



**Mchinji Community Focused
Maternal Death Review Project**

**Community Maternal
Death Review**

Training Manual

June 2011, second edition

Acknowledgements

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The Mchinji District Maternal Death Review Team	
<p>Mchinji Maternal Death Review Management Team District Health Management Team Safe Motherhood Co-ordinator: K.Gondwe Reproductive Health Co-ordinator: E. Chagunda BFHI Co-ordinator: E. Mitochi MaiMwana Management: T. Phiri MaiMwana Health Service Strengthening Officers: H. Chapota E. Kainja</p>	
<p>Community Maternal Death Review Teams In each GVH in the district Chairperson: GVH 3 Community HSAs in the GVH area 3 volunteers (Male and Female, selected by GVH)</p>	
Health Facility Maternal Death Review Teams	
<p>Health Centre Maternal Death Review Teams Chairperson: In charge of health centre Medical Assistant Nurse/Midwives Senior HSA HSA based in the health facility</p>	<p>District Hospital Maternal Death Review Team DHMT Safe Motherhood Co-ordinator: K.Gondwe TBA Co-ordinator Reproductive Health Coordinator Laboratory Technician in-charge Pharmacy Technician in-charge Maternity Nurse & Clinician in-charge Female ward Nurse & Clinician in-charge Transport officer Head driver</p>

Aim of the project

This project is a collaboration of the Mchinji District Health Office and MaiMwana Project. The project aims to reduce maternal deaths in Mchinji district and improve maternal health. If it is successful, the project may be rolled out across Malawi.

Maternal deaths

A maternal death is the death of a woman during pregnancy, childbirth or within 6 weeks of delivery or termination. In most countries of the world, maternal deaths are very rare. Unfortunately in Malawi, many women still die every year. The government statistics show that 807 women die for every 100,000 births. In Mchinji district there are about 100 maternal deaths every year. The Government aims to reduce the number of deaths by three quarters by 2015, in line with the Millennium Development Goals. We know that nearly all these deaths could be prevented if women are educated and empowered, if they can choose when they want to become pregnant, if they receive care to prevent pregnancy complications, if they have access to skilled attendant at delivery, if they receive emergency obstetric care as needed and if they have access to care after birth to avoid later complications of childbirth.

