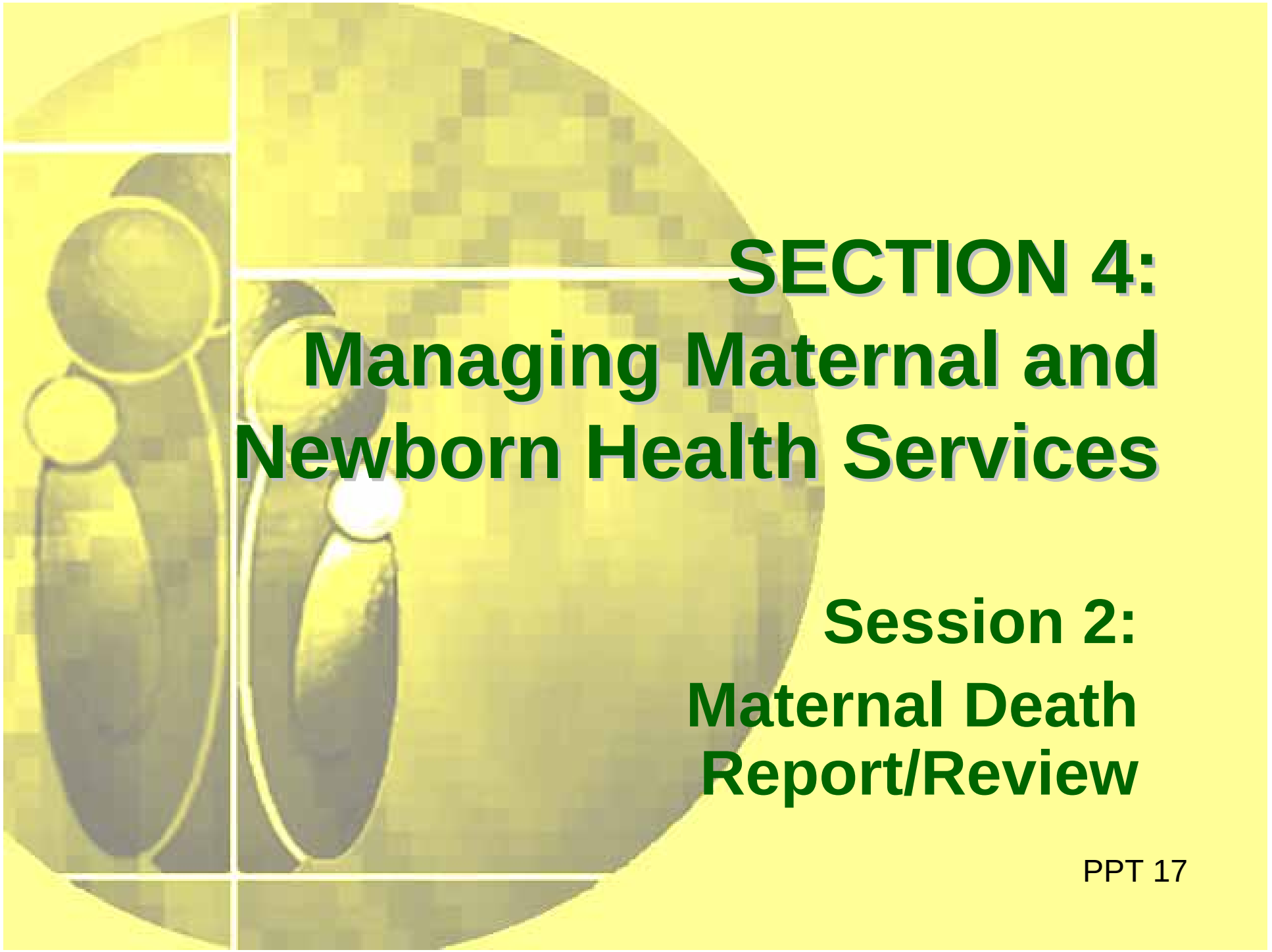

SECTION 4: Managing Maternal and Newborn Health Services

Session 2: Maternal Death Report/Review

What is maternal death?

- It is the death of a woman while pregnant or within the 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy but not including deaths from accidents.

What is a maternal death review?

- **A system of determining the circumstances behind the death of a pregnant or postpartum woman and determining the most likely cause/s of her death after which resolutions and actions are made to prevent future maternal deaths.**

Why conduct a maternal death review?

- **To help you find ways to preventing maternal deaths**

- **To assist health officials, the Mayor *barangay* captains and council members, local leaders and the community to provide appropriate support and timely interventions in the care of women**

Steps in maternal death review

1) Find out incidents of deaths among women 15-49 years old at the end of each month.

- Ask about occurrences in every *barangay* from BHWs, TBAs, barangay captains and local leaders.
- Check death registration at the municipal civil registry office.
- Check incidences from hospitals, lying-in clinics and birthing centers.

2) Track down maternal deaths.

- Obtain contact names and addresses.
- Visit the home of the dead woman.

Steps in maternal death review

3) Conduct a postmortem interview.

- Introduce yourself to the family/relatives and the purpose of your visit.
- Always observe tact and prudence during the interview.
- Note the date, time of the interview and location.
- Ask about:
  - General information about the woman
  - About the pregnancy/delivery
  - About the death
    - The respondent/s

Remember:

- Review all maternal deaths in your area of assignment
- Keep information confidential and only for the use of maternal death review
- Share information but not personal details of the dead woman
- No punitive action should result from the maternal death review

Steps in maternal death review

4) Thank family and relatives for the interview.

5) Analyze data.

- **Verify circumstances that may have caused delays in seeking care, in arriving at the appropriate level of care, in receiving care at the institution.**

- **Identify availability/unavailability of resources and attendants to care.**

Steps in maternal death review

6) Identify probable cause of death.

- Is it due to an obstetrical complication? What complication?

- Is it due to a previous or existing disease made worse by the pregnancy? What disease?

- Are there other factors that contributed to the death? What are they?

- How did lack of resources, logistics and community support affect the death?

Steps in maternal death review

7) Determine what could have been done to prevent the death.

- Identify possible areas where you may have been able to help. How?
- Identify areas where the health officials, barangay captains and council members and local leaders may be able to help.
- Identify areas where the community may be able to help.
- Share your analysis, findings and thoughts during maternal death review meetings.

Steps in maternal death review

8) Report maternal death.

- Submit filled out community interview form (from DOH Maternal review manual)

9) Organize a Maternal Death Review meeting with the Mayor, key stakeholders

- RHU staff, *barangay* captain and council members, community leaders, DOH representative and Provincial Health Office representative.
- Ensure action plans are laid out on how to prevent maternal deaths in the future.