MDSR ACTION NETWORK

NEWSLETTER

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July 2016

Dear Action Network members,

Welcome to our July 2016 MDSR Action Network newsletter! I would like to offer a very special welcome to new members, including those who joined the Network at the Midwifery Symposium, Women Deliver or from Malawi.

In this edition, we look at the role of multi-disciplinary teams, within maternal death surveillance and response (MDSR) systems, with a particular focus on the central importance of midwives.

If you have stories or examples of how different actors in the health system have played an important role in MDSR including those directly involved in using evidence to develop and implement actions plans, please email them to us so that we can share with all the MDSR members.

Also in this edition:

- Read what experts say about the lessons learnt from working with multi-disciplinary teams from around the world in our Expert Opinions piece
- Hear how we took the MDSR Network to the Midwifery Symposium and Women Deliver conference, where a host of world leaders were gathered
- We share a number of resources which highlight the importance of the roles of different groups in the MDSR system
- Read how social autopsy has been used in Bangladesh to engage community action

We are also delighted to share country updates providing highlights from achievements and progress in implementing MDSRs and MPDSRs. Real action is happening all over the world!

And finally…

Connect | a call for submissions

We need your case studies, experiences and publications for our upcoming newsletters.
We're interested in methods of measuring maternal deaths and near misses, as well as your experiences of establishing perinatal death reviews and your opinions on how easily these can be integrated into MDSR systems.

Do you have anything you would like to share amongst our members so that they can learn more about these topics? Please get in touch if you do.

In addition, do get in touch if there's an issue relating to MDSR which you think would make a great newsletter topic.
Best wishes,

Louise Hulton
Network Co-ordinator
MDSR Action Network

Inspire and connect | expert opinions from around the world

The role of multi-disciplinary teams in maternal death surveillance and response

We asked six experts from Malaysia, Ireland, Ethiopia and India about the importance of multi-disciplinary teams in MDSR systems. Here are the insights they shared with us.

Our contributors have all worked closely with MDSR (or maternal death review, which is a component of MDSR) in various guises, contexts and parts of the world. We have drawn together common themes from their insights to draw out lessons learned for the successful implementation of multi-disciplinary health actor involvement in MDSR.

Several of our expert contributors who interviewed for this piece emphasised the need to involve broad civil society, community or religious stakeholders in the process of the review of maternal deaths, because, as Fiona Hanrahan, a senior midwife and midwifery reviewer of maternal deaths in Ireland, noted: "Not all maternal deaths are as a result of medical conditions or obstetric complications".

As discussed in our March issue, involving a wide range of stakeholders such as communities and civil society in the MDSR process is essential to learning about the individual, familial, socio-cultural, economic and environmental factors that might have contributed to a maternal death. A multi-stakeholder approach involving all of these groups as well as health system actors is ideal.

In this issue, we are focusing on the teamwork required between clinical and non-clinical actors in the health system when working in MDSR systems. What do our experts say about how these multi-disciplinary teams can most effectively contribute to reviewing maternal deaths worldwide?

The importance of multi-disciplinary teams in MDSR
Our expert contributors agreed that successful MDSR systems always require the involvement of a range of clinical and non-clinical staff within the health system. "MDSR is team work," explained Dr V P Paily, state coordinator of the Confidential Review of Maternal Deaths in Kerala, "It can be successful only as a team."

Edel Manning, a midwife and ultrasonographer, and coordinator of the Maternal Death Enquiry Ireland, emphasised that a multi-disciplinary approach in the review process is essential "in order to make a complete assessment of factors impacting on the maternal death" to identify any system failures or training needs within the team.

Neglecting a multi-disciplinary approach can result in "a vital piece of the 'jigsaw puzzle' being missed" when investigating maternal deaths, explained Fiona Hanrahan, Assistant Director of Midwifery and Nursing and midwifery reviewer of maternal deaths in Ireland. She highlighted that the circumstances surrounding many maternal deaths are often complex and require multiple specialties other than midwifery and obstetrics: "As a midwife, I am aware of my limitations particularly in very complex cases. … It is crucial that the reviews follow the path that the patients take and [do] not look at any 'event' in isolation." In Ireland, Ms Hanrahan explained, the maternal death review meetings involve contributors with different areas of clinical expertise, for example pathologists to interpret the post-mortem report; psychiatrists to comment on the mental health of the patient; or midwives to provide insight into the antenatal or postnatal care received. These specialist insights can shed light on, and offer alternative perspectives on the circumstances surrounding maternal deaths.

This approach is mirrored in India, where Dr Paily explained that the involvement of multiple disciplines is vital because "more and more maternal deaths are due to non-obstetric causes like cardiac disease and psychiatric illness."

The involvement of such specialists can support development of learning packages, as occurs in Malaysia. Dr Ravichandran Jeganathan, obstetrician and gynaecologist, and Chairman of Confidential Enquiries for Maternal Deaths in Malaysia, highlighted how being open to engaging with different members of the multidisciplinary team can enable improvements in quality of care and better guidance for health professionals. He explained how findings from reviews of maternal deaths revealed that a large proportion of recent cases to be among women with cardiac disease. In response, cardiologists were engaged in the discussions about improving care for these women. This has resulted in the development of national guidelines for the management of heart disease in pregnancy, which has just been launched.

In addition to health professionals, non-clinical health system actors such as health inspectors, administrators, particularly administrative heads, and politicians are also essential in the process. A paper by Dr Paily and colleagues describes the importance of targeting administrators as a key group who benefit from awareness training about the advantages of MDSRs. While clinical actors can lead the surveillance and review processes, the engagement of non-clinical health system actors is vital to enable the 'response' aspect of the MDSR cycle in terms of identifying and ensuring funding, resource allocation, and policy changes to allow recommendations and actions to be implemented.

The role of midwives within multi-disciplinary teams
Midwives play different roles in different health systems and MDSR models, but in many contexts midwives are the primary providers of antenatal, intrapartum and postnatal care.

This proximity to the delivery of care positions midwives to provide a unique contribution to successful MDSR systems: "They have crucial information to contribute," argued Dr Ruth Lawley, a British obstetrician and gynaecologist who is currently working with the E4A programme in supporting the Ministry of Health to roll out the MDSR system in Ethiopia. "They will be familiar with the case, they'll understand more from the woman's perspective, they'll know the context in terms of what drugs or equipment were available … they'll know why the woman presented at a health facility late, or what her family dynamics are".

These unique insights that midwives can bring to the review of maternal deaths and more widely in MDSR allows committees to make the most relevant decisions. The involvement of midwives is important at all stages of the review, from ascertaining cases, through the review process, to implementing the actions recommended by the review. As Dr Jeganathan stated: "if we exclude them, then the MDSR system is very weak".

Unfortunately, in some settings, midwives are not as involved in the review of maternal deaths or more widely in MDSR systems as they could be. However, our experts assert that this needs to change. As Dr Paily noted: "In our own state of Kerala at present, the role played by midwives is secondary, but this has to change. It is mostly an obstetrician-centred [model of] care, but actual observation and conduct of labour are [conducted] by midwives in most of the hospitals. There is [a] need to bring them up to share more responsibility."

"In many low-income countries, midwives often occupy quite a low status [within the health systems]," explained Dr Lawley, "However that does not mean that they can't and shouldn't play a role in MDSR. I think there is generally an increasing recognition that midwives have a vital role to play in MDSR."

Supporting effective teams

Our expert contributors suggested various ways to support multi-disciplinary teams to more effectively play their roles.

Notably, the importance of good leadership and coordination was highlighted. Ms Manning emphasised the essential role of the overarching review coordinator: a role which often requires dedicated funding in order to effectively manage the process and overcome the time and schedule constraints of the contributors. Dr Lawley highlighted the importance of a strong chair of the review meetings, who is able to call equally upon all members to contribute.

The "buy-in" of strong leaders who are committed to MDSR processes is essential for the system to function effectively: "If you haven't got the buy-in of the senior obstetrician or gynaecologist in a facility setting or if you haven't got the buy-in of the health managers, the CEO, the medical directors, etc., your system is not going to be successful" said Dr Lawley.

