifery training was lacking. With the new curriculum in place, there is an increased interaction between the midwifery students and clinicians. Maternal Foetal Medicine as a sub -specialty was also advanced to optimise the care of the mother and foetus at risk.

Malaysia's success in reducing maternal deaths stems from a range of issues; many of which may not necessarily be unique to the country, but rather generic enough for other countries to draw from. We learnt that:

- It was important to start with achievable targets, maybe at a facility level and thereafter moving forward, rather than aiming for the entire nation to come on board at the very outset.
- The processes had to be non-punitive with no naming, blaming or shaming.
- Engaging all the major stakeholders in the system, including from the public and private health services, academics, NGOs and the politicians, was crucial to make it work.
- A "top down" approach with a strong political will to see the change happen was necessary to push things through.
- Monitoring maternal deaths should receive priority from all quarters. For instance, maternal mortality ratios in Malaysia became a key performance indicator for the Minister of Health and the Director General of Health.

Whilst scarce "resources" is a reality for everyone, being discouraged by it did not help. Having a dedicated team of people with the passion to see our mothers live longer and willing to persevere for it was enough to start establishing the MDSR/CEMD. Mapping another country's success onto our own would not be the best way. Rather, tailoring the learning from other successes to suit our own needs is certainly

recommended. Setbacks, brickbats and disappointments are all important ingredients towards achieving success in MDSR/CEMD.

The Malaysian journey has been far from being a bed of roses. We have stumbled, fallen, halted and even rejected along the way. But have picked up the pieces, dusted off the dirt and have moved forward. Success, as you can see, has followed.

Learn

Resources | New guidance

WHO and CDC. 2013. Maternal Death Surveillance and Response – technical guidance: Information for action to prevent maternal death

New technical guidance on Maternal Death Surveillance and Response is now available and we are delighted to be able to share them with you. They are also available for download here. This key document introduces the critical concepts of MDSR, including goals, objectives, and specific instructions for implementing each surveillance component, as well as outlining how districts can set up MDSR processes to strengthen surveillance and response. It provides up-to-date guidance to health care professionals, health care planners and managers, and policy makers working in maternal health, and those who measure maternal mortality. It seeks to accompany them in setting up, implementing and strengthening MDSR systems to ensure that no woman dies of preventable causes while giving birth.

FIGO LOGIC. 2013. Maternal Death Review Guidelines & Maternal Death Review Training Curriculum

Early September, FIGO LOGIC published its Maternal Death Review Guidelines as well as a Maternal Death Review Training Curriculum. The practical MDR guidelines aim at supporting clinicians, health systems and facility administrators, MNCH programme managers, NGOs and policy makers in assessing quality of care in their own settings, and build their capacity to conduct maternal death reviews at facility-level. The training curriculum is designed to accompany these guidelines and support their implementation in practice. Together, they are key tools to support local stakeholders to move forward with MDSR implementation in their own contexts. The tools were field tested in Cameroon with the support of the Society of Obstetricians and Gynaecologists of Cameroon.

Resources | Journal articles

A recently published article (Soumik Banerjee, Priya John, Sanjeev Singh (2013), "Stairway to Death: Maternal Mortality beyond Numbers", *Economic and Political Weekly*, Vol 48:31.) presents key findings from the analysis of 23 maternal deaths which occurred between April 2011 and March 2012 in two blocks of the Godda district of Jharkhand (India). This qualitative study aimed at recording maternal deaths at the local level as well as identifying the non-medical factors that contributed to these deaths. Improper and multiple referrals, absence of easily accessible and quality emergency obstetric care, lack of transport facilities and high out-of-pocket expenditure were key factors contributing to delays at multiple levels – delays in seeking care, reaching the health facility and receiving adequate care. This study thus shows how reviewing maternal deaths can highlight a range of non-medical factors which all contribute towards preventable maternal mortality, and need to be addressed in policy and practice.

More can be read about maternal death reviews in Jharkhand (India) in Nizammudin Khan, Manas Ranjan Pradhan (2013), "Identifying factors associated with maternal deaths in Jharkhand, India: A verbal autopsy study", *Journal of Health, Population and Nutrition*, Vol 31:2. This paper reports on the findings from the reviews conducted on a total of 470 maternal deaths which occurred in 2006-2007. These were verbal autopsies which collected data at the household level and found that these deaths were related to a range of inter-related medical and non-medical (socio-demographic, economic and cultural) factors. In addition, this study confirmed that maternal mortality disproportionately affects poor, less educated women, showing existing disparities. Three packages of recommendations stem from these findings: strengthening the quality of antenatal, emergency obstetric and post-abortion care; strengthening the broader health system as well as building the capacity of the health workforce; implementing behaviour change interventions and mobilising the community to increase maternal and obstetric care usage.