Project summary

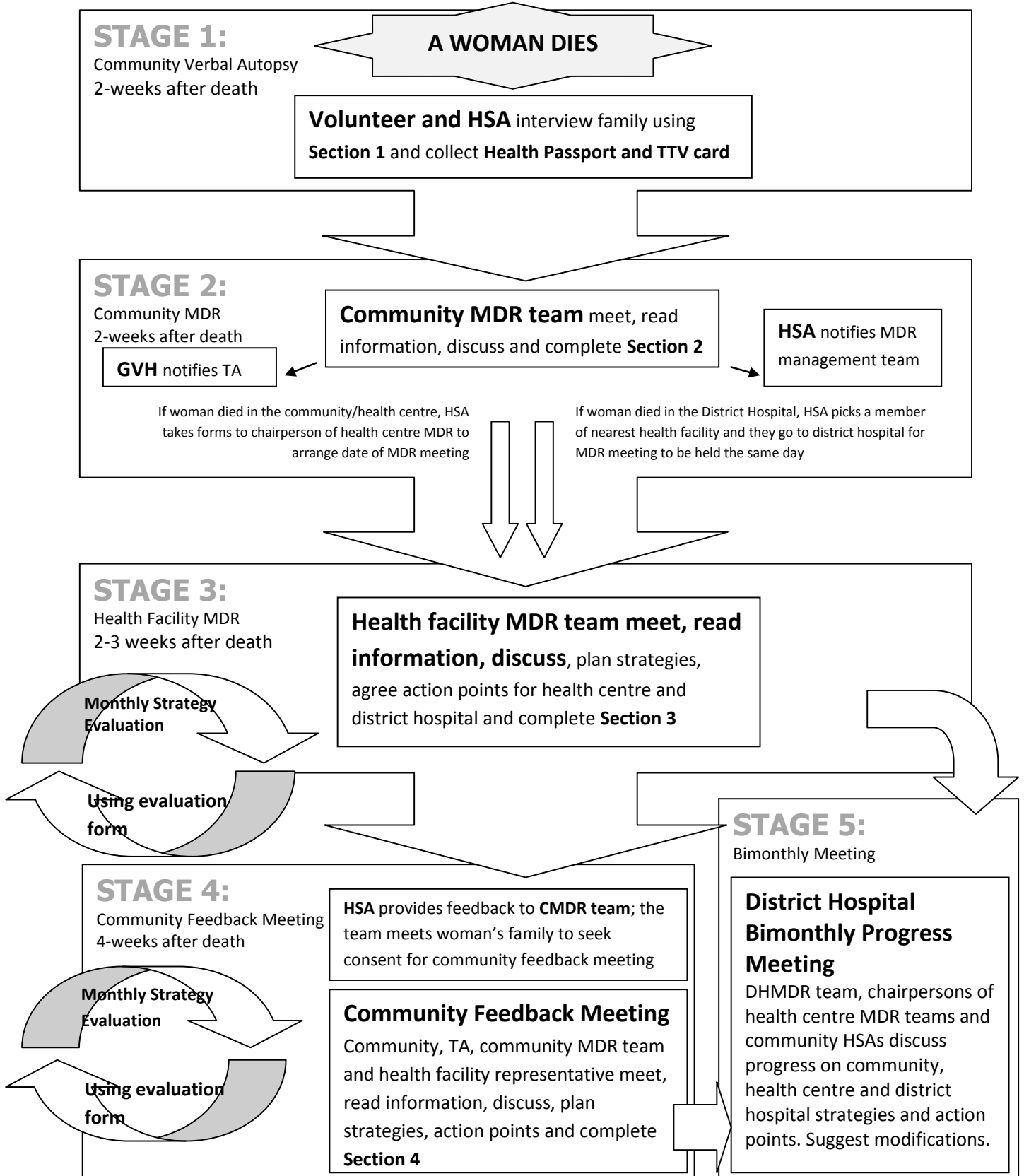
When a woman dies during pregnancy, childbirth or postpartum, there are many reasons why this might have happened. Most of the factors leading to the death are preventable. So, each death can teach us lessons about how to prevent other deaths in the future. This process is called a **Maternal Death Review (MDR)**. This project will use **community MDR teams** in every village and **health facility MDR teams** in every health facility in Mchinji district, including all health centers as well as the district hospital. The teams' role is to help the woman's community and health facility to understand why the death occurred and learn from it together. The project will also enable the community and health workers to find solutions to the problems they discover, to prevent women from dying in the future. The information from these meetings will go back to the District Hospital MDR team, to learn about why women are dying in Mchinji district and to share this information and the planned strategies with other communities throughout the district. In this way, every death will help to prevent other women from dying in the district.

The purpose of this project is NOT to find fault with any individual or to put blame on the woman, the family and the community or health staff. The purpose is to give everyone an opportunity to think about how things could be improved IN FUTURE. The whole project relies on maintaining a BLAME-FREE environment so that people can be honest and thoughtful rather than defensive.

Project timeline

July 2010	Briefing of DEC members and Mchinji District Health management team
July 2010-September 2010	Development of tools and manuals
November 2010	Ethical Approval by National Health Sciences Research Committee
December 2010	Briefing of ADC & AEC members in 4 pilot areas
December 2010	Training of community and health facility MDR teams in 4 pilot areas and District Hospital
December 2010-April 2011	Pilot of project in 4 pilot areas
April 2011	Feedback from pilot teams
May 2011	Briefing of Ministry of Health Officials
May 2011	Feedback of assessment to pilot ADCs & Health facilities and Stakeholders, amendment of project
June 2011	Briefing of ADC & AEC members in 5 roll-out areas
June 2011	Training of community MDR teams and health facility MDR teams in remaining areas in the district
July 2011-December 2011	Roll-out of project across the district
December 2011	Feedback from all teams involved
January 2011	Dissemination of project results Nationwide
January 2011-ongoing	Continuation of project in Mchinji district under DHMT if it has been successful

Community Focused MDR Project diagram



Summary of the MDR process

Stage 1: 2 weeks after death

Community Maternal Verbal Autopsy using Section 1

When a member of the Community MDR team hears about a woman's death they must inform the other members of the team. If it is a maternal death, they should initiate the maternal death review process.

