MDSR Action Network
Every maternal death counts

Connect | Inspire | Challenge | Learn | Act

Welcome

Dear Action Network members,

Welcome to our December 2015 edition of the MDSR Action Network's newsletter! Following on from the FIGO World Congress in October, we have exciting updates and news on MDSR, setting the scene for further developments in 2016.

At the October Congress, the World Health Organization (WHO), in partnership with UNFPA, launched an online report on the status of MDSR implementation around the world. The report provides promising insights on the progress of implementing MDSR, with 90 per cent of countries surveyed reporting they have national policies on the notification and review of all maternal deaths. Although there are still gaps in implementation, progress is being made, which is our incentive to push progress further in the New Year. You'll find in the report country profiles, maps, and case studies on global MDSR implementation, including six case studies from the MDSR Action Network from our website. Congratulations to the contributors!

In this edition

In this edition, we focus on progress to date on MDSR implementation around the world:

- Be inspired and challenged by a case study on Ethiopia's experiences in putting the 'R' in MDSR.
- Learn from:
  - Various country experiences shared at the MDSR workshop, which took place in the wake of FIGO in Vancouver
  - Resources on the international classification of diseases – maternal mortality
  - The importance of MDSR in strengthening accountability
  - Confidential enquiry into maternal deaths and stillborns in the United Kingdom and/or Ireland
  - Facility death reviews in Bangladesh
  - Using mortality audits to count stillbirth and neonatal deaths
- Read about MDSR in action with updates from around the world, including the Philippines, Malaysia, Nigeria, Malawi, and Tanzania.

Inspire and challenge | Case study | Ethiopia

ETHIOPIA PUTS 'R' IN MDSR

In May 2013, the Federal Ministry of Health launched Ethiopia's MDSR system. By the end of 2014, the system had been introduced in 17 zones and has been integrated into the existing surveillance system. This case study presents the findings of a preliminary audit of responses to maternal death. The "response" arm of MDSR is recognized to be the most challenging part of MDSR with few centres managing to respond in an organised constructive manner to maternal death.

A preliminary audit of responses to maternal death from health facilities at different levels of the health system demonstrated an average of 3 responses to each maternal death.

The audit captured 211 responses to 71 maternal deaths at 33 health facilities/ communities. Of the 211 responses 39% were aimed at improving care within the hospital or health centre demonstrating a constructive approach to the MDSR process. In other words, health facility staff did **not** simply pass blame to the community or referring health facility for the woman's death and say "she came too late".

Actions improved feedback and training to staff, improving services available at the health facility, improving access to essential drugs and equipment and redistribution of staff to improve effectiveness. A further 35% of responses targeted community awareness of the need to access health care in pregnancy. This was done through a variety of methods including regular women's groups, community meetings and pregnant women's conference.

The Medical Director at Dodola Hospital donating blood to increase blood availability for transfusions

MDSR information is a powerful tool of communication between health professionals and communities. Fifteen per cent of actions involved communication with referring health facilities thereby strengthening referral pathways, whilst the remaining 10% targeted the regional or zonal offices to improve transport systems and obtain essential drugs.

It is noted that the majority of the responses taken were not expensive in terms of cash but contributed to staff professional development and raising community awareness of maternal health issues.

To read more, take a look at Ethiopia's MDSR Newsletter here and a case study in the WHO's global MDSR report here.

Acknowledgements: Case study written by Evidence for Action (E4A) in Ethiopia.

Learn | Resources and Journal articles

RESOURCES FROM THE MDSR WORKSHOP IN VANCOUVER

On 4th October 2015, an MDSR workshop took place at the FIGO World Congress led by the WHO and UNFPA in collaboration with FIGO. The workshop aimed to identify opportunities to strengthen the MDSR global implementation and the contribution of MDSR to Ending Preventable Maternal Mortality beyond 2015 by:

- Providing a forum to discuss and identify the opportunities and challenges facing MDSR implementation post-2015
- Sharing lessons from the field on selected key topics relevant to sustained MDSR implementation
- Identifying mechanisms and activities to strengthen global collaboration in MDSR implementation.

The workshop included presentations and "marketplace" discussion sessions on five themes. Please follow links to resources available from, or associated with, these sessions.