A notable challenge is finding professionals with the suitable competencies and time to commit to the process, as noted by Ms Hanrahan, especially as the review of cases requires notable time commitments and may require challenges to one's own professional opinions. She explained that the selection of experts must not be compromised despite this challenge, and highlighted the importance of ensuring that health professionals involved should be those who demonstrate "a real interest in the work as reviewing cases is a commitment of time… [and should]… have an open mind to the opinion of other disciplines."

Our experts believe that communication and respect across disciplines and professions is essential to the review process, but not always forthcoming. Bringing together different disciplines with different ideas and approaches may, on occasion, lead to major differences of opinion or be complicated by poor communication.

Unequal power relations between clinical and non-clinical health actors may also pose a challenge, warned Renu Khanna, co-coordinator of the 'Dead Women Talking' civil society initiative into maternal deaths in India. This challenge, however, may be overcome through creating an environment for respectful teamwork throughout the MDSR process, where all contributors of different cadres and disciplines can contribute to the discussions equally. There is a sense that the importance of this factor had started to become more widely acknowledged, for example in Ethiopia Dr Lawley described that there is "more recognition that teamwork is needed, and training across professional groups is now becoming more common."

In Kerala, Dr Paily described how such an environment has been achieved in committees by ensuring all contributors are volunteers to their positions and roles in MDSR, and explained that uniting them behind the common goal of preventing avoidable maternal deaths is important.

In Ireland, Edel Manning explained the strong preference for face-to-face multi-disciplinary team discussion of cases, as opposed to individual members of the team reviewing the cases remotely, as this was felt to be most educational and supportive. Importantly, being able to share findings in light of the insights of other reviewers enabled a more transparent and comprehensive picture of the circumstances surrounding cases that would otherwise be missed when cases are reviewed in isolation from other reviewers.

Tied to this, there is consensus among our experts for a strong need to promote a 'no blame' culture: "we must encourage [committees to learn] how to work better together … not as a fault-finding machine, but as a fact-building one" said Dr Jeganathan. Dr Paily and Ms Hanrahan also highlighted the importance of maintaining confidentiality in all discussions to avoid "the blame game" when discussing maternal deaths.

To support implementation of effective MDRS processes, clear guidelines towards contextually-adapted standardised manuals and tools are necessary. In addition, promoting the roles of multi-disciplinary team members through information campaigns and workshops is important to raise awareness among stakeholders, as supported by Dr Paily and colleagues.

Supporting midwives within teams

Our experts offered recommendations for strengthening the role of midwives within MDSR systems in contexts where they had been traditionally excluded from the process.

Firstly, midwives must be embedded in the structure of the system for them to be valued and have a voice. The role of midwives should be advocated for at all levels of the health system, from national to facility level. Guidelines supporting their roles in MDSR can help build their acceptance in the committees and embed their involvement in the system, as has been done in Ethiopia. As Dr Lawley argued, the "long-term survival of the MDSR system […] depends on the buy-in of midwives. Midwives are often vital in terms of active risk management on a labour ward and they can play a prominent role in the reviews."

Secondly, training about the importance of MDSR and its components should be part of the pre-service curricula for midwifery in order for midwives to enable them to "to contribute more confidently and effectively to the MDSR system" said Dr Lawley. In Malaysia, Dr Jeganathan described how MDSR has been routinely integrated in the training manuals of midwives and nursing staff, which has helped to build their capacity and sensitise them to the process.

"[Midwives] are the back bones of any maternal health service."

Dr Jeganathan, National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia

Beyond pre-service training, the importance of continuous, in-service training is necessary because, as Fiona Hanrahan explained, "most of the work of the reviewer is based on relevant experience grounded in [the] knowledge of current guidelines". Thus, ensuring that reviewers and other contributors to MDSRs are aware of changes and developments is important. Further, guidelines for midwives in the local languages explaining the content, process and ethics of conducting reviews of maternal deaths is important as a way to ensure holistic and culturally relevant contributions are made by a wider set of contributors, as is the experience of Renu Khanna in India.

Fiona Hanrahan raised an additional and important point about supporting colleagues, particularly those newly involved in the review of maternal deaths, who should be mentored by a more experienced reviewer. As she explained, reviewing in detail the circumstances surrounding a death can be "mentally strenuous". It is important to "develop personal strategies to separate yourself, emotionally, from the stark reality that each case you review involves a family losing a loved one and, often, young children and a new baby never knowing their mother". Tapping into a professional network for support, such as fellow reviewers, could provide vital support, she suggested.

In conclusion, as part of the broad stakeholder involvement in MDSR systems and processes, it is important that clinical and non-clinical health actors are equally empowered across disciplines and professions to each contribute their unique and valuable voice to the process of learning and growing from every tragedy of a facility-based maternal death, free from blame and as part of a cohesive team with a shared commitment to improve the health of mothers and their babies.

Acknowledgments: This piece was written based on interviews and feedback from six expert contributors:

- Dr Ruth Lawley, obstetrician and gynaecologist, and Technical Support Unit Coordinator for E4A in Ethiopia working with the Ministry of Health to establish MDSR
- Ms Edel Manning, midwife, ultrasonographer and Coordinator of the Maternal Death Enquiry Ireland
- Ms Fiona Hanrahan, Assistant Director of Midwifery and Nursing at Dublin's Rotunda Hospital and midwifery reviewer of maternal deaths with MBRRACE
- Dr Ravichandran Jeganathan, National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia, President of the Obstetrical and Gynaecological Society of Malaysia, and Chairman of Confidential Enquiries for Maternal Deaths
- Ms Renu Khanna, social scientist and women's health and rights activist in India, and co-coordinator of the 'Dead Women Talking' civil society initiative into maternal deaths

- Dr V P Paily, Senior Consultant and Head of Department at Rajagiri Hospital, Kerala, India and State Coordinator of the Confidential Review of Maternal Deaths in Kerala

Inspire and challenge | feedback from the Midwifery Symposium

Young midwives in the lead

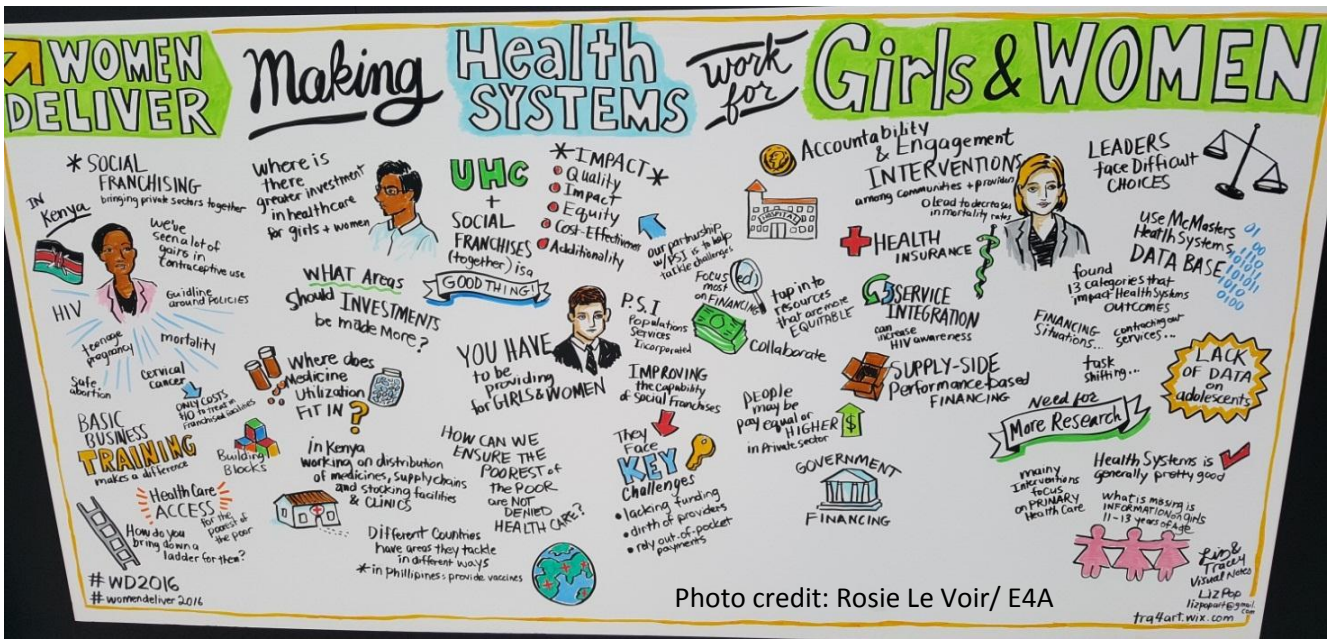
Coordinator of the MDSR Action Network, Dr Louise Hulton, worked with young midwife leaders as part of the Midwifery Symposium to demonstrate the value of multi-disciplinary team involvement in MDSR


Photo credit: E4A

In the lead up to the 2016 Women Deliver Conference in Copenhagen, the UNFPA, the World Health Organization and the International Confederation of Midwives held a satellite Midwifery Symposium titled 'Young Midwives in the Lead'.

