Gender Mainstreaming in Maternal Death Surveillance and Response Systems in Africa

May 2015
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Foreword

Guided by the Continental Policy Framework on Sexual and Reproductive Health and Rights and its Maputo Plan of Action, African countries have made significant strides in the fight to reduce preventable maternal and child deaths over the past decade. Despite commendable achievements, challenges still continue to hinder progress at the required rates of change. Africa remains a highly risky region for women to become pregnant and give birth; women in Africa, still face a 1 in 39 lifetime risk of dying due to pregnancy or child-birth related complications. In 2013, there was an average of 800 maternal deaths daily worldwide; of these 500 occurred in Africa excluding North Africa.

Efforts to address poor maternal health have traditionally included provider focused interventions to improve access to quality health services. However, as maternal mortality ratios remain stubbornly high throughout large parts of the world, attention is shifting to the impact of social and cultural factors on women’s access to healthcare. This includes gender inequality in the form of decision making, education, access to property and investment opportunities as well as violence and harmful traditional practices.

In line with the declaration of the 15th Ordinary Session of the AU Assembly held in Kampala, Uganda in 2010, maternal deaths should be notifiable. Maternal Death Surveillance and Response (MDSR) is meant to account for each maternal death and put in place interventions to prevent future deaths. These systems allow governments to track, systematically review, and subsequently address factors that contributed to maternal deaths. Implementing and strengthening MDSR systems in the continent is among the key strategies advocated by the AUC Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) to reduce maternal mortality. Previous assessments of maternal death audit systems have pointed to their use to track and respond to direct medical causes of death and review gaps at health facilities. As we start to acknowledge that gender discriminatory behaviours and practices are some of the underlying causes of fatal maternal outcomes, it is important that the systems capture and address the sociocultural factors contributing to maternal death.

It is my pleasure to present this report, which looks at gender inequality and its relation to maternal mortality and proposes practical ways to make MDSR systems more gender sensitive and responsive. I believe adoption of the proposed recommendations is an important step in the fight to reduce the unacceptably high maternal mortality rates on the continent. I call upon all stakeholders to work together to ensure the MDSR systems are gender sensitive and responsive.

H.E. Dr. Mustapha S. Kaloko
Commissioner for Social Affairs
Acknowledgements

This study was conducted using a participatory process and benefitted from the inputs and technical expertise of numerous international, national and local stakeholders. The African Union Commission (AUC) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) would like to acknowledge the following organizations for making their knowledge and resources available throughout this process: the ministries of health in the study’s five focus countries (Chad, Ethiopia, Nigeria, South Africa and Tunisia), the Society for Gynaecology and Obstetrics in each study country (or its local equivalent), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

We express our gratitude to the health managers, health workers, members of civil society and others who acted as key informants, sharing their experiences, knowledge and insights related to maternal health, maternal death surveillance and response system and the specific challenges faced by pregnant women in their local setting. Further, we sincerely thank all participants in the validation workshop.

We thank the lead consultant, Atinuke Odukoya, and her research team for the time and effort they dedicated to conducting the study, as well as Ms. Adebake Akinrimisi for her valuable contributions. We would also like to appreciate Ms. Anne Schoeneborn for her editorial work.

Finally, the AUC and UN Women extends deep gratitude to the Government of France whose support under the Muskoka Initiative made possible the publication of this study.
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUC</td>
<td>African Union Commission</td>
</tr>
<tr>
<td>CARMMA</td>
<td>Campaign on Accelerated Reduction of Maternal Mortality in Africa</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MDSR</td>
<td>Maternal Death Surveillance and Response</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UN Women</td>
<td>United Nations Entity for Gender Equality and the Empowerment of Women</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive Summary

Purpose

The AUC and UN Women, Ethiopia commissioned this preliminary study to consider the way maternal death audits, or the more recent and comprehensive approach—maternal death surveillance and response (MDSR) systems—are currently being used to track gender inequalities, and to make recommendations on the way these systems can be improved to better track gender-related contributors to maternal mortality. Specifically, the research team aimed to:

- Document the global standards and best practices for tracking and responding to gender inequalities and gender-based violence in MDSR systems
- Identify gaps related to the analysis of gender inequality and gender-based violence in MDSR systems in Africa
- Develop a framework for tracking and responding to gender inequalities and gender-based violence in MDSR systems in Africa
- Make actionable recommendations on mainstreaming gender in MDSR systems in Africa

Study Methodology

The researchers conducted in-depth interviews with key informants in five African countries—Chad, Ethiopia, Nigeria, South Africa and Tunisia—which were purposively selected to achieve balanced regional representation and comprise countries with varied maternal mortality ratios (MMRs). In total, seventy-three (73) in-depth interviews were conducted between November 2014 and January 2015 in the study’s five focus countries. The data generated from these interviews was analysed using qualitative data analysis methods. In addition, a desk review was conducted of documents sourced from the ministries of health in the five focus countries and other relevant documents, including Demographic and Health Survey reports and maternal death audit guidelines and reports. These documents were analysed using basic content and context analysis methods.

Findings

This study found that key informants in the five focus countries identified several facets of gender inequality—including a woman’s lack of decision-making power and gender-based violence—as factors that contribute to maternal mortality in their respective countries. The study also found that MDSR systems in the five focus countries do not specifically incorporate the tracking of gender inequality or gender-based violence. Further, in many cases, members of MDSR committees were neither conversant with gender discourse nor did they fully understand the significance of mainstreaming a gender perspective in MDSR systems.

Recommendations

Recognizing that gender inequality in its many forms contributes to women’s risk of maternal morbidity and mortality—and that very little data is currently being collected to tease apart these linkages and more accurately assess how significant individual gender-related contributors really are—the study recommends that a gender perspective is mainstreamed in MDSR systems. A framework is recommended to support this effort, identifying four dimensions along which actions need to be taken:

- Advocacy
- Adapting MDSR guidance documents to be more gender-focused
- Strengthening MDSR systems
- Providing gender training to MDSR committees
1. Introduction

Recognizing the considerable impact that maternal mortality has on women and families—particularly in developing countries—Millennium Development Goal 5A aimed to reduce the maternal mortality ratio (MMR) by 75 per cent between 1990 and 2015. By 2013, the global MMR had decreased by 45 per cent—from 380 to 210 deaths per 100,000 live births. While a considerable achievement, this reduction falls notably short of the target. Africa South of Saharan is particularly impacted by maternal morbidity and mortality, as the region with the highest burden of maternal mortality in the world—510 deaths per 100,000 live births. In 2013, 62 per cent of maternal deaths took place in this region and, for every death, another 20-30 women experienced acute or chronic morbidity, often with permanent health consequences that undermine their normal functioning.

Maternal deaths are tragic because most are, in fact, preventable. There are proven health interventions, many of which are simple and low-cost, that are very effective in preventing and treating pregnancy-related complications. To ensure that women have access to these interventions, it is crucial that women have access to quality antenatal care and that all deliveries are attended by a skilled birth attendant. Progress has been made in this domain as well—the proportion of deliveries attended by skilled health personnel in Africa South of Saharan increased from 40% in 1990 to 53% in 2012—however, this means that nearly half of women are still giving birth without essential obstetric care.

There are diverse causes that prevent women from receiving quality obstetric care, some as seemingly straightforward as not having a geographically accessible health facility and others that are embedded in a complex set of social and cultural realities. This makes it critically important to have institutionalized systems in all countries to both track maternal deaths and investigate the causes of each individual death. At the 15th Ordinary Session of the African Union Assembly in 2010, member states committed to instituting a strong monitoring and evaluation framework at the country level to provide accurate and timely maternal health data, including making maternal deaths notifiable and instituting maternal death reviews (also called maternal death audits), a strategy for identifying the factors that contributed to specific maternal deaths so that similar deaths can be prevented in the future.

