Connect | Inspire | Challenge | Learn | Act

Welcome

Dear Action Network members,

Welcome to the May 2014 edition of the MDSR Action Network's newsletter.

Emphasising action for maternal survival has never been more important! New estimates for maternal mortality were released by the UN agencies last week, which confirm that progress is possible. Leadership and partnership, evidence and innovation, short-term and long-term strategies and much more are the ingredients for progress and success.

We are very encouraged by this progress, but also realise that we need to be more ambitious and need to keep chipping away constantly. I'd like to call upon all of you to take the opportunity to build evidence as well as lead and catalyse action in your own contexts.

At our end, we have been taking small but sure steps… and are delighted to announce that the MDSR Action Network's very own website is now live! I'd like to extend a very personal welcome to this website through **this video**.

On here we currently host all the material we have so far shared with you through these newsletters, as well as have created spaces for you to interact with peers and colleagues. We hope the website grows to become a key source of all MDSR related information and support for you. Please bookmark the web-link: **http://mdsr-action.net**, explore the website and send us your feedback and suggestions. We also bring you our regular updates and links to publications.

Most developed nations continue to record fairly low maternal mortality ratios, but still strive further to make pregnancy and childbirth safer. Even when relatively strong health systems exist, maternal deaths can slip through the system unrecorded and unidentified, or could potentially increase due to epidemiological changes (such as complications related to obesity, diabetes, etc.). Robust systems which are responsive to these issues are therefore important as Edel Manning points out in the case study from Ireland, featured in this issue.

Do keep writing in – we value your inputs and contact!

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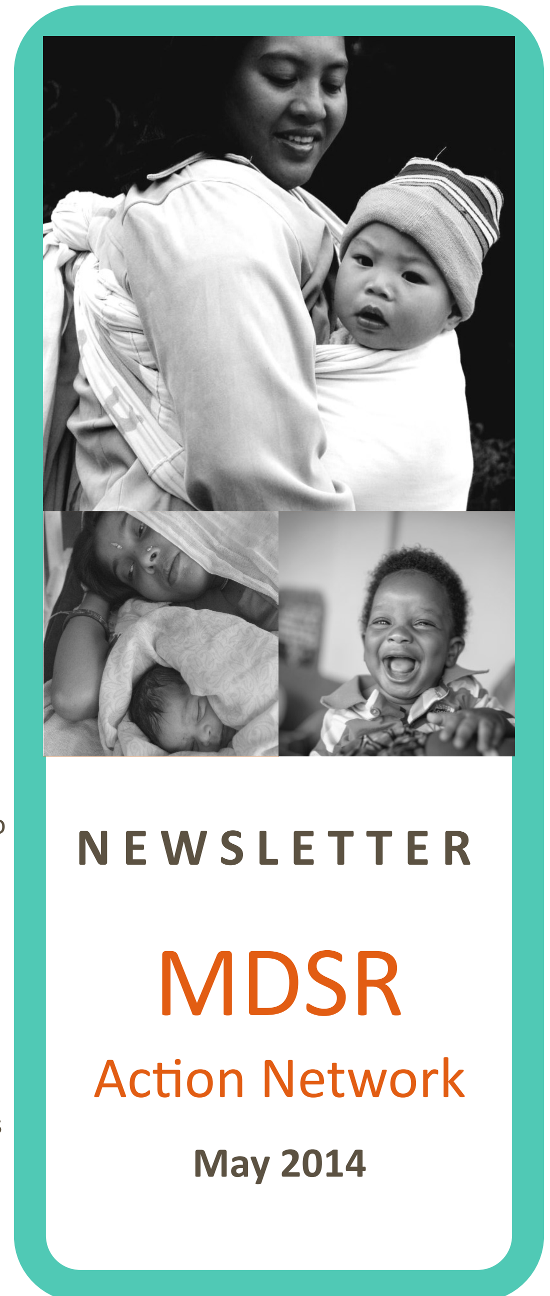

NEWSLETTER

MDSR

Action Network

May 2014

Edel Manning is a trained midwife and currently the MDE Ireland Co-ordinator who is responsible for the co-ordination of the maternal death enquiry process and dissemination of MDE recommendations.

