Maternal Death Surveillance and Response Systems

Improvements in quality of care

Introduction

Maternal death surveillance and response (MDSR) systems can improve measurement of maternal mortality, uncover the underlying factors that lead to maternal deaths and provide recommendations to improve quality of care.

Identifying underlying factors of maternal deaths is not enough – these findings need to be acted upon to prevent further deaths and improve quality of care

General considerations

Taking action and implementing recommendations from MDSR

- Taking action to reduce avoidable maternal mortality is the reason for conducting MDSR
- Recommendations from community-based MDSR approaches such as verbal autopsy may lead to development of community interventions including public education, health promotion activities and changes in community service delivery
- Recommendations from facility-level MDSR approaches may lead to changes in clinical practice, reorganization of health facilities and development of clinical guidelines
- Recommendations from national-level enquiries have the capacity for change on a larger scale by acting on recommendations at an institutional, local and national level by a broad range of stakeholders

Malawi

Hospitals set up designated quality improvement (QI) teams of health professionals working in the maternity unit. The QI team met whenever there was a maternal death to review the case and determine contributing factors to maternal mortality. After three years of implementing QI initiatives, facility-based maternal mortality decreased within a two year period (2005 to 2007)

Kongnyuy et al, 2011

Botswana

The maternity mortality monitoring system involves maternal death and morbidity reviews at facilities and analysis by the National Maternal Mortality Audit Committee. Recommendations are fed back from the national level to all stakeholders. The monitoring system contributed to national policy changes, as maternal death was made a notifiable event in 2006 .

Mogobe et al, 2007

Key points

Enabling factors for taking action

- People who are responsible for making changes should be involved in the MDSR process from the very start to ensure buy-in and ownership of all staff members involved
- Commitment from decision makers and key stakeholders at the community, facility, district and national levels is required in order for action to be taken on recommendations
- Assigning dedicated human resources to monitor implementation of recommendations to improve quality of care can be effective
- Findings must be disseminated to key stakeholders in order for action to be taken. Feedback from community-based reviews can take the form of team meetings, community meetings, printed reports, training programmes or posters. Feedback from sub-national and national reviews can be disseminated through publication of scientific articles and reports, findings can be posted on websites, newsletters, bulletins, fact sheets, press releases, conferences, posters, training programmes
- Evaluation should be undertaken to determine whether recommendations have been implemented to ensure MDSR process is reducing avoidable maternal mortality. If recommendations were not implemented, barriers should be identified and strategies to overcome these barriers should be developed.

Malawi

A review of nine hospitals in three districts found that recommendations from maternal death reviews were implemented when senior staff and decision makers were involved in the process from the beginning and committed to changes and implementation of recommendations.

Kongnyuy et al, 2011

Indonesia

In Southern Kalimantan, midwives play a key role in reporting deaths from the community and participate in district-level maternal death review sessions. The process had led to the development and dissemination of guidelines to standardise case management among midwives, and access to magnesium sulfate to better manage eclampsia.

Supratikto G et al,2002

Malawi

Teams were more likely to act on recommendations made from maternal death reviews when the Ministry of Health provided external support and expertise.

Kongnyuy et al, 2011

For more information or to join the MDSR Action Network

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MDSR Action Network

Every maternal death counts