Welcome

Dear Action Network members,

Welcome to the March 2014 edition of the MDSR Action Network newsletter!

Time has flown really quickly – it is has been nearly a year since we launched this network and newsletter. We are really delighted to hear from several of you who have written to us sharing stories and experiences. Please keep them coming! This is what we are here for – to hear your stories and share them with other members of the network. We will be delighted to feature them in future newsletters for a start, and will soon be able to feature them on our upcoming website too.

Yes—we are working very hard to set-up a website to bring together resources and link-up people so that information and knowledge from various parts of the globe on maternal death surveillance and response (MDSR) are available and easily accessible. We will soon announce the website launch, so keep your eyes open for updates.

Over the past few months, MDSR have been gaining traction with local, national and international actors. At the FIGO conference last October, Maurice Bucagu from the World Health Organization reported that 33 African countries were newly adopting MDSRs or adapting existing systems to make them more response orientated. A vast majority of these countries already had some sort of maternal death notification mechanism in place and many also had functional maternal death reviews committees. The exciting news is that real progress is being made in various ways. In our last newsletter we mentioned how Nigeria had introduced national MDR guidelines that are being adopted by various states.

In this newsletter we bring you updates from the field reporting on the progress underway in Cameroon and H4+ supported African countries. Our highlight is the case study by Zenaida Dy-Recidoro (Philippines), writing about how her country which has recently strengthened its MDR system.

We hope you find all this engaging and useful for your own work!

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NEWSLETTER

MDSR ACTION

NETWORK

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Inspire | Case study | Philippines

Zenaida Dy-Recidoro, the Chief Health Programme Officer at the Family Health Office at the Department of Health in Philippines, presented at the WHO MDSR workshop in London about the country's MDR system.

Following the workshop, Philippines moved from a Maternal Death Review and Reporting system to Maternal Death Surveillance and Response system, and she presents here some of the steps taken to emphasise response:

From Maternal Death Reporting and Review (MDRR) to Maternal Death Surveillance and Response: The Philippines Experience By Zenaida Dy-Recidoro (RN, MPH)

Maternal Death Reporting and Review System in the Philippines had been established in 2007 to generate, analyse and respond to maternal mortality data from the Local Government Units (LGUs). MDRR had harnessed the public health system in the collection and quality assurance of maternal death reporting and the identification of systemic gaps that contributed to maternal mortality. This included reports on facility-based maternal deaths as well as those happening in the communities. The Local Government Unit was key to the system as the local health providers were the main actors in the reporting and review process.

The Philippines is composed of three islands, divided into 17 regions and further subdivided into 80 provinces and 40 chartered cities. LGUs in the Philippines are constituted of provinces which include chartered cities and municipalities. With one provincial health officer for each of the 80 provinces, and nearly 1500 municipal and city health officers, the LGUs are autonomous units that manage their own health systems and may have their own health policies, nevertheless guided by the national level Department of Health's policy directives. Multiple stakeholders within and across LGUs has called for regular orientation and co-ordination to ensure 'buy-in' and support to the National Safe Motherhood Programme including the MDRR implementation.

In this decentralised health system, Provincial Review Teams (PRT) and City Review Teams (CRT) have had critical inputs into the MDRRs. Municipal and city health officers and hospital chiefs have generated basic data on maternal deaths and the PRTs and CRTs have ensured that health system's related cause of death was identified and system's response to the identified gap(s) were planned and implemented over time.

Each PRT is headed by the Provincial Health Officer (PHO) - a medical doctor, and includes doctors from primary and tertiary facilities, representatives from each inter-local health zone (another level of the LGU similar to a District Health System), and the Center for Health Development (the regional office) and a private medical doctor. Whilst the reporting of maternal death is a continuing activity at community and facility levels; the policy for the review requires PRTs and CRTs to conduct a review at least once a year and present the result to relevant stakeholders.

Reviews focus on improving the system: health regulation, referral, financing, service delivery, and so on. This could include identifying larger policy gaps as well as simple gaps in the system such as stock-outs of life saving drugs at pharmacies, ill-equipped laboratories, delayed procurement of essential drugs and supplies, lack of or no emergency transport, incomplete recording of vital information, treatment or procedures in patients' charts, absence of health staff, etc.

Review results are reported back to stakeholders who need to act on the gap. For instance, if it involves community action such as support during referrals, then results are presented to community members, or if they are relevant for a particular group such as midwives, a forum with them is organised. Support is sought from the Local Chief Executives and the Department of Health as necessary in the implementation of recommendations to address the gap(s).

The shift to MDSR in 2013 was not difficult as it capitalised on the MDRR, and placed a greater emphasis on **'Response'**. The PRTs are now required to submit a report to the National Safe Motherhood Program of the Department of Health, on the details of the case reviewed and to include status of the '**Response'** implementation.