The Symposium brought together global Young Midwifery Leaders (YMLs) who were selected to be involved through a highly competitive process. The objectives of the Symposium were to:

a) Support young midwives with leadership potential to become powerful strategic leaders and advocates, who can engage in national policy dialogues with a stronger evidence-based voice.
b) Emphasise the vital role that midwives can play in achieving the new Sustainable Development Goals and equip them with increased knowledge about global commitments, latest research findings and evidence base, and knowledge of global midwifery programmes to fulfil this role.
c) Create a global network of YMLs to serve as a platform for exchanging good practices and innovations for improving quality of midwifery care and enabling the young midwives to have a wider impact across the entire health and social care system.
d) Showcase how global investments in YML can help improve quality of midwifery practice and emphasising the importance of investment in research, advocacy, mentorship and leadership skills of young midwife leaders.



The organisers of the Symposium invited Dr Hulton, to participate as a technical resource and an advocate to raise awareness of the MDSR Action Network. In a session titled 'Harnessing the Evidence', Dr Hulton worked with a group of young midwife leaders to familiarise them with the process of MDSR and to support them to take the lead in advocating for the MDSR model in their home countries.

She was joined by Louise Silverton from the Royal College of Midwives who supported the exercise.
The session was the perfect opportunity to engage YMLs in a discussion about the importance of their role in every aspect of the cycle of MDSRs, from the identification and notification of maternal deaths, through the

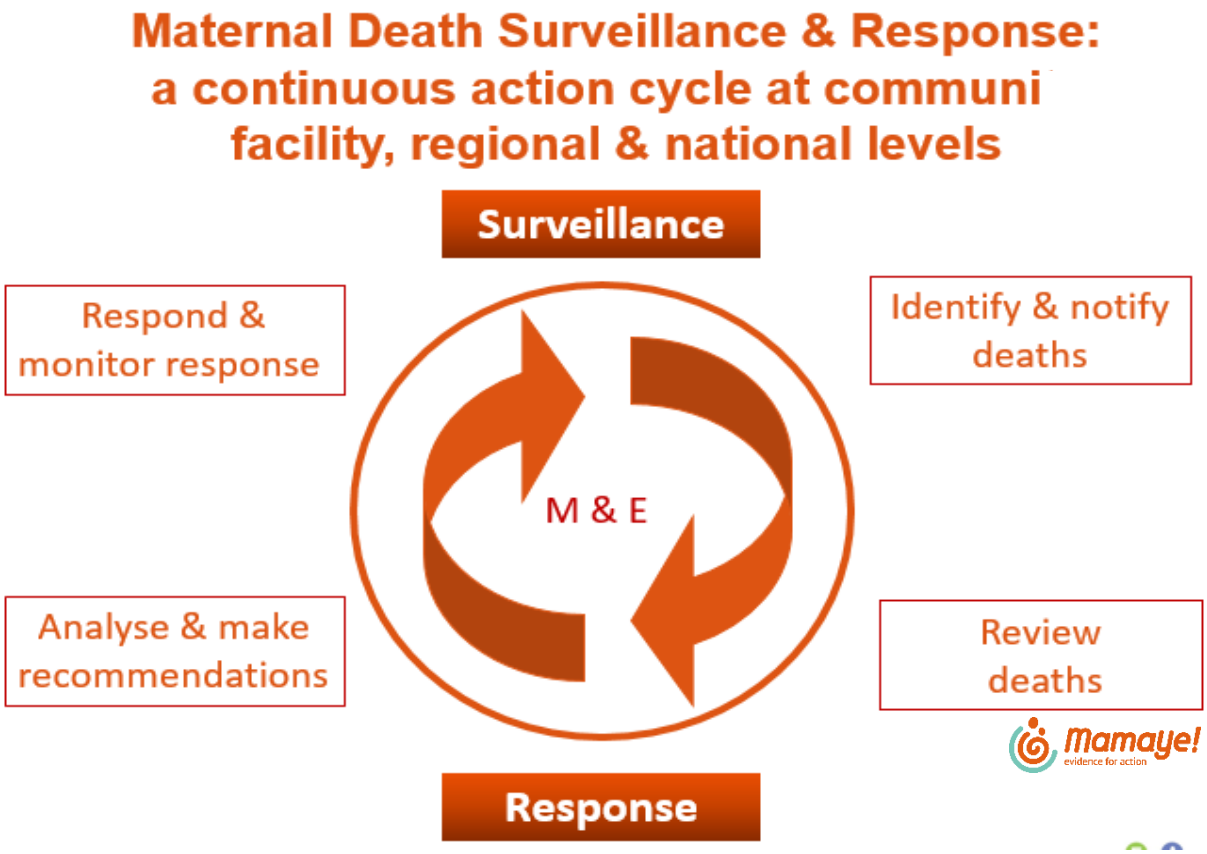
review and analysis process, to the creation, implementation and monitoring of recommendations to improve quality of care.

It was emphasised that the fundamental principles of the MDSR model protect and support health workers through the process, with confidentiality, anonymity and a 'no name, no blame' culture essential to the success of the model.

Dr Hulton explained the role that midwives and other healthcare professionals can play in establishing these principles:

- **Confidentiality:** local data collectors and involved health care workers should be the only staff to see the names of the deceased and keep that knowledge contained within the review committees. All individuals with access to identifying information should sign a non-disclosure confidentiality agreement
- **Anonymity:** all paperwork involved in the reviews should have identifying names obscured or absent to protect the patient, family, friends, and staff members involved
- **'No name, no blame' culture:** there needs to be acknowledgements throughout the health system that mistakes do happen, and a constructive approach taken when they do. Learning from mistakes allows preventive measures to be taken in the future. 'No blame' should never mean 'no accountability', but support and training are better solutions to preventing future deaths than encouraging healthcare workers to shoulder blame. The establishment of a multi-professional committee to oversee MDSR can go a long way towards building a sense of solidarity and understanding of the crucial role that each cadre of worker, including midwives, plays in the process. This sort of committee can also bring in new perspectives on the process and draw a fuller picture

Finally, the YMLs were engaged in a short role play where they were asked to make the case to Clinical Officer (played by International Confederation of Midwives' Senior Midwifery Advisor, Nester Moyo) for introducing MDSR to measure maternal and newborn deaths and identify evidence-based actions needed to improve quality of care.



The YMLs stepped up to the challenge and delivered a compelling case to the Clinical Officer for establishing MDSR in order to create an evidence-based culture of accountability and action for women and babies.

The training and advocacy opportunity for these YMLs during the 'Harnessing the Evidence' session directly delivered on the objectives of the Symposium by providing YMLs with the practical tools to be able to draw on evidence, strategically advocate for improvements, and in so doing, take the lead on MDSR. To read more about the Midwifery Symposium in the ICM website, please click here.

Acknowledgements: This case study was informed by feedback from Dr Louise Hulton and materials drafted for the 'Harnessing the Evidence' session.

