WORLD HEALTH ORGANIZATION
EUROPE

Making Pregnancy Safer

Multi-Country review meeting on maternal mortality and morbidity audit "Beyond the Numbers"

Report of a WHO meeting

Charvak, Uzbekistan 14-17 June 2010

Abstract

Every year, many women suffer pregnancy-related complications and a number die; added to this is the burden of perinatal mortality and morbidity. Most maternal and perinatal complications and deaths can be averted with basic and effective low cost interventions, even in countries where resources are limited. Within the WHO Making Pregnancy Safer programme, Beyond the Numbers (BTN) presents a series of approaches that show how this can be accomplished through the use of appropriate case reviews, analysis and dissemination of recommendations. The 1st European regional BTN workshop was held in Issyk Kul, Kyrgyzstan in 2004, the 2nd was held in Yerevan, Armenia, in 2005, involving in total 14 countries in the WHO European region. The objectives of the workshops were to introduce the concepts of BTN and demonstrate how they can be used as tools for improving clinical management and outcome of care. Furthermore to support countries in selecting and implementing BTN approaches tailored to local conditions in line with their specific needs and available resources. In the following years several of these countries started implementation of Confidential Enquiries into Maternal Deaths and Near Miss Case Reviews. The multi-country review meeting, Charvak Uzbekistan 2010, invited teams from countries in the Region which started implementation of selected BTN approaches, to share lessons learned and experience to further improve and enhance the positive effect of the quality of care for mothers and babies in the countries.

Keywords

MATERNAL MORTALITY
MATERNAL HEALTH SERVICES – organization and administration
ALBANIA
ARMENIA
AZERBAIJAN
GEORGIA (REPUBLIC)
KAZAKHSTAN
KYRGYZSTAN
REPUBLIC OF MOLDOVA
ROMANIA
RUSSIAN FEDERATION
TAJIKISTAN
TURKEY
TURKMENISTAN
UKRAINE
UZBEKISTAN

Abbreviations

BCA	biannual collaborative agreement
BTN	Beyond The Numbers
CAH	child and adolescent health
CEMD	Confidential Enquiry into Maternal Death
CPS	Country Policies and Systems (section of WHO Regional Office for Europe)
EBM	Evidence-based Medicine
EPC	Effective Perinatal Care
FCH	family and community health
GEM	gender mainstreaming
IMPAC	Integrated Management of Pregnancy and Childbirth
MCH	maternal and child health
MDGs	Millennium Development Goals
MPS	Making Pregnancy Safer
NCAMM	National Committee on Maternal and Child Mortality
NCCEMD	National Committee on CEMD
NGO	Non Governmental Organization
NMCR	near-miss case review
NPO	national professional officer
RHL	(WHO) Reproductive Health Library
RHR	reproductive health and research
SC	Steering Committee
ToT	training of trainers
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Contents

1 Executive summary

The key mission of the WHO, Making Pregnancy Safer programme is to support improvement of maternal and child health (MCH) in the region, the ultimate goal of its work being to help improve the health of and care for mothers and babies. This is done with the collaboration and good partnership with the Ministry of Health (MoH). MPS works in countries is to help the MoH and government prioritize, coordinate and identifying the gaps in their health system.

Building on existing programmes and the characteristics of the Region, MPS designed a framework and steps for implementation, including a set of complementary tools specifically adapted for these countries. Moreover, it has created a roster of international and local experts to provide support to activities. Partner agencies, such as the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and others play an indispensable role in disseminating MPS methodologies and materials throughout the Region.

All the activities carried out in the Region by the MPS programme are carefully planned step by step, in order to ensure that the MoH and the maternities have the right foundation, technical capacity, local expertise, adapted tools and guidelines as well as the correct supervision. All these components are prerequisite and mandatory for the successful implementation of the audit of maternal mortality and morbidity audit.

Most of the countries involved in this Region have a traditional system of audit of maternal deaths, which is not based on evidence, no multi-disciplinary approach, and uses punitive methods.
As underlined above, BTN is one of many components of the MPS programme, which aim at improving the quality of care in maternities, through confidential, evidence based, professional case reviews.
The multi-country BTN meeting held in Charvak in June 2010 provided a mid-term review of achievements and challenges met in the different countries, gave the opportunity to document real lessons learned and update plans for the future.

The outcomes of the meeting were the following:

Achievements:
BTN is successfully implemented in 5 countries, and is in early phase of introduction in 7 other countries who have requested to be involved.
BTN implementation includes improvement of emergency care, better use of updated standards and facility based protocols, better teamwork around childbirth, **e**nhanced role of midwives, and consideration of women's opinion.

Lessons learned:
Implementation of principles and practice of Making Pregnancy Safer WHO Europe Effective Perinatal Care is essential as a basis for successful BTN introduction.
Many of the recommendation springing from the case reviews are related to organizational issues.
National clinical guidelines on major obstetric complications are a pre-requisite for BTN introduction; local algorithms and protocols should be developed.
Support from managerial level and MoH, and external support from experts are crucial for appropriate BTN implementation.

Challenges:
Health professionals still fear punishment preventing them from providing real information; breach of confidentiality; insufficient skills on new audit methodology; staff shortage and migration of health professions trained in BTN approaches.
Documentation of process, results, and lessons learned is to be strengthened.

2 Introduction to Making Pregnancy Safer

Childbirth is mostly a positive experience but, in many parts of the world, mothers and babies still die unnecessarily as a result of preventable factors. Lack of access to services contributes to these deaths, as does the lack of providers' capacity to identify and manage complications and provide the right support to women and their newborn babies. Broader determinants – such as education, income, poverty and gender inequalities – also influence the outcome of childbirth.

WHO launched the Making Pregnancy Safer (MPS) programme globally in 2000 to help countries scale up access to essential interventions to reduce maternal and newborn morbidity and mortality and improve health. The key message of the MPS global strategic approach[1] is to ensure skilled care at every birth within the context of a continuum of care.

Further, all women should have the highest attainable standard of health, secured through the best possible care before and during pregnancy, childbirth and the postpartum period. This continuum of care encompasses the life-cycle of the woman, from adolescence through to the birth of her child. In addition, it includes all levels of the health system from the household to the first service level, and a higher-level referral service site, as appropriate for the needs of each mother and newborn baby. Technical and financial capacity building should ensure sustainability: self-reliance in these areas is a target for national governments and partners working collectively.

Although maternal mortality is decreasing in the WHO European Region, significant inequities in access to quality care still exist between and within countries. For the last decade, the WHO Regional Office for Europe has supported countries in using an evidence-based approach through its Making Pregnancy Safer programme. Member States and partners recognize this programme as a powerful forerunner in setting models of intervention and supporting the implementation of best practices in maternal and neonatal health. This work also contributes to the global efforts to reach the Millennium Development Goals (MDGs); MDGs 4 and 5 address the health of mothers and children.

Member States value the health of mothers and their children as a fundamental asset to society and a pillar of health systems' performance. The experience gained over the years shows which interventions work, and provides several examples of their successful implementation in countries.

Complications of pregnancy and childbirth still rank among the causes of death and disability in young women and babies – deaths that in many cases can be prevented. Societies are obliged to make use of available evidence-based approaches to prevent these avoidable deaths, but need to do more. The WHO Regional Office for Europe will continue to coordinate and carry out actions with partners to ensure the attainment of the highest possible level of health for mothers and babies.

2.1 Making Pregnancy Safer, Regional Office for Europe

MPS introduction in this region started in 2001. First, Regional Office for Europe designed a training package, **Effective Perinatal Care (EPC)**, to stop unnecessary and harmful practices and initiate a number of low-cost, family-centred practices supported by evidence. Unlike earlier training courses, this one teaches doctors, midwives and nurses together instead of separately, and combines theoretical training with clinical practice. In addition, it emphasizes the role of the midwife, often an underpaid and underestimated professional.
The next step was the introduction of **evidence-based medicine (EBM)**, a new concept for some health professionals. The programme conducts a course training professionals to find the best available scientific

[1] Making a difference in countries: Strategic Approach to Improving Maternal and Newborn Survival and Health, WHO Department of Making Pregnancy safer, 2006

evidence for any intervention, to learn how to develop clinical guidelines and to harmonize their working practices with them.
In some countries, fear of punishment from health authorities has crippled accurate reporting and real case reviews in the maternity wards, and thereby hindered necessary improvements. WHO developed a methodology called **Beyond the Numbers** to identify the reasons behind maternal deaths and serious complications. When the other components were implemented, MPS started supporting the use of confidential, professional enquiries, without blame or punishment, ensuring that needed changes in care provision and organization can be made. Consequently, understanding the underlying factors that led to these deaths is essential, if wanting to save mothers' lives and to reach the Millennium Development Goal nr. 5.
With the **assessment of the quality of hospital care for mothers and newborn babies**, WHO offers maternity hospitals the chance to make a comprehensive check of their services and identify key areas needing improvement. This tool lists essential medicines and equipment, measures staff routines with international standards, includes service users' views and makes recommendations for the hospital team and the health system.
Regionalization of perinatal care is an approach intended to rationalize existing health care services to ensure that each mother and baby is cared for in an appropriate facility, with clear criteria for where different risk categories should give birth and indicators for monitoring results. Using a bottom-up approach, MPS involves key professionals in redesigning the organization of perinatal care.
The European **strategic approach for making pregnancy safer** provides countries with guidance on developing or updating policies for health system reform. The related **tool for assessing the performance of the health system** guides health staff, administrators and politicians to evaluate the health care complex and find ways to amend the shortcomings encountered.
Over the years, experience has shown that the right combination of these tools and activities benefits the health of mothers and babies.

3 Introduction to Beyond the Numbers

The philosophy of Beyond the Numbers (BTN) is simple: maternal deaths can be avoided even in resource-poor countries; however, to do so requires the right kind of information on which effective interventions can be based promoting understanding of the factors that led to the deaths. Case reviews can provide evidence of where the main problems lie, what can be done in practical terms and key areas requiring interventions by the health sector and community, allowing development of up-to-date evidence-based clinical guidelines.

Systematically combining findings of individual reviews of women's deaths into wider maternal death or morbidity reviews will allow a more robust analysis; outcomes of such reviews resulted in practical changes in the provision of maternal care with significant improvements to outcomes of care, providing a baseline against which to monitor the success of interventions. Such a method for monitoring implementation of recommendations is an essential part of the system, providing stimulus for health sector action and reminding health professionals and review committees that their recommendations need to be evidence-based. The results of case reviews can also have a powerful advocacy role and can be used by Ministry of Health, government and decision-makers to raise awareness and mobilize national and donor resources.

BTN is a practical guide written by leading international experts and describes five proven approaches for reviewing cases of maternal death or morbidity. There is no one size fits all solution to maternal deaths and complications. Even if causes and determinants are similar, each country, district, facility or community faces a unique set of problems and constraints that need to be worked out on an individualised approach. The philosophy proposed in BTN and its methodologies for case reviews can be the first step in this process.