Inspire | Case study | Ireland

Establishing a confidential maternal death enquiry in a low maternal mortality context

In recent decades, Ireland has been credited with a low maternal death rate: 3 per 100,000 live births. This was based on data derived from the Irish civil death registration system. However, in acknowledging national and international evidence, it was considered that in the absence of active case ascertainment, under-reporting and misclassification of maternal deaths occur, even in countries with advanced civil registration systems.

The aim of establishing a confidential enquiry into maternal deaths was therefore not just to ascertain numbers, but principally to promote safer pregnancy by learning how such tragedies could be avoided in the future. This could make a major contribution to informing and improving standards of care in maternity services.

Formal reviews of maternal deaths did not exist until 2009, when the confidential Maternal Death Enquiry (MDE) Ireland was established, with the stated objective of linking with the UK Confidential Enquiry into Maternal Deaths (CEMD). Given the relatively small number of maternities in Ireland (70,709 in 2012) there was much to be gained from pooling Irish data with that from the UK. Joining a larger cohort of maternal death case reviews would help to preserve confidentiality and allow for more meaningful analysis and recommendations. The UK, our nearest neighbour, has a similar maternity service and a respected and validated methodology in the 60 year old CEMD, which could easily be adapted in the Irish context.

Credit: Muusa Photography

The UK CEMD is a part of the national Maternal, Newborn and Infant Clinical Outcomes Review Programme, which was previously run by the Centre for Maternal and Child Enquiries (CMACE), and was transferred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) in 2012. MBRRACE-UK is collaboration run by five UK universities and its first report covering 2009 to 2012, including Irish data, is expected to be published in 2014.

Establishing MDE Ireland had its own challenges. First, engaging and establishing support at governance level with stakeholders in the Irish maternity service including: the national health authority, maternity service providers, multidisciplinary health professionals and academics proved more protracted than expected. This process was driven by a dedicated Maternal Mortality in Ireland Working Group, a joint Institute of Obstetricians and Gynaecologists in Ireland/Health Service Executive initiative which helped to garner the required support. Inviting multidisciplinary representatives from relevant stakeholders to join the Working Group, in the development stage, was considered key to establishing commitment for the project. Although support for the ethos of the project was widely considered as laudable, issues of concern related to data protection, potential adverse litigation and anticipated review of cases by other agencies outside the MDE Ireland process.

Second, lobbying for funding to staff a 'stand- alone' office with a co-ordinator to implement the CEMD required much negotiation. This was due to current monetary constraints within the Irish health services. And third, the transfer of the governance and management of the UK CEMD from CMACE to MBRRACE brought its own challenges. There was some uncertainty as to the continuance of the CEMD in the UK during the year 2011 and early in 2012. Support for the on-going collaboration with UK during this interim period required maintaining confidence in the process at Irish governmental and clinical level.

It was also clear to us that confidence and 'buy-in' for MDE Ireland was paramount at the service level as it was a 'top down' approach. We attempted to build this by:

- Raising awareness and support for the MDE through presentations at the service level, articles in multidisciplinary journals and a national workshop
- Promoting awareness that the MDE process is independent of clinical incident reporting and local review of serious adverse incidents
- Alleviating concerns regarding potential litigation. In MDE Ireland, confidentiality is assured through a process of anonymisation of data submitted to the MDE prior to multi-disciplinary assessment of cases. There is no disclosure of information to any outside agency.
- A fundamental component of the UK CEMD process is dissemination of recommendations from enquiry reports. Since its inception, MDE Ireland has promoted this element of the audit cycle through a series of organised educational events.

MDE Ireland published its first triennial report in 2012. With due regard to preserving confidentiality, this was a generalised report with detailed case findings being reserved for the collaborative UK CEMD report. As experience in the UK and other European countries has shown, a key learning point was that a proactive approach to case ascertainment identified maternal deaths that were not captured by the civil death registration system. This was achieved by establishing a national reporting network to the MDE at service level and collaboration with coroners. Establishment of same was labour intensive and despite support letters from governing bodies, was challenging as participation in the Enquiry is policy, but not statutory, for publically funded health care providers.

