MDSR Action Network

Be part of the network that saves mothers' lives!

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

Social autopsy in maternal and neonatal health

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

The root causes considered encompass physical, environmental, cultural, and social factors. Through participatory dialogue, potential causes of death are identified and suggestions are made of measures to prevent future deaths that are appropriate and achievable in the community. This innovative approach has been used to prevent child injury prevention in Bangladesh in the past[1]. It has been recently introduced to reduce maternal and neonatal death.

Over the last six years, Bangladesh has introduced a maternal and perinatal death review (MPDR) system. It was initially piloted in January 2010 for the first time by the Ministry of Health and Family Welfare (MoHFW) within the scope of the Joint Government of Bangladesh and United Nations Maternal and Newborn Health Initiatives in Thakurgaon district[2,3].

Unicef, Bangladesh has been partnered with The Centre for Injury Prevention and Research, Bangladesh to provide technical and implementation support to the government. WHO, UNFPA and professional bodies engaged in designing, support in implementation and monitoring with the financial support from Global Affairs Canada, UKAID and European Commission [4].

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

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

Shefali, a 19 year old woman from Dhormogor village, decided the deliver her first baby by a skilled birth attendant after attending a social autopsy meeting:

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

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

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

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

to do in my case" Shefali explained.

The aim of conducting SA in MPDR is not necessarily to collect data related social factors to be analysed at higher level, but rather the process aims to support dialogue and action within the community in where a death has already occurred. The SA sessions are conducted in a non-blaming environment where examples of deaths are analysed and initiatives to prevent similar types of complications occurring in near future in the same community are proposed. The neighbours and relatives of the family get the opportunity to discuss on their own mistakes, and the community can collectively identify factors that influenced the death. This participatory approach, facilitated by a government health worker, opens up a platform to help communities understand the mistakes and provide an opportunity to avoid such deaths in future[7].

According to the World Health Organization, social autopsy has not been widely practiced and still lacks of a standardised method. However, at present it aims to address the first of the 'Three Delays': namely barriers to seeking care[8].

Process of conducting social autopsy

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

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

Later on, from the discussion and comments, the health worker facilitating the session presents some information, education and communication materials to show the community what they need to do if any maternal or neonatal complications arise, and how to take corrective decisions. The health worker requests the participants commit to future prevention work and also gives community leaders/ elites the opportunity to state their commitment to work on future death reduction.

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

The effect of social autopsy on the community

SA has a number of positive contributions to make to the community, including:

1. **Building knowledge*:*** The SA session discusses maternal, perinatal and neonatal complications and their potential outcomes. The facilitator uses pictorial representations of different scenarios of complications and explains what is needed in such cases. Thus, the community learn from what has already happened to their own community and then how those cases could be prevented in the future. This pictorial presentation with detailed description from the health worker helps the illiterate and lower educated people of different ages to clearly understand. Moreover, the process of talking through IEC materials also helps the older participants who are the decision makers in the family (for example the mothers-in-law or fathers-in-law) to know about potential complications of mother and newborn.

2. **Creating a platform to self-reflection (community reflection):** SA allows an open discussion where neighbours, villagers, and relatives of the deceased are able to start a dialogue among each other about what really went wrong during a case of maternal or newborn death or stillbirth. This platform allows community members to reflect on their own role in the lead up to the death and question what they could have done differently.

3. **Enhancing community empowerment and leadership:** The participation of different stakeholders in the SA session enhances the empowerment of the community and builds leadership attitudes. A death occurring in a community is always a tragic and emotional event. When people come to understand the social factors behind the deaths and understand their own mistakes, they feel empowered through knowledge to prepare

themselves to prevent such complications in the future. Furthermore, the participation of the community leaders, local elites, and elected local government personnel ensure leadership of the community towards positive action.

4. **Increasing commitment:** At the end of the discussion, the community participating in the SA are encouraged to make commitments to preventing deaths in the future. The community leaders or local government personnel promise in front of their own villagers to work together to prevent such complications resulting in maternal and newborn death.

5. **Increasing equity and male participation**: SA is more than just a conventional courtyard meeting, both because it focuses on positive actions to prevent future deaths, but also because it supports equal participation between men and women. It is important that men attend, especially those who are decision makers in the family, however the facilitator ensures the participation of different stakeholders and an equal opportunity for men and women to speak.

