Maternal Death Surveillance and Response Systems

Maternal death reviews and verbal autopsy

Introduction

Maternal Death Reviews include data collection, identifying the cause of death and consideration of whether the death was avoidable. Avoidability is a proactive concept. Lessons learnt are applied to prevent future deaths from similar factors.

Maternal death reviews have become increasingly common practice in facilities in resource poor countries since the publication by WHO of 'Behind the Numbers' in 2004. The purpose is to save lives and not apportion blame.

Maternal death reviews: key considerations

- **Essential features** include multi professional committees and involvement, anonymity of patient and healthcare staff involved and objectivity of reporting.
- **Actions** to improve quality of care and the service are the primary outcomes.
- **Local ownership** and feedback is critical and improves data collection quality.
- **Coordination between facility and community reviews** is essential to build a full picture
- **Multiple level review**; each case review should be considered at local, district and higher levels
- **Non-medical factors** are often more important in determining whether a woman lives or dies than medical factors

Uganda

Maternal deaths were prospectively investigated at a district hospital for the period of one year.

17 deaths were identified, of which 13 were direct obstetric deaths. The lack of an emergency room was estimated to have contributed to six of the deaths.

(Somigliana et al 2011)

Botswana

At district level it was noted that some facility based committees were not functioning optimally and did not report regularly. There seemed to be a lack of ownership as the committee was attached to individuals rather than positions. Regular monitoring and supervisory visits are sometimes required.

(Mogabe et al 2007)

Recommendations

Set up

- Introductory awareness and training programmes for all staff encourage support and participation and are critical to success
- Regular, formalised, facility based review is a good basis from which to build an MDSR system
- Each facility needs an MDSR Coordinator who relates well to other staff, is supportive but also has sufficient authority to review data quality , coordinate data from different sites and assign work to others
- The MDSR committee collectively needs expertise to identify medical and non-medical problems that contributed to the death. This should include individuals with local knowledge as well as a doctor and a nurse or midwife
- The committee should agree a depth of review that is realistic and appropriate to the setting. It should be as simple as possible but with the flexibility to do more in depth review as required
- Engagement of senior staff, such as the head of department, and managers is vital to the effectiveness of the process

Tools and forms

- WHO have developed generic tools which are available for adaptation to local settings and include both facility review forms and verbal autopsy forms for use in the community
- Inclusion of some mandatory data eg attendance of Skilled Birth Attendants at delivery allows inter country comparison
- The tools used should facilitate identification of the three delays
- The tools should be easily understood , in local languages using local terminology
- Pilot testing is essential to refine the tools and improve the work of the data collectors
- Training of data collectors should be as practical as possible and include practical exercises

Use of tools

- Wherever possible the cause of death should be classified as direct/indirect obstetric death or incidental death
- Where problems with medical care are identified an audit is a useful way of providing further information and improving care
- All data collection is anonymous, a key linking the identity to the case number should be kept in locked storage
- The review summary should be as concise and relevant as possible. Usually it is best written by someone with a strong medical background
- Review at district level needs regular, structured meetings to review case summaries. Frequency of the meetings is dependent on the number of cases. A worksheet helps ensure the full range of possible problems is considered.

For more information or to join
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MDSR
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Every maternal death counts