To gauge the progress of this effort, the AUC commissioned a study to assess the implementation of maternal death audits systems in Africa in 2012, in collaboration with UN Women. The study documented the status of implementation in seven focus countries—including key challenged facing—and made a series of recommendations to further strengthen maternal death audit systems in the region. The study acknowledged the significance of gender inequality and gender-based violence as factors that contribute to maternal morbidity and mortality, but due to the study’s broader scope, did not report any findings specific to this domain. As such, the researchers recommended a follow-up study to investigate what could be learned about the contribution of gender inequality and SGBV to maternal morbidity and mortality from existing maternal death audit systems.

In response to this recommendation, the AUC and UN Women Ethiopia commissioned this preliminary study to specifically consider the way maternal death audits, or the more recent and comprehensive approach—maternal death surveillance and response (MDSR) systems, are currently being used to track gender inequalities, and to make recommendations on the way these systems can be modified to better track gender-related contributors to maternal mortality.

Specifically, the study aimed to:

- Document the global standards and best practices for tracking and responding to gender inequalities and gender-based violence in MDSR systems
- Identify gaps related to the analysis of gender inequality and gender-based violence in MDSR systems in Africa
- Develop a framework for tracking and responding to gender inequalities and gender-based violence in MDSR systems in Africa
- Make actionable recommendations on mainstreaming gender in MDSR systems in Africa
2. Background

2.1. Key Definitions

The WHO defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal deaths are categorized as either direct obstetric deaths—for example, in cases of haemorrhage, pregnancy-induced hypertension, sepsis or unsafe abortion—or indirect obstetric deaths—which includes those related to HIV, malaria or other pre-existing medical conditions.

To ensure that as few cases as possible are missed, recent technical guidance on conducting MDSR recommends that any death of a woman of reproductive age trigger a review of her medical record to determine her pregnancy status. Nevertheless, it is important to consider the implication of the fact that the current definition of maternal death excludes deaths from accidental of incidental causes. This means, for example, that deaths resulting from intimate partner violence—as well as other forms of gender-based violence—are not classified as maternal deaths and are therefore not reflected in maternal mortality statistics. As a result, some researchers have argued that maternal mortality measurement is not sufficiently gender-sensitive and have called for a more inclusive definition of maternal mortality that considers intimate partner violence as a cause of death.

The most recent set of international medical diagnostic codes includes a new, supplementary diagnostic category: pregnancy-related death. This term is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of cause of death. Once countries fully rolled out the new set of codes, this broader category will help more effectively track the full denominator of women dying while pregnant or in the postpartum period.

Two additional terms of particular relevance are:

- Maternal near miss, defined as the near death of a woman who has survived a complication occurring during pregnancy or childbirth or within 42 days of the termination of pregnancy.
- Maternal morbidity, the causes of which are many and complex, has not historically had a single, uniform definition. A special international Maternal Morbidity Working Group was recently formed to develop a specific definition and standardized identification criteria for maternal morbidity, and has agreed on the following definition to be proposed for inclusion in future international diagnostic codes: any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing.

2.2. Conceptualizing the Factors Leading to Maternal Morbidity and Mortality: The Three Delays Model

There are many, diverse factors that contribute to maternal morbidity and mortality. A conceptual framework that is commonly used to categorize these factors is the three delays model. This model identifies three types of delay that inhibit women from accessing timely obstetric care, namely delays in the decision to seek care, delays in identifying and reaching a health facility and delays in the receipt of adequate and appropriate treatment (see Table 1).

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7 WHO 2013a.
8 Espinoza 2005.
9 WHO 2010.
10 Say 2009.
11 Firoz et al. 2013.
12 Thaddeus 2013.
Table 1: Examples of the Three Delays in Seeking Health Care

<table>
<thead>
<tr>
<th>First Delay: Decision to Seek Care</th>
<th>Second Delay: Reaching a Medical Facility</th>
<th>Third Delay: Receiving Adequate Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to recognize danger signs</td>
<td>• Distance from a woman’s home to a care facility or provider</td>
<td>• Lack of health care personnel</td>
</tr>
<tr>
<td>• Lack of money to pay for medical expenses/transport</td>
<td>• Lack of roads or poor conditions of roads</td>
<td>• Gender insensitivity of health care providers</td>
</tr>
<tr>
<td>• Fear of ill-treatment at health facility</td>
<td>• Lack of emergency transportation, whether by land or water</td>
<td>• Shortages of supplies such as emergency medicines or blood</td>
</tr>
<tr>
<td>• Reluctance of the mother or the family to seek care because of cultural constraints</td>
<td>• Lack of awareness of existing services</td>
<td>• Lack of equipment for EmOC</td>
</tr>
<tr>
<td>• Lack of power—by woman or attending family member—to make decisions</td>
<td>• Lack of community support</td>
<td>• Lack of competence of health care providers to deliver EmOC</td>
</tr>
<tr>
<td>• Lack of encouragement from relatives and community members to seek care</td>
<td></td>
<td>• Weak referral system (includes transportation and communication)</td>
</tr>
<tr>
<td>• Unavailability of someone else to take care of the children, the home or livestock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lack of accompaniment to health facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3. Gender Inequality and Gender-Based Violence as Contributors to Maternal Morbidity and Mortality

Gender inequality has many implications both on women’s access to and uptake of maternal health services, and can contribute to all three of the aforementioned delays. One study that used data from 31 countries—21 of which are in Africa—found that women’s educational, economic and empowerment status are significantly associated with utilization of maternal health services.14 Its findings indicate that women who have completed primary education are nearly five times more likely to have had a skilled birth attendant at delivery than less educated women, and almost three times more likely to have attended at least four antenatal care visits. Further, the odds of having a skilled attendant at delivery for women in the poorest wealth quintile are 94% lower than that for women in the highest wealth quintile. Finally, women with the maximum empowerment score were 1.3 times more likely to have had a skilled birth attendant and 1.5 times more likely to have attended at least four antenatal care visits.

Gender-based violence—including intimate partner violence, rape, forced abortion, and harmful traditional practices such as female genital mutilation, child marriage and adolescent pregnancy—are rooted in gender inequality and can have serious health consequences for pregnant women. To provide just two examples:

**Intimate partner violence.** In addition to being associated with late entry into prenatal care, accounts for a largely unrecognized proportion of maternal mortality.15 Research conducted in one region of India found that 16% of all deaths during pregnancy were the result of partner violence.16 In addition, the study’s findings showed that approximately 70% of maternal deaths in that region went unrecorded and 41% of recorded deaths were misclassified. Intimate partner violence is a significant problem in Africa, as approximately 37% of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (compared to 30% globally) and as many as 40% of all murders of women are committed by intimate partners (compared to 38% globally).17

- **Adolescent pregnancy** puts girls at increased risk of maternal morbidity and mortality. Girls aged 10-14 years are 5-7 times more likely to die in childbirth, and girls aged 15-19 years are twice as likely—compared to women over 20 years of age.18 Adolescent pregnancy is common in Africa South of Sahara, in part due to the frequent occurrence of child marriage; approximately 42% of women aged 20 to 49 in the region were married or in union before the age of 18.19 Very young mothers are at particularly high risk of obstructed labour, which is not only a common direct cause of maternal mortality, but can also lead to obstetric fistula, a severe maternal morbidity that often results in incontinence, extreme stigma and social segregation when left untreated. It is estimated that over 2 million young women live with untreated obstetric fistula in Asia and Africa South of Sahara.20

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13 Source: WHO 2013a.
14 Ahmed 2010.
15 WHO 2002.
17 WHO 2013b.
18 UN 2001.
19 UNICEF 2014.
20 WHO 2014a.
2.4. Tracking and Responding to Maternal Mortality via Maternal Death Audits and MDSR Systems

**Maternal Death Audits**

A primary approach used to investigate and respond to maternal mortality is that of the maternal death audit, which is an in-depth systematic review of maternal deaths to identify the underlying factors and circumstances that contributed to each death. When implemented correctly, the lessons learned from the audit are used to prevent other, similar deaths from occurring in the future, usually by improving the quality of care available to pregnant women. It is not a process for apportioning blame or shame, but rather is intended to empower local authorities to understand what occurred in each case and to take steps to save other women’s lives. There are different approaches used to conduct maternal death audits, many of which are described in Section 4.

