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?
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.