In India, maternal death review provides detailed information on various factors at community and facility levels that influence maternal health outcomes. A key challenge is to analyse the large volume of paper based data collected through the tools. Further challenges include the expansion of the database of records of maternal deaths on a daily basis, data elements are repeated across tools, tracking pregnant women who move between mothers and husbands houses during and after delivery, gaps in linking MDR with an existing online health management information database makes tracking, reporting, and timely analysis of data difficult to inform policy, program implementation and monitoring towards results.

A national MDR software to address the above-mentioned concerns and strengthening data management systems was developed, deployed and scaled up in India. Till date over 2100 health personnel have been trained across ten states and 2200 maternal death records are available in the system. One set of data analysis shows that majority of deaths occurred in women aged between 18-25 years, with at least 2-3 antenatal visits and no postnatal checkups, with causes linked with post partum hemorrhage, eclampsia, anemia, sepsis, ruptured uterus. Inability of the women to recognize the danger signs, coupled with delay in seeking care, arranging for transport, initiating treatment at the facility, and lack of blood contributed to the maternal death. The timely information available at all districts and blocks has enabled health teams to better plan and act on solutions to improve maternal health outcomes.

Key challenges, lessons learnt, and demonstration of the use of the software to track maternal deaths, understanding related causes, gaps in services delivery etc will be highlighted. The lessons learnt from India's experience has implications for other countries in using innovative technologies to address large scale public health issues towards improving maternal health outcomes.