Inspire and challenge | feedback from the Women Deliver conference

Making the case for MDSR at Women Deliver

The MDSR Action Network was also represented at the Women Deliver conference through an Options UK evening side event on 'Accountability for Health Results'.

Photo credit: E4A

The event included talks and booths about Options' work in Nigeria, Nepal, Tanzania and Malawi as well as Options' regional network and platforms. We were joined by MamaYe, Africa Health Budget Network, The Girl Generation and African Health Stats.

The MDSR booth at the event exhibited materials highlighting Options' MDSR work worldwide, including copies of the MDSR Action Network newsletter and the MDSR scorecards from Sierra Leone and Nigeria. It provided a great opportunity to share resources and experiences of how different countries are using MDSR to strengthen accountability to improve the care of mothers and babies.

Dr Tunde Segun, Country Director of MamaYe-E4A Nigeria, manned the booth and engaged with a steady stream of visitors, talking them through the materials, answering questions, and inviting them to sign up for the MDSR Action Network newsletter. Almost all of those approaching the booth readily agreed to sign up to be kept in the loop on this important issue.

Dr Segun spoke to a crowded room about how the MamaYe-E4A programme in Nigeria has supported MDSR. For example, four states have now established MDSR scorecards, which measure the strength of the MDSR system and can act as powerful catalysts of action to improve quality of care.

In Jigawa State, the MDSR data showed clearly that more maternal deaths were occurring at night, and action was taken to modify staff rotas to ensure senior midwives were on duty during the night shifts.

In Ondo State during the last quarter of 2015 and first quarter of 2016, the MDSR scorecard showed that sepsis had overtaken haemorrhage as the primary cause of maternal death. Health care providers, policy makers and stakeholders discussed these findings, looking at gains made in addressing haemorrhage by improving the functionality of blood banks in Ondo, but also in terms of the practical actions the state could take to confront sepsis.

Actions such as lobbying to get the most effective antibiotics available under the state's free maternity services are being considered.

Finally, Dr Segun celebrated Nigeria's pioneering spirit on MDSR by sharing the fact that during the FIGO World Congress in Vancouver 2015, the World Health Organization had revealed that Nigeria was the only country at that time to have produced an MDSR scorecard at the sub-national level.

Acknowledgements: This case study was informed by feedback from Dr Tunde Segun, Country Director for Evidence for Action in Nigeria.

Learn | case study from Bangladesh

Social autopsy as an intervention tool in the community to prevent maternal and neonatal deaths: experiences from Bangladesh

Social autopsy (SA) is an innovative strategy whereby a trained member leads a group within a community through a structured, standardised analysis of the root causes of a death or serious, non-fatal health event.

Photo credit: Animesh Biswas/CIPRB

The root causes considered encompass physical, environmental, cultural, and social factors. Through participatory dialogue, potential causes of death are identified and suggestions are made of measures to prevent future deaths that are appropriate and achievable in the community.

This innovative approach has been used to prevent child injury prevention in Bangladesh in the past[1]. It has been recently introduced to reduce maternal and neonatal death.

Over the last six years, Bangladesh has introduced a maternal and perinatal death review (MPDR) system. It was initially piloted in January 2010 for the first time by the Ministry of Health and Family Welfare (MoHFW) within the scope of the Joint Government of Bangladesh and United Nations Maternal and Newborn Health Initiatives in Thakurgaon district[2,3]. Unicef, Bangladesh has been partnered with The Centre for Injury Prevention and Research, Bangladesh to provide technical and implementation support to the government. WHO, UNFPA and professional bodies engaged in designing, support in implementation and monitoring with the financial support from Global Affairs Canada, UKAID and European Commission [4].

The MPDR system reports each of the community's maternal deaths, neonatal deaths and stillbirths[5] which are then followed up within 7 to 21 days of the death occurring using "verbal autopsies". These verbal autopsies are conducted with a carer or family member of the deceased, focus on symptoms prior to death, and are used to understand the medical causes and contributing factors relating to maternal and neonatal deaths[6].

The Government of Bangladesh in 2010 agreed to introduce social autopsy to help examine the social determinants of a maternal death, neonatal death or stillbirth and learn how to prevent these from occurring again in the future. Social autopsies are planned to be conducted in the community after a verbal autopsy and usually within a month from the date of death.

The aim of conducting SA in MPDR is not necessarily to collect data related social factors to be analysed at higher level, but rather the process aims to support dialogue and action within the community in where a death has already occurred. The SA sessions are conducted in a non-blaming environment where examples of deaths are analysed and initiatives to prevent similar types of complications occurring in near future in the same community are proposed. The neighbours and relatives of the family get the opportunity to discuss on their own mistakes, and the community can collectively identify factors that influenced the death.

This participatory approach, facilitated by a government health worker, opens up a platform to help communities understand the mistakes and provide an opportunity to avoid such deaths in future[7].
According to the World Health Organization, social autopsy has not been widely practiced and still lacks of a standardised method. However, at present it aims to address the first of the 'Three Delays': namely barriers to seeking care[8].

Process of conducting social autopsy
In the government health system, the MPDR focal person at upazila level assigns a front-line health worker to conduct a social autopsy session in the community after each verbal autopsy has been completed. The SA is conducted in the presence of neighbours and relatives of the deceased. The facilitator also invites community leaders, elite persons, and local elected government leaders to participate in the session.

In the presence of around 30-50 people, the health worker facilitates the session in which neighbours initially describe what happened before the death in detail. From the description, a discussion is started and people participating in the session identify social errors and barriers and what could be done to prevent such deaths in the future.

Later on, from the discussion and comments, the health worker facilitating the session presents some information, education and communication materials to show the community what they need to do if any maternal or neonatal complications arise, and how to take corrective decisions.

The health worker requests that the participants commit to future prevention work. The health worker will give community leaders and elites the opportunity to state their commitment to work on future death reduction.

Following this event, the community are aware about what were mistakes or errors may have contributed to a specific death and how those types of deaths can be prevented in future. Engaging community leaders, elites and senior persons in the community creates a positive environment for individuals to collectively commit to improving health seeking behaviour. Usually one social autopsy session takes around 45 minutes to one hour. They are often organised for the early morning or late afternoon, which opens up scope for male participants to attend the session. This is especially important because men are the decision makers in the family in the majority of cases.

The effect of social autopsy on the community
SA has a number of positive contributions to make to the community, including:

1. **Building knowledge*:*** The SA session discusses maternal, perinatal and neonatal complications and their potential outcomes. The facilitator uses pictorial representations of different scenarios of complications and explains what is needed in such cases. The community learn from what has already happened to their own community and how those cases could be prevented in the future. This pictorial presentation with detailed description from the health worker helps the illiterate and lower educated people of different ages to clearly understand. Moreover, the process of talking through IEC materials also helps the older participants who are the decision makers in the family (for example, the mothers-in-law or fathers-in-law) to know about potential complications of mother and newborn.
2. **Creating a platform to self-reflection (community reflection):** SA allows an open discussion where neighbours, villagers, and relatives of the deceased are able to start a dialogue among each other about what really went wrong during a case of maternal or newborn death or stillbirth. This platform allows community members to reflect on their own role in the lead up to the death and question what they could have done differently.
3. **Enhancing community empowerment and leadership:** The participation of different stakeholders in the SA session enhances the empowerment of the community and builds leadership attitudes. A death occurring

Shefali, a 19-year old woman from Dhormogor village, decided to deliver her first baby with a skilled birth attendant after attending a social autopsy meeting.

“I come to attend a meeting to my neighbour’s courtyard in where there was a discussion going on a maternal death just occurred two weeks back. I come to know first time that the mother had severe bleeding after delivery and waited whole night, local birth attendant suggested to wait until morning. They waited over eight hours. Everybody in the meeting said that if the mother could transfer earlier, she could survive” Shefali recalled.

The social autopsy of this maternal death found that women in the community tended to deliver with an untrained birth attendant at home and they believed bleeding after delivery was a usual thing and nothing to be worried about.

When the participants in the social autopsy identified their own mistakes after learning about the dangers of post-partum haemorrhage from the health workers, they committed to transfer women faster to a health facility in cases of bleeding in the future.