Although the overall maternal mortality rate identified by MDE Ireland (outlined in the table overleaf), compares

favourably with other countries, it is important to avoid complacency. The ongoing enquiry process and collaboration with the UK CEMD will provide learning points for health professionals in advancing quality and safety within the Irish maternity services. Our findings were that maternal deaths, occurring during the years 2009-2011 inclusive, were predominately attributed to indirect causes (52%), with a further 24% of cases being attributed to both direct obstetric and coincidental causes. Given the increasing number of pregnant women presenting in Ireland with co-morbidities, this has highlighted the on-going need for appropriate pathways of care and pre-conception counselling. Also, the disproportionally high representation of ethnic minorities in this cohort challenges us to address health seeking behaviours of immigrant pregnant women in a country that provides free maternity services for all pregnant women.

Country	Maternal Mortality Rate / Ratio
Ireland: CSO 2009 *Central Statistics Office (2012) Report on Vital Statistics 2009. Stationery Office. Dublin. This is based on data collated from the civil registration system.*	4 per 100,000 live and stillbirths
Ireland: MDE Ireland 2009-2011	8.4 (95% CI: 4.1 – 12.5) per 100,000 maternities
CEMD UK 2006-2008 *Lewis G (ed) (2011). 'Saving Mother's Lives: Reviewing maternal deaths to make motherhood safer: 2006- 2008', Centre for Maternal and Child Enquiries (CMACE), 118 supplement 1: March 2011*	11.39 per 100,000 maternities
United States of America: 2008 *WHO, UNICEF, UNFPA and The World Bank. Trends in Maternal Mortality: 1990 to 2008 .WHO 2010, Geneva.*	24 per 100,000 live births
France: 2008 *WHO, UNICEF, UNFPA and The World Bank. Trends in Maternal Mortality: 1990 to 2008 .WHO 2010, Geneva.*	8 per 100,000 live births

For further information on MDE Ireland please visit their website - www.mdeireland.com

Learn | Resources and Journal articles

To complement the case study from Ireland featured in this newsletter, we would like to highlight the publication - **Saving Mothers' Lives Report 2011, Reviewing maternal deaths to make motherhood safer: 2006-2008.** This is the eighth report of the Confidential Enquiries into Maternal Deaths in the UK and whilst this mainly presents the key findings from the enquiries, it also provides a useful set of ten overarching recommendations that were drawn up based on the findings.

Whilst some of these recommendations may be unique to the UK and developed countries, it is interesting to note several that could be applied to other contexts as well. These mainly refer to providing information to women, strengthening technical capacities of health-workers, improved referral systems and building team-work and information sharing amongst health-workers. The report serves as a useful guidance for providing quality care to women.

The recent report on MMR estimates for 2013 that was released by the UN agencies - **Trends in Maternal Mortality: 1990 to 2013** - shows a 45% decline in global maternal deaths between 1990 and 2013. The burden and risk of maternal death remains the highest in sub-Saharan Africa and South Asia with these regions accounting for 62% and 24% of the deaths, respectively. Whilst absolute numbers show that India and Nigeria account for one third of all global maternal deaths, country level MMR estimates show that Sierra Leone records the highest (1100), while Chad and Somalia have the highest lifetime risk of maternal death.

Giving birth is becoming safer, but not yet at the rate at which it should to meet the MDG targets in many countries. The report attributes this progress to "leadership and partnership, evidence and innovation, development and implementation of dual short-term and long-term strategies, and adaptation to change."

A key challenge this report highlights has to do with measuring maternal mortality. According to the report, "Less than 40% of countries have a complete civil registration system with good attribution of cause of death, which is necessary for the accurate measurement of maternal mortality". Three issues could affect measurement – deaths of women of reproductive age not being recorded at all; even when deaths are recorded, pregnancy status or cause of death being unknown and deaths therefore not being reported as maternal deaths; or difficulties in attributing a woman's death as a maternal death due to lack of medical certification or misclassification on the ICD -10 coding.

Current estimates therefore have to statistically adjust for such lapses. This report presents re-estimated figures for previous years using the same approach as it has used in previous years, but with updated data from existing countries and data from two additional countries, so that the trends across years and countries are comparable.