The literature contains several examples of the effectiveness of properly conducted maternal death audits in triggering positive changes in maternal health facilities and, when the community is an integral part of the process, in communities as well. A study at a district hospital in Senegal found that, following the implementation of maternal death audits, there was an improvement in the availability and management of blood products, an improvement in the overall organization of care, and an increase in blood transfusion rates. In addition, by year three of implementation, mortality in the maternity unit had decreased by 55%.

Further, a recent pilot study conducted in Malawi found that a community-linked maternal death audit process implemented in one district not only led to the identification of numerous maternal deaths missed by existing data collection systems, it increased action and accountability among health workers and prompted a variety of community-based actions to improve maternal health—including the institution of bye-laws to prevent traditions posing a risk to pregnant women and activities to educate men on their roles and responsibilities in supporting women during pregnancy, delivery and the postpartum period. After one year of implementation, the process had resulted in high rates of completion of community-planned actions (82%), as well as district hospital (67%) and health centre (65%) actions to prevent maternal deaths.

Maternal death audit processes have yet to be fully institutionalized in most African countries due to challenges that include weak health systems, a lack of adequate dedicated resources, insufficient country-level guidance and coordination, and inadequate health work training and support. The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), an initiative launched by the AUC in 2009, has contributed to the increased political will that will be necessary to scale up maternal death audit processes across the region. Significantly, in 2012, the initiative coordinated a regional workshop with representatives from 26 sub-Saharan African countries that focused specifically on maternal death audits.

**Maternal Death and Surveillance and Response System**

A more comprehensive, on-going surveillance system that builds on the maternal death audit is that of the Maternal Death Surveillance and Response System (MDSR). This more recently developed system is a continuous action cycle that aims to identify, notify and review all maternal deaths in communities and facilities, providing information to develop effective, data-driven interventions that will reduce maternal mortality and permit the measurement of their impact (see Figure 1). The cycle continues as cases are identified and reviewed, paying particular attention to monitoring whether recommended actions have been implemented and whether they are proving effective.

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22 Dumont 2006.
23 Bayley 2015.
24 WHO 2013a.
Historically, capturing accurate data related to maternal death has been extremely challenging, in part because maternal death is prone to both under-reporting and misclassification, and because many of the countries with the highest MMRs have the weakest routine reporting systems. MDSR systems offer an approach to improve the accurate identification, counting and reporting of maternal deaths and also have the capacity to provide sub-national data that can help promote action and accountability.

2.5. Tracking and Responding to Gender Inequalities and Gender-based Violence in MDSR Systems

As reviewed previously, gender inequality and gender-based violence are often tightly interwoven with the factors that lead to maternal morbidity and mortality. Yet, tracking gender inequality and how it contributes to individual cases of maternal death has not been a specific focus of MDSR systems. Currently, relevant international guidelines incorporate inquiry and documentation related to gender inequality and gender-based violence in the following ways:

- In the maternal death audit guidelines published by the International Federation of Gynaecologists and Obstetricians, team-building sessions that include an interactive session on gender and health are recommended before beginning maternal death audit training, in order to raise awareness of how gender affects access to health services and to encourage members of the review committee to view events through a ‘gender lens’ when reviewing cases.

- Recent international MDSR technical guidance includes gender-related issues among the factors committees should generally consider when assessing if a death was avoidable or not. Specifically, it recommends committee members “assess social and economic barriers related to the status of women, women’s literacy level and gender-based beliefs and practices that may be a root cause of poor service utilization”. However, in the sample data collection tools the guidance document provides, there are few specific prompts related to gender-inequality or gender-based violence.
In the sample maternal death reporting form provided, the only place information related to gender-inequality or gender-based violence could be recorded are the spaces provided for a primary and secondary cause of death, and in the space for additional remarks.

Among the specific types of data recommended for collection at the community level, clues might be provided by answers to the basic socio-demographic questions, the open-ended questions enquiring about other contributing factors, and the question, “were there any barriers to obtaining care, such as geographical, financial, or social or other responsibilities?”

In the 32-page community autopsy questionnaire, other than open-ended questions about the events leading up to the death, the following items could provide clues:

- Did she suffer from any injury or accident that led to her death? (yes or no)
- What kind of injury or accident did the deceased suffer? (road traffic accident, fall, drowning, poisoning, burns, violence/assault, other)
- Was the injury or accident intentionally inflicted by someone else? (yes or no)
- What are the reasons why she (or someone else on her behalf) did not seek health care before she died? (multiple choice)
- What difficulties did she have when she sought health care? (multiple choice)

In the summary form for maternal death in facility, the answer to the following question may provide clues: “If there was a delay by the women seeking care, why? Include personal, family oriented, and community oriented problems including social and financial”.

This general lack of specific prompts guiding those conducting maternal death audits to specifically consider or enquire about how gender-inequality and/or gender-based violence may have contributed to the maternal death is problematic, as it prevents the standardized documentation and meaningful tracking of these relevant factors. To help address this gap, the final section of this report provides a series of recommendations on how MDSR systems could be modified to incorporate a more specific focus on how gender-inequality and gender-based violence contribute to maternal mortality.
3. Study Methodology

To meet the study objective of identifying gaps related to the analysis of gender inequality in MDSR systems in Africa, the researchers conducted in-depth interviews with a variety of key informants in five African countries. Face-to-face interviews were conducted whenever possible and, when not possible, information was gathered from key informants via phone or email communication. The research team opted to utilize the qualitative research method of in-depth interviewing because it allows for the capturing of a broad range of nuanced responses from participants and is particularly appropriate for discussions about a topic as complex and multi-faceted as gender inequality.

To gain an understanding of country-specific standards for tracking and responding to gender inequalities in MDSR systems, the research team conducted a desk review of documents sourced from the ministries of health in the five focus countries. The researchers also reviewed Demographic and Health Survey reports, MDSR guidelines and reports, and other materials provided by MDSR committees and in-country stakeholders.

3.1. Sample

Five countries were purposively selected to be included in the study, one from each of Africa’s five regions (see Table 2). These countries were selected in order to achieve balanced regional representation and to comprise countries with varied MMRs (i.e., a balance of countries with relatively high and low MMRs). Countries were only considered for inclusion in the study if they were already implementing some type of maternal death audit/MDSR system.

Table 2: Focus Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Region</th>
<th>MMR (per 100,000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chad</td>
<td>Central Africa</td>
<td>980</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>East Africa</td>
<td>420</td>
</tr>
<tr>
<td>Nigeria</td>
<td>West Africa</td>
<td>560</td>
</tr>
<tr>
<td>South Africa</td>
<td>Southern Africa</td>
<td>140</td>
</tr>
<tr>
<td>Tunisia</td>
<td>Northern Africa</td>
<td>46</td>
</tr>
</tbody>
</table>

The interviewees from each country were purposively selected from the categories summarized in Table 3 to obtain a wide range of perspectives from civil servants, health care providers, representatives from civil society organizations and community members. In total, seventy-three (73) in-depth interviews were conducted between November 2014 and January 2015 in the five focus countries.