“Nobody can stop me [choosing to] deliver by a trained birth attendant, now I clearly know about maternal complications. If I do any mistakes, me or my child may die. I know and understand from today’s meeting, photos were displayed, it’s now clear to me what I have to do in my case” Shefali explained.

in a community is always a tragic and emotional event. When people come to understand the social factors behind the deaths and understand their own mistakes, they feel empowered through knowledge to prepare themselves to prevent such complications in the future. Furthermore, the participation of the community leaders, local elites, and elected local government personnel ensure leadership of the community towards positive action.

4. **Increasing commitment:** At the end of the discussion, the community participating in the SA are encouraged to make commitments to preventing deaths in the future. The community leaders or local government personnel promise in front of their own villagers to work together to prevent such complications resulting in maternal and newborn death.
5. **Increasing equity and male participation**: SA is more than just a conventional courtyard meeting, both because it focuses on positive actions to prevent future deaths, but also because it supports equal participation between men and women. It is important that men attend, especially those who are decision makers in the family, however the facilitator ensures the participation of different stakeholders and an equal opportunity for men and women to speak.
6. **Increasing the agency of pregnant women:** In this type of interactive informative discussion on the issue of maternal and newborn death and stillbirths, pregnant mothers often feel empowered to learn and participate. The platform allows pregnant mothers the opportunity to understand each of the issues related to pregnancy and match their knowledge with their own experience of pregnancy. Therefore, the women become more conscious, active and careful about complications and the importance of health care seeking.
7. **Increasing heath care seeking:** It has been observed that after an SA has been conducted in a community, local facilities have seen increases in women attending for antenatal, postnatal and newborn care. Therefore, it seems that when the informed stakeholders voice their commitment to improving health care seeking, they do often follow through and support their women to attend the facility or health care centre. In this way, facility-based delivery can also be increased, and a number of good examples have been already seen in Bangladesh where women choose to deliver in a facility and advise the same for their peers, for example the case of Shefali, a 19 year-old woman from Dhormogor village.

Acknowledgement: This case study was written by Dr Animesh Biswas, PhD, Senior Scientist, Reproductive and Child health Unit at Centre for Injury Prevention and Research, Bangladesh (CIPRB), Dhaka, Bangladesh. It was reviewed by Dr Riad Mahmud, Health Specialist (MNH), UNICEF Bangladesh, Dr. Abu Sadat Md. Sayem, Health Officer, (HMIS and Planning), UNICEF Bangladesh and Prof. MA Halim, Director, RCH unit, CIPRB, Bangladesh. For more information on social autopsy in Bangladesh, email Animesh Biswas via: ani72001@gmail.com or animesh@ciprb.org

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Learn | resources on multi-disciplinary involvement in MDSR

Theme resources

The role of midwives in the implementation of maternal death review in health facilities in Ashanti region, Ghana

This qualitative Master's thesis from the University of the Western Cape, South Africa, highlights findings from the Ashanti region in Ghana, where midwives are actively involved in all stages of the implementation of facility-based maternal death review, including:

- reporting and certifying maternal deaths
- collecting and documenting evidence in order to notify the public health units
- processing and preparing evidence for the audit meetings
- participating in the audit meetings
- helping to formulate recommendations as part of the audit team,
- disseminating, implementing and monitoring the recommendations of the audit report.

The author found that midwives play a vital role, especially in facilities where there were no other clinical cadres of staff. The author recommends:

- Junior midwives be included in MDR meetings to build their confidence and involvement in MDR
- Continuous in-service training on issues related to MDR for nurses and midwives
- Inclusion of MDR in the Nurses and Midwifery Council of Ghana curriculum
- Specific training for midwives on their particular role within the MDR process

Experiences with facility-based maternal death reviews in northern Nigeria

This mixed-methods study emphasised the value of teamwork, commitment and champions at health facility level to facility-based MDR in Nigeria. The authors found that where key members of MDR committees transferred, where facilities were understaffed or there was a lack of supportive supervision, these problems significantly undermined the sustainability of the MDR process. They recommend MDR be institutionalised in the Ministry of Health to provide adequate support to staff.

An innovative approach to measuring maternal mortality at community level in low-resource settings using mid-level providers: a feasibility study in Tigray, Ethiopia

This paper proposes a community-based approach to measuring maternal mortality based on a feasibility study conducted in 2010-2011 in Tigray, Ethiopia, based on the concept of 'task shifting'. Priests, traditional birth attendants and community-based reproductive health agents were given responsibility for locating and reporting all births and deaths, and they assisted mid-level providers to locate key informants for verbal autopsy. From there, nurses and nurse-midwives were trained to administer verbal autopsies and assign cause of death according to WHO ICD-10 classifications. The study highlights the feasibility of using existing community and health structures to implement MDR.

The difficulties of conducting maternal death reviews in Malawi

This article uses a strengths, weaknesses, opportunities and threats (SWOT) analysis to assess the difficulties faced in conducting MDR in Malawi. It highlights the importance of the multi-disciplinary team in promoting collaboration and in ensuring issues relating to different disciplines are addressed. Good leadership, an emphasis on building staff capacity and ensuring the motivation of different members of the MDR committees are vital for sustainability and success.

Preventable maternal mortality in Morocco, the role of hospitals

This analysis of the findings of the national confidential enquiry around maternal deaths conducted the Ministry of Health in Morocco shows that 54.3% of the deaths analysed in 2009 could have been avoided if appropriate action had been taken at health facilities. This contradicted previous beliefs that the main causes of maternal death were due to women delaying seeking care. Lack of competence or motivation of staff were linked to the majority of cases of substandard care these women received. The authors recommend that the managers of local health systems and practitioners themselves received the information and means to support them to implement the recommendations of the audits. This study highlights the importance of involving hospitals and health providers in the audit process and particularly in supporting them to respond to findings.

Improving obstetric care in low-resource settings: implementation of facility-based maternal death reviews in five pilot hospitals in Senegal

This mixed-methods study conducted in five hospitals in Senegal found that the implementation of maternal death reviews were hampered by issues such as the non-participation of the head of department at audit meetings and the lack of feedback about the audit meetings to staff who did not attend. Factors which supported the MDRs included the involvement of the head of the maternity unit who acted as a moderator during audit meetings and the participation of managers in the audit meeting to plan appropriate and achievable actions to prevent future maternal deaths. The authors conclude that leadership is vital to secure MDR success.

Helping midwives in Ghana to reduce maternal mortality
This case study highlights the work of the Kybele humanitarian organisation in a referral hospital in Accra, Ghana. A Kybele midwife team member worked alongside doctors and midwives to support them to review maternal deaths and design quality of care improvements through small group work, supportive and targeted teaching. The case study notes that lack of observation and monitoring of sick women had previously contributed to maternal mortality and highlights the need for basic midwifery care to improve. Through the partnership model, the midwives at the hospital identified key areas of improvement, including better monitoring of women using partographs. The author emphasises that midwives' autonomy, standards and scope of practice within an interdisciplinary team were vital to their provision of safe care.

Gender mainstreaming in maternal death surveillance and response systems in Africa
This report, published by the African Union Commission and UN Women in May 2015, examines how maternal death audits or MDSR systems are being used to track gender inequalities. The researchers carried out in-depth interviews with key informants from five African countries (Chad, Ethiopia, Nigeria, South Africa and Tunisia) as well as a documentary analysis of key documents. On the basis of the findings from this research, the document provides recommendations on ways these systems can be used to monitor more effectively gender-related contributors and how to mainstream gender in MDSR systems in Africa.

Confidential review of maternal deaths in Kerala: a case study
This paper by Dr Paily and colleagues, describes the processes and findings from the Confidential Review of Maternal Deaths (CRMD) in Kerala, India. The paper describes how actions and recommendations were developed based on the findings, and on how the response and monitoring has been conducted a pilot phase to support continuous improvements in the delivery of quality of care. One of the key lessons learned relaters to the importance of raising awareness among administrator as a key group who can support the process of CRMDs as members of the multi-disciplinary team.