The results of case reviews determines what, if any, avoidable or remediable clinical, health system or community-based factors were present in the care provided to the women and enable health care providers and health planners to learn from the errors of the past.
Any of the BTN approaches results in recommendations for change that should, particularly in resource-limited countries, be evidence-based, simple, affordable, effective and widely disseminated. Most of the clinical recommendations are in line with the evidence-based guidelines that are part of the global WHO IMPAC[2] tools and Effective Perinatal Care training package developed by the WHO Regional Office for Europe and partners.

3.1 The Framework of Beyond the Numbers in the Euro Region

Reviews of maternal dearth cases and severe complication are carried out by hospitals and by MoH in almost all countries in the WHO European Region. These reviews target identifying "mistakes" and culprits and hand down disciplinary sanctions. One of the major outcomes in most instances is punishment of health staff, despite often death and complications happen for reasons that are beyond their possibility for action, and are often systemic. Therefore these traditional reviews are counterproductive to full identification of cases, gathering appropriate information regarding each case, and prevent professional discussions, finding real reasons and developing effective preventive measures.

The challenge in many countries in WHO European region is to replace these well-established but dysfunctional quality control system inherited from the past, by BTN which has different objectives and mechanisms. Unlike traditional maternal death reviews, BTN methods are supportive, not punitive. They depend on frank discussion of strengths and weaknesses in case management; professionals speaking out are not threatened with disciplinary action or criminalization. BTN approaches are based on updated scientific evidence and not on opinions, they are confidential.

The development of a key set of clinical guidelines for major obstetric complications, as well as management of normal childbirth, in order to provide sound reference for case reviews, was as prerequisite for WHO to initiate work in countries which requested to introduce BTN. Therefore, capacity building in EBM and support to national teams, international expertise on draft documents, as well as support to stewardship function of MoH for official endorsement, was ensured as a component of MPS and to provide basis for BTN.

In this particular region, the WHO has initiated the implementation of two out of the five available approaches: the Near-Miss Case Review (NMCR) at facility level, Confidential Enquiries into Maternal Deaths at national level. Both approaches share same principles of confidential, evidence based, team professional reviews

Near-miss case reviews can be used at hospital level, as this approach works with cases of complications into pregnancy, including assessment on what was done well and what can be improved. An essential part of this approach is to voice the surviving woman's story and her experience of the incident. Step by step the team who treated the woman evaluates the case and identifies possible challenges and incorporates improvements and changes of practice into the existing clinical guidelines at the facility.
As a "grass roots" activity they empower local staff including midwives, who did not play an active role in previous reviews. No deaths being involved, usually they do not imply involvement of judiciary and mandatory punishment. Because the women have survived, their perspectives on the care they have received can be taken into account. For the same reason there is always something to applaud, making it easier for team members to open up, discuss frankly and avoid blaming one another. The strategy to start

[2] IMPAC is a comprehensive set of norms, standards and tools that can be adapted and applied at the national and district levels in support to country efforts to reduce maternal and perinatal morbidity and mortality. Available from Department of Reproductive Health and Research, WHO Geneva. Consult website http://www.who.int/reproductive-health/index.htm for other information.

with near-miss case reviews and to delay confidential enquiries until the context is ready for them appears to be wise.

The second approach implemented in the region is Confidential Enquiry into Maternal Death (CEMD), and aims at providing broad recommendations and influencing the overall policy at national level. In order to make qualified general policy decisions this approach requires a certain number of cases. An independent team of experts evaluates anonymous cases of maternal death from different facilities throughout the country, and develops overall policies from the reviews.

Confidential enquiries into maternal deaths are a comprehensive BTN approach and a "gold standard" for systematic investigation of maternal deaths. As a national operation they are logistically demanding and require changes in the legal framework in many countries where the investigation of maternal deaths involves the prosecutor. It is a challenge to convince those in authority that confidential enquiries are more effective than the existing system.

Several factors facilitated the implementation of BTN approaches. WHO is well respected by authorities. Workshop facilitators are not only technically knowledgeable but also represented both Western and Soviet backgrounds and can speak from experience about overcoming barriers in both systems. Workshops involve clinicians, managers and politicians, and allow sufficient time (4+ days) for participants to adjust their thinking. Linking up with partner organizations, e.g. United Nations Children's Fund, United Nations Population Fund and United States Agency for International Development, is successful; in addition partners also promote other MPS components. The implementation of BTN profited from other components of MPS, such as EPC and EBM, having run for a while, and changes in knowledge, skills and practice around childbirth implemented, when BTN was introduced. Health workers were thus well prepared to compare actual case management with evidence based standards.

3.2 General BTN recommendations for the European region

- In the long-term, BTN approaches are efficient; but investments must be made in order to start the process. Time, skills and financial resources are required to implement recommendations.
- The two approaches selected by most countries involved in this region (CEMD and NMCR) complement and strengthen each other, contributing to develop short and long term recommendations, and guidance to provide actions at local and national level.
- CEMD is an appropriate national approach that can provide evidence of the main causes to be overcome in order to avoid maternal mortality. CEMD analyses deaths, showing what practical action can be taken and highlighting key areas where the health sector and community need to take action, as well as overall directions for improving clinical outcomes.
- NMCR at facility level represents a useful approach for self-evaluation, aiming at improving maternal health services. NMCR allows an in-depth qualitative analysis of shortcomings in the case management, highlighting also the positive elements in the care offered, and ensuring that women's and families' perspectives are taken into account during the quality improvement process.
- Translating findings into action is the overall purpose of case reviews. Without interventions based on review recommendations, the process is worthless. Findings form a baseline against which to monitor the impact of changes in clinical practices. Therefore, a method for monitoring implementation of review recommendations should be part of the system. This provides a stimulus for health sector action, reminding review committees that their recommendations must be evidence-based.

The generic framework for the implementation of BTN approaches, for which steps have been adapted to the specific country context, and the support provided by the WHO is illustrated in the table below:

The WHO Europe steps for Beyond The Numbers implementation

Making Pregnancy Safer:
EPC, EBM, QoC, Assessment

BTN Tools available at global level

BTN translation into Russian, print, dissemination

Regional Workshop

1. Participants from Ministry of Health, key stakeholders and partners
2. Introduction to BTN's 5 approaches
3. Agreement on BTN introduction
4. Agreement on selected approach for each country
5. Development of plan of action for each country

Activities in countries

1. General agreement from Ministry of Health and request to WHO for conducting BTN National workshop
2. Development/update and official approval of key clinical guidelines for major obstetric complications.
3. Development of draft for the legal framework regarding BTN (Prikaz)

National Workshop

1. Representatives from: Ministry of Health, partners, health professionals, organizations, maternities, social workers and juridical system
2. Review BTN's methods of investigation, with special focus on one or two approaches
3. Endorsement of one or two selected approaches
4. Develop plan of action to introduce and implement the selected approaches

Near-miss case reviews at facility level	**Confidential enquiry into maternal death**
1. Steps for implementation	1. Steps for implementation
2. Propose pilot sites	2. Identify National Committee
3. Responsible identified	

Activities in country

Finalize and approve legal framework, choice of pilot sites, draft tools

Technical Workshops

Near-miss case review at facility level	**Confidential enquiry into maternal death**
Participants: From pilot sites	Participants: Top-level clinicians

Finalize tools

Pilot	Collecting and reviewing cases
International experts review	International experts review
Follow-up to the reviews recommendations	Follow-up to the reviews recommendations

As made explicit in the table, the role of the WHO in the process of change is not to guarantee funding but to provide tools, technical assistance, support and advocacy, whereas the partner organizations take up the task of piloting the approaches.

4 BTN inter-country activities

Regional Workshops on "Beyond the Numbers"

Two regional workshops on Beyond the Numbers (BTN) have been conducted in the European region, one in Kyrgyzstan in 2004, and one in Armenia in 2005. The purpose of these workshops was to help countries select and introduce any one – or a combination – of the five suggested approaches to case reviews from the BTN methodology in order to reduce the burden of death and morbidity. Participants from the following countries attended the first workshop: Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan and the Republic of Moldova, and the second one was attended by representatives from the following countries : Albania, Armenia, the Former Yugoslav Republic of Macedonia, Romania, Russian Federation, Turkey and Turkmenistan. Based on the success of these regional workshops, each participating Member State considered which of the approaches was most feasible at national and facility level, and worked on developing a plan of action for introducing and implementing BTN in their respective countries.

5 Multi-country review meeting on BTN, Charvak, Uzbekistan, June 2010

To review the implementation in the region, and to provide a forum to share lessons learned, the WHO Regional Office for Europe organized a regional meeting that was attended by 80 participants from 14 countries (Albania, Armenia, Azerbaijan, Georgia, Kyrgyzstan Kazakhstan, the Republic of Moldova, Russian Federation, Romania, Tajikistan, Turkmenistan, Turkey, Ukraine and Uzbekistan) .
Participants represented health professionals involved in the pilot implementation of BTN approaches, as well as Ministry of Health representatives. Most countries until now have chosen one or two approaches (out of five) - Near Miss Case Review (NMCR) at facility level and Confidential Enquiry into Maternal Deaths (CEMD) at national level.
The review thus gathered delegates from countries where a series of capacity building activities at regional and national level on the main selected BTN approaches (NMCR) and (CEMD) have been over the last 6 years.
Key partner organization, which have supported and collaborated with WHO over the years in the implementation of the BTN activities were also participating to the meeting, these included representatives from UNFPA, JSI, USAID, EngenderHealth, GTZ among others.

The MPS programme is, together with related programmes in the area of family and community health conducting a Regional Meeting on the progress in the MDG 3,4 and 5 is planned in Albania in Sept 2010 this will further reinforce the exchange of lessons learned and collaboration, among and within countries as well as with other partners.

5.1 Objectives

The objectives of the meeting were to:

- To present and discuss experiences, challenges and lessons learned during the initial implementation of Beyond The Numbers in different countries
- To provide technical inputs from international experts in order to strengthen and implementation at national level
- To ensure documentation of progress in order to disseminate results
- To reinforce partnership with key stakeholders and international and national organizations
- To identify areas in which further support by WHO and partners will be a key, in order to scale-up implementation and monitoring of interventions.

5.2 Findings and recommendations

Since the introduction of BTN approaches in the region, good progress was achieved in the region overall, with some countries (MDA, UZB, KAZ) showing impressive progress, and some other lagging behind for various reasons, but willing to and committed for the implementation.

The progress varies depending of the methodology implemented - NMCR or CEMD – with champions ready and willing to become a knowledge hub for neighbour countries and to those that for various reasons had little or no progress. The workshop provided an opportunity for the latter group to identify barriers and ways of overcoming them, and for the former group to identify strategies for scaling up. To date, the intensity and quality of implementation depends on WHO' and partners' experts providing tutorial supervision.