Table 3: Key Informants Targeted for In-Depth Interviews in Each Country

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Number Targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative of the local government health department</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Health maternal death audit/MDSR project coordinator or focal person/desk officer</td>
<td>1</td>
</tr>
<tr>
<td>Public or community health care worker</td>
<td>1</td>
</tr>
<tr>
<td>Maternal death audit/MDSR committee member or committee head at the state/provincial or facility level</td>
<td>1</td>
</tr>
<tr>
<td>Non-governmental organization working on maternal death audits/MDSR and/or maternal health issues</td>
<td>1</td>
</tr>
<tr>
<td>The Society of Gynaecology and Obstetrics, or in-country equivalent</td>
<td>1</td>
</tr>
<tr>
<td>Health care providers, including one obstetrician (or doctor experienced in obstetrics) and one nurse (preferably a midwife/matron)</td>
<td>2</td>
</tr>
<tr>
<td>Community leader or representative</td>
<td>2</td>
</tr>
<tr>
<td>Women’s group leader</td>
<td>1</td>
</tr>
<tr>
<td>Pregnant woman or woman of reproductive age</td>
<td>2</td>
</tr>
<tr>
<td>Married, male community representative</td>
<td>2</td>
</tr>
<tr>
<td>Development partner working on maternal death audits/MDSR</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
</tbody>
</table>
3.2. Data Collection

The researchers conducted in-depth interviews with participants using a structured interview guide (see Appendix V) and took detailed notes on participant responses. In non-English speaking contexts, the researchers translated the interview guide and conducted interviews in the local language. The notes from these interviews were then translated into English for data analysis. Ethical clearance was sought in each of the focus countries, but due to time constraints it was only obtained in Ethiopia in time for data collection. Participation in the study was voluntary and free from any form of coercion. The researchers fully briefed each participant on the purpose of the study before beginning the interview and the participant provided verbal consent before the interview proceeded.

3.3. Data Analysis

Data generated from the in-depth interviews was analysed using qualitative data analysis methods. The analytic process involved reviewing the interview transcripts in order to identify key ideas contained in the data, and then grouping these ideas into specific themes.

Maternal death review forms and guidelines were analysed using basic content and context analysis methods.

3.4. Limitations

This study had a number of limitations. First, translations of the interview guide and participant responses—between English, French and the local languages spoken in Chad and Ethiopia—may have introduced bias to the data collection process and, therefore, to the study’s findings. This bias may have been augmented by the fact that no back-translation was carried out.

Furthermore, due to the lack of full ethical clearance in four of the focus countries, a number of respondents stated that their responses should be considered as reflective of their opinions alone, and many wished to keep their identities confidential.
4. Findings

This study found that key informants in the five focus countries identified several facets of gender inequality—including a woman’s lack of decision-making power and gender-based violence—as factors that contribute to maternal mortality in their respective countries. The study also found that the MDSR systems in the five focus countries do not specifically incorporate the tracking of gender inequality or gender-based violence. Further, in many cases, members of MDSR committees were neither conversant with gender discourse nor did they fully understand the significance of mainstreaming a gender perspective in MDSR systems.

4.1. Maternal Health Priorities

The maternal health priorities identified by study participants were similar across all five focus countries. Respondents in Ethiopia, Nigeria, Chad and South Africa emphasized the need to increase the number of skilled health professionals, strengthen the capacity of existing health facilities and promote institutional delivery as significant priorities in their respective countries. As a key informant in Ethiopia stated, "when it comes to the issue of maternal health, our focus is on reducing the mortality rate. With this, the first thing is ensuring that all mothers deliver at institutions—promoting institutional delivery. We are promoting the fact that no woman should give birth at home. . . . We have managed to increase the number of skilled professionals, especially midwives, through the accelerated training program so as to respond to the greater need".

In addition, respondents in Nigeria and Chad identified increasing access to family planning, expanding the number of health facilities in rural areas, increasing antenatal care attendance and increasing the availability of emergency obstetric care as important maternal health priorities. Respondents in South Africa and Nigeria articulated the importance of HIV prevention programs because, as one respondent noted, "HIV is one of the highest contributing factors to maternal deaths in the country".

Respondents across the study countries made reference to specific aspects of gender inequality, particularly the importance of alleviating poverty through the empowerment of women and preventing adolescent pregnancy. No respondents specifically mentioned addressing gender-based violence as a maternal health priority, indicating either that participants do not consider it to rank highly among maternal health priorities or that gender-based violence is not a significant part of the local discourse around maternal morbidity and mortality.

4.2. Factors Contributing to Maternal Morbidity and Mortality

According to the study’s participants, many factors contribute to the vulnerability of girls and women to obstetric complications and maternal mortality. Respondents in all focus countries indicated that among the direct causes, haemorrhage is the most common cause of maternal mortality in their local context. Respondents also described a wide range of indirect factors—many of them interrelated—that they see as contributing to maternal morbidity and mortality. These factors include:

Women’s Lack of Decision-Making Power

Many respondents across the study’s focus countries described patriarchal family structures that limit women’s autonomy and ability to make decisions. As one key informant stated, "The Ethiopian family system is patriarchal so everything is controlled by the husband and, hence, the women are not involved in the decision-making process." Similarly, a community health worker in Nigeria indicated, "Most women have no say in the family and they wait for their husbands to make decisions". A Tunisian respondent explained, "In most of our regions, men control household expenses and decision-making in the family, who may be reluctant to use its limited resources for health care and nutritional needs of women".

Respondents indicated that these patriarchal norms significantly affect women’s ability to make decisions about when and how to seek health services and, of particular relevance, whether to go to the hospital in the case of pregnancy-related complications. A number of respondents explained that, although a woman may play a role in the decision-making process, in the end, she often must go along with whatever her husband decides. A respondent in Ethiopia stated, "She decides. Of course her husband is also part of the decision-making process. Especially in the rural areas, if the husband doesn't approve, she might not go". Similarly, a respondent from South Africa explained that, "the low socio-economic status of women affects the decision-making power of women in the marriage and sometimes they are forced to rely on their husbands to make the decision regarding their sexual and reproductive health for them". In addition, a respondent in Chad noted that, "In general, the woman has no decision-making power regarding transport to a health facility when she is in labour or having birthing complications requiring surgery. The voice of the family remains dominant. The authority of one or other of the men close to the pregnant woman (brother, husband, uncle) is predominant in terms of the socio-cultural milieu from which the pregnant woman comes".

Gender-Based Violence

Study participants described multiple forms of gender-based violence faced by girls and women in their countries, including physical
and sexual abuse. Respondents in Chad, Nigeria and Ethiopia spoke of harmful traditional practices, such as early marriage and female genital mutilation, that they feel particularly contribute to maternal morbidity and mortality. According to a respondent in Ethiopia, “Girls and women in the country are exposed to gender-based violence, either as a traditional practice by the community or by their male counterparts. Rape, abduction, child marriage and female genital mutilation are some of the major forms of gender-based violence to which girls and women are subjected.”

Respondents in Nigeria identified the issue of early and forced marriage of girls to older men as a factor contributing to maternal mortality, especially in the north of the country. According to respondents, early marriage promotes gender imbalance and puts young girls at risk of pregnancy-related complications, HIV and other sexually transmitted infections. According to one respondent in Nigeria, “girls are not educated, they get married off early and start childbirth at a premature age. Once internal organs are not properly developed for pregnancy and delivery, it becomes dangerous and can cause maternal death”.

Respondents also indicated that gender-based violence often goes unreported and that data is generally not collected that links gender-based violence and maternal morbidity and mortality. A key informant in South Africa stated, “Gender-based violence cases are sometimes reported, but not direct cases. Few reported gender-based violence cases are directly linked to maternal death. Domestic violence is more probable, but also rarely reported. I recall a case where a man kicked his pregnant partner in the stomach and the foetus was detached from the placenta.” Another respondent described a similar instance of violence, demonstrating the anecdotal nature of gender-based violence-related causes of maternal mortality. “I knew of a lady that was beaten up and ruptured her uterus, she died with the baby too.” Several respondents explained that, although victims of gender-based violence may present to a health facility, it is often only the immediate health complication that is documented, rather than the underlying causes.