Act | updates from around the world

Malaysia | Strengthening MDSR at national and regional level

The MDSR system in Malaysia is often referred to as a model upon which other countries can learn about how success can be achieved with limited resources. To support other countries in taking forward MDSRs, the Government and Ministry of Health of Malaysia are actively supporting implementation in Lao PDR, Vietnam and Nepal with regular visits conducted by Dr Ravichandran (Ravi) Jeganathan, the National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia. Dr Jeganathan summarised the focus of his advocacy during the Lao PDR meeting as a call for ensuring adequate skilled birth attendance for each community at village level by ensuring that each village to have at least one midwife.

During these visits, local teams are guided in how to adapt and develop tools to conduct the investigation process, and have been trained how to conduct maternal death reviews. Specific attention is given to clarify the concept of a non-punitive approach and how the response mechanism can be implemented and achieved with ease, even with minimal resources.

Dr Jeganathan is a keen advocate for including medical and

nursing students on the training to ensure their exposure to the concept of MDSRs early on in their career.

In Malaysia, the sixth edition of the **Report on the Confidential Enquiries into Maternal Deaths in Malaysia 2009 - 2011** is now available upon request.

In addition, a near miss registry is being finalised; parameters have been identified and tools drafted. This near miss approach will be piloted in one district hospital in September 2016 to ascertain its validity.

Acknowledgements: This country update was informed by feedback from Dr Ravichandran Jeganathan, the National Head of Obstetrics and Gynaecological Services at the Ministry of Health in Malaysia. For previous country updates of Malaysia and a case study written by Dr Jeganathan, follow the links or visit the MDSR Action Network website.

Ethiopia | Scaling up MDSR across the health system

Evidence for Action (E4A) has been supporting the Federal Ministry of Health to strengthen the maternal death surveillance and response system in Ethiopia over the last five years. In the last quarter, the MDSR system has seen significant scale up, with technical assistance at national level and in Oromia, Amhara and Southern Nations, Nationalities and People's region to support the extension of coverage of MDSR across Ethiopia.

In Amhara, MDSR training at zonal and woreda level have been held in all zones. Four weeks ago, a round of training was conducted in the region aimed at strengthening hospital facilities to use MDSR, with evidence from the two most functional zonal MDSR systems used to demonstrate the potential impact.
Training on integrating MDSR into the health system has also been conducted in 11 zones in Oromia since the end of February 2015, with over 380 participants attending from previously untrained zones. Three training sessions have been held in the Maji, Mizan and Yirgalem centres in the region to support MDSR integration, attended by a total of 181 participants from five zones.

In addition, the MDSR engagement by stakeholders at all levels of the health system has increased. For example, earlier this year, a special meeting of East Harege Zone representatives together with CEOs and Medical Directors from all five referral hospitals in Dire Dawa and Harar was coordinated and hosted by Ato Ali, Head of East Harege Zone, to discuss the fact that many of the women who die at hospitals in Dire Dawa and Harar are from East Harege Zone. This cross-regional, cross-zonal collaboration established valuable channels for communication about improving the referral process, the early transfer of critical patients, prioritising maternity patients and orientating ambulance drivers on the needs of maternity patients.

Supportive materials have been developed to help promote MDSR, such as a manual for National Public Health Emergency Management / MDSR and a promotional video targeted at leaders and decision-makers has been produced to give an overview of the workings of the MDSR system in Ethiopia. The video encourages institutionalising a 'no blame' approach, and uses real life examples to outline the process and purpose of MDSR as well as the importance of engaging staff from all tiers of the health system.
Finally, as E4A Ethiopia DfID funding ended in March and an extended contract supported by the Gates Foundation was implemented from April, a technical symposium has been organised to take stock of lessons learned on MDSR so far and discuss future implications for strengthening the MDSR system to become nationally embedded in Ethiopia.

To read more about the MDSR work in Ethiopia, see the Ethiopia February 2016 newsletter, or look out for the upcoming June 2016 version, here.

Acknowledgements: This country update was developed based on feedback from Dr Ruth Lawley, Technical Support Unit Coordinator for E4A in Ethiopia, as well as information from the E4A quarterly report and the February 2016 Ethiopian newsletter.

Tanzania | Rolling out MPDR to new regions

A maternal and perinatal death reviews (MPDR) system has been embedded in Mara Region in Tanzania with support from the Mama Ye-E4A programme. This programme worked with the Ministry of Health to establish accountability mechanisms at and council levels in line with the national MPDR guidelines which ensures timely reviews of the implementation progress. The evidence-based National MPDR Guidelines have been replaced by MPDSR guidelines.

Mara was chosen by the Ministry of Health to act as an initial roll-out region for the new MPDSR guidelines in Tanzania. A subsequent assessment suggests that health care providers and managers have the required skills to implement the national guidelines effectively across all levels of service delivery and administration. This brings optimism that for the first time in the national implementation of maternal and perinatal death audits, progress will be monitored and evaluated to inform subsequent responses in maternal and perinatal survival and well-being for transformative gains across the health sector and beyond.

In embedding a functioning action and response cycle through the MPDSR process, Mama Ye-E4A ensured that decision-makers have been supported to continue to deliver against their responsibilities and commitments such that a functioning action and response cycle is embedded and sustainable in Mara region. The last quarter saw the end of the Mama Ye-E4A programme in Tanzania, but the important progress and championing of the establishment and subsequent roll-out of MPDSR looks set to continue under the remit of the GIZ-supported Tanzania German Health Support Programme.

The MPDSR system has been rolled out by the Ministry of Health to two more regions of Kagera and Lindi. Already, training has been conducted for key personnel in all hospitals in the two regions, regional and council health management team members and to stakeholders' staffs supporting the two regions in RMNCAH namely Jhpiego and GIZ respectively. MPDSRs are recognised as key accountability and quality of care improvement mechanisms and referred to in the National Health Sector Strategic Plan 2016-2020- an important health sector guiding document beyond RMNCAH to ensure they remain a priority in the years to come. They have also been incorporated in the final drafts of the One Plan II (National RMNCAH Strategy for 2016-2020).

At the national level, the WHO country office has released funds for rolling out MPDSR across all regions in the country using the same platform that was used to roll-out the Sharpened National Accelerated Plan for Reduction of Maternal, Newborn and Child Deaths. Thus, significant activities are expected countrywide with a focus to impact appropriate skills in MPDSR implementation across all regions.

Acknowledgements: This update was informed by feedback from Moke Magoma, former Evidence Advisor on Mama Ye-E4A Tanzania; a March 2016 policy study conducted by Dr Sarah Clark (University College London), Dr Stephanie Smith (University of New Mexico), and Dr Moritz Hunsmann (French National Centre for Scientific Research); country director reports; and Mama Ye-E4A quarterly reports.

Bangladesh | Rolling out MPDSR across the country

Following a successful pilot in Thakurgaon district in 2010 by UNICEF[1,2,3], the Ministry of Health and Family Welfare (MoH & FW) of Bangladesh has taken the lead and made a commitment to gradually scale up maternal and perinatal death surveillance and response (MPDSR) across the entire country by 2021.
The national guideline for MPDSR has been approved and the Quality Improvement Secretariat of the Health Economics Unit at the MOH & FW is working with key stakeholders including Directorate General of Health Services, Directorate General of Family Planning, UNICEF, UNFPA, WHO, The Centre for Injury Prevention and Research, Bangladesh and other partners to plan for the roll out in a phase wise manner.

To date, MPDR/ MPDSR is being implemented in 17 out of Bangladesh's 64 districts with support from UNICEF in 13 districts and, Save the Children in four districts, with implementation due to take place in two more districts supported by UNFPA in 2016. A series of planning meetings are being conducted by the MoH & FW with the experts to finalise the roll out plan, determining training modalities, review processes, etc. UNICEF, Bangladesh has been providing technical and implementation support to the Ministry of Health and Family Welfare for rolling out MPDSR in collaboration with UNFPA and WHO.