It is recommended that WHO EURO continues to provide technical support to oversee quality, and in the same time starts to develop strategies to make the process in time less dependent on WHO direct support, and self-sufficient in long run. It is recommended therefore:

(1) in countries that are by now successfully implementing BTN approaches for about 3 years, and it seems that national capacity was created, to develop a plan to make them self-sufficient in near future by embedding BTN approaches into the existing systems, and if appropriate, replacing existing systems. Some of the option were suggested by participants during the meeting (i.e. gradually abolish the traditional analysis of maternal deaths in MDA and leave only the CEMD; in KAZ to replace in time the external supervision by WHO facilitators by the supervision by "curators" from the local health authorities, given their capacity is built to do so in a qualitative way).

(2) to support twinning arrangements between Member States that are at different level of expertise in implementing BTN approaches, including between western and eastern countries. Virtual facilities for networking might be a useful complementary tool.

In addition to these, when basic principles and sufficient knowledge and skills are in place for the selected approaches, and implementation is ongoing, to explore possible implementation of additional other approaches. One example is the system of near miss cases surveillance in UK, UKOSS, presented during this workshop. It is highly recommended that WHO supports the implementation of UKOSS-like systems in Member States.

At the end participants filled a questionnaire for the evaluation of the workshop (Annex 4). They rated mostly as excellent the relevance of content towards country needs, application and feasibility, quality and content of presentations and group work, providing suggestions for improvement.

5.3 Proceedings

After the opening of the meeting by the Ministry of Health (MoH) representative from Uzbekistan, WHO representative and the country director of UNFPA, the objectives of the meeting were presented. The topic of maternal mortality and morbidity review was introduced as well as a summary of the mortality and morbidity audit using the BTN approaches.

As implied by the title" Beyond the Numbers" it is important to know statistics, however, it is even more important to identify what lies behind numbers. In many countries the normal outcome of traditional audit is punishment and the analysis of a death or complication is based exclusively on medical records. However, the principle of BTN is that information collected is not leading to punishment and confidentiality of information at all levels is mandatory, and the key to success. Standards are used to measure the adequacy and quality of care, and the recommendations of audit are put forward to promote changes/improvements, not to identify guilty persons. When a proper review has been carried out, as per BTN methodology, it turns out that in most cases it is the health care system which is to be blame for failures.

From the many examples given during the first day, delegates learned from countries which are already in implementation stage – among them the Republic of Moldova, Uzbekistan and Kazakhstan. Furthermore, two countries are in the final preparation of the preparation of the first report on CEMD –Moldova and Kazakhstan.
BTN is successfully implemented in 5 countries, and is in early phase of introduction in other 7 of those countries who have requested to be involved.
Outcomes of BTN implementation include: improvement of quality of emergency care, strengthened use of standards and facility based protocols, better teamwork around childbirth, **e**nhanced role of midwives, and consideration of women's opinion.

Among lessons learned it was clear that the implementation of Making Pregnancy Safer and of principles and practice of WHO Europe Effective Perinatal Care are essential as a basis for successful BTN introduction.
Many of the recommendation springing from the case reviews are related to organizational issues.

National clinical guidelines on major obstetric complications are a pre-requisite for BTN introduction; local algorithms and protocols should be developed.
Support from managerial level and MoH, and external support from experts are crucial for appropriate BTN implementation.
Challenges include fear to provide real information, insufficient skills on new audit methodology, breach of confidentiality and punishment for unfavourable outcomes, staff shortage and migration of health professions trained in BTN approaches.

The status of MCH is a good indicator as it reflects the public health situation in the country. However, reporting can be deficient in many countries. Especially in the former soviet countries and eastern European countries, there is a tendency by the government/MoH to try and reach internationally set standards and achieve certain level of indicators "by order"; meaning a "prikaz" an administrative order. Not complying with the quota included in these prikaz, can have severe consequences for the facilities and/or health professionals; this sets the basis for fear of punishment, which creates a difficult situation not only for getting honest and accurate data and estimates, but hinders real improvements in care as well as proper collaboration with partner organizations and agencies. Regional differences even within one country could be significant, and in many cases maternal mortality and morbidity remains unacceptably high. One of the many positive aspects of the BTN methodology is its' positive effect on the collecting and use correct data.

5.3.1 Day 1: Partnership in BTN implementation

During the first session of the day key partners shared their experience of the reasons behind the successful implementation of BTN one component being the need for fruitful collaboration and partnership with MoH as well as with international organizations and NGOs working in the area of maternal and child health.

Partners present at the meeting involved representatives from UNFPA, JSI, EngenderHealth, and USAID. The format of the session was a panel discussion where the partners were asked to focus on the following questions:

- How BTN fits in the partner organization mandate
- Which was the specific support provided to BTN implementation
- Which will be the specific support provided to BTN implementation

The criteria's for a successful partnership in implementation of BTN was discussed and shared during the panel session and includes the following components:

- Streamline activities in the countries and delegate areas of interventions among partners to avoid duplication of activities
- Agree on unified approaches in strategic planning and implementation (national programme development and implementation);
- Help increase community and medical society awareness and support;
- Promote sustainability and ownership by national key stakeholders and ensure international expertise and exchanges as needed;
- Agree on shared reporting and publishing of success stories and lessons learned,
- Sharing experience in regular international forums

For the best possible results crucial factors/recommendation are: the commitment of leaders and decision makers at all levels; the taking into consideration and opinion of patient and family members; realistic and understandable objectives, and the acknowledgment of the importance of the role and scope of work of midwives.

5.3.2 Day 1: Legal framework

Another common feature in all the countries present, for the successful implementation of the BTN is the fact that legal endorsement by the MoH is prerequisites for the smooth implementation of the NMCR and CEMD. This component of the BTN was presented and discussed in the panel session on legal framework for implementing BTN approaches.

The panel discussion focused on the achievements in including the legal issues related to BTN in 3 countries (Uzbekistan, Russian Federation and the Republic of Moldova), and were the following:

- MOH orders had been issued
- Support for implementation was ensured
- National Steering Committee have been established, roles and responsibilities identified;
- Better understanding of BTN approaches is achieved among managers and leaders through their active involvement and better informing.

Each country also presented other steps to be taken, such as:

- Reports on implementation outcomes being published;
- Convincing health care providers to ensure real information;
- Development of national guidelines and protocols and introduction into educational programmes

The discussions arising from the topic raised by the 3 country examples touched upon different aspects and practical points, such as the establishment of a Steering Committee (SC) and its terms of reference, involvement and/or needed approval of Ministry of Justice and Ministry of internal affairs;
Further points of discussion were whether autopsy should be compulsory; but also conflict of interest for SC members who participate in both audit systems – traditional and confidential. The issue of conflict between CEMD and legal enquiry is difficult and needs further investigations and decisions. Last, was discussed how to ensure motivation and create incentives for members of a national SC involved in BTN to raise professional prestige and interest, for example some suggested that there would be a need for financial motivation to be considered from governmental side.

Conclusions

1. Legal framework is very important support to BTN implementation – MOH order or legal basis is essential. It should include description of National SC, its roles and responsibilities, main methodology etc.
2. Fear of violation of confidentiality can be minimized through setting effective system and mechanisms of anonymization of information (CEMD), and rules for confidential case reviews, which should be described in the MOH order.
3. Development of clinical guidelines, protocols and standards for care should ensure basis for BTN implementation in order to support and protect health care providers.
4. Excessive attention to maternal and perinatal outcomes may lead to inadequate, immediate, purely administrative response (such as punishment) to even small changes in mortality rate, and might become a negative factor with regards to appropriate professional case reviews.

5.3.3 Day 2: Near Miss Case Review

During day two of the meeting, participants presented and discussed experiences, challenges and lessoned learned during implementation of near miss case reviews (NMCR) at facility level and proposed recommendations for further expanding of this quality improvement approach. This day started with presentation of Gelmius Siupsinskas on latest estimates of maternal mortality ratios globally and the progress achieved in reducing maternal deaths in the European region. He mentioned that it is essential to

have good data collection systems at national level to plan strategies to reduce maternal and perinatal mortality rates, but more important to look beyond the numbers to know real causes of deaths and complications and, based on this, to plan strategies for addressing existing problems. Valentina Baltag made an overview on NMCR methodology and how this approach was implemented in the Region. She stressed the benefits of this methodology for improving quality of health care, what are the steps of audit process, and which tools and skills are necessary to implement NMCR. The speaker also stressed out that the goal of implementing NMCR is not only revealing deficiencies of care and developing recommendations, but even more importantly, to implement the recommendations into the practice.

During panel session representatives from four countries have been asked to present their experience in introducing NMCRs, challenges they faced during implementation process, the way they solved these problems, and suggest how effectively initiate audit process in the countries that are going to implement NMCRs. These countries (Uzbekistan, Kazakhstan, Kyrgyzstan, Tajikistan, and Moldova) have a quite long experience in implementing NMCRs in pilot facilities and most of them started or are about to start scaling up the methodology to other maternities. Each of the presentation was followed by lots of questions from participants on details of NMCR; most challenging aspects of this audit approach were discussed in details. Based on presentations of experiences of NMCRs implementation in these particular countries and panel discussions, participants of the Workshop come to an agreement that:

1. NMCR is an effective approach for improvement of quality of care at facility level. Improved team work and multidisciplinary collaboration, increased role of midwifes, systematic use of evidence based protocols and standards of care, incorporation of women perspective were the most important achievements mentioned by representatives of all countries. An environment free of blame and accusation is another important result – a shift from old review system which aim was to detect mistakes, guilty persons and punishment. In many facilities implementation of NMCR improved dramatically quality of emergency obstetrical care and decreased number of severe complications: speakers presented as evidences data showing reduced number of hysterectomies, blood transfusions and long hospital admissions.

2. As the main purpose of NMCR is to detect management deficiencies and explore women/family opinions about offered care and, based on this, to propose solutions and recommendations how to improve quality of health care services, administration of facilities is the most interested part in favor of this form of audit. Most recommendations and solutions developed during case reviews were related to organization of care and without involvement and permanent monitoring from facility managers it is difficult to implement and maintain changes. Facility administration has also a crucial role in maintaining a non-judgmental and non-punishment environment as one of the main prerequisites of successful implementation of NMCR audit.

3. Successful implementation of NMCR was possible only in facilities that have sufficient number of providers with long time experience in implementing evidence based perinatal technologies, trained in essential perinatal care (EPC) or effective obstetrical and neonatal care courses (EONCC). Another important prerequisite is existence of evidence based protocols and standards on management of most frequent obstetrical complications (hemorrhages and severe preeclampsia/eclampsia) agreed on national and facility level.

