December Issue

Connect | Inspire | Challenge | Learn | Act

Dear Action Network members,

Welcome to the December 2014 edition of the MDSR Action Network's newsletter!

This edition of the MDSR Action Network newsletter focuses on a selection of recent publications on maternal death reviews. From an important civil society report in India which recommends ensuring that MDR reports and their actions are made public to a social autopsy from a human rights perspective, there is something in here for you.

This issue's case study from Uganda highlights how investing in village health teams has resulted in a 30% reduction in population-based maternal mortality as well as stimulating advocacy efforts and community mobilisation.

I would like to draw your attention to the special supplement issue of the International Journal of Gynecology and Obstetrics, which has a wealth of relevant articles and guidelines.

Read also about the power of MDSR in Ethiopia, a special supplement in BJOG on quality of care and a journal article identifying the most common avoidable factors in maternal and perinatal deaths in low resource countries.

Finally, from Nigeria, we have both an update of the range of MDSR activities taking place, which demonstrates the importance of political will at national and state level, and a summary of a study evaluating the effectiveness of the use of facility-based MDRs in the north.

Inspire | Case study | Uganda[1]

Saving Mothers, Giving Life Initiative—Establishing a Maternal Death Surveillance and Response System in Uganda

Although Uganda's Ministry of Health has made great strides in recent years to improve maternal health and reduce the number of maternal deaths, the maternal mortality ratio was still high (estimated at 438 deaths per 100,000 live births by 2011 UDHS).[2]

Uganda was one of two countries selected for a pilot project — Saving Mothers, Giving Life (SMGL) — to rapidly reduce maternal deaths through community and facility-based interventions. The SMGL model employs a comprehensive approach that builds upon existing district health systems, including strengthening the evidence base for improving maternal and perinatal survival.

Through the SMGL initiative, over 4,000 village health teams were trained, one for each 100-300 households, to identify any deaths of women of reproductive age (WRA) through routine monthly monitoring visits. Their reports were compiled and submitted to the sub-district health coordinators. Approximately six to eight weeks after a death, the household was visited by a team trained in verbal autopsy procedures.

Improving the System: Lessons

In establishing a district level maternal death surveillance system in Uganda, we learned that

1. **Identification of all deaths to WRA was important in improving the efforts to detect all maternal deaths.** MDSR monthly reports revealed that WRA deaths declined at a faster pace than the number of maternal deaths, suggesting that village health teams and others in the data-collection process were focusing increasingly on identifying pregnancy-associated deaths and neglecting surveillance of all deaths of WRA.

[1] For further detail on this case study, including methodology and evaluation, please visit the MDSR Action Network website. For further information on SMGL, reports can be found at: www.savingmothersgivinglife.org/our_work/reports/index.aspx. This case study was written by Florina Serbanescu, Susanna Binzen, and Diane Morof, from CDC/DRH, and Frank Kaharuzaon behalf of SMGL Uganda.

[2] Uganda Bureau of Statistics and ICF International Inc. *Uganda Demographic and Health Survey 2011. Preliminary Report.* Kampala, Uganda: Uganda Bureau of Statistics and Calverton, MD: ICF International Inc.; 2012.

2. **Continuous supervision and quality assurance of the SMGL maternal mortality surveillance system needs to be carefully planned, implemented and maintained.** This includes clear case definitions, periodic reminders of importance and of the process of reporting, accountability, monitoring of results, information sharing and linkages with action.
3. **Real-time data on population maternal mortality were used in village health team meetings to advocate for increasing their prevention and community mobilisation activities.** The leadership of Kibaale district allocated resources for building a bridge that helped connect several communities with high mortality rates to the main road and increased access to emergency obstetric care. The Ministry of Health is planning to scale up the MDSR to other non-SMGL districts. With an established network of trained community health workers, the SMGL districts are planning to add perinatal surveillance activities in 2015.

The MDSR system in Uganda can be further improved through communication of its results and the actions that were taken to prevent maternal deaths to all stakeholders, including the communities where these deaths occur.

The study found that during its first year of implementation, SMGL activities were associated with a reduction of 30% in the population-based maternal mortality in four districts in Uganda (Kibaale, Kabarole, Kyenjojo and Kamwenge), from 452 to 316 deaths per 100,000 live births.

Learn | Resources and Journal articles

A Civil Society Report on Maternal Deaths in India[3]

Civil Society Report on Maternal Deaths in India describes the findings of an analysis of 124 maternal deaths identified and documented over two years between January 2012 and December 2013. The analysis is a part of the Dead Women Talking initiative, established by several civil society organisations in response to the high maternal mortality in the country.

The 124 maternal deaths were first identified by community members and civil society. Following a home visit to verify if the death was a maternal death, families of the deceased are invited to participate in a social autopsy.