Recent activities include:

- A six-member team comprising representatives from the MOH & FW, professional societies, UNICEF and WHO attended the regional MPDSR Meeting organised by the WHO's South East Asia Regional Office in February 2016, where progress on MPDSR in Bangladesh to date and plans for the country wide phase wide scale up by 2020.
- National MPDSR tools (death notification, community verbal autopsies, facility death reviews) have been simplified by MOH & FW. Key variables incorporated in District Health Information System software of Management Information System of Directorate General of Family Planning which will enable real time data tracking

- MPDSR national guideline sharing workshop was organized by the Health Economics Unit, MOH & FW in Chittagong division in May 2016 with support from UNICEF. Participants included health and family planning managers from division, district and upazila level, health officers of the City Corporation, obstetricians and neonatologists from the teaching hospitals and other related stakeholders. News of the workshop can be seen by clicking here.
- A case study on social autopsy titled 'Social autopsy triggered community responses for averting maternal and neonatal death in Bangladesh' was published in WHO global website in April which was prepared jointly by UNICEF Bangladesh, MOH&FW and the Centre for Injury Prevention and Research[2]. Click here to read this.

Upcoming events: July – September 2016

- A dissemination workshop on the newly developed national guideline on MPDSR will be organized by the Quality Improvement Secretariat, HEU, MOH&FW with support from UNICEF
- An experience sharing meeting on MPDSR with 17 districts will be organised by Director General of Health Services, MOH&FW with support from UNICEF.
- A dissemination workshop of the newly developed national guideline on MPDSR will soon be held by the Quality Improvement Secretariat of the ministry. Seven divisional sharing and orientation workshops are in the upcoming plans of the ministry.

Acknowledgements: This update was prepared by Dr Riad Mahmud, Health Specialist (MNH), UNICEF, Bangladesh, and reviewed by Dr. Md. Aminul Hasan, Deputy Director, Health Economics Unit, Ministry of Health & Family Welfare; Dr. Lianne Kuppens, Chief Health section, UNICEF Bangladesh; Dr. Abu Sadat Md. Sayem, Health Officer, UNICEF; Dr. Shayma Khorshed, Consultant, Health Economics Unit, Ministry of Health & Family Welfare and Dr Animesh Biswas, Senior Scientist, Reproductive and Child Health Unit of CIPRB, Bangladesh.

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Nigeria | Ensuring the sustainability of MPDSR

With the support of the MamaYe-E4A programme over the last five years, Nigeria has worked to embed the MDSR process at state level in the country –and is the only setting that we knew of with a sub-national level maternal death review (MDR) scorecard at the time of dissemination in October 2015.
In the last few quarters in Ondo State, two MDR scorecards have been developed by the Evidence Sub-Committee of Ondo State Accountability Mechanism for Maternal and Newborn, Health supported by E4A-MamaYe. These scorecards were based on the MDR data from all secondary-level facilities and two Mother and Child Hospitals in the state and aim to challenge the previous lack of reporting and review of maternal deaths. The scorecards were disseminated at a stakeholder meeting in Ondo and one of the key findings (that sepsis had overtaken haemorrhage to become the highest cause of maternal death) sparked lively debate.

The attendees explored the issues from both the woman's and the facility's point of view, and suggested strategies on both fronts for example, educating women on personal hygiene during antenatal care whilst also encouraging prompt referral of cases of premature rupture of the membranes at facilities.

One of the key issues discussed was while Ondo State Mother and Child Hospital provides most maternal, newborn and child health (MNCH) services for free, the most effective antibiotics, cephalosporins, are not exempted from costs. This means that staff may be forced to prescribe women cheaper antibiotics because they cannot afford cephalosporins. This was also leaving women open to the risk of being sold fake drugs by pharmacies, which would be ineffective against sepsis. The Ondo meeting attendees discussed strategies to counter this issue, for example, advocating at state level to get cephalosporins included in the free MNCH services, and using TruScan, a device which can detect fake drugs, to ensure women are being given genuine drugs.

While MamaYe-E4A's presence in Ondo State ended in March 2016, key components of the programme are being integrated into the DfID-funded MNCH2 programme in Jigawa, Kano, Katsina, Zamfara, Yobe and Kaduna States including MDR scorecards and advocacy. In addition, under a new contract from the Gates Foundation, MamaYe-E4A is working to replicate this success in other States, including setting up similar systems in Lagos State.

Recent successes in Bauchi State include the review of MDR reports from 2015 by the Bauchi State MDSR Steering Committee, which enabled them and the Bauchi State Accountability Mechanism for MNCH to convene a stakeholder meeting to discuss and identify causes of maternal death and create action plans. At this meeting it was revealed that the highest cause of maternal death was anaemia, and possible factors causing this were identified to include the high prevalence of worm infestation and poor nutrition among women, as well as supply-side issues such as inadequate access to health services and lack of blood supplies. Discussions then focused on how to tackle these issues: how to ensure women are de-wormed regularly, provide nutrition education on diet using local foods, and how to make sure facilities have functional blood banks.

In Lagos State, the recent inauguration of the maternal and perinatal death surveillance and response system included launching a committee at state-level and supporting the training of 135 health care providers across secondary facilities and one tertiary facility. Training was conducted in four batches and was the first MamaYe-E4A had conducted under the updated national MPDSR guidelines which aimed to integrate perinatal death review into MDR systems.

This national level focus on perinatal death is being consolidated. In June, the National MPDR Steering Committee meeting members discussed building on the experience of MamaYe-E4A and MNCH2 in training health care providers on the updated MPDSR guidelines. A workshop was planned for the end of June where MamaYe-E4A and MNCH2 could share their training methodology, slides and materials to support the national MPDR Steering Committee in developing a training manual on MPDSR.

This focus on perinatal death is also filtering down to state level: the last MDR scorecards from Ondo State (January to March 2016) highlighted perinatal death review data in line with the national shift towards a commitment to perinatal survival.

To view the MDR scorecard for Ondo State (January to March 2016), please click here.

Acknowledgements: This country update was compiled from feedback from Dr Tunde Segun, Country Director for E4A-MamaYe Nigeria, and content from E4A quarterly reports.

Sierra Leone | Investing in MDSR

In Sierra Leone, significant investments have been made to move MDSR-related work forward over the last quarter. The National MDSR Committee held a meeting in June 2016, chaired by the Director of Reproductive and Child Health, with representatives from UNICEF, UNFPA, WHO as well as a representative of other health NGOs including Options, to assess progress and propose strategies for the next quarter. The meeting highlighted to following achievements and activities:

- MDR committees at district level which had operated before the Ebola outbreak have been restructured and adapted to MDSR Committees and inaugural meetings have been completed in all districts except Western Area.
- In some districts, the process of actively reviewing deaths has begun.
- Social media platforms are being used to support the multi-professional communication needed to sustain and grow the MDSR system through a WhatsApp groups for District Medical Officers, Midwife Investigators, M&E Officers, Disease Surveillance Officers and other stakeholders. The World Health Organization has supported the development of an MDSR database using EpiData and training material including presentations on MDSR to support collection, inputting and analysis have been developed.
- UNFPA is supporting a pilot regional blood collection campaign in response to findings from reviews of maternal deaths from haemorrhage between June and July 2016, as well as providing desktop computers to all districts for MDSR activities and supporting educational discussion programmes on maternal and child health on radio and television.

The meeting provided a good opportunity to plan further consultative meetings, for example, with Paramount chiefs in June and religious and women's groups at later dates, to ensure wide stakeholder buy-in to the system and maximum impact for MDSR data in the future.

Acknowledgements: This country update was informed and approved by Bockarie Sesay, M&E Advisor for Options-PMEL, in Freetown, Sierra Leone.

Malawi | Pioneering MDSR in new districts

In Malawi, the Reproductive Health Directorate, National Committee for Confidential Enquiries into Maternal Death (NCCEMD) and UNFPA are taking a lead in the establishment of MDSR in three new districts (Mzimba, Nkhata Bay and Rumphi) in the northern zone. Over the last few years, MamaYe-E4A has worked in the central and southern regions to introduce components of MDSR into several districts, and this expertise is now being called upon in the expansion of the system to the new districts.