4. Use of specific standards of care, developed for NMCR process, that includes not only actions to be done in a particular clinical situation, but also defining by whom and how quickly the actions should be accomplished, were mentioned as a very efficient modality for organizing obstetrical emergency care. Monitoring visits revealed that all providers from facilities implementing NMCRs including midwifes and nurses, know very well what protocols say and do their best to respect protocol's recommendations. As a result of NMCR implementation in many pilot facilities, staff proposed and elaborated new, non-existent at national level protocols.

5. NMCRs aim is to improve quality of care at facility level by revealing missed opportunities using "door to door" approach and proposing solution to overcome them. It was a clear understanding among participants that NMCR do not look at events that happen before admission: this was important to avoid blaming colleagues offering antepartum care and to focus only on improving practices and organization of care at facility level.

6. Information from women and families not only offers new and important details on the management of cases, but also was an efficient tool to improve quality of care and to increase patient satisfaction - the most important criteria of quality of medical services. At the same time it was stressed that is very important to do a methodologically correct interview with woman and family; it was mentioned that number of complains decreased dramatically in many facilities as a result of women interviews.

7. Implementation of NMCRs in all countries was a step by step process which main components were: a. technical workshops to discuss organizational and practical issues how to start reviews and develop necessary tools and skills; b. piloting in motivated and prepared facilities under methodological and technical support of WHO and local experts; c. additional training of staff in some challenging issues like interview methodology or how correctly run an NMCR meeting. When first pilot facilities became experienced in conducting NMCRs, some countries started the scaling up .

8. Developing and implementing efficient recommendations and solutions have been a challenge for many facilities and permanent support from external experts (national and international) through monitoring visits and evaluation workshops was very important. Partner organizations support (UNFPA, USAID, UNICEF ...) was essential for organization of national and technical workshops and monitoring and evaluation visits.

9. Persistence of punitive supervision, looking for "guilty" professionals and practicing disciplinary actions against them were considered as the most important barriers for implementation of NMCR reviews in pilot facilities. Punishment and judgmental attitude may be a more important obstacle for rolling out near miss case reviews to other, less motivated and prepared facilities.

In general, most meeting participants were highly impressed by successful implementation of NMCR in many countries of the Region, by positive changes in quality of emergency obstetrical care and dramatically improved provider-provider and providers-patients relations induced by audit process. Representatives of countries that did not practice NMCRs mentioned that are going to start implementation of this promising quality improvement approach after the meeting.

In the second half of the second day of Workshop, participants were divided for group work. Each country delegation was asked to list the challenges/barriers and opportunities for Near Miss Case Review (NMCR) implementation and the plans to improve/start NMCR implementation in their countries. Later on, four mixed groups were organized consisting from countries that have experience in NMCR implementation and those that have not. Participants were asked to find common challenges/barriers and common opportunities in NMCR implementation and to list the common steps necessary to implement NMCRs. Outcomes of group work by countries are presented in the Annex 2.

Common challenges/barriers and opportunities, as well as common planned steps to implement NMCRs, were presented and discussed in the plenary (see Annex 3). Most participants agreed that this group work was an excellent opportunity to share experiences and lessons learned during NMCR implementation and to offer useful recommendations how to start more efficiently and smoothly the process.

5.3.4 Day 3: Confidential Enquiries into Maternal Deaths

The morning session was dedicated to see how the CEMD methodology has been implemented in the European region. James Drife presented the methodological principles and the United Kingdom implementation experience, after this Stelian Hodorogea presented the CEMD implementation process in the region based on the Moldova experience as a model applicable for other CIS countries with similar health systems.
A number of questions arose following the presentations, which confirmed the importance of following certain measures before staring the CEMD at national level, and that many barriers and challenges have to be overcome before it can be implemented.

Results from CEMD have shown that the public health sector has been strengthening, for example the audit results revealed that vulnerable population (the poor, migrants) had limited/less access to health services, and this led to direct changes in how to receive, seek out and improve contact and service provision to these groups.
It was also clarified that the UK CEMD approach which has been the main method introduced in this Region is not the only existing one, there are various examples of reviewing maternal mortality and CEMD is conducted in other western countries as well.
The importance a separating the information gathering of mortality cases from MoH, and ensuring that the process is completely independent from the MoH was again underlined during the discussions. The MoH receives the audit results only, nothing else.

One major topic arising again and again, as for the NMCR, was how to ensure the confidentiality. Again it was stressed that the facility which has a case of mortality, appoint a person, e.g. the midwife to gather all information and the anonymizes it. After this process, the information goes to MoH. During the 50 years of work in the UK, there has never been any encroachment from the judicial system, since the CEMD commission work has always had a high authority in the country and by law is protected from the infringement of the court. The major protection is the confidentiality of the audit.

One of the recommendations ensuing from the discussion was to encourage the participants to familiarize themselves with the published UK CEMD reports available on the Internet, since it would give an introduction to the Audit and would allow understanding and implementing CEMD in the country better. The report highlights systemic errors and recommendations from the UK experience.

Following, a panel representing a selected number of countries (Armenia, Kazakhstan, Moldova, Ukraine and United Kingdom) made short presentations on the steps taken in their respective country to implement CEMD and on barriers and challenges leading to start (or **not** start) CEMD at national level based on the proposed frame:

- What was done successfully for the CEMD implementation? What are the evidences of these successes?
- What were the challenges/barriers for CEMD implementation? How did you try to address them?
- What are the current plans to improve CEMD implementation?
- What are the most important messages/advises you want to give to countries that are planning to start the implementation of the CEMD?

Gayane Avagyan from Armenia from informed that despite the activities conducted with WHO technical support, on informing the obstetrician society and the confirmation that the CEMD methodology is a necessity for Armenia it was not possible start implementation f CEMD because of the difficulty of ensuring confidentiality.

Kanat Sukhanberdiyev from Kazakhstan informed that the CEMD started taking off after the adoption of the methodology after the first year of implementation. A CEMD Committee is in the process of preparing the report for different target groups.
The audience raised questions about the publishing of the CEMD report in KAZ after only one year, and it was explained that the analysis of the collected data already allowed making recommendations on the systemic errors, furthermore the preparation of the preliminary report allowed them to gain additional experience.
Questions were raised about the type of documents collected for the CEMD analysis and the selection criteria's, which were medical documentation and questionnaires according to the CEMD methodology. For the KAZ example the cases are distributed to the experts who prepare a short summary of each case. This is reported at the Committee session for further discussion and decision-making. It was also said that all committee and regional coordinators' work is done free of charge, as an additional workload with the responsibilities. However, the KAZ example showed that initially 90% of the first received questionnaires were of bad quality. For the national Committee meeting they invited the chief oblast ob/gyn's and after that the quality increased and now only 25% of the questionnaires are of poor quality.

An additional comment form the WHO representative underlined that, as everyone know, the punitive system in the CIS countries leads to the manipulation of the mortality causes showing a high number of unmanageable cases. In such situation the confidential audit allows to overcome this kind of cases. One should not dramatize over the fact that the results of postmortem examination are not available.

Stelian Hodorogea from theRepublic of Moldova informed that after three years of experience in implementing CEMD it has been decided, that in MDA there is a need to pay attention to the regional coordinators' training and overcoming of fear and skepticism, perfecting the information collection methodology considering the existing experience. There is a hope that the audit can also provide information on the vulnerable population groups.
One of the main concern from the audience was on how Moldova solved the necessity of two existing audit methodologies (traditional and a new one). The issue is not solved yet, however a decision will be made once the first CEMD report is published (expected to be published in September 2010). To maintain confidentiality they consider keeping both. The main result from the new audit method is that the CEMD changed the experts' mentality about conduction of the audit, specifically in the search of the causes and not whom to blame.

Valentina Kolomeichuk from Ukraine presented their traditional model of maternal death audit. The country has been introduced to the CEMD methodology and MoH conducted a preliminary orientation and planning workshop on implementation of CEMD. However, there is little progress for the moment. The main obstacle is the resistance to accept a new approach and the fear of competition from the traditional audit. It has been decided meanwhile to analyze the NMCR at the facility level.
However UKR as experienced definite progress on the health system strengthening, which has been conducted prior to the introduction of new criteria The technical support to the country is provided by Who and JSI and about 20% of the regions have implemented MPS related activities such as (EPC and EBM).

James Drife representing the United Kingdom informed that in the UK, after a thorough introduction to the CEMD implementation in UK, on how the audit has become a tool for problem solving at political as well as on hospital manager's level with reference to the resulting CEMD data. However, the CEMD committee does not directly affect the decision-making, or resource allocation among regions.
The question from the audience arose whether it would be appropriate to conduct the CEMD in a small country with less number of mortality cases or if it would be possible to combine the audit among several small despite them all the being independent, the expert confirmed that it would be feasible to combine them upon joint research of the problems as on the level of a separate region.

The presentations from the countries showed that sharing the knowledge on the experienced barriers countries starting implementation provide a very good lesson for other countries on how to avoid

complications and make sure the steps for implementation are more effective. The discussions were open and very constructive. Reflexions were also made on the influence of mass medias based on the UK presentation, in order to further promote the BTN approaches and gain the trust and a positive relation with communities and better understanding the outputs of BTN tool.. Indeed it would be fruitful to inform all national partners on benefits and it is a way to avoid barriers.

During the afternoon session each country delegation was asked to write 3-4 critical issues for the establishment and/or sustainability of CEMD at national level. The participating country representatives were divided into 4 groups: Group A: Moldova, Azerbaijan, Romania; Group B: Kazakhstan, Albania, Georgia, Turkey; Group C: Armenia, Russian Federation, Uzbekistan; Group D: Kyrgyzstan, Tajikistan and Ukraine. Additionally each delegation was asked to reflect on the topic and the relevance to their country:

- What are the key challenges/barriers for implementation of CEMD?
- What solutions would you propose to address them?

To start with representatives from Moldova and Kazakhstan were asked to facilitate the country delegations which are planning to start/or have just started implementation, to develop the realistic action plan to launch the CEMD tool. The participants found this exercise of using an experience from countries that have benefited from implementing BTN very useful.

The groups presented the barriers to Implementation which could be: lack of political commitment, psychological barriers, lacking of common approach on Save Motherhood implementation among partners, poor quality of medical records, risk being punished, conflict of interest among traditional and new CEMD committee participants). The next steps for implementation according to Group A was to: overcome the barriers was to initiate activity on quality assessment on MCH; arrange an introduction meeting on BTN to policy makers; facilitate knowledge sharing among countries, strengthening national legislation, training of national representatives

5.3.5 Day 3: Obstetric Survey System Methodology

During the meeting the representative of the National Perinatal Epidemiology Unit of the University of Oxford Mrs.Marian Knight presented a newly implemented system on near miss cases surveillance in UK, UKOSS. The system is a combination of surveillance systems that provides opportunity for quick reaction to sudden change in the prevalence of a certain near miss conditions, with criterion based audit. It is relatively inexpensive, effective, provides opportunities for public health response, research and quality improvement. It is highly recommended that WHO supports the implementation of UKOSS-like systems in MSs.

