Documenting Maternal Deaths: The process and things to keep in mind

What is a maternal death?

- A maternal death is the death of a woman
  - while pregnant or within 42 days of termination of pregnancy/after delivery,
  - from any cause related to or aggravated by the pregnancy or its management,
  - but not from accidental causes

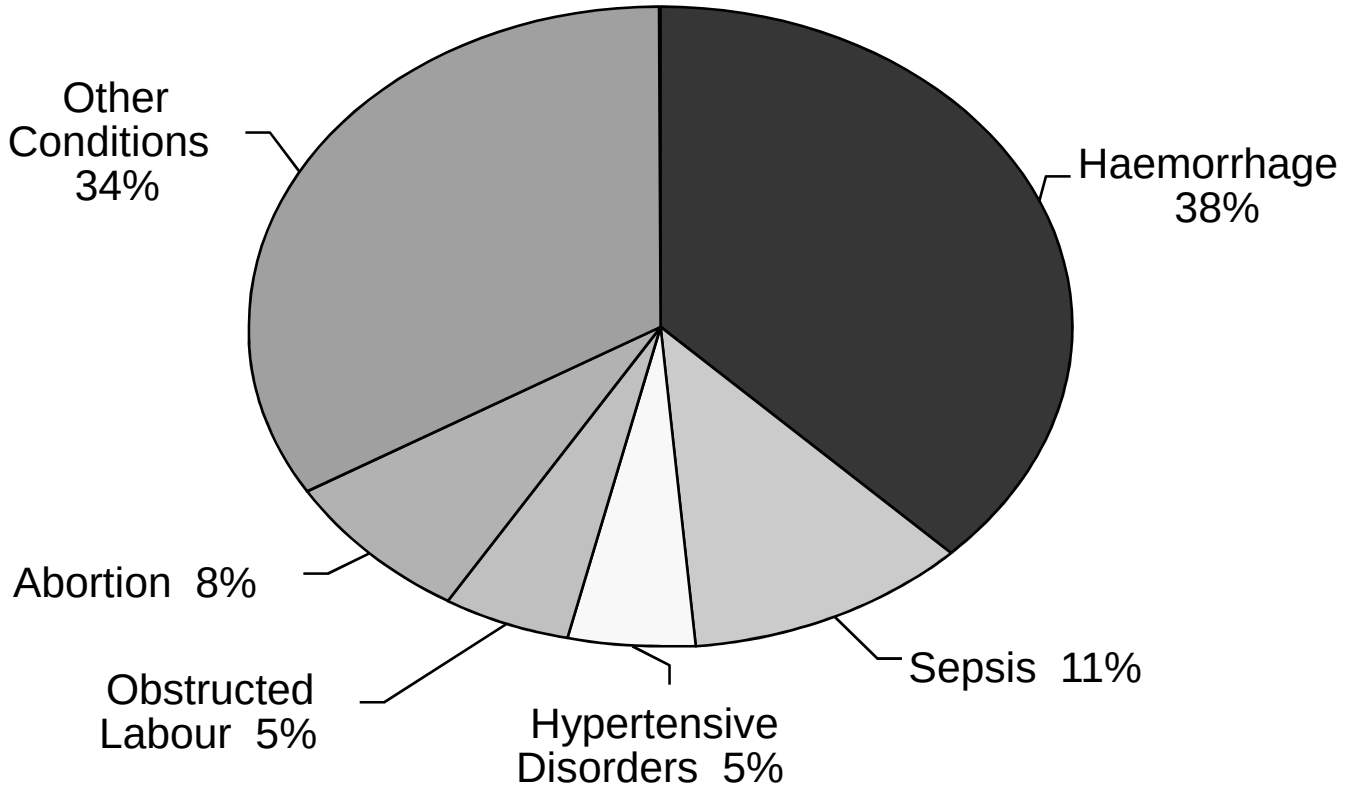
Measurement of maternal deaths

- Maternal mortality ratio (MMR)

- *Number of maternal deaths during a given time period in a specific location per 1,00,000 live births occurring during the same time-period and in the same location.*

In India, more than two-thirds of all maternal deaths occur in a handful of states:

- India : 212
- Assam: 390
- Bihar/Jharkhand: 261
- MP/Chattisgarh: 269
- Orissa: 258
- Rajasthan: 318
- Uttaranchal/UP: 359
- Andhra Pradesh: 134
- Karnataka: 178
- Kerala: 81
- Tamil Nadu: 97
- Gujarat: 148
- Haryana: 153
- Punjab: 172
- Maharashtra: 104
- W. Bengal: 145



What are women dying of?

Steps of Maternal Death Review

1. Reporting of the death
2. Verifying whether it is a maternal death
3. Community Based Review of all maternal deaths
4. Analysis
5. Action

1. Reporting of Deaths: What deaths should be reported?

– maternal deaths?

- pregnancy related deaths?

- or all deaths in the 15-49 yr age group

2. Verification is needed to check if the reported death is a maternal death

- who verifies?

- what needs to be asked to check whether it is a maternal death?

3. Community Based Review of all maternal deaths

- Who collects the information?
- Govt –technical largely bio-medical investigation
- CSO - Social Determinants of Health, non-obstetric causes of death, entitlements, continuum of care, discrimination/denial, rights based framework and accountability

4. Analysis

5. Action

Why is Maternal Death Surveillance important?

- Provides an opportunity to assess quality of care
- Helps in identification and notification of maternal deaths
- Helps in reviewing circumstances and medical causes leading to the death
- Helps in identifying remedial factors and interventions that can save women's lives
- Helps in recommending corrective action

Tools used for CB-MDR

- Form for reporting
- Form for verification
- Tool for Community Based review of maternal death

What should we look at while documenting Maternal Deaths

Do NOT just document the incident of maternal death.
Get information on:

1. Did the woman have knowledge of entitlements/receive entitlements?
2. What was the social status of the deceased woman?
3. What was her pregnancy history
4. Trace the steps once she decided to seek care

- Was she examined immediately in hospital?
- Was she referred without treatment?
- Was she denied admission
- Was she asked for money to begin treatment?

HEALTH FACILITY VISIT: Checklist

- Presence of a help-desk, notice board, toll free number displayed?
- Doctors on duty – list? Nurses on duty – list with contact numbers?
- Are all records regarding the treatment of the woman available to the family on request?
- Was the doctor on duty when the woman died?
- Who was handling the birth?
- What is the condition of the labour room, how many beds, how many women usually come?
- Does the Labour Room clearly display charts/instructions about what to do if something goes wrong? Protocols for managing complications?
- **Health workers' rights** – their workload, duty hours, their level of recent training and supervision?

Some other points to bear in mind

- Informed consent
- Confidentiality
- Sensitivity
- we need to be careful about fault-finding vs fact-finding
- CSO cannot conduct MDRs independently – must work closely with the Ministry at the centre and with state and district level governments officials and frontline providers,
- and ensure that the learning is “fed back into the system” rather than adopting an adversarial outsider stance.

Possible challenges during Conducting MDR

- Paper trail is missing in most cases of deaths in rural areas –admission slip, prescriptions, receipts, death certificate, post-mortem etc
- Officials of the health system do not readily share information
- Victimization of family giving details of circumstances leading to maternal deaths especially if it is a case of denial of services or medical negligence
- Field researchers maybe threatened by the health officials/providers who may impede the process of conducting CBMDRs to establish the cause of death

Thank you