Adolescent Pregnancy

Many respondents stated that adolescents and young women have limited access to health services due to shame and the culture of silence surrounding sexual and reproductive health care. Respondents in all five countries indicated that adolescent pregnancy is a significant cause of maternal mortality, as teens tend to hide their pregnancies and, as a result, often do not receive adequate antenatal care. In addition to having less access to care, some respondents noted that young women receive lower quality care than older women. A South African respondent described her own experience becoming a mother at age 19: “I was treated with disrespect and disregard. I cried my eyes out throughout and had no support from the nursing staff at all. From my experience, the hospital staff discriminate against young mothers and single mothers and therefore do not pay attention to them or their complaints, even when the women are right”.

Poverty and Other Socio-Economic Factors

Respondents in all of the study’s focus countries described a strong link between poverty and maternal death. As a Nigerian respondent stated, “poverty is a major factor. The people are poor. Even when the facility is next door, many cannot afford to pay for services”. Similarly, a South African woman explained, “socio-economic factors contribute to poor maternal health, as many women do not have external help and means of meeting their needs”.

Many respondents across the five countries identified the struggle to pay for transportation to health facilities as a specific barrier to health care, particularly for women living in rural settings. According to a respondent in Chad, “motherhood has a cost that the husband or the author of a pregnancy does not necessarily assume. Many women and especially adolescent girls face the expenses related to their pregnancy by themselves. In rural areas, this is even more so when the means of transport to regularly report to antenatal care or to the nearest health facility in the case of childbirth complications are often lacking.” Similarly, a community leader in Nigeria stated, “The major problem is poverty. Take for instance someone who should go for antenatal care but has no transport money. Lack of good nutrition is also a factor, but the basic issue is poverty. 99 per cent of the problems encountered have their root in poverty.”

Key informants also cited low education and literacy levels as important contributors to maternal morbidity and mortality. They reported that women’s and girls’ level of education strongly affects their decision-making abilities, their access to health information and their awareness of maternal health risks. Further, the more education a woman has, the more empowered she will be to reject harmful traditional beliefs and practices that may increase her risk of maternal morbidity and mortality.

Cultural Factors

Respondents indicated that specific cultural values and beliefs have a significant impact on maternal health outcomes. For example, respondents in all five focus countries described a cultural preference for home delivery. According to key informants in Nigeria, Chad, Ethiopia and South Africa, the use of traditional healers and traditional birth attendants is a major reason women with obstetric complications delay seeking medical care. According to one respondent in South Africa, “Women also face a number of cultural issues which affect their health. They visit sangomas [traditional healers] who give them traditional medicines which affect their health and that of the unborn babies”. Another stated, “many mothers go to sangomas for treatment and only report in hospitals when the desired or expected outcome is not achieved. They are often given strong cocktails of herbs and sometimes poisonous medicines to digest that kill
the child and sometimes kill the mother too, or result in complications for both”. In Nigeria, one key informant noted that, “some families do not believe in orthodox medical facilities and they cannot be convinced otherwise, they make use of traditional birth attendants”.

Key informants in Chad described a general cultural preference for vaginal delivery and a reluctance to seek medical help in cases of obstetric complications. Respondents reported that, even in the case of an obstetric emergency, a pregnant woman’s family members may turn to traditional healers for treatment, delaying the woman’s access to proper medical care. According to interview respondents in Chad and Nigeria, some communities believe caesarean section will inevitably result in a woman’s death, which in some cases leads the family members of a woman in need of a caesarean section to refuse to sign the consent form for the procedure. Further, respondents in Chad and Nigeria indicated that a woman’s relatives may refuse to donate blood in cases where a transfusion is required because of negative cultural interpretations related to this medical procedure.

Several respondents also indicated that women can find it difficult to discuss how they feel during pregnancy and childbirth. In some contexts, it is seen as a form of strength and dignity when a woman endures her labour pains in silence. Particularly in Nigeria, respondents indicated that the cultural expectation in some areas that women are to be seen and not heard is a norm that can significantly impact women’s maternal health decisions. In addition, a number of respondents indicated that religious beliefs can influence health-seeking behaviours; for example, a fatalistic acceptance of death in the name of religion may make women and their families less likely to actively seek medical intervention in the case of an obstetric emergency.

Health Infrastructure

Respondents across the study’s focus countries stated that inadequate health infrastructure contributes to maternal death. They reported that the number of health facilities is insufficient and that many existing facilities are not properly equipped, do not have sufficient staff and do not provide high-quality services. In Chad, key informants described insufficient supplies at a main hospital, including insufficient availability of blood, emergency kits and oxygen. In addition, as a result of power issues, many health facilities are unable to provide emergency obstetric care services around the clock. Respondents also cited inadequate roads and transportation systems as factors frequently inhibiting women’s access to maternal health care.

Governance

Respondents in Chad and Nigeria referenced poor governance and lack of political will as factors contributing to maternal morbidity and mortality. According to respondents in Chad, there is insufficient action at the policy level to reduce maternal mortality, as exemplified by the lack of effective implementation of Law No. 006/PR/2002 on the promotion of reproductive health; the non-adoption of several draft texts that protect the rights of women, including against gender-based violence; and the non-adoption of the code on the person and the family, which would raise the minimum age of marriage to 17. In Nigeria, on the other hand, respondents indicated that corruption contributes to maternal morbidity and mortality because funds allocated for maternal health are not always used for their intended purpose, resulting in ill-equipped health facilities.

Conflict and Civil Unrest

Respondents in Nigeria expressed concern that recent conflict and civil unrest may be negatively impacting maternal health. Specifically, respondents indicated the need for research to study the maternal health effects of the Boko Haram insurgency in the north-eastern part of the country. As stated by one key informant, “the insurgency may have also increased levels of gender-based violence in the country; however, research is required to understand the ramifications of the conflict situation on maternal health in the country”.

4.3. MDSR: Experiences at the Country Level

The researchers reviewed the approaches currently being used to conduct maternal death audits, or MDSR, in the five focus countries, and the extent to which they incorporate the tracking of gender inequality and gender-based violence. In addition to analysing the information provided by key informants, the researchers utilized AusAID’s Guide for Gender and Development as the basis for reviewing the tools and forms used to conduct MDSR in the study’s focus countries. Specifically, the researchers used the key guiding questions included in the guide to help assess the level of sensitivity and commitment to principles of gender equality reflected in the tools and forms.

While some type of maternal death audit/MDSR has been conducted in South Africa and Tunisia since 1997 and 1999, respectively, Chad, Ethiopia and Nigeria have only recently introduced MDRS systems. Each country uses one or more of the five most common audit approaches, summarized in Table 4.

29 AusAID.
Table 4: Approaches to Conducting Maternal Death Audits

<table>
<thead>
<tr>
<th>Approach</th>
<th>Description</th>
<th>Countries Using Approach</th>
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| Facility-based maternal death audit          | • In-depth investigation of the causes of, and factors associated with, maternal deaths occurring at health facilities  
• Provides information that can be used to improve obstetric care  
• Ideally includes a community representative to provide insight into community-level contributing factors                                                                                                                | Chad  
• Ethiopia  
• Nigeria  
• South Africa  
• Tunisia                                                                                                                |                          |
| Community-based maternal death audit / verbal autopsy | • In-depth, non-judgmental investigation of the causes of—and factors associated with—maternal deaths occurring outside of health facilities  
• Involves interviewing family members about the circumstances that led to the maternal death                                                                                                                                                                 | Ethiopia  
• South Africa                                                                                                           |                          |
| Confidential enquiries into maternal deaths  | • A national or sub-national multidisciplinary committee meets periodically to systematically investigate a representative sample of (or all) documented maternal deaths to identify the causes and associated factors  
• The investigation is carried out in a confidential manner (“No blame, no shame”)                                                                                                                                  | South Africa  
• Tunisia                                                                                                                |                          |
| Investigation of severe maternal morbidity / near-misses | • An in-depth investigation into the factors that led to the near miss, what worked well in the treatment of the life-threatening complications, and lessons learned  
• Unlike the other approaches, in this method, the pregnant woman herself is interviewed, creating the opportunity to obtain first-hand insight into the circumstances of the near-miss                                                                 | Ethiopia  
• South Africa                                                                                                           |                          |
| Clinical audit                                | • A systematic review of the obstetric care provided to pregnant women against established protocols or criteria  
• Aimed at improving the quality of care                                                                                                                                                                                                                                     | Ethiopia  
• South Africa                                                                                                           |                          |

Findings revealed that MDSR data-collection forms and systems in the five focus countries do not specifically incorporate the tracking of gender inequality or gender-based violence.