The UK Obstetric Surveillance System (UKOSS) is a national system established in the UK to study a range of rare disorders of pregnancy, including severe ‘near-miss’ maternal morbidity. Rare disorders such as maternal deaths and near-miss cases are otherwise difficult to study and clinical practice is rarely evidence-based. Each month a card is sent to clinical staff nominated for reporting (obstetricians, midwives and anaesthetists) in each hospital in the UK with a maternity unit. The card lists the particular conditions being reviewed and reporters are asked to return the card indicating the number of cases seen in the unit in the previous month. They are also asked to return a ‘nil report’ if there have been no cases. In response to the report of a case, a specific data collection form is sent out to be completed with basic demographic information about each case and details of her known risk factors, management and pregnancy outcome. This information may then be used for ongoing surveillance of disease incidence or prevalence, audit of guidelines or change in practice, investigating risk factors, describing management techniques, to conduct emergency surveillance in response to emerging conditions of public health importance and to assess outcomes for women and their infants. The approach is particularly useful in settings with large numbers of

hospital units, either as a precursor to, or to complement ongoing Confidential Enquiries into maternal deaths.

5.3.6 Day 4: Planning for the immediate future

The theme of Day Four was "Planning for the immediate future". At the main session of the morning, country delegations discussed the next steps required for BTN implementation, considered the resources required and set timelines for progress.

The day began with a plenary session with two presentations. The first, by Dr Alberta Bacci, reminded the delegates that although they were from many different countries the common issues were shared by all. Her presentation emphasized the need for teamwork and sharing of information and ideas, instead of the "top-down" authoritarian approach which has been traditional in countries in this Region. Examples were given of how practice has already changed in several countries with the introduction of BTN methodology.

The second presentation was by Ms Sine Gyrup, who had interviewed, with the help of interpreters, a large number of the delegates during the previous three days. She had asked delegates to explain how change could be triggered in their country. From their responses she identified three factors – trust, understanding and motivation – which can be fostered by dialogue and leadership. Her presentation included anonymised quotes from several interviewees, which illustrated the innovative effects of BTN and the need for teamwork to make change successful.

Delegates were then split into groups by the session chairman, Gelmius Siupsinskas, and animated discussion followed as each country discussed specific plans for the introduction of BTN. The general mood of enthusiasm was abundantly clear. Delegates were aware that some countries would be invited to present their plans after the coffee break, at the final plenary session.

There were four presentations, from selected countries, with optimistic timelines for the next steps in implementation. Time did not allow detailed questions or criticism of these plans and indeed such discussion would not have been appropriate among such a diverse group of countries in plenary session. The plans developed are included in Annex 3,and are meant to serve as a basis for further discussions for finalization at country level involving larger representation from MoH, key stakeholders and partners.

At the end of this session several delegates expressed their warm appreciation of WHO for organizing such an inspiring and successful meeting despite the difficulties caused by current political problems in this part of the Region. The positive atmosphere generated at this meeting was indeed remarkable. Countries which were only beginning to consider implementing BTN were evidently inspired by those where progress had already been made, and there was a perceptible feeling that no-one wanted to be left behind in the process of implementation. Informal partnerships had been formed at the meeting and there was enthusiasm for the suggestion that communication could continue via email and/or conference calls in the future.

5.3.7 Changes and exchanges

Apart from the technical improvements and outcomes from introducing and adopting BTN approaches, (and based on the framework on page 6), a master student in communication was invited to carry out research on the process of change that health care providers go through when they are adopting and internalising the new approaches of the BTN. When the commitment of MoH and key stakeholders are ensured and the legislative framework is in place, when the health professionals have become familiar with the technical tools and basic skills, then experts and WHO experience shows that the providers undergo an important and very positive change in the attitude, motivation and way of working, which also improve the quality of care for mothers and babies.

The researcher (Sine Gyrup) based her findings on interviews with a large number of health professionals in the countries participating to the meeting, as well as key experts, WHO representatives at regional and country level and partners.

Because of the existing culture within this particular region, it has been very difficult to get behind the numbers, because of the fear of telling the correct details, which is a prerequisite for conducting the reviews. For that reason, the methodology used by the WHO breaks with years of professional practice, structure and mentalities within the health systems in the region. After years of working on the implementation of BTN in the WHO European region, one of the challenges has been to make people feel comfortable about changing old practices and mentalities. The great challenge has been to make people understand that the practice of blame and punishment is not an effective way to improve the quality of health care and does not solve any of the real reasons surrounding maternal and perinatal mortality. Instead, encouraging open communication rather than holding a single person responsible for the missed opportunities is the right appraoch. One of the core tasks of the WHO has been to establish understanding and support the creation of an environment where truth is associated with positive outcomes.

The three main conclusions from the meeting and the lessons learnt so far regarding the process of change are: (1) to produce successful outcomes, where people are willing to make changes, BTN requires support from all stakeholders involved in the approach; (2) the support can only be gained through information and profound understanding of the approach by all participants involved; (3) finally the process of change is gradual, and varies among countries, and "learning by doing" has been shown to be an effective way of gaining trust towards the changes.

Other key elements identified through the methodology of BTN are dialogue, leadership and teambuilding, which facilitate a favourable environment for change.

Throughout the meeting one of the objectives was to encourage countries to speak openly about both the challenges and changes they are experiencing. The main goal for the WHO was to share and exchange experience and support the countries in their process of change. The dialogue among participants started a process where people were listening and open to learn from other countries' experiences. In the end, the dialogue created a better understanding of the processes that countries were undergoing or were about to undergo and the challenges they were facing. The dialogue made the participants aware that they were not the only ones struggling with these issues. At the same time, some of the countries demonstrated how they had been able to deal with their challenges, which encouraged other countries to move forward.
During the meeting participants realized that change is possible and also experienced support and friendship, which made it clear that no one is left alone with their own challenges. Therefore, by exchanging experiences participants felt comfortable to take the next steps.
The meeting itself became clear proof that although making changes is a gradual process, they can occur when people collaborate and engage in open dialogue. Through dialogue and exchanges people began to reflect and question their own practices, and engaged in better team work with colleagues, understanding the need for collaboration to support changes.
Therefore, a valuable lesson learnt from the meeting is that interaction and exchange is an important way of making progress and overcoming challenges. Each participant has something to contribute, which in the end supported the progress of the implementation of BTN in the countries.

The process of open dialogue, which BTN uses to identify positive outcomes and missed opportunities, and the focus on solutions, can be integrated into various settings and areas of work. Clearly the process of engaging in dialogue, exchanging experiences and communicating at a horizontal level foster a greater cohesion among stakeholders. The methodology behind BTN is applicable within countries, between countries, within office and among offices, within facility and among facilities, within institutions and among institutions and also among partners. If wanting to create greater understanding for the overall coherence and to identify and address the real challenges faced in a given context, this approach can be a tool to assure the right priorities. Further, the methodology fosters responsibility and motivation among the stakeholders involved, which in the end produces sustainable and lasting outcomes based on the

participants' efforts. In reality, group dialogue can be difficult to co-ordinate as it requires a certain amount of time and the availability of all necessary participants.
At the same time, BTN demonstrates that when working in an environment where time is in short supply and where prioritization of tasks can cost lives, these maternity wards prove that the need for continuous dialogue in order to improve efficiency and health outcomes has to be a prioritization. Even under these circumstances, where time is very limited it is possible for the health care providers to find time to engage in dialogue because they have come to realize that dialogue makes them more efficient and improves the service they provide, which in the end makes them capable of saving women's lives. The working conditions and pressures associated with providing maternal care in less than ideal environments puts things into perspective and very clearly demonstrates both the importance and ability to engage in dialogue and implement Beyond the Numbers.

5.4 Annex 1 – Programme

Sunday, 13 June		
15:00 – 17:30	Facilitators pre-meeting	
18:00 – 19:00	Pre-registration	
Monday, 14 June		
8:30 – 9:00	Registration of participants	
09:00 - 09:30	Inaugural session	*Ministry of Health, Uzbekistan,* *WHO Country Office,* *UNFPA*
09.30 – 9:40	Objectives of the regional meeting	*Alberta Bacci, MPS, WHO Regional Office for Europe*
9:40 – 10:15	Beyond The Numbers: how it contributes to strengthening health systems to improve maternal and neonatal health	*Alberta Bacci*
10:15 -10:45	Regional presentations: An overview of introduction of maternal mortality and morbidity audit using WHO Beyond The Numbers approaches.	*Stelian Hodorogea*
10:45 -11:15	Break	
11:15 – 12:00	Partner's contribution to BTN implementation. *Each partner will be asked to focus on the following questions:* • *How BTN fits in the partner organization mandate* • *Which was the specific support provided to BTN implementation* • *Which will be the specific support provided to BTN implementation*	UNFPA, UNICEF, USAID, GTZ, EngenderHealth
12:00 – 12:30	Discussion	
12:30 - 14:00	Lunch	
14:00 – 15:30	Legal framework for implementing WHO Beyond the Numbers, CEMD and NMCR	*Panel: James Drife, Stelian Hodorogea, Valentina Baltag, partners and country representatives: Uzbekistan, Russian Federation, Moldova*
15:30 – 16:00	Break	

16:00 – 16:45	Challenges and solutions for legal framework in countries	*Plenary discussion*
16:45 – 17:30	Feed back	*Plenary*
Tuesday, 15 June	**Specific approaches for case review:** **Near Miss Case Reviews at hospital level**	
9:00 – 9:40	Near-miss case reviews at hospital level: What is this method, how was it implemented in the European region	*Valentina Baltag, Gelmius Siupsinskas*
9:40 – 10:00	Discussion	
10:00– 10:30	Panel discussion on near-miss case reviews in maternity hospitals in selected countries	*Country Representatives:, Uzbekistan, Kazakhstan*
10:30-11.00	Break	
11:00-11:30	Panel discussion on near-miss case reviews in maternity hospitals (continued)	*Country Representatives: Tajikistan, Kyrgyzstan*
11:30-12:00	Discussion	
12:00 – 12:30	Group work on near-miss case reviews: Challenges and strategies	*Group work - 1*
12:30 – 14:00	Lunch	
14:00 – 15:30	Group work on near-miss case reviews: Challenges and strategies *Each delegation will be asked to reflect on the topic and the relevance to their country. Each country delegation will write 3-4 critical issues for the establishment/ sustainability of NMCR at hospital level*	*Group work – 1 continued*
15:30 – 16:00	Break	
16:00 – 17:00	Presentations of group work *Country delegations will present 3-4 critical issues for the introduction, dissemination, documentation of NMCR at hospital level*	*Group work - 1 presentations*
17:00 – 17:30	Discussion about critical issues and main highlights	
Wednesday, 16 June	**Specific approaches for case review: Confidential Enquiry into Maternal deaths**	