The findings of the social autopsy were analysed and recommendations developed using a framework developed to identify gaps that contributed to the deaths across four domains: technical factors, health system factors, social factors, and human rights.

Challenges:

- **Number of training sessions:** One training session on social autopsies was not sufficient to train civil society organisation staff.
- **Incomplete information from families:** Information from families needed to be triangulated as they did not always want or were unable to provide a complete story behind the death.
- **Deaths under certain conditions missed:** Late maternal deaths and deaths due to unsafe abortions and home deliveries were likely missed. As a result, greater efforts, such as training community-based organisations, were needed to ensure deaths under these conditions were recognised.
- **Difficulty in getting the health system perspective:** In almost all districts any attempt to link with the government conducting verbal autopsies was not successful. There was also resistance from the health system to cooperate in CSO-led social autopsies, questioning the expertise of the team conducting the social autopsies and thus not engaging with the findings.
- **Blame culture:** There was a culture of blaming those at the lowest of the hierarchy for the death, such as peripheral health workers. This meant that health workers were reluctant to speak about the deaths.

Recommendations include:

- Involve multiple stakeholders in the MDR process, such as CSOs, community-based organisations, and local governance structures such as Village Health and Sanitation Committees.

---

[3] **Full reference:** Subha, Sri, B. & Khanna, R. (2014). *Dead Women Talking: A civil society report on maternal deaths in India.* CommonHealth and Jan Swasthya Abhiyan.

- Ensure that Action Taken Reports are on the agenda for the MDR committee meetings and are made public. Feedback loops should be established in order for lessons learnt from preventable maternal deaths to be used by the health system and for community action.

IJGO's special supplement on FIGO's Leadership in Obstetrics and Gynecology for Impact and Change initiative

The International Journal of Gynecology and Obstetrics has published a special supplement about the Leadership in Obstetrics and Gynecology for Impact and Change (LOGIC) initiative. This initiative was launched by the International Federation of Gynecology and Obstetrics (FIGO) to build capacity for their members in Burkina Faso, Cameroon, Ethiopia, India, Mozambique, Nepal, Nigeria, and Uganda.

This supplement documents the major achievements of the completed programme in a series of articles, including:

- Emerging lessons from the FIGO LOGIC initiative on maternal death and near-miss reviews by Gwyneth Lewis
- Guidelines and tools for organizing and conducting maternal death reviews by Vincent De Brouwere, Véronique Zinnen, Thérèse Delvaux, & Robert Leke
- Training health professionals in conducting maternal death reviews by Vincent De Brouwere, Véronique Zinnen, Thérèse Delvaux, Philip Njotang Nana,& Robert Leke
- Improving maternity care in Ethiopia through facility based review of maternal deaths and near misses by Yirgu Gebrehiwot & Birukkidus T. Tewolde
- Every death counts: Electronic tracking systems for maternal death review in India by Chittaranjan Purandare, Ajey Bhardwaj, Manisha Malhotra, Himanshu Bhushan, & Paramanand Keshavlal Shah

Please note payment of subscription is required to access the supplement.

BJOG's special supplement on quality of care

An International Journal of Obstetrics and Gynaecology has published a special supplement International Reviews: Quality of Care, covering review articles, country studies, and commentaries on the provision and accurate assessment of quality of care for maternal and newborn health. In particular, the supplement highlights experiences in developing and implementing different types of audit to improve the quality of maternal and newborn health, including maternal and /or perinatal death reviews, confidential enquiries, near miss audits, and clinical audits.

Audit-identified avoidable factors in maternal and perinatal deaths in low resource settings: a systematic review[4]

In the journal article Audit-identified avoidable factors in maternal and perinatal deaths in low resource settings: a systematic review, Hasan Merali and colleagues present the findings of a systematic review of all published audits in low and low-middle income countries in order to identify the most common avoidable factors of maternal and perinatal deaths worldwide.

Notably, the majority (two-thirds) of avoidable factors were accounted for within the category health worker-oriented factors, such as substandard practice of health workers and delay in receiving care on admission. The leading three factors of deaths were:

- substandard practice of health workers
- patient delay to seek care
- lack of capacity in blood transfusion

The review reiterates the valuable insight that audits provide in identifying systematic deficiencies in clinical care, which in turn can be used for targeting interventions to address these system failures. What's more, the very fact that the causes of maternal and perinatal deaths are often similar in low-resource settings means that these avoidable factors could be used to inform a rational design of health systems.

[4] **Full reference:** Merali, H., Lipsitz, S., Hevelone, N., Gawande, A., Lashoher, A., Agrawal, P., & Spector, J. (2014). Audit-identified avoidable factors in maternal and perinatal deaths in low resource settings: a systematic review. *BMC Pregnancy and Childbirth*, *14*(1), 280.