Respondents in Tunisia indicated that the local MDSR system does not currently include a focus on gender-related issues, social determinants of maternal death or gender-based violence. In fact, several study participants indicated that they do not consider gender inequality to be a significant issue in Tunisia: “I think that Tunisian women are emancipated; she prepares her sexual and reproductive life and I don’t think that gender constraints are important”. On the other hand, members of local MDSR committees noted a recent increase in maternal deaths in rural areas and stated that recommendations had been made to begin investigating the social and economic determinants of maternal mortality, using a human rights-based approach.

In South Africa, although a highly developed MDSR system is in place, respondents indicated that gender inequality and gender-based violence is not tracked effectively via the system. According to a respondent involved in carrying out maternal death audits, “the committee does not look at social issues of health in detail...the quality of local reviews needs to improve and recommendations of the national committee must be implemented.” Respondents stated that there is a particular need to introduce questions focused on gender-based violence, considering the high levels of violence in the country. In addition, some respondents indicated that there is an increase in reported cases of alcohol and drug use among pregnant women, so these issues should specifically be probed in maternal death audits.
In Nigeria, respondents indicated that both gender inequality and gender-based violence represent a significant problem in the country, but that these issues are not actively tracked in maternal death audits. One key informant who participates in maternal death audits stated, “At the facility level, we do not oversee gender-based violence. In terms of maternal death audits, we have not analysed what is happening, but in the country generally there is an increase in gender-based violence, especially rape, and more people are coming out to speak of their experiences”. Another respondent stated that the MDRS system in Nigeria is still evolving, and that it may be too early to identify specific gaps in the system, but that “there is national apathy towards implementing maternal death audits”.

In Ethiopia, maternal death reporting comprises basic information about the deceased woman and a summary of clinical and contributory factors pertinent to the maternal death. Clinical causes include direct and indirect obstetric causes and contributory factors include those pertaining to the three delays described previously. A majority of respondents in Ethiopia indicated that they felt gender-specific issues were indirectly represented under the categories of delay one and two, and that they were not more specifically incorporated because the concept of gender is so broad and subjective, it is difficult to list all of its features in the reporting format. Key informants in Ethiopia also indicated that the MDSR system suffers from a number of challenges, including a lack of prioritization at the regional level, insufficient financial and technical resources, staff turnover and fears of medical malpractice. Community-based maternal death audits suffer from particular challenges, including difficulties in reaching all rural areas due to financial constraints and insufficient personnel to carry out the work. Also, in some cases respondents reported unwillingness among family members to participate in the verbal autopsy or provide accurate information.

The study findings in Chad revealed that the concept of MDSR is still very new in the country and most of the respondents lacked familiarity with the process. The implementation of MDSR was launched in three of Chad’s 22 regions (Logone Occidental, N’Djamena and Ouaddai), but the process is not fully operational. According to one key informant, “I am involved in the maternal death audit process, except it has just started. I followed the training of trainers on maternal death audits and have also contributed to the establishment of some teams that have already started the process. There was an audit that took place already in Moundou in October 2014”. Apart from the health staff directly involved in the MDSR trainings, few key informants were familiar with the process. Respondents who knew of MDSR pilots at specific health facilities noted clinical staff seemed confused by the process and would benefit from further training.
5. Conclusions

A commitment to the promotion of gender equality is well established in the African region. As exemplified by CARMMA, there is also ever strengthening political will in the region to further reduce maternal mortality. Recognizing that gender inequality in its many forms contributes to women’s risk of maternal morbidity and mortality—and that very little data is currently being collected to tease apart these linkages and more accurately assess how significant individual gender-related contributors really are—it becomes clear why it is important to mainstream gender in MDSR systems (see Box 1). Leveraging these systems to generate data that help elucidate maternal mortality’s root cases—with all their complexity—has the potential to empower policy-makers and local stakeholders to better target interventions and resources to address the problem. In other words, by using these tools to begin filling the existing information gap will free us to move beyond isolated anecdotes of the way gender inequality contributes to maternal deaths, to using real evidence to trigger and inform action.

Box 1: Gender Mainstreaming Defined

Gender mainstreaming is a globally accepted strategy for promoting gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities—policy development, research, advocacy/dialogue, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects.
6. Tracking and Responding to Gender Inequality and Gender-based Violence in MDSR Systems in Africa: Recommendations for Action

This section proposes recommendations to support gender mainstreaming in MDSR systems. The framework identifies four dimensions along which actions need to be taken:

1. Advocacy
2. Adapting MDSR guidance documents to be more gender-focused
3. Strengthening MDSR systems
4. Providing gender training to MDSR committees

6.1. Advocacy

In order to marshal the needed political will and resources that will be required to effectively mainstream gender in MDSR systems, targeted advocacy will be needed at the international, regional and national level to:

- Lift gender inequality much higher on the maternal health agenda.
- Encourage governments to commit adequate, ongoing funding and resources to continue efforts to strengthen maternal death audit systems and eventually develop them into fully operational MDSR systems.
- Ensure that government bodies and other stakeholders are responsive to key MDSR findings, once systems are operational. For example, if it becomes clear that intimate partner violence is contributing to a large number of maternal deaths, advocacy will likely be needed to ensure that sufficient resources are allocated to implement targeted interventions to address this issue.

6.2. Adapting MDSR Guidance Documents to be More Gender-focused

As reviewed previously, existing MDSR guidance documents and tools do not specifically focus on how gender inequality contributes to cases of maternal mortality. Thus, it will be important that existing guidelines are adapted at the international and national level to better track gender-related factors known to contribute to maternal morbidity and mortality. This will include revising maternal death audit forms to specifically probe respondents about a wider range of contributing factors, for example:

- Income and/or access to financial resources
- Level of autonomy and engagement in household decision-making
- Education, including years of schooling and literacy
- Exposure to gender-based violence and harmful traditional practices, including:
  - Intimate partner violence
  - Child marriage
  - Forced abortion
  - Female genital mutilation
  - Rape or other sexual violence
- Exposure to harmful cultural or social norms that increase pregnant women’s risk of obstetric complications
- Exposure to gender-based discrimination

Recognizing that there are many complex and interlinked factors that can prevent women and girls from accessing appropriate health care—and that gender inequalities are manifested in different ways in different social and cultural contexts—it is recommended that each country convene a process to adapt its in-country guidelines and tools. Specifically, this process should:

- Utilize a highly participatory approach that includes local gender experts and representatives of civil society—both women and men—as an integral part of the process.
- Include the formulation of specific probing questions tailored to the local country context for use by MDSR committees.
6.3. Strengthening MDSR Systems

The findings of this study corroborate examples in the literature indicating that many African countries are currently facing challenges in the implementation of functional MDSR systems. These challenges include insufficient technical, human and financial resources to fully institutionalize MDSR, leading to inconsistent processes, incomplete reporting and a lack of supervision, coordination and accountability. Thus, it will be necessary to strengthen existing systems in these countries, while also increasing the emphasis on gender. Specifically, countries should:

- Introduce and/or strengthen the implementation of verbal autopsies and near-miss investigations, which are often the most strategic in gathering information about gender-related factors contributing to maternal mortality. Near-miss investigations often prove particularly useful—and can be conducted both at the health facility and community level—as they enable the survivor to speak for herself, telling her own story and describing the circumstances that led her to suffer an obstetric emergency. Further, as a significant proportion of women in Africa give birth outside of health facilities, verbal autopsies are a crucial strategy for investigating the maternal deaths often missed by facility-based maternal death audits.