9:00 – 9:45	Confidential Enquiries into Maternal deaths: What is this method, how was it implemented in the European region	*James Drife, Stelian Hodorogea*
9:45 – 10:30	Panel discussion on CEMD in selected countries *Countries will present a short info on steps to implement CEMD and on barriers and challenges to (**not**) start CEMD review at national level.*	*Country representatives: Armenia, Kazakhstan, Moldova,*
10:30 – 11:00	Break	
11:00- 11:30	Panel discussion on CEMD selected countries (continued)	*Country representatives: Ukraine, United Kingdom*
11:30– 12:30	Group work on Confidential Enquiries into Maternal Deaths: Challenges, strategies, results, documentation	*Group work - 2*
12:30 – 14:00	Lunch	
14:00 – 15:30	Group work on Confidential Enquiries into Maternal Deaths: Challenges and strategies *Each delegation will be asked to reflect on the topic and the relevance to their country.* *Each country delegation will write 3-4 critical issues for the establishment/ sustainability of CEMD at national level*	*Group work – 2 continued*
15.30 – 16:00	Break	
16:00 – 17:00	Presentations group work 3 *Country delegations will present 3-4 critical issues for the introduction of CEMD at national level*	*Group work -2 presentations*
17:00 – 17:15	United Kingdom. Obstetric surveillance system	*Marian Knight*
17:15 – 17:30	Discussion about critical issues and main highlights	
Thursday, 17 June	**Planning the immediate future**	
9:00 – 9:15	Beyond The Numbers, different approaches common issues	*Alberta Bacci*
9:15 – 9:25	How to trigger change	*Sine Gyrup*

9.25 – 10:30	Introduction and group work on development / update of BTN action plan *Country delegations discuss initial resources and timelines required for BTN to make progress in their country:* ❑ *Draft/update objectives of a national BTN strategy* ❑ *Indicate which approach should be introduced or refined in each country and why*	*Gelmius Siupsinskas* *Group work – 3*
10:30 – 11:00	Break	
11:00 – 12:30	Presentations of group work Country delegations present feedback, way forward and country recommendations	*Group work - 3 presentations*
12:30 – 12:40	Workshop evaluation	
12:40 – 13:00	**Closure**	

5.5 Annex 2 – List of Participants

Albania

Fatjon Balla,
Obstetrician-Gynaecologist, Maternity “Mretëresha Geraldinë”

Fedor Kallajxhi
Head of Obstetrics Department, Maternity Hospital Koco glozheni,

Nineta Nasufaga
Midwife, Maternity “Kiço Gliozheni”

Armenia

Ruzanna Abrahamyan;
Obstetrician-Gynaecologist, Institute of Perinatology, Obstetrics and Gynaecology

Gayane Avagyan;
Chief Specialist, Mother and Child Health Care Unit Department

Tigran Ovannisyan;
Chief of Maternity Department, Medical Centre of Erebni

Azerbaijan

Faiza Aliyeva;
Director, National Reproductive Health Center

Sudaba Ismailova ;
Chief Doctor, Maternal Clinic 7

Leyla Rzaguliyeva ;
Chief, Maternal Child Health Commission

Georgia

Akaki Bakradze,;
Deputy Director of Tbilisi Maternity House

Paata Machavariani,
Professor of Gynaecology Department of TSMU

Kazakhstan

Ardak Ayazbekov;
Deputy Director, Turkestan city perinatal centre

Kanat Sukhanberdiyev ;
Obstetric& Gynecologist National Maternal Child Health Centre

Roza Rhekeyeva;
Doctor of regional centre, Healthy Lifestyles

Talshyn Ukybasova
Deputy Head Ob & Gyn., National Mother and Child Health Centre

Kyrgyzstan

Arsen Askerov ;
Associate Professor Ob & Gyn. Department Kyrgyz Russian Slavic University

Aichurek Jumalieva ;
Head of Maternity Department Talas Oblast Hospital

Natalia Kerimova
Head, Ob & Gyn Department, Kyrgyz State Medical Institute of Training and Retraining

Republic of Moldova

Valentina Diug;
Assoc. Prof. Obstetrics-Gynaecology Medical University

Marin Rotaru;
Chief Specialist Obstetrician, Ministry of Health

Rodica Scutelnic;
Head, Policy Medical Care for Woman, Children and Vulnerable Groups Ministry of Health

Romania

Serban Mihnea Nicolescu
Institute for Mother and Child Care Polizu Ob & Gyn Hospital

The Russian Federation

Tatiana Victorovna Vygonskaya, Rostov Oblast

Oleg Semenovich Filippov;
Deputy Head, Maternal Child Health, Ministry of Health

Mikhail Kirichenko;
Head, Perinatal Centre; Volgograd Region

Tajikistan

Indira Akmalkhodjaeva;
Senior Gynaecologist, Sudg Region, Department of Health

Gulbahor Ashurova;
Head, Safe Motherhood Department

Maidagul Sharipova;
Head, Maternity Department, Kurgan Tube Hospital

Urunbish Usakova;
Specialist, Ministry of Health

Turkey

Ece S Abay
General Directorate Mother and Child Health and Family Planning

Rifat Köse; Director General
Mother-Child Health and Family Planning Sihhiye

Ferit Saracoglu
Numune Training and Research Hospital

Turkmenistan

Zohre Allaberdiyeva;
Head, Department of Maternal Child Health

Bibijan Karriyeva ;
Physician, Maternal Child Health

Gulya Murykova;
Deputy Director, Maternal Child Health Department

Ukraine

Iryna Chibisova;
Specialist Ob. & Gyn Department Ministry of Health

Valentyna Kolomeychuk;
Deputy Head, Obstetric-Gynaecology Department Ministry of Health

Valentyna Zaleska;
Deputy Head Maternal and Child Health Department, Ministry of Health

Uzbekistan

Asomiddin Kamilov;
Deputy Minister Ministry of Health

Diyora Arifdjanova;
Head of Maternal Department Ministry of Health

Dilorom Asranculova ;
Head, Department Andijan Medical Institute

Guldjahan Babadjanova ;
Professor , Obstetrician-Gynecologist Department Tashkent Medical University

Shahida. Babadjanova;
Deputy Director Republican Perinatal Centre

Adelyna Lubchich;
Director, Republican Perinatal Centre

Muyassar Nasirova ;

Head, Department of Fergana Regional Perinatal Centre

Saydazim Sultanov;
Director National Obstetrician-Gynaecologist Institute

Rustam Yuldashev ;
Director, Karshi Branch of Obstetrician-Gynaecologist Institute

Klara Yadgarova
Institute of Advanced Medical Studies

Nodira Islamova;
Leading specialist Maternal Department, Ministry of Health

Feruza Nishanova;
Deputy Director, National Obstetrician-Gynaecologist Institute

Makhmuda Kattakhajaeva ;
Head of department Tashkent Medical Academy

Bakhtiyor Khodjixanov;
Legal counsellor, Ministry of Health

Partners

Jan Sand Sørensen;
UNFPA Representative for Uzbekistan, Country Director for Tajikistan & Turkmenistan,

Mavjuda Babaramudova,
Project Director, Azerbaijan RH/FP Project c/o EngenderHealth

Feruza Fazilova;
National Professional Officer, UNFPA Uzbekistan

Alexander Kossukhin;
Assistant Representative UNFPA Kazakhstan

Meder Omurzakov;
Assistant Representative UNFPA Kyrgyzstan

Helene Lefevre Cholay;
Project Director, Maternal and Infant Health Project

Nilufar Rakhmanova ;
Project Management Specialist, Health & Education Office, USAID/CAR/Tashkent

Temporary Adviser

James Drife;
Professor, Leeds west Yorkshire ls8 2ex
United Kingdom

Stelian Hodorogea;

Assistant Professor, Department of Ob. & Gyn. State Medical University, Moldova

Marian Knight;
Senior Clinical Research Consultant, Public Health National Perinatal Epidemiology Unit; University of Oxford

Gelmius Siupsinskas;
Professor Senior Specialist in Obstetrics

World Health Organization Regional Office for Europe

Gaukhar Abuova, National Professional Officer
WHO Country Office, Kazakhstan

Alberta Bacci; Regional Coordinator Making Pregnancy Safer
WHO Regional Office for Europe

Valentina Baltag; Technical Officer
WHO Regional Office for Europe

Larisa Boderscova; National Professional Officer
WHO Country Office, Moldova

André Calmîs; IT Assistant
WHO Regional Office for Europe

Anastasiya Dumcheva; National Professional Officer
WHO Country Office, Ukraine

Sine Gyrup; WHO, intern
WHO Regional Office for Europe

Henrik Khachatryan; National Professional Officer
WHO Country Office, Armenia

Assel Mussagalieva, WHO; National Professional Officer
WHO Country Office, Kazakhstan

Fakhriddin Nizamov; National Professional Officer, Health Systems
WHO Country Office, Uzbekistan

Vladimir Shchigolev; National Professional Officer
WHO Country Office, Russian Federation

Elena Tsoyi; National Professional Officer
WHO Country office in Uzbekistan

Ida. Strömgren; Programme Assistant
WHO Regional Office for Europe

5.6 Annex 3 – County action plans

ALBANIA

Objectives	**Activities (specific!)**	**Responsible person/Institution**	**Supporting partners/organizations**
1. To inform policy makers and managers of health to save women lives by improving quality of care	1. To adopt the order of the Ministry of Health for implementation of NMCR and CEMD in the health system	Ministry of Health	WHO
	2. To develop criteria for members of the Committee	Ministry of Health Professional NGOs, Health institutions for maternal and new born care	WHO
	3. To establish regional committees for implementation of NMCR and CEMD	Ministry of Health Professional NGOs, Health institutions for maternal and new born care	WHO, Ministry of Health, Professional NGOs
	4. To identify sources of financing and development of procedures for implementation of NMCR and CEMD	Ministry of Health, Professional NGOs	WHO
	5. To establish cooperation with media to conduct raising awareness of population on the programme		
2. To develop the legislation targeted to support the implementation of NMCR and CMED	1. To organize the meeting with all players and stakeholders of the programme	Government, Parliament, Ministry of Health, decision and policy makers	WHO
	2. Development of guidelines and standards	Ministry of Health, Health institutions and NGOs	WHO