Experiences with facility-based maternal death reviews in northern Nigeria[5]

The journal article Experiences with facility-based maternal death reviews in northern Nigeria presents the findings of a study evaluating the effectiveness of the use of facility-based MDRs by the Partnership for Reviving Routine Immunization in Northern Nigeria – Maternal Newborn and Child Health (PRRINN-MNCH).

The evaluation uncovers a number of findings, including:

- Only 93 (12.1%) of the total maternal deaths reported in HMIS for the same facilities had been recorded on the MDR forms and only 52 of these maternal deaths had been reviewed; a mere 6.7%.
- Despite the minimal number of MDRs taking place in these facilities, the MDRs that were conducted did result in improved quality of care, such as the better management of patients and the mobilisation of resources.
- The process of using MDRs stopped for some time in the 11 hospitals visited for the study. Reasons included the transfer of key MDR committee members, inadequate supportive supervision and shortage of staff. Most did, however, restart with revitalisation of the MDR process by PRRINN-MNCH staff.
- Challenges reported included fear of blame felt by health workers, shortage of staff to undertake committee meetings, inadequate supportive supervision and low quality record keeping.

The authors conclude by highlighting successful features of the MDR process, including teamwork, commitment, champions at the health facility level to lead the process, and guidance, coordination and support from the national and state Ministries of Health.

Please note payment of subscription is required to access the supplement.

African Health Stats

Hot off the press is African Health Stats, an innovative data site from the African Union Commission's Department of Social Affairs that allows you to chart, map and compare key health indicators across all 54 African Union member states. All data is taken from officially-recognised international sources and covers 33 health indicators covering RMNCH, HIV and AIDS, malaria, tuberculosis and health financing.

Act | Updates from around the world

The power of MDSR in the community: experiences from Ethiopia

"The mother had no ANC and came late; she died on the way to hospital. After the MDSR we used this case as an example to provide education to the community" *SNNPR Health centre Head*
"MDSR helps linkage from facilities to the community" *Dire Dawa Health Centre Midwife*

Ethiopia has one of the lowest skilled birth attendance rates in the world with 82% of the population living in rural areas. The MDSR system therefore hinges on community verbal autopsies as well as facility reviews.
MDSR is proving to be a valuable tool for improving communication between health workers and communities. Health workers who visit the family home to carry out a verbal autopsy when a mother dies give the essential message that the mother's death matters.

In addition, the health workers can use the information gathered from the verbal autopsy to educate the community about danger signs and the benefits of health seeking behaviour using real examples.
MDSR is not just about improving clinical management but also is a powerful advocacy tool in the community.

To read more about experiences of using MDSR in Ethiopia, take a look at the country's latest MDSR Newsletter published in early November 2014. It includes comments and case studies from around the country on the actions taken from MDSR findings.

---

[5] **Full reference:** Hofman, J.J., & Mohammed, H. (2014). Experiences with facility-based maternal death reviews in northern Nigeria. *International Journal of Gynecology and Obstetrics, 126* (2): 111–114.

Continuing MDSR activities in Nigeria

A number of activities in relation to MDSRs and MDRs have been taking place in Nigeria at both the national and state-level:

- **Nigeria finalises national MDR guidelines and tools** on 8/9 August following a broad stakeholder meeting to finalise and harmonise comments. We are now waiting for their national launch.
- **Jigawa State's MDR Review meeting:** Gunduma Health System Board organised a two day Jigawa State MDR Review Meeting in Kano, Nigeria, on the 16/17 August 2014. Attendees included the State MDR Committee members and three members from 12 facilities providing CEmONC. The meeting reviewed implementation of MDRs in Jigawa State. Key highlights from the meeting include:
    1. MDRs are being conducted in all 12 CEmONC-level facilities in Jigawa State.
    2. MDR meetings are being held twice a month in each facility to review maternal deaths and discuss possible actions and recommendations.
    3. More MDR forms were printed and distributed to the facilities during the meeting.
    4. The review helped many facilities in requesting more magnesium sulphate from the State in order to avert death from eclampsia.
- **One year on for Kaduna State's MDSR pilot:** As part of the continued implementation process of the pilot, a two-day state-level meeting took place on the 8/9 July. The meeting was attended by a variety of key stakeholders, including health care providers from the eight facilities participating in the pilot, the Commissioner of Health, the Permanent Secretary, the Director of Public Health. Key highlights include:
    - A review of the progress of the MDSR pilot
    - An overview of the new national MDR guidelines
    - The introduction of the Action Network for Maternal Survival
    - The development of action plans and recommendations that respond to MDR findings from the pilot
    - The introduction of the idea of the digitalisation of MDRs

And finally…

As ever… please share this newsletter with your colleagues and others who may wish to join this Network. And keep an eye on our website for more publications, case studies, resources and more:

mdsr-action.net

Please keep sharing your stories and publications. We look forward to them!

Louise
l.hulton@evidence4action.net