- **Death notification:**
  - Improving maternal death notification: Experiences from Uganda. *Presented by Florina Serbanescu (CDC).*
- **Data, communication and advocacy:**
  - Role of civil society in MDSR: experiences from India. *Presented by Subha Sri (CommonHealth, India).* Click here to read a related civil society report on maternal deaths in India from CommonHealth.
  - How to communicate the message? Role of advocacy in communicating in MDSR. *Presented by Sara Bandali (E4A).*
  - Data innovations and visualization: Using scorecards to measure the strength of Maternal Death Review (MDR) systems in Nigeria and inform MDSR in Sierra Leone. *Hosted by Tunde Segun (E4A) and Mohamed Yilla (E4A)*
  - Data innovation and communication: Experiences from India. *Hosted by Ajey Bhardwaj (Federation of Obstetric and Gynaecological Societies of India).* Click here to read a related article on the development of an electronic MDR system in India.
- **Funding agencies:**
  - The role of funding agencies in MDSR support. *Presented by USAID.*
- **Professional society involvement:**
  - The role of professional bodies and government agencies in MDSR: The Malaysia Experience. *Presented by Dr Ravichandran Jeganathan (Ministry of Health, Malaysia)*.
  - Professional society involvement: The UK experience. *Hosted by Dr Paul Fogarty (Royal College of Obstetrics and Gynaecologists).* The Royal College of Obstetrics and Gynaecologists (RCOG) works to improve women's health care across the world. Founded in 1929, the RCOG now have over 13,500 members worldwide and works with a range of partners both in the UK and globally to improve the standard of care delivered to women, encourage the study of obstetrics and gynaecology (O&G), and advance the science and practice of O&G. Click here to read more about the Royal College of Obstetrics and Gynaecologists.
- **Scaling up:**
  - Going to scale: experiences from Tanzania and Ethiopia (see implementation coverage for 2014 and 2015). *Hosted by Moke Magoma (E4A) and Azmach Hadush (E4A).*

RESOURCES ON INTERNATIONAL CLASSIFICATION OF DISEASES – MATERNAL MORTALITY

Liverpool School of Tropical Medicine have shared the following resources:

- An article by Charles Ameh and colleagues on "Using the new ICD-MM classification system for attribution of cause of maternal death-a pilot study" in *BJOG: An International Journal of Obstetrics & Gynaecology.*
- An article by Helen Owolabi on "Establishing cause of maternal death in Malawi via facility-based review and application of the ICD-MM classification" *in BJOG: An International Journal of Obstetrics & Gynaecology.*

STRENGTHENING ACCOUNTABILITY TO END PREVENTABLE MATERNAL DEATHS

This article by Matthews Matthai and colleagues in the *International Journal of Gynecology and Obstetric's* October supplement World Report on Women's Health 2015 describes the MDSR system, explaining its role as a mechanism for strengthening accountability and ending preventable maternal deaths. The article also provides updates from around the world on how far the system is being implemented using findings from the WHO Global Maternal, Newborn, Child and Adolescent Health (MNCAH) policy survey 2013-2014. This information has since been updated with findings from the MDSR implementation monitoring survey (April-Sept 2015) presented in the WHO's latest online report on the status of MDSR implementation globally.

The article highlights that around the world countries are adopting MDSR into policy. However, there is a gap between policy development and placing it into practice:

- Findings from the MNCAH policy survey found that three-quarters of high-priority countries surveyed had a policy stating that all maternal deaths must be reviewed and yet less than a third had a national MDR committee that meets on a quarterly basis.
- More recent findings from the MDSR implementation survey has found that 90 per cent of countries surveyed had a policy stating that all maternal deaths must be reviewed and yet 42 per cent had a national MDR committee that meets at least biannually.

The authors conclude that training more health workers, monitoring and evaluation, and building partnerships with technical experts are recommended to support greater up-take of MDSR.

CONFIDENTIAL ENQUIRIES INTO MATERNAL AND PERINATAL DEATHS IN THE UNITED KINGDOM

MMBRACE- UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) have recently launched two reports:

1. "MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth"
2. "Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13"

The reports present fin dings from confidential enquiries that took place in the United Kingdom and/or Ireland on stillbirths and maternal deaths. In addition to presenting key findings, the reports provide key recommendations for action aimed at a variety of stakeholders.

FACILITY DEATH REVIEW OF MATERNAL AND NEONATAL DEATHS IN BANGLADESH

This article by Animesh Biswas and colleagues in *PLoS ONE* presents findings of a qualitative study with healthcare providers involved in Facility Maternal and Newborn Death Reviews (FDRs) in two districts in Bangladesh: Thakurgaon and Jamalpur. The study aimed to explore healthcare providers' experiences, acceptance, and effects of carrying out FDRs.

The study found that there was a high level of acceptance of FDRs by healthcare providers and there were examples of FDRs leading to improvements in quality of care at facilities, such as the use of FDR findings in Thakurgaon district hospital which ensured that adequate blood supplies were available, which saved the life of a mother who had severe post-partum bleeding. The article also identified gaps and challenges in carrying-out FDRs to consider for future efforts, including ensuring incomplete patient records and inadequately skilled human resources to carry out FDRs.

The authors conclude that FDRs are a simple and non-blaming mechanism to improving outcomes for mothers and newborns in health facilities.

To read more about maternal and newborn death reviews in Bangladesh, take a look at several case studies: two from the MDSR Action Network website: "Mapping for Action" and "eHealth to support MPDRs"; and another in the WHO's global MDSR report here.

COUNTING EVERY STILLBIRTH AND NEONATAL DEATH THROUGH MORTALITY AUDIT TO IMPROVE QUALITY OF CARE FOR EVERY PREGNANT WOMAN AND HER BABY

This article by Kate Kerber and colleagues in *BMC Pregnancy & Childbirth* presents the findings of a review and assessment of evidence for facility-based perinatal mortality audit in low- and middle- income countries and the status of policies and their implementation on maternal and perinatal mortality audits.