With support from MamaYe-E4A in Balaka, district stakeholders have established MDSRs where there had not been any maternal deaths investigated for a substantial period of time. MamaYe-E4A worked with district authorities to use Health Management Information System and MDSR data to compile a district data dashboard: a user-friendly visual display of graphs in an Excel spreadsheet allowing decision-makers to easily use data to inform their decisions. Based on the analysis of these data, annual MDSR reports were developed, and submitted by the Maternal Health Coordinator to the Director of Health for Balaka to the District Council. The reports highlighted issues with lack of blood and equipment, and the information prompted the District Commissioner for Health to work in collaboration with representatives of civil society and representatives of the community to start fundraising for resources for the health sector.

This type of support is now being extended through MamaYe-E4A to selected districts in the northern region (Rumphi, Nkhata Bay and Mzimba) through funding through the Gates Foundation, in collaboration with the RHD, NCCEMD and UNFPA through the process of establishing the MDSR systems. Through a series of intensive meetings in June, representatives of MamaYe-E4A have supported these organisations to take the lead on MDSR through:

1. Developing an MDSR monitoring tool for national level monitoring of the districts' work on MDSR
2. Adapting a maternal death audit form to be used by the districts themselves to monitor their own progress
3. Putting together a 2016 workplan, including a commitment to support districts to produce their own quarterly reports according to the guidelines in order for district level decision-makers to be able to take action without having to wait for feedback from the national level monitoring. The plan also includes a proposed meeting between the NCCEMD committee and the National Minister for Health in July to share the progress report on the status for MDSR in the country
4. Developing terms of reference for MamaYe-E4A'ssupport of MDSR-focused supportive supervision visits in the three districts.

In addition, MamaYe-E4A has been asked by the CCEMD to finalise the MDSR reports from 2014 and 2015, where these reports have experienced delays related to missing or un-submitted data.

In the last quarter, priorities in the new districts include establishing quarterly supervision of the community-MDSR (cMDSR) committees by district teams and training new cMDSR committees in verbal autopsy. Where there are periods of an absence of maternal deaths at this level, the momentum of the cMDSR committees is being maintained through a broader involvement in the MamaYe campaign. Committee members are engaging in work as MamaYe activists and also as activists mobilising their communities to give blood during the National Blood Transfusion Services' blood donation drives to help prevent maternal deaths from haemorrhage.

District health authorities in the northern districts have also been supported to replicate the district data dashboard model used in Balaka. Based on evidence arising from the dashboards and MDSR data, e evidence-based advocacy materials have been developed, which call upon different groups to act in support of improving the lives of mothers and babies. For example, in Nkhata Bay, the district data dashboard has revealed that 22 women died from pregnancy or childbirth-related causes between 2013 and 2015, and posters and leaflets were developed to call on healthcare workers, district leaders and traditional authorities to address this issue.

Finally, Malawi is also in the process of establishing nationwide best practice guides. The training of health workers in MDSR has so far been based on the national guidelines, but the Ministry of Health is in the process of standardising the training through establishing a training manual. A database is also being established to list all the health workers already trained in MDSR so that they can be called upon to help scale up the system.

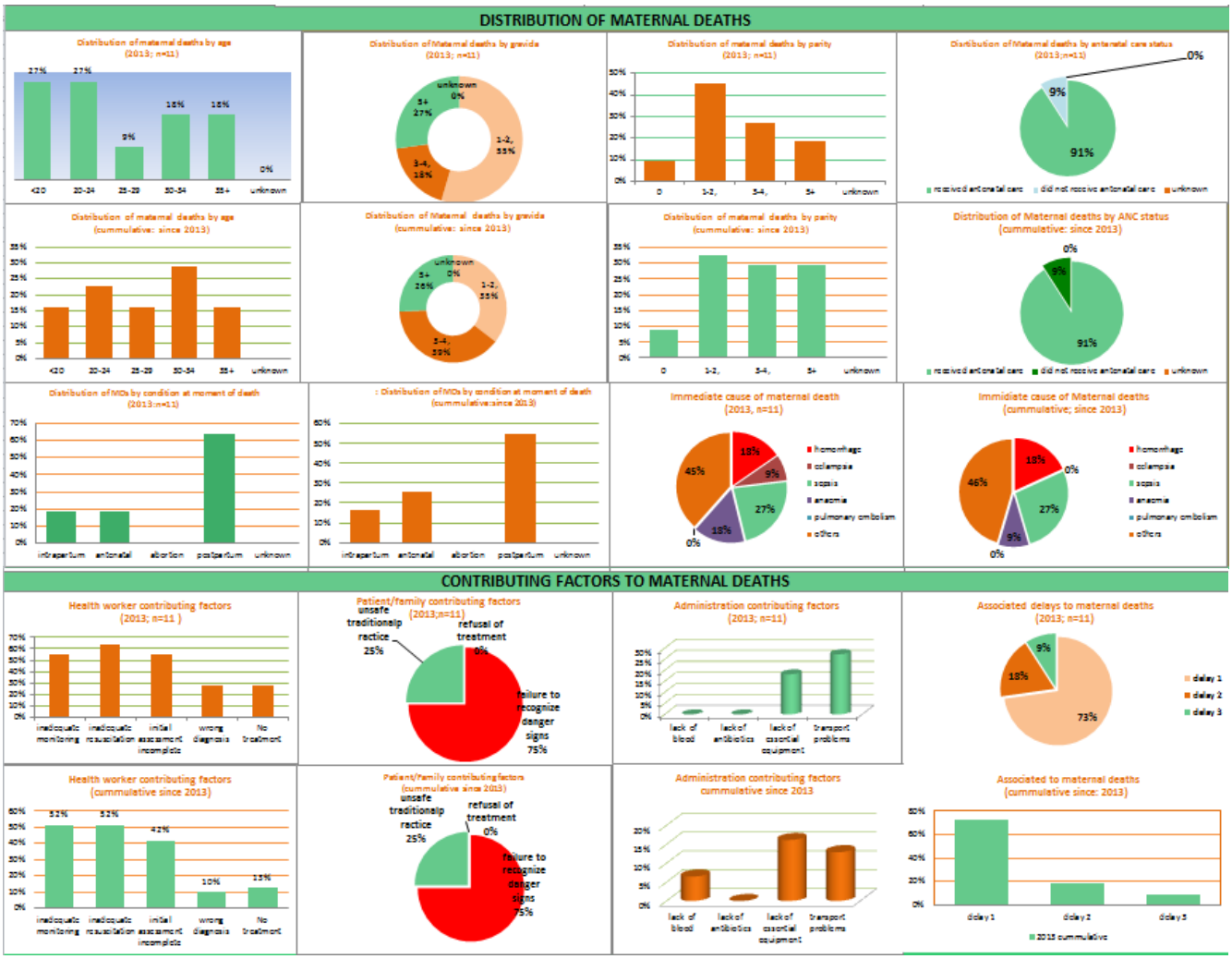

Illustration of dashboard data from a district in Malawi

To view the posters and leaflets developed in Nkhata Bay to call for stakeholder action, please click here and read more about how this evidence on maternal health is used to drive accountability from this link.

Acknowledgements: This country update was developed based on feedback from Project Manager for MamaYe-E4A, Lumbani Banda, and Evidence Advisor for MamaYe-E4A, Hajj Daitoni, as well as updates from the programme reports.

Act | in other news…

- The Ministry of Health in **Uganda** has introduced a policy on maternal and perinatal death review in all government and private hospitals. Read more here.
- The Government in the **Republic of Ireland** is considering establishing compulsory public inquiries into the deaths of women and babies in childbirth. Read more here.
- In **Ghana**, maternal and perinatal death audit trainings were rolled out in some regions in response to a decline in the number of maternal death audits conducted between 2014 and 2015. Read more here.
- A national maternal death prevention campaign in the **USA**, led by the Association of Maternal and Child Health Programs and the Center for Disease Control and Prevention, aims to establish maternal mortality review panels in states which do not currently have one. Read more here.
- In **Kerala, India**, the Confidential Review of Maternal Deaths data from 2006-9 has been compiled into a report titled 'Why Mothers Die: observations, recommendations'. It's accessible here**.**