ARMENIA

Objectives	Activities (specific!)	Timelines	Responsible person/Institution	Supporting partners/organizations
Preparation of evaluation report of NMCR pilot in Armenia	Evaluation of the pilot project of NMCR	October 2010	Gayane Avagyan, MoH Henrik Khachatryan, WHO ARM CO	WHO
Functioning (active) national and local committees on NMCR	- Local seminars, workshops, trainings - maternity visits	October-November 2010	Gayane Avagyan, MoH Henrik Khachatryan, WHO ARM CO Tigran Oganesyan, Erebouni M/C Ruzanna Abrahamyan, IPOG	WHO
MoH order ("prikaz") indorsed on NMCR and appropriate legislative documentation	Prepare MoH order and appropriate legislative documentation	By the end of 2010	Razmik Abrahamyan, MoH/IPOG Gayane Avagyan, MoH	WHO
MoH order ("prikaz") indorsed on CEMD and appropriate legislative documentation	Prepare MoH order and appropriate legislative documentation	By the end of 2010	Razmik Abrahamyan, MoH/IPOG Gayane Avagyan, MoH	WHO
Re-organized (updated) composition of the national committee on CEMD	Prepare MoH order	By the end of 2010	Razmik Abrahamyan, MoH/IPOG Gayane Avagyan, MoH	
Endorsed and implementation of CEMD forms and appropriate documentation	Preparation, adaptation of forms and appropriate documentation on CEMD	By the end of 2010	Razmik Abrahamyan, MoH/IPOG Gayane Avagyan, MoH	WHO
Prepare current report on NMCR	Monitoring of NMCR implementation process	2010-11 (on quarterly basis)	Gayane Avagyan, MoH Henrik Khachatryan, WHO ARM CO	WHO

AZERBAIJAN

*Country plan for implementation of **NMCR** (near-miss case reviews)*

Objectives	**Activities (specific!)**	**Timeline**	**Responsible person/institution**	**Supporting partners/organizations**
Gain support of key health decision-makers	Informing through: Personal meetings Reports Conducting a round table (10-15 participants) Orientation meeting Mass media publication	21-30 Jun 21-30 Jun 1-15 Jul Subject to agreement with MoH и ME July	National coordinator RH Chairman / Members of the Obstetrics Commission under the MoH MoH Press Center	Parliament Ombudsman National office for RH WHO/AZEEH USAID
Analysis of the situation for implementation of SM principles	Assessment of mother and newborn services quality	Subject to agreement with MoH ME	MoH R&D establishment Ob/Gyn	Intensive search for support UNFPA UNICEF WHO USAID WB

*Plan for implementation of **NMCR** (near-miss case reviews)*

Objectives	**Activities (specific!)**	**Timeline**	**Responsible person/institution**	**Supporting partners/organizations**
Development of a regulatory framework for NMCR	Familiarize with the experience and regulatory framework for institutions that implement NMCR Draft and approval of MoH Order: - Establishment of a working group - Selection of institutions (2-3) - Definition defines	Subject to agreement with MoH and ME	Professional therapeutic department According to the results of OC	Kyrgyzstan Uzbekistan Moldova

Objectives	Activities (specific!)	Timeline	Responsible person/institution	Supporting partners/organizations
Training of the work group, coordinators, health personnel from selected institutions	- First national meeting - Work visits to countries that implement NMCR - Trainings	Subject to agreement with MoH и WHO и ME	RH Center WHO/AZE	Intensive search for support UNFPA UNICEF WHO USAID WB Moldova Kyrgyzstan Uzbekistan
Improvement of mother and newborn services quality	- Development of necessary protocols/standards (ДМ) - Distribution, training	2010-2011	ЦРиОЗ R&D establishment Ob/Gyn AMU Az State Institute for Postgraduate Education	WB USAID ME

*Country plan for implementation of **NMCR** (near-miss case reviews)*

Objectives	Activities (specific!)	Timeline	Responsible person/institution	Supporting partners/organizations
Training of a work group, coordinators, health personnel from selected institutions	- First national meeting - Work visits to countries that implement NMCR - Trainings	Subject to agreement with MoH и WHO и ME	RH Center WHO/AZE	Intensive search for support UNFPA UNICEF WHO USAID WB Moldova Kyrgyzstan Uzbekistan

GEORGIA

Objectives	**Activities (specific!)**	**Timeline**	**Responsible person/institution**	**Supporting partners/organizations**
Georgian Association of Obstetricians/Gynecologists will establish a multidisciplinary confidential audit group	A special meeting of the Association dedicated to this problem	1 quarter 2011	Tengiz Asatiani Nino Machavariani	Ministry of Health USAID
The association will offer the obstetrical facilities the possibility to develop their own "near-miss" criteria				
The Association will establish a group with a task of informing health facilities' management about the importance of these methodologies and ways of fund-raising				

KAZAKHSTAN

Kazakhstan action plan for NMCR implementation

Objective	Concrete activities	Dates	Responsible person/institution	Partners
Improving NMCR methodology in the pilot facilities	Technical assistance/ field visit of the national coordinator and an expert to SKO and Almaty	September-October 2010	National MCH Centre	MOH, WHO
Information exchange	Development of the first NMCR report	December 2010	National MCH Centre	MOH, WHO
Monitoring of the quality of the implementation	Review of a two year implementation with involvement of an international consultant	November-December 2011	National MCH Centre	MoH, UNFPA
Informing medical society	Workshops for ob/gyns on NMCR and CEMD implementation	Within 2011	National MCH Centre	MoH, UNFPA
Expanding pilot facilities	National workshop, selecting new pilot facilities and their mentors (for adopting and supporting the new ones)	В течение 2011	National MCH Centre	MoH, UNFPA, WHO

Kazakhstan action plan for CEMD implementation

Objective	Concrete activities	Dates	Responsible person/institution	Partners
Informing medical society	Development and publication of the report (with external review)	October 2010	National MCH Centre, Astana	MoH, WHO
Informing politicians and civil society representatives	National workshop on presenting the	March 2011	National MCH Centre, the association of	MoH, WHO, UNFPA

	report results		ob/gyns	
Strengthening technical capacity of the regional coordinators	Training on CEMD methodology	December 2010	National MCH Centre	MoH, National MCH Centre
Maintaining the support for regional coordinators from the side of local authorities	Meeting with heads of regional health departments	October 2010	National MCH Centre	MoH, National MCH Centre
Monitoring of implementation	Review meeting with involvement of international expert	December 2011	National MCH Centre	MoH, WHO, UNFPA

KYRGYZSTAN

Objectives	Activities (specific!)	Timeline	Responsible person/institution	Supporting partners/organizations
Raise key decision-makers' commitment to BTN methodologies	A meeting on further audit implementation plan, particularly a decision on allocation of resources for technical support of MoH with partners	End of June	Secretary Health Care Department MoH	WHO, UNFPA, GTZ, ADB, WB, UNICEF, NGO, prof. associations, LAC
	Orientation seminars for key decision-makers (management of clinics, management of MoH, society, politicians and other partners	July-November 2010	Secretary Health Care Department MoH	UNFPA, WHO, GTZ, Ombudsmen, Government MOI, Ministry of Youth, Ministry of Labour, Ministry of Education, local self-administration, mass media – TV, journalists
	Repeated discussion of the collection and transfer problem with local CEMD coordinators and other partners through regional meetings	August-October 2010	Secretariat MoH	WHO, UNFPA, UNICEF, USAID, GTZ, NGO, Ombudsmen
	Training for local coordinators on improvement of interviews	September-October 2010	Secretary MoH	WHO, UNFPA, UNICEF, USAID, GTZ, NGO, Ombudsmen
Implementation in the respective supervision system for monitoring sustainability	Development of MoH Order, training of supervisors of MoH based on methodologies	August-September 2010	MoH	UNFPA, GTZ, UNICEF, NGO
Assessment of BTN methodology implementation	Assessment of BTN methodology implementation by external experts	November 2010	MoH, WHO	WHO, UNFPA, GTZ

Mid-term implementation plan for extension of the CEMD methodology on other health facilities	Round-table "Implementation of CEMD", discussion with partners	August-October 2010	MoH	WHO, UNFPA, UNICEF, GTZ, NGO
	Work group for development of CEMD monitoring and assessment tools	July-August 2010	MoH	LAC, HIF, WHO, UNFPA, UNICEF, GTZ, NGO
CEMD monitoring and assessment in pilot clinics	Assessment and presentation of results to partners	August-November 2010	MoH	WHO, UNFPA, UNICEF, GTZ,
Conducting CEMD	Collection and analysis of MD cases	Meeting of the Committee once in a month	Secretary MoH	GTZ, UNFPA, NGO
Preparing for the report	Studying of other countries' reports by members of the National Committee	August-November 2010	Secretary MoH	WHO, UNFPA, UNICEF, GTZ,
	Sharing experience with other countries	August-December 2010	WHO	WHO, GTZ, UNFPA
Internal assessment of efficiency of implementation of BTN methodologies	National meeting on maternal audit	February-March 2011	MoH	WHO, GTZ, UNFPA
Development of report	Development of report with discussion	August-September 2011	Committee, MoH	WHO, UNFPA, UNICEF, GTZ,

REPUBLIC OF MOLDOVA

NMCR: further steps in Moldova

Objectives	Activities (specific!)	Timelines	Responsible person/Institution	Supporting partners/organizations
Continue the NMCR implementation within the medical institutions	Local NMCR Committees meetings with the methodological support of supervisors	July 2010	MoH	Supervisors (Кураторы), WHO
Evaluation of the NMCR implementation within medical institutions	Development of the mechanisms of NMCR evaluation	August 2010	MoH	Supervisors (Кураторы), WHO
Presentation of the NMCR evaluation results and recommendations	- Workshop on NMCR evaluation results and recommendations for further improvement - Report on NMCR implementation/evaluation	December 2010 March 2011	MoH	Supervisors (Кураторы), WHO
Continue the NMCR implementation and its scaling up at the level of emergency care	- Training of the Emergency Care professionals - Conducting of the NMCR meetings on the level of emergency care	July 2010 September 2010	MoH	UNFPA, Consultative department of the Municipal clinical Hospital №1, from Chisinau
Monitoring of the NMCR implementation	Development of the NMCR monitoring mechanisms	April 2011	MoH	National Committee

CEMD: further steps in Moldova

Objectives	Activities (specific!)	Timelines	Responsible person/Institution	Supporting partners/organizations
Information of all stakeholders (community members, decision makers, professionals, etc.) regarding the CEMD analyses results	To present the CEMD report and its recommendations:	September-October 2010	National Committee	MoH, Professionals association
	- MoH Council			

	- Professional Association - Ob/gyn Congress			
Capacity building for National Committee and local coordinators	Training of the new members of the national Committee and local coordinators in BTN methodology	October 2010	National Committee	MoH, WHO
Continuing of CEMD implementation at national level	Applying the CEMD methodology for reviewing the MM cases during 2009-2011	November 2010 - 2012	National Committee	WHO
The monitoring of the CEMD report recommendations' implementation	Development and approval of the mechanisms of the monitoring of the CEMD report recommendations' implementation	April 2011	MoH	National Committee