6. **Increasing the agency of pregnant women:** In this type of interactive informative discussion on the issue of maternal and newborn death and stillbirths, pregnant mothers often feel empowered to learn and participate. The platform allows pregnant mothers the opportunity to understand each of the issues related to pregnancy and match their knowledge with their own experience of pregnancy. Therefore, the women become more conscious, active and careful about complications and the importance of health care seeking.

7. **Increasing heath care seeking:** It has been observed that after an SA has been conducted in a community, local facilities have seen increases in women attending for antenatal, postnatal and newborn care. Therefore, it seems that when the informed stakeholders voice their commitment to improving health care seeking, they do often follow through and support their women to attend the facility or health care centre. In this way, facility-based delivery can also be increased, and a number of good examples have been already seen in Bangladesh where women choose to deliver in a facility and advise the same for their peers, for example the case of Shefali, a 19 year-old woman from Dhormogor village.

This case study was written by Dr Animesh Biswas, PhD, Senior Scientist, Reproductive and Child health Unit at Centre for Injury Prevention and Research, Bangladesh (CIPRB), Dhaka, Bangladesh.

It was reviewed by Dr Riad Mahmud, Health Specialist (MNH), UNICEF Bangladesh, Dr. Abu Sadat Md. Sayem, Health Officer, (HMIS & Planning), UNICEF Bangladesh and Prof. MA Halim, Director, RCH unit, CIPRB, Bangladesh. For more information on social autopsy in Bangladesh, email Animesh Biswas via:ani72001@gmail.com or animesh@ciprb.org

Photo credit: Animesh Biswas/CIPRB

References

1. Baset M.; Towner E.; Mashreky S.; Rahman A.; Biswas A. ; Rahman A. (2012). Social autopsy: a community-based intervention in preventing road traffic injuries – experience from Bangladesh*. Injury Prevention, 18(1): A205-A205.*

2. Biswas A.; Rahman F.; Halim A.; Eriksson C; Dalal K. (2014). Maternal and Neonatal Death Review (MNDR): a useful approach to identifying appropriate and effective maternal and neonatal health initiatives in Bangladesh. Health, 6: 1669-1679.

3. Biswas A. (2016). Maternal and perinatal death review (MPDR): experiences in Bangladesh. *World Health Organization.* Cited on 06 December 2015. Available from: http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/bangladesh-study/en/

4. Mahmud R.; Sohel HA.; Sharif M.; Kuppens L.; Rakhimdjanov S.; Sayem ASM.; Khan M.; & Biswas A. (2016). Social autopsy triggers community response for averting maternal and neonatal death in Bangladesh: Experience from 'Maternal and Perinatal Death Review in 10 Districts'. World Health Organization. p.1-5. Available from: http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/social-autopsy-bangladesh/en/

5. Biswas A.; Rahman F.; Eriksson C.; Dalal K. (2014). Community notification of maternal, neonatal deaths and still births in maternal and neonatal death review (MNDR) system: experiences in Bangladesh. Health, 6(16): 2218-2226.

6. Halim A.; Utz B.; Biswas A.; Rahman F.; van den Broek, N. (2014). Cause of and contributing factors to maternal deaths; a cross-sectional study using verbal autopsy in four districts in Bangladesh. British Journal of Obstetrics and Gynaeocology, 121(4): 86-94.

7. Biswas A. (2015). Social Autopsy: A social intervention to explore social barrier and errors behind maternal deaths due to pre-eclampsia/ eclampsia and haemorrhage in rural Bangladesh. Available from: http://www.ciprb.org/poster-presentation-on-social-autopsy/

8. Waiswa P.; Kalter H.D.; Jakob R.; Black R.E. (2012). Increased use of social autopsy is needed to improve maternal, neonatal and child health programmes in low-income countries. Bulletin of the World Health

Organization, 90.

This entry was posted in Case studies, Featured and tagged Bangladesh, Maternal and Perinatal Death Reviews, Social Autopsy on July 6, 2016 [http://mdsr-action.net/case-studies/social-autopsy-as-an-intervention-tool-in-the-community-to-prevent-maternal-and-neonatal-deaths-experiences-from-bangladesh/] by Network Coordinator.