The introduction of MDRR (now MDSR) has **brought some immediate policy changes** both at the local and national levels with an aim to improve quality of maternal and newborn health services even in challenging settings. Among the changes introduced are:

- Adoption of a national policy on implementing health reforms to rapidly reduce maternal and newborn mortality
- Local ordinances discouraging home births assisted by TBAs and providing for the conduct of maternal death reviews
- A policy that requires licenses from the national level (i.e. the Department of Health) to operate birthing homes that are managed by private midwives (prior to the introduction of MDSR, midwives clinics operated on the basis of a business permit issued by the LGUs)
- The Philippine Health Insurance Corporation made it mandatory for midwives clinics to present a

memorandum of agreement with an obstetrician and paediatrician when they apply for maternity care package accreditation; this would ensure that a specialist is available on call in case complications occur

- At the local level, Provincial and Municipal Health Offices entered into partnerships with private hospitals and private transport groups to make referrals more efficient. These partnerships also need to be covered by a memorandum of agreement between them

While the similarity of MDRR to MDSR is apparent in the Philippines context, the shift to **MDSR is viewed as advantageous as it stresses the need to respond to each maternal death with relevant actions to prevent similar deaths in the future.**

Learn

Resources|Journal articles

We bring to you three papers which highlight the importance of reliable data reporting systems which are crucial for efficient allocation of resources.

These papers present some common challenges around the process of implementation and the quality of data, providing useful learning to countries aiming to strengthen their own maternal death reporting systems. Whilst the papers present fascinating findings about the information the system has and has not been able to generate, it would interesting to see more about implications and evidence of the response that it has encouraged. We hope to see more such studies in the future as the aspect of response linked to the evidence assumes a greater focus across the globe.

The 2013 paper Implementing a maternal mortality surveillance system in Morocco – challenges and opportunities, by S. Abouchadi, A. Belghiti Alaoui, F.Z. Meski, and V. De Brouwere in *Tropical Medicine and International Health, Vol 18* (3), describes the development of the maternal death surveillance system (MDSS) in Morocco and discusses initial results.

When DHS surveys highlighted a high MMR in Morocco in 1997 and 2003 [227 and 228 per 100 000 respectively], the Ministry of Health established the National Commission on Maternal and Neonatal Mortality Reduction, in 2007 to strategise how the high levels of mortality can be reduced. One key aspect of the strategy was the systematic reporting and analysis of maternal deaths, by documenting the location, the cause and circumstances of each maternal death. Although a routine reporting system for maternal deaths covering all public health facilities already existed it did not cover private facilities or all home deaths. The MDSS was designed to bridge this gap and the data collection includes:

- mandatory reporting by local authorities (rural *moqadems* and the urban Municipal Hygiene Bureaus) of all home deaths of women aged 15 – 49 to local health services
- reviews of discharge registers at all hospitals to record all hospital deaths of women of reproductive age in a special register

Maternal deaths are then identified and reviewed through confidential audit and verbal autopsy. Quarterly reports are submitted to the MDSS central team. After the first year of implementing the MDSS which relies on a Reproductive Age Mortality Study (RAMOS) approach covering the whole country, one of the weaknesses appeared to be the incompleteness of data. This helped to consider the shortcomings in the processes of reporting, particularly in the rural areas. However, over all, the system allowed for the identification of 12.3% more pregnancy-related deaths in health facilities than the routine information system. It enabled a better understanding of the causes and circumstances of maternal deaths, it also provided a basis for action. To read this paper, click here. Subscription of payment required for full article.

Studies using maternal death audit methodologies are widely available, but few discuss the challenges in their implementation. The 2014 paper Easier said than done: methodological challenges with conducting maternal death review research in Malawi, by Thorsen V.C., Sundby J., Meguid T. and Malata A., in *BMC Medical Research Methodology, Vol14*, critically reflects on a facility-based maternal death review study in Lilongwe, Malawi, using the five step mortality surveillance cycle framework that was used for the study, and highlights the methodological challenges faced while doing such reviews.

The study was conducted at comprehensive emergency obstetric care units of a secondary hospital and a tertiary hospital. The study found that there were gaps in identifying and reporting on maternal deaths that may have happened in units/wards other than the maternity unit, which may have led to under-reporting.

Data was also found to be as being poorly maintained, missing or incomplete in many cases, as there was no system in place for health information collection and storage in cases of maternal mortality. Whilst language barriers and cultural norms were thought to have potentially influenced data from the communities, busy schedules and fear of blame were some of the issues faced at the facility level.