- Include community representatives and other local stakeholders with particular insight into the socio-cultural circumstances that lead to maternal deaths in MDSR committees. (Findings from this study revealed that none of the five focus countries include a community representative on MDSR committees.) In addition to providing valuable insights, community representation often serves to improve awareness of key risk factors at the community level, strengthen facility-community linkages and increase accountability for the implementation of action points resulting from the audit process.

- Implement strategies to ensure that recommendations resulting from maternal death audits are followed up on and implemented. (A significant issue raised in all five focus countries was insufficient follow-through on the recommendations made by MDSR committees.)

- Ensure that all maternal death audit reports include a specific summary of gender-related factors that the committee believes contributed to the maternal death.

- Ensure that maternal death audits are performed—and national statistics are collected for—“pregnancy-related deaths” as well as “maternal deaths”.

- Establish/strengthen ongoing collaboration between the gender focal point in the ministry of health and the focal points overseeing the MDSR process, with a focus on guaranteeing that gender issues are integrated in MDSR plans, assessments and reports. In addition, the gender focal point should play an active role in any national multidisciplinary committee tasked with carrying out confidential enquiries into maternal health.

6.4. Providing Gender Training to MDSR Committees

This study’s findings indicate that members of MDSR committees in many African countries lack familiarity with gender concepts and discourse. In order to successfully mainstream gender in MDSR systems, it will be very important to provide gender-focused training to health workers and other stakeholders involved in carrying out maternal death audits. Ideally, a gender specialist should play a lead role in these trainings, providing insight into how to effectively ask relevant probing questions, regardless of the respondent’s own knowledge of gender concepts.
References

3. African Union. 2010. "Assembly of the African Union; Fifteenth Ordinary Session; Decisions, Declarations, Resolution".
Appendix

APPENDIX I:

GENDER CONCEPTS

Gender

“Gender” is a term used to describe the characteristics of women and men that are socially constructed, while “sex” refers to traits that are biologically determined. Gender therefore describes all the socially given attributes, roles, activities, and responsibilities connected to being male or female in a given society.31

Gender equality

“Gender equality” is the absence of discrimination, on the basis of a person’s sex, in providing opportunities, granting access to services, and allocating resources and benefits. In other words, gender equality means an equal visibility, empowerment and participation of both sexes in all spheres of public and private life.32

Gender equity

“Gender equity” refers to fairness and justice in the distribution of benefits and responsibilities among women and men. The concept recognizes that women and men have different needs and strengths, and that these differences should be identified and addressed to rectify imbalances between the sexes.

Gender analysis

“Gender analysis” identifies, analyses and informs action to address health inequalities that arise from the different roles of women and men—or the unequal power relationships between them—and the consequences of these inequalities on their health. People are born female or male, but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles.

Gender mainstreaming

Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women and men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality.33

31 Gupta 2008.
32 Council of Europe 1998.
33 As defined by the UN Economic and Social Council in 1997.
APPENDIX II:
COUNTRY-LEVEL REPORTS AND GUIDELINES REVIEWED

Ethiopia
1. “Maternal death and Near Miss Remedial Factors Assessment and Notification Tool”; “Maternal Death/Near Miss Audit Case Summary Form”; “Maternal Death Reporting Format, Verbal Audit Summary Form”; Facility-based Ward Notification Form”; Facility-based Near Miss Abstraction Form”. Ethiopia.

Nigeria

South Africa
APPENDIX III:

RESEARCH TEAM

1. Atinuke Odukoya       Consultant, Nigeria
2. Victoria Balogun      Data Collector, South Africa
3. Lydie Beassmeda      Data Collector, Chad
4. Mohammed Chaouch      Data Collector, Tunisia
5. Olasumbo Oladipo     Data Collector, Nigeria
6. Rofiah Ololade Sarunmi Data Collector, South Africa
7. Tseday Zeraycob      Data Collector, Ethiopia
APPENDIX IV:

INTERVIEW GUIDES

Semi-structured interview guide for interviews with MDA committee members and MDA project coordinators

A. Country Information

1. Date of interview/date completed (dd/mm/yyyy):
2. Country name:
3. African region:
   - Central Africa
   - East Africa
   - North Africa
   - South Africa
   - West Africa
4. Current MMR:
5. Year:
6. Source:

B. Contact Information of Respondent

1. Name of person interviewed/who filled out the form:
2. Title:
3. Name of organization/department:
4. Role in MDA committee (if applicable):
5. Telephone:
6. Email:
7. Skype ID (if available):
8. Interview type (e.g. telephone, in person):

C. Name of Interviewer:
BACKGROUND
1. We are aiming to get a better understanding of maternal health and death audits in Africa. From your perspective, and given your experience in maternal health, what are the maternal health priorities in your country?
2. What are the contributory factors that you think contribute to maternal mortality and morbidity? (Probe for various factors that lead to maternal deaths, factors related to SGBV, and take notes on details regarding how SGBV contributes to death among pregnant and postpartum women)
3. Apart from the factors mentioned earlier, what other factors do you think are contributing to maternal death and morbidity? (Probe for socio-economic factors like poverty, etc.)
4. Reflecting on your experience in maternal health, what are the priority gender issues in maternal health?
5. Can you provide specific details of gender-related issues—such as lack of decision-making power of women, religious or cultural restrictions—that limit women from accessing health care services?
6. How do you/your programme/committee/health system respond to the identified issues? What are you doing currently?

MATERNAL DEATH AUDITS
1. Do you know about maternal death audits?
2. Are you involved in maternal death audits? In what ways are you involved with them? What are you doing? (Probe for knowledge and involvement with MDA committees and for length of involvement)
3. What are the approaches to maternal death audit being used in your country? Please describe.
4. How is your maternal death audit committee constituted? How many males and how many females are on the committee?
5. Who else is working on improving maternal health/maternal death audits in your country?
6. In what ways has the maternal death audit process been successful? What is going well? What needs to change to have even more success?
7. What gaps do you see in the maternal death audit system and processes?
8. What kinds of changes would you like to see in the maternal death audit processes?
9. We identified gender inequalities earlier—are you addressing these inequalities? What do you think you can do to include gender equality in maternal health?
10. How is gender equality being incorporated into maternal death audits? If it is not being incorporated, how do you think it could be incorporated into maternal death audits?
11. State three major challenges or constraints to incorporating gender equality into maternal death audits?
12. What are your suggestions for overcoming these challenges/barriers?
13. What suggestions do you have to ensure gender is mainstreamed into the maternal death audit system?

CONCLUDING QUESTIONS
1. Can you share with us copies of your maternal death audit guidelines, strategy, reports, etc.?
2. What else would you like to tell me but didn’t because I did not ask the right question? Any other comments/insights/questions you would like to share?
GENDER MAINSTREAMING IN MATERNAL DEATH SURVEILLANCE AND RESPONSE SYSTEMS IN AFRICA

Semi-structured interview guide for interviews with: representatives of national government health departments; representatives of state (or equivalent) government health departments; representatives of local government health departments; public or community health care workers; health care providers, etc.

