Context

Belgium is a small country (120 000 deliveries per year) and cannot on its own develop sufficient power to study the prevalence, management and outcomes of severe maternal conditions. However, participation in the larger INOSS endeavour appears to be meaningful.

This is why the **B.♀SS** initiative has been developed since 2011. This Belgian Obstetric Surveillance System follows the methodology recommended in the Randolph Concordat of 2010. The **B.♀SS** was initiated after the concordat was developed (2011).

Organisation

B.♀SS is funded by the Ministry of Health for a fixed period. At this point sustainability has not been secured. The data collection is shared between a Flemish and a French speaking team. The Flemish team collects from maternity units in Flanders (55% of births), and the French speaking team liaises with the French speaking hospitals of Wallonia as well as with the hospitals in Brussels, of which most are bilingual.

People working on the project

Flanders team: Myriam Hanssens (KU Leuven), Griet Vandenberghe (U Ghent), Joachim Van Keirsbilck (Bruges) Brussels team: Yvon Englert, Virginie Van Leeuw, Laura Guzy (UL Bruxelles)

INOSS liaison officier: Sophie Alexander (UL Bruxelles)

Conditions collected at present: eclampsia (UKOSS definition), uterine rupture (broad definition), peripartum hysterectomy (UKOSS definition) and peripartum embolisation (same clinical episode)

SWOT

Strengths – Out of 101 maternity units, all but 3 are participating. The non-participants are small units with less than 1000 deliveries a year, and an average risk population. The rates observed are in the same order of magnitude as published data or other earlier studies, which makes the collaborators confident that there is good registration of cases. In addition many maternity units use information technology which allows double checking. There is also a culture of providing good data as Flanders developed a medical Birth Registry more than twenty years ago (SPE)[i] and a parallel institution is now functioning for Wallonia and Brussels (CEpiP)[ii]

Weaknesses: some maternity units inform the **B.♀SS** centres about the cases but find filling in the forms time consuming and difficult. It is important to remember that clinicians are overworked, and that the pressure to use time on activities that generate money is strong in a fee for service system. Another weakness is that for the same reason, there has not yet been a meeting of **B.♀SS** collaborators and that the interface between the two units is not

formalised. There are no risk (adverse clinical events) midwives in Belgium, but the consultant in charge of the labour ward (or his locum) appears to be attentive to registering all cases

Opportunities – The increase in maternal age, in severe conditions, the large migrant population (60% of babies in Brussels have a mother born outside Belgium) mean that severe maternal morbidity is on the rise, and has become a concern for all. Developing a local database, but which can be compared to similar cases collected in other INOSS countries is a true opportunity.
Another potential opportunity is that until now it has never been possible to develop a Confidential Enquiry into Maternal Deaths (CEMD). The project has been discussed on various occasions, but clinicians were reluctant. On the other hand CEMDs are occurring in neighbouring countries: UK, France and the Netherlands. In the US there is a strong push to re-establish the process universally and systematically[iii] . It is hoped that collecting severe morbidities will lead on to the systematic review of maternal deaths.

Threats – The greatest concern is the sustainability of the project.

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[i] SPE report for 2011 http://www.zorg-en-gezondheid.be/uploadedFiles/NLsite_v2/Cijfers/Cijfers_over_geboorte_en_bevalling/SPE_jaarrapport%202011.pdf

[ii] CEpiP website http://www.cepip.info/

[iii] Goodman D, Stampfel C, Creanga AA, Callaghan WM, Callahan T, Bonzon E, Berg C, Grigorescu V. Revival of a core public health function: state- and urban-based maternal death review processes. J Womens Health (Larchmt). 2013;22(5):395-8