Decisions around assigning cause of death and classifying deaths according to the International Classification of Diseases – 10, in the absence of reliable clinical or laboratory data to supplement diagnostic procedures led to differences in judgement between reviewers and clinicians. This paper while highlight the potential methodological challenges also provides some recommendations to help resolve them. To explore the findings of this study, click here. No subscription required.

An issue paper published in 2013 by the United Nations in Zimbabwe (Maternal Mortality in Zimbabwe: Evidence, Costs and Implications United Nations in Zimbabwe) highlights the unacceptably high maternal mortality ratio which has worsened by 28% from 1990 to 2010,. Recent data shows that the MMR now stands at 960 deaths per 100,000 live births according to the Demographic Health Survey 2010-11.

According to WHO 2004 estimates, about 2,593 DALYs per 100 000 females are lost per year in Zimbabwe due to maternal causes. The Ministry of Health and Child Welfare (MoHCW), implemented a national Maternal Death Notification System (complementing the national Health Management Information System) aimed at strengthening tracking, monitoring and reporting of maternal mortality in the country, but the system is reported to be inadequate. The system reports deaths at facilities but not those in the community and not attended to by professional health care staff. Due to high level of home-births and poor post-natal care, many deaths go unreported.

Zimbabwe can improve maternal survival through investing in proven and effective maternal health services and strengthening health monitoring systems. Amongst other strategies for improvement, strengthening civil registration vital statistics system is recommended as a way to do improve reporting, and the paper also calls for designing and using innovative data collection and analysis methods that allow for the real-time monitoring of maternal deaths. To read this issue paper, click here.

Act | Updates from around the world

News from Cameroon

A MDSR system is currently being set-up in Cameroon, reports Dr Seidou Moluh who is one of the network members from this country. A workshop brought together 40 participants – obstetricians-gynaecologists, paediatricians, epidemiological surveillance actors, and government representatives – from all parts of Cameroon in Douala in November 2013. The workshop set the ground for building an effective MDSR system in the country and explored different methods for conducting maternal death reviews. It was decided that the pre-existing Integrated Disease Surveillance and Response will be adapted and used for the surveillance of maternal

deaths as well. We look forward to hearing more on how this progresses in Cameroon.

News from the UNFPA

MDSR is high on UNFPA's agenda and various initiatives are underway to support their initiation, implementation and scaling-up in priority countries. UNFPA is part of the H4+ partnership which includes UNAIDS, UNICEF, UN Women, WHO and the World Bank. With funding from the Canadian government, H4+ is currently supporting efforts to accelerate progress in maternal and newborn health in five countries (Burkina Faso, Democratic Republic of Congo, Sierra Leone, Zambia and Zimbabwe).

In November 2013, UNFPA and other H4+ agencies convened the third H4+ Inter-Country Annual Planning Meeting in Freetown, Sierra Leone. The meeting discussed progress made during 2013 in all five countries; identifying priorities and developing a workplan for 2014; enabling lesson-sharing and identifying country technical assistance and program support needs. A special session at this meeting also discussed progress of MDSR intervention in-country, positioned MDSR within the 2014 workplan as well as identified needs in terms of technical assistance for the scaling-up of MDSR. The importance of MDSRs for strengthening quality of care and ensuring accountability to reduce preventable maternal and newborn deaths was emphasised. The quality and outcome of MDSR, follow-up on review findings and recommendations, involvement of traditional leaders, professional health associations/councils and human resource capacity to provide reliable data were seen as some of the key issues which needed to be addressed everywhere. MDSR was included in the 2014 country-level plans. For example,

- Democratic Republic of Congo plans to start MDSR across its health system in 2014, looking towards Burkina Faso for learning and best practices.
- Zimbabwe plans to build on a global team to mobilise technical assistance around MDSR.
- Sierra Leone plans to reach 60% coverage of all maternal deaths in the country through MDRs. Continued analysis will be needed, especially on district and community levels.

In addition, a five-day annual planning meeting of high-burden countries supported through UNFPA's Maternal Health Thematic Fund (MHTF) took place in Dakar in January 2014. MDSR is one of the four priority areas for the MHTF, and as such the fund will be supporting efforts to implement MDSR in a range of countries.

And finally…

Over the past months and following the London WHO workshop last September, we have had conversations about creating a repository of tools and resources that can help with MDRs and MDSRs. We are currently trying to list and gather the various shareable tools and resources available. If you have shareable tools or practical resources (online or as soft copies), please do send them to us and we will be sure to add them to the repository. Aside from this, feel free to flag up or send us updates, publications, guidelines or research papers, which might be useful for other network members.

This is your Action Network! Please share your own work and feel free to write to us if you need any help locating a resource. And as ever… do share this newsletter with your colleagues and others who may wish to join this Network.

We look forward to more discussions and actions to save mothers' lives!

Louise

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