A. Country Information
1. Date of interview/date completed (dd/mm/yyyy):
2. Country name:
3. African region:
   - Central Africa
   - East Africa
   - North Africa
   - South Africa
   - West Africa
4. Current MMR:
5. Year:
6. Source:

B. Contact Information of Respondent
1. Name of person interviewed/who filled out the form:
2. Title:
3. Name of organization/department:
4. Role in MDA committee (if applicable):
5. Telephone:
6. Email:
7. Skype ID (if available):
8. Interview type (e.g. telephone, in person):

C. Name of Interviewer:
BACKGROUND: GENDER ISSUES IN MATERNAL HEALTH SERVICE DELIVERY SYSTEM

1. We are aiming to get a better understanding of maternal death audits in Africa. From your perspective, what is the maternal mortality situation in this country?
2. What are the maternal health priorities in your country?
3. What socio-economic or cultural constraints do people face in accessing maternal health services at each level of service delivery?
4. What are the current steps that the government is taking to address this problem?
5. What are the issues related to adolescent sexual and reproductive health in your country?
6. What is the prevalence of maternal death? What are the major clinical, environmental and socio-economic causes of maternal death in your country? Cultural causes?
7. What factors reduce women’s access to health services? (Probe for factors such as timing of services, distance to facilities, lack of transport money, lack of female staff in clinics, etc.)
8. Is violence against women prevalent in your area? What community or health care services are offered to abused women?
9. Are there woman-to-woman services in maternal health programs (including reproductive health and family planning)? Does lack of woman-to-woman health services constrain women from using health services?
10. Are sexually transmitted infections a problem in your community? For men? For women? Are there societal attitudes that constrain the population from recognizing or reporting such infections? Are there cultural constraints on measures to protect against the spread of sexually transmitted infections?
11. Reflecting on your experience in maternal health, what are the priority gender issues in maternal health? (Looking for specific details of gender-related issues—such as lack of decision-making power of women, religious or cultural restrictions—that limit women from accessing health care services)
12. How does your programme/committee/health system respond to the identified issues?

MATERNAL DEATH AUDITS

1. Have you heard about maternal death audits? Are you implementing maternal death audits in your country? What approaches do you have in your country for maternal death audits?
2. (Probe for knowledge and involvement with MDAs and MDA committees and for length of involvement)
3. Is there a national guideline on the composition and size of maternal death audit committees in your country? Can you share a copy with us?
4. In what ways has the maternal death audit process been successful? What is going well? What needs to change to have even more success?
5. What gaps do you see in the maternal death audit system and processes?
6. What kind of changes would you like to see in the maternal death audit processes?
7. Is gender equality being integrated into maternal death audits? If yes, how? If no, why not?
8. What suggestions do you have for ensuring that gender is mainstreamed into the maternal death audit system?

CONCLUDING QUESTIONS

1. Can you share with us copies of your maternal death audit guidelines, strategy, reports, etc.?
2. What else would you like to tell me but didn’t because I did not ask the right question? Any other comments/insights/questions you would like to share?
Semi-structured interview guide for interviews with: non-governmental organizations working on MDAs and maternal health issues; societies of gynaecology and obstetrics (or its country equivalent); development partners, etc.

A. Country Information
1. Date of interview/date completed (dd/mm/yyyy):
2. Country name:
3. African region:
   - Central Africa
   - East Africa
   - North Africa
   - South Africa
   - West Africa
4. Current MMR:
5. Year:
6. Source:

B. Contact Information of Respondent
1. Name of person interviewed/who filled out the form:
2. Title:
3. Name of organization/department:
4. Role in MDA committee (if applicable):
5. Telephone:
6. Email:
7. Skype ID (if available):
8. Interview type (e.g. telephone, in person):

C. Name of Interviewer:
BACKGROUND: GENDER ISSUES IN MATERNAL HEALTH SERVICE DELIVERY SYSTEM

1. We are aiming to get a better understanding of maternal health issues in Africa. From your perspective, what are the maternal health priorities in your country?
2. What factors contribute to maternal mortality and morbidity? (Probe for factors related to SGBV and take notes on details regarding how SGBV contributes to death among pregnant and postpartum women)
3. What socio-economic or cultural constraints do people face in accessing maternal health services at each level of service delivery?
4. What is the prevalence of maternal death? What are the major clinical, environmental and socio-economic causes in your country? Cultural causes?
5. Reflecting on your experience in maternal health, what are the priority gender issues in maternal health? (Looking for specific details of gender-related issues—such as lack of decision-making power for women, religious or cultural restrictions—that limit women from accessing health care services)
6. How does your programme respond to the identified issues?

MATERNAL DEATH AUDITS

1. Have you heard about maternal death audits? Are you implementing maternal death audits in your country? What approaches do you have in your country for maternal death audits?
2. (Probe for knowledge and involvement with MDAs and MDA committees and for length of involvement)
3. In what ways are you involved with maternal death audits? (Probe for knowledge and involvement with MDA committees and for length of involvement)
4. What specific activities does your organization do related to maternal death audits?
5. What is your opinion of maternal death audits in the country? In what ways has the maternal death audit process been successful? What is going well? What needs to change to have even more success?
6. What gaps do you see in the maternal death audit system and processes?
7. What kind of changes would you like to see in the maternal death audit processes?
8. Is gender equality being integrated into maternal death audits? If yes, how? If no, why not?
9. What suggestions do you have for ensuring gender is mainstreamed into the maternal death audit system?

CONCLUDING QUESTIONS

1. Can you share with us reports and documentation on maternal health and maternal death audits in your country; reports of activities or research conducted on maternal health issues by your organization, etc.?
2. What else would you like to tell me but didn’t because I did not ask the right question? Any other comments/insights/questions you would like to share?
Semi-structured interview guide for interviews with: community representatives; women’s group leaders; pregnant women/women of reproductive age; community leaders; male community members, etc.

A. Country Information
1. Date of interview/date completed (dd/mm/yyyy):
2. Country name:
3. African region:
   - Central Africa
   - East Africa
   - North Africa
   - South Africa
   - West Africa

B. Contact Information of Respondent
1. Name of person interviewed/who filled out the form:
2. Title:
3. Telephone
4. Interview type (e.g. telephone, in person):

C. Name of Interviewer:

BACKGROUND: GENDER ISSUES IN MATERNAL HEALTH SERVICE DELIVERY SYSTEM
We are aiming to get a better understanding of maternal health in Africa and the challenges women face in accessing health care services.

1. Within the last year, have you heard of women dying during pregnancy, childbirth or within 6 weeks of delivery? How frequent is maternal death in your country/community?
2. From your perspective, what factors contribute to maternal death/near-deaths in your community and country? (Probe for factors related to SGBV and take notes on details regarding how SGBV contributes to death among pregnant and postpartum women; clinical, socio-economic, cultural causes, etc.)
3. How important is it that a woman/your wife/daughter-in-law attend all of the recommended antenatal care visits? Who decides if she goes?
4. If a woman does not attend antenatal care during pregnancy, what do you think causes her not to do so?
5. What socio-economic or cultural factors hinder women from accessing maternal health services at each level of service delivery?
6. Who makes the decision to take a pregnant woman with complications to the hospital?
7. What are the obstacles that women face in accessing maternal health care in hospitals?
8. What are the attitudes of men in this community towards getting medical help for their wives when they experience pregnancy-related complications? What challenges do they face?
9. Where else can women get maternal health services in the community/country if they do not go to the hospital? (Probe for details of where they go—traditional birth attendants, religious maternity homes, churches, private clinics owned by midwives, etc.)
10. What challenges do women face when they go to these alternative places for care?
11. What cultural practices in the community/country are specific to adolescent girls/women of reproductive age? Do these practices have any effect on their maternal health? (Discuss what these practices are and probe for issues of female genital mutilation, including which type is performed, beliefs about this practice, etc.)
12. How can we reduce the number of women who die as a result of pregnancy-related complications in your community?
**MATERNAL DEATH AUDITS**

1. Have you heard about any group that investigates maternal deaths? *(Probe for knowledge of MDA committees—verbal autopsies, facility maternal death reviews, etc. What do they do? If no knowledge of MDAs, skip this section.)*

2. What is your opinion of maternal death audits in the country? In what ways has the maternal death audit process helped to improve women’s access to quality maternal health care services? What is going well? What needs to change to have even more success?

3. What gaps do you see in the maternal death audit system and processes?

4. What kind of changes would you like to see in the maternal death audit processes?

**CONCLUDING QUESTIONS**

7. What else would you like to tell me but didn’t because I did not ask the right question? Any other comments/insights/questions you would like to share?