"Ending preventable maternal deaths: the time is now" – a comment published in *Lancet Global Health*, Volume 1, Issue 4, 2013, by Flavia Bustreo, Lale Say, Marge Koblinsky, Thomas W. Pullum, Marleen Temmerman and Ariel Pablos Méndez – reaffirms the need to accelerate progress towards the elimination of all preventable maternal mortality, and highlights recent targets and tools designed in this respect. Between 1990 and 2015, maternal mortality underwent a decline of nearly 50% globally, from 543 000 maternal deaths per year to 287 000. But efforts need to be sustained and strengthened, and current discussions on the post-2015 agenda offer a great opportunity for a global push to end all preventable maternal deaths. This comment also describes new targets on maternal health set up by WHO, the US government and other stakeholders, as well as the tools they designed to track progress against these targets. Lastly, this paper argues that new strategies are needed to catalyse this progress, should address the multiple causes of death beyond their clinical causes, and should take into account context-specific challenges. MDSR systems are highlighted as a necessary and key first step in this respect, with improved information allowing for the development of strategies addressing the multiple, context-specific causes of maternal mortality.

Resources | Useful websites

"Why did Mrs. X die? Retold"

This is a short yet powerful film about a woman's journey through pregnancy and childbirth, and presents the dangers women are facing across the world and the importance of helping them.

This is a remake of the World Health Organization 1980's film "Why Did Mrs Die?", which was based on a lecture by the founder of the Safe Motherhood Movement, Professor Mahmoud Fathalla. The new version has been produced by Hands On for Mothers and Babies, an organisation making educational tools for women in poor areas of the world.

UNFPA website: www.safebirthevenhere.org

And while we stay alert about the dangers and prepare ourselves to respond to any that might arise, we also wanted to highlight the positive news about lives being saved. The risk of maternal deaths in crises zones is very high and efforts need to be strengthened in such areas to save lives. Please do support UNFPA's work presented on the website by sharing this widely.

Act

Updates from around the world

FIGO first African Congress and MDSR Workshop

October 2013 saw the first FIGO African Congress which included a number of presentations from delegates on MDSR. The event was preceded by another WHO training workshop with 30 delegates from around the world. This was an opportunity for participants to familiarise themselves with the new MDSR Technical Guidance and to share progress and challenges in establishing MDSR systems in their settings. Evidence 4 Action (E4A) is working to support efforts to strengthen MDSR in six countries across Africa and hosted an afternoon session dedicated to the 'response' part of the MDSR cycle. Country Directors for E4A from Ethiopia, Malawi, Tanzania, Nigeria, Ghana and Sierra Leone shared examples of efforts to establish mechanisms to ensure the review of maternal deaths result in appropriate actions at all levels. These included the production of findings from annual reports from MDSR Committees in clear, easily accessible formats for a wider range of audience to support advocacy; the establishment of a national level network with broad stakeholder representation able to monitor and track progress against actions, and advocate and mobilise as appropriate; and the creation of a multidisciplinary working group bringing together representatives from a range of professional associations to ensure active engagement from e.g. Midwife Associations, Anaesthetists as well as Obstetricians and Gynaecologists in contemplating learning from the review of deaths which may have implications for their professional practice.

Maternal death review programme launched in India

India recently launched a new government programme to track pregnant women and any complications they experience, which would help medical professionals and researchers to understand the circumstances that lead to maternal deaths. Findings from the reports will be shared with district and state level officials for their action. A software programme to support this, which has been developed by the Federation of Obstetric and Gynaecological Societies of India (FOGSI), is being rolled out across hospitals and primary health centres. To read more about this programme, click here: www.figo.org/news/fogsi-and-indian-government-launch-maternal-death-review-0011554.

And finally...

We have received several responses to the questionnaire that we recently sent out to all of you. Thank you very much for letting us know your views! **We would love to hear from those of you who are yet to send in your responses** – they are very valuable to us.

Remember to share this newsletter with your colleagues and others who may wish to join this Network. Also do send in your news and views – we are delighted to feature interesting news from all over the world.

Very best
Louise
l.hulton@evidence4action.net

Evidence for Action hosts the Maternal Death Review Action Network on behalf of the World Health Organization's Maternal Death Surveillance and Response Working Group.

www.evidence4action.net
www.mamaye.org/action-network