A profile for each country including a graph of the MMR trend and the source of data used in the estimation can be found on the **WHO website**. Maternal death reviews therefore are an important tool for counting deaths, capturing the details on cause of death and more importantly, to help "initiate necessary actions to prevent deaths." And as the report points out "implementation of the MDSR system should help to accelerate progress towards MDG 5 and make maternal deaths rare events beyond 2015". For more details download the report **here**.

An article - **Autopsy-certified maternal mortality at Ile-Ife, Nigeria**, by Amatare Dinyain, G Olutoyin Omoniyi-Esan, Olaejirinde O Olaofe, et al, published in the International Journal of Women's Health 2014:6 41–46, reports on findings based on a retrospective review of post-mortem autopsies of maternal deaths at a hospital in Nigeria over a five year period.

Whilst autopsies have been established as invaluable tools for preventing maternal deaths in various contexts, in Nigeria autopsies became pivotal for conducting confidential enquiries of maternal deaths. The study confirmed that the leading causes of death in this context were similar to those in other developing countries.

An important aspect this study highlighted was the disparity it found between clinical and autopsy diagnoses in 34 out of the 84 cases it studied. These discrepancies were identified across the various causes of maternal death. This article, too confirms that accurate diagnoses are important as they bear implications for the actions to be taken to improve maternal survival.

Act | Updates from around the world

The Maternal Survival Action Network in Sierra Leone

Last year in April, we had reported that a Maternal Survival Action Network was being developed in Sierra Leone. This network was launched soon after and is now active. Earlier this year the Action Network convened at a meeting hosted by the Office of the First Lady in Sierra Leone.

Strategic partners including the First Lady, UNAIDS, the Global Fund, the RCH Directorate and programme, the Internal Rescue Committee, the Health for All Coalition, Safe Blood Services, and the National MDR Committee Representatives attended this meeting to discuss potential actions based on MDR recommendations.

Discussions focused on one of the priority areas for action for the Action Network - 'strengthening blood services to enable prompt access to safe blood transfusion' and some of the strategies that were presented included:

- establishment of a centrally coordinated national blood programme
- phasing-out of the hospital based blood transfusion system which involves blood donation from relatives of patients with a high risk of latent HIV
- increasing blood collections from voluntary blood donors

- ensuring quality assured testing and safety of blood for transfusion
- rationalising blood use to improve efficacy and minimise wastage

The meeting arrived as several recommendations including those relating to earmarking for specific funding towards blood services; drawing up comprehensive plans for services and advocacy; advocating for legislation; and other implementation issues as well.

The Action Network's activities have also included helping the Office of the First Lady in setting up district level CARMMA communities which will help to ensure action and response to MDR findings as well as promote better use of clinics and reporting of community maternal deaths amongst other activities.

MDSR in Ethiopia is gathering momentum

After an intensive and extensive period of training on the National Guidelines for MDSR, many hospitals and health centre committees are now functional and regularly review Maternal Deaths and near misses, making changes to improve care.

Deaths are increasingly being reported up to regional and national level and a second wave of training to extend the system is about to begin. The MDSR system has been received really well and in the words of the chief executive of Butajira Hospital:

"The MDSR system is very nice. We share lots of things in order to solve the problems every month. Even if we don't have a death we discuss the near misses."

According to an update from a network member, an example of specific actions being taken at the facility level in Ethiopia includes the purchase of a new generator at a District Hospital in Oromia (pictured above) in response to a maternal death which had occurred during a power shortage.

And finally...

Pregnancy is not a disease. Childbirth is not 'suffering'. It is creation of new life and maternal survival is a reflection of how well a country 'celebrates' this. Dr. Fred Sai is **reported to have said at a meeting in Ghana,** that maternal mortality should become an index for development of all countries. We couldn't agree more!

Please connect with us and other colleagues through this Action Network to make this possible. Share with everyone your learning and experience. Send us your updates, publications, guidelines or research papers to be included in the next newsletter and on the website.

And as ever… please share this newsletter with your colleagues and others who may wish to join this Network.

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