The authors found that only 17 countries have a policy on reporting and reviewing stillbirths and neonatal deaths despite evidence suggesting that birth outcomes can be improved if the audit cycle is completed. Key challenges in completing the audit cycle and where improvements are needed were identified in the health system building blocks of "leadership" and "health information systems". Evidence based solutions and experiences from high-income countries are provided to help address these challenges.

The authors conclude that the system needs data systems, such as cause of death classifications, best practice guidelines to monitor performance, leaders to champion the process and bring about a no-blame environment, and access to decision-makers at other levels to address systematic challenges.

Act | Updates from around the world

PHILIPPINES

Update from Zenaida Dy-Recidoro, Chief Health Programme Officer at the Department of Health

The Philippines is a small country with a complicated political structure. We have a decentralised health system which makes program implementation sometimes difficult to follow up. But modesty aside, we are making some success in the safe motherhood programme. MDSR is among the provisions of Republic Act 10354 or the Philippine Responsible Parenthood and Reproductive Health Law of 2012. Our local government units are actively participating in MDSR and slowly but surely systems reforms are happening on the ground.

MALAYSIA

Update from Dr Ravichandran Jeganathan, National Head of Obstetrics and Gynaecological Services at the Ministry of Health

MDSR in Malaysia is in its fourth year of inception. It complements the Confidential Enquiry into Maternal Deaths that has been in existence since 1991. As part of MDSR feedback, we have weekly updates on the most recent data on maternal deaths for the week and compare this data to the same week the previous year. Based on the findings of the MDSR committee (which meets at least four times a year) a near miss registry is being formed and the ground work is completed. As we leave the MDG and move on to the SDG we see a greater role for MDSR.

NIGERIA

Update from Dr Tunde Segun, County Director E4A- Nigeria

At national level, the Federal Ministry of Health (FMOH) is planning to institutionalise Maternal and Perinatal Death Surveillance and Response (MPDSR) in Nigeria. As part of this, the FMOH carried out four zonal orientation meetings of representatives of the 36 State Steering Committees and the FCT, on MPDSR in Lagos, Port Harcourt, Jos and Kaduna in early November, which covered in-country experiences of implementing MPDSR at the facility and community level. The meetings were attended by a variety of stakeholders, including representatives from the FMOH, the WHO, Save the Children, E4A, UNICEF and the Society of Gynaecology and Obstetrics of Nigeria.

As a result of these four zonal orientation meetings, the FMOH established a virtual MDSR network on MPDSR titled 'Maternal and Perinatal Death Surveillance and Response in Nigeria' and is hosted on Facebook.

At sub-national level, in Ondo State, the first zonal facility MDR training has taken place for MDR agents, who included Chief Medical Directors, heads of the Obstetrics and Gynaecology departments, and the nurse/midwife or matron in charge of the hospital labour ward. In Kano, a two-day MDR review meeting has taken place for the State and Facility MDR Committees, which resulted in the development of a workplan

for August 2015 to February 2016. In Bauchi State, the Technical Working Group on MDRs successfully trained 131 Facility MDR Committee members from 25 out of the 26 General Hospitals in the State. The committees have drawn up workplans to begin reviews in their facilities.

MALAWI

Update from Lumbani Banda, Project Manager for E4A-Malawi

At national level, the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD) quarterly update meeting took place at the end of August. The meeting focussed on revising the Terms of Reference of the NCCEMD members and how they should be reporting. MDSR tools have also been reviewed in Malawi in order to integrate duplications in data collection and lessen the burden on those reporting. Now the MDSR form in the DHIS II system will not be filled in, but instead all MDSR variables have been integrated into the Maternal and Newborn Health form in DHIS II. Another form has also been created to track recommendations at district level.

Participants of the cMDSR committee training

At sub-national level, in Kasunga, four more community MDSR (cMDSR) committees were trained in the area of Senior Chief Kaomba. The senior chief dedicated his time as one of the participants for the three day training.

TANZANIA

Update from Dr Moke Magoma, Evidence Advisor for E4A-Tanzania

The Ministry of Health and Social Welfare (MOHSW), in collaboration with several stakeholders including WHO, UNFPA, UNICEF, E4A, national professional bodies, and Tanzanian and international research institutions, have updated the existing Maternal and Perinatal Death Review system to Maternal and Perinatal Death Surveillance and Response (MPDSR) in light of latest technical guidance. The updated MPDSR guidelines were approved in November by the MOHSW and are now being rolled-out across Tanzania through a phased approach, starting in Mara region. To read more about Tanzania's MPDSR guidelines, take a look at this case study by E4A.

And finally…

We are already planning our future issues for 2016, which include:

- "Multidisciplinary teams in MDSR". In this issue we would like to explore the role of different cadres of health professionals in the MDSR system, especially the role of Midwives.
- "Adding the "P" to MDSR: initiating dialogue on Maternal and **Perinatal** Death Surveillance and Response". Following from World Prematurity Day on 17th November 2015, we would like to include an issue which engages with debates on perinatal deaths in MDSR. For more resources from World Prematurity Day, please see here and here.

If you have any stories, publications or views, you'd like to share on these two issues or even ideas for other newsletters, please do not hesitate to contact me. We look forward to them!

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