ROMANIA

N/A

THE RUSSIAN FEDERATION

On implementation of BTN tool in the Russian Federation (not latest update – have not yet received)
Expected Outputs:
1. Input in to Improvement of Demographic situation in the Russian Federation and decreasing the MMR and IMR.
2. Implementation of evidence based technologies.
3. Strengthening the National capacity building.
4. Effective use of limited recourses.
5. Support client oriented initiative and promotion of client satisfaction with the quality of health care

Activity	**Time Frame**	**Responsible Institution**	**Partners**
To identify the pilot facilities to start BTN implementation (NMCR initially)	July 2010	Local Health Committee	WHO
To issue MOH Order on nomination of pilot health institutions	July 2010	Local Health Committee, Regional Perinatal Centers	Health Department of Volgograd and Rostov city
Conducting the local technical BTN workshops for the local staff in the pilot facilities	September-October 2010	Regional Perinatal Centers, WHO CO	Local Health Committee, WHO
Developing/Updating the clinical protocols on main maternal health problems in the region	On-going activity	Local Health Committee, Regional Perinatal Centers	WHO, Volgograd and Rostov Medical University
Conducting the technical workshop for the interviewers	tbc	WHO CO	Local Health Committee, Health Department of Volgograd city, Volgograd and Rostov Perinatal centers
To set up a working group for support BTN implementation in the pilot facilities and region	September-October 2010	Heads of pilot facilities	WHO
To agree a definition of “Critical case”	October 2010	Heads of pilot facilities	WHO, Local Health Committee
To develop and approve the working plan for the NMCR working group	October 2010	Heads of pilot facilities	Local Health Committee
To start NMCR session with support of WHO CO	October-November 2010	Heads of pilot facilities	Local Health Committee
Collaboration with mass media	On-going activity	Local Health Committee	Volgograd and Rostov Medical University

		, Heads of pilot facilities	
Preparation of preliminary progress report to the MOH	November-December 2010	Local Health Committee, Heads of pilot facilities	WHO
Refreshing one-two days BTN workshops for local staff	On-going activity	Heads of pilot facilities, WHO CO	WHO

TAJIKISTAN

*Plan of the Republic of Tajikistan on implementation of **NMCR** (near-miss case reviews) and/or **CEMD** (confidential enquiries into maternal deaths)*

Task	**Activity**	**Dates**	**Responsible person/organization**	**Partners/supporting organizations**
Implementation of NMCR at the national level	1. Conduction of the national meeting on CEMD and NMCR 2. Selection local coordinators 3. Training of local coordinators	1. 30 June 1. July 2010 2. September 2010 – December 2010	MoH, (Ashurova G.) Association of Ob/Gyns of RT (Kurbanova M.Kh.), coordinators from pilot maternity hospitals	WHO, UNFPA
Analysis of existed situation – achievements and lost opportunities	1. Visit of external experts at the NMCR pilot maternity hospitals 2. Conduction of the National meeting with involvement representatives of the TJK government, head of health department of the President office	25 – 31 August	MoH (Ashurova G) and Ob/Gyn association (Uzakova U.)	WHO, UNFPA

Scale up of supervision activities on NMCR and CEMD	1. Visit of the national facilitators in the maternity hospitals at the quarterly basis 2. Monitoring of NMCR implementation with WHO expert	2010 – 2012	Coordination committee on NMCR and CEMD	WHO, UNFPA
Development of standards	1. Establishment of inter-sectoral working group (Ob/gyns, resuscitators, anesthesiologists, midwives)	June	MoH	WHO GTZ
	1. Development of standards: anesthesia of operative deliveries • Acute renal failure in obstetrics • HELLP syndrome	July 2010 – January 2011	MoH (Ashurova G.)	WHO, GTZ
	1. Development of standards: anesthesia of operative delivery • Acute renal failure in obstetrics • HELLP syndrome	July 2010 – January 2011	MoH (Ahmedov D.A. – main resuscitator of MoH)	WHO, GTZ

	1. Approval of standards by MoH: • Management of high risk deliveries	July 2010	MoH (Ashurova G.)	
	2. Training of medical staff on anesthesiology and resuscitation standards	2010	MoH	GTZ
Improvement of quality of data collection for CEMD: • Interview of family members of died women	1. Inform head of Islamic University 2. Training of volunteers among alumni of Islamic university 3. Involvement of members of public Council on health	2010	Safe motherhood association	UNFPA

TURKEY

Objectives	Activities (specific!)	Timelines	Responsible person/Institution	Supporting partners/organizations
To review legislation framework	Advocacy activities to politicians and MOH	2 years	TJOD, Association of Midwifes and association of Nurses	MoH, NGOs and WHO
To establish environment to build up trust	Training and sharing ideas	2 years	TJOD, Association of Midwifes and association of Nurses	MoH, NGOs and WHO
To strengthen the medical records	Training and making the necessary changes on medical forms	2 years	MoH	TJOD, Association of Midwifes, association of Nurses, NGOs and WHO

TURMENISTAN

Turkmenistan in common with international organizations implements new WHO programs in the health practice.

Since 2007 the country transferred to criteria of registration of live and still births. A national program of "Safe Motherhood" 2007-2011 was adopted in Turkmenistan and approved with number BG/17 by Order of 19 December 2006. Implementation of the program in the practice of obstetrical facilities is successful and, irrespective of a rather short term, starts bringing positive results in improvement of the health of women of reproductive age, decrease of morbidity and maternal mortality. ***NMCR*** *(near-miss case reviews) is a part of the "Safe motherhood" program, implementation will facilitate improvement of the quality of care at obstetrical facilities.*

Objectives	Activities (specific!)	Timeline	Responsible person/institution	Supporting partners/organizations
Informing of management (MoH) on the benefits and necessity of this methodology	Meeting report	June 2010	National MCH Center	
	Conduct orientation meeting with managers with the cooperation of international experts;		MoH and MIIT, National MCH Center	WHO

Prepare a legislative framework for implementation of the methodology;	MoH и MIIT Order, Establishment of a coordination Committee	November-December 2010	MoH and MIIT, National MCH Center	
With the cooperation of international experts, train specialists in the enquiry/review methodology;	trainings	February-April 2011	MoH and MIIT, National MCH Center	WHO
Conduct adaptation to local working conditions		April-May 2011	National MCH Center	WHO
Beginning of work		May-June 2011	National MCH Center	

Barriers in implementation of Near-Miss Case Reviews in Turkmenistan

- Inadequate understanding of the managers of need and benefits of the methodology;
- Case review may cause fear of punitive measures among health workers;
- Inadequate information about this methodology will make it difficult to collect full information about quality of care provided;
- Identification of near-miss conditions;
- Need for review of a large number of medical documentation;
- Lack of trained audit specialists.

UKRAINE

Tasks	Activities	Dates	Person in charge /Institution	Partners/ Supporting Organizations
Preparation of the MoH Prikaz	Establishment of working group. Involvement of leading specialists and scientists. Determination of pilot institutions for NMCRs Studying the experience of countries, implementing audit	June – September 2010	Ministry of Health	WHO
Advocacy of the approach «Beyond The Numbers»	Presentation of the project at the Ministry of Health Collegium (Advocacy for the Heads of the Department of health, Chief obstetricians-gynaecologists, leading scientists of the country and the members of association of obstetricians-gynaecologists) Negotiations with the partners Meeting of Association of obstetricians-gynaecologists Meeting of Association of Nurses (midwives are members of Association of Nurses)	23-24 June 2010, Volyn June –July 2010 September 2010, Autonomous Republic of Crimea ?	Ministry of Health Ministry of Health Ministry of Health Ministry of Health	WHO WHO WHO, USAID/JSI MIP WHO, USAID/JSI MIP
Technical workshop	Involvement of external expert (s) Determination of participants Logistics	November -December 2010	Ministry of Health	WHO USAID/JSI MIP Other partners?
Determination of composition and place of the Committee, the coordinators at the	Order of the Ministry of Health regarding coordinators Training of coordinators (2	December 2010 – January 2011	Ministry of Health	WHO USAID/JSI MIP Other

national and regional level (CEMD) and subsequent training	days) Involvement of external experts			partners?
Training of specialists in pilot medical institutions (NMCR)	Involvement of external experts Training (1-2 days)	December 2010 – January 2011	Ministry of Health	WHO USAID/JSI MIP Other partners?

UZBEKISTAN

NMCR

Goal	Activities	Data	Responsible	Partners
Enhance of NMCR implementation	Implementation in Republic of Karakalpakistan (MoH order and technical support)	October 2010	MoH, S. Sultanov	WHO, UNFPA, GTZ
	Implementation in Tashkent and Syrdarya regional perinatal centers	October - November 2010	MoH, S. Babadjanova	WHO, UNICEF
Technical and supervision support in maternities where NMCR implemented	Supervision, support, monitoring visits, cross visits	2010 -2011	MoH, S. Sultanov	WHO, UNICEF, UNFPA, GTZ
Experience sharing, documentation of process	Technical meeting	November 2010	MoH, S. Sultanov	WHO, UNICEF, UNFPA, GTZ
Information sharing with medical society	Publications	2010-2012	Association of obstetrician-gynaecologists, coordinators	

CEMD

Goal	Activities	Data	Responsible	Partners
Assessment of early implementation of CEMD	Inviting of WHO experts on CEMD meeting	2010-2011	National committee (NC) director	MoH WHO, UNICEF, UNFPA
Training for regional coordinators	Technical workshop	By the end of 2010.	Secretary of NC	MoH, UNICEF, UNFPA, GTZ
Continue CEMD implementation	Collect all cases and continue regular CEMD NC meetings	2010-2011	Secretary of NC	MoH, WHO
Equip CEMD NC	office accessories, equipment	2010	UNFPA	UNFPA
Lesson learns from UK	Study tour in UK	2011	NC and Association of obstetrician-gynecologists	MoH, UNICEF, UNFPA, GTZ
Information analyzed and development of recommendations	Preparation of CEMD report	2012.	NC and Association of obstetrician-gynaecologists	MoH, WHO, UNICEF, UNFPA

5.7 Annex 4- Evaluation of Workshop

Evaluation of workshop	1 excellent	2 good	3 fair	4 inadequate	5 irrelevant
1. Objective met	34	14			
2. Relevance of the content towards country needs	33	16			
3. Relevance of content towards application and feasibility	26	19	3		
4. Professionalism of facilitators	47	2			
5. Quality and content of presentations	35	14			
6.Group work effectiveness/feedback	30	18	1		
7. Meeting/schedule/duration of sessions	29	17	2		
8. Clarity about next steps to be taken in country *	7	5	1		
9. Numbers/variability of participants	26	21	1		
10. Administrative and logistic arrangements	30	16	3		
11. Hotel conditions	5	27	14	3	
12. Food	5	22	25	7	
13. Other suggestions for improvements					
Total questionnaires 49					