A maternal death is the death of a woman during pregnancy, childbirth or up to 42 days (6 weeks) following delivery or termination.

The Community MDR team volunteer and HSA should visit the family of the woman who has died. They should offer condolence and gain the family's consent to take part in the project. Then they should interview a close family member and complete the Community Maternal Verbal Autopsy (Section 1). They should also collect the woman's health passport and TTV card if the family gives their consent. They should leave one copy of the consent form with the family. They should contact the nearest health facility or the MDR management team if they have any query about the process.

Stage 2: 2 weeks after death

Community Maternal Death Review Meeting using Section 2

Following the interview, the Community MDR team should meet and discuss the information in the Community Maternal Verbal Autopsy (Section 1), health passport and TTV card. They should summarize the community and health facility factors they feel contributed to the death and suggest strategies to prevent similar deaths in the future. They should complete the Community Maternal Death Review Team Summary (Section 2). The chairperson of the team (GVH) should inform the TA, to invite him for the Community feedback meeting in 2 weeks time. Following this meeting the HSA is responsible for the form, the health passport and TTV card. The HSA should take this paperwork to the district hospital if the woman died there (for the MDR meeting to be held the same day), or otherwise take it to the nearest health centre, and hand it to the chairperson of the health facility MDR team, who should contact MaiMwana and the district hospital representative to invite them to the meeting, to be held within the following week.

Stage 3: 2-3 weeks after death

Health Facility MDR Meeting using Section 3

The health facility MDR team and community HSA should meet at the health facility, with the support of the MaiMwana staff and the district hospital representative. They should read out the information in section 1 and 2, the health passport and TTV card. They should discuss this information to agree on the medical cause of death. They should suggest community factors that may have contributed to the death and suggest community strategies to prevent future deaths. They should agree on factors at the health centre and district hospital that may have contributed to the death, plan strategies to prevent future deaths, agree action points, sign to take responsibility for each action point, and plan when they will review the effectiveness of their strategies. This process does not stop here, but should continue, with monthly evaluation of the strategies, whether they are working or need to be modified .

They should copy the contributing factors, strategies and action points on to the evaluation form to use at their next monthly meeting. The HSA will take the form back to the community

Stage 4: 4 weeks after death

Community Feedback Meeting using Section 4

The community MDR team should arrange the Community Feedback Meeting and invite the TA, health facility representative and other influential people in the community as well as all men, women and young people. Before the meeting the HSA should meet with the Community MDR team to review the form. He should then summarise the events leading up to the death, using only information from the verbal autopsy and no confidential information from the health facility records. Then they should go to the family to return the Health passport and TTV card and gain their consent to share the information at the Community Feedback Meeting.

The summary of events leading up to the death should be read out to the community and then discussed in detail. The HSA will read the health facility contributing factors, planned strategies and action points. The HSA will then read the community contributing factors and strategies suggested by the Community MDR team and the health facility MDR team. Everyone should discuss the issues and they should agree on community factors that may have led to the death, plan community strategies to prevent future deaths, agree action points, sign to take responsibility for each action point, and plan when they will review the effectiveness of their strategies. This process does not stop here, but should continue, with monthly evaluation of the strategies, whether they are working or need to be modified.

Stage 5: Every 2 months

District Hospital Bimonthly Progress Meeting using Section 5

Every 2 months, the district hospital MDR team will hold a meeting to discuss all the deaths that have happened in the district during the previous 2 months. The meeting will include the district hospital MDR team, the chairperson of each health facility MDR team (or their representative) and the HSAs from any village where a maternal death has occurred. The HSA will read the summary of events leading up to the death and the community contributing factors, planned strategies and action points. (There is no need to read and discuss sections 1 and 2 of the form as this will take too long). The health centre and district hospital representatives will then read their contributing factors, strategies, action points and report their progress, using their evaluation forms. If the action points have been achieved the team should be congratulated. If progress has been poor they should discuss what can be done to improve progress. The participants may make suggestions of changes to strategies to ensure they will be achieved. They will be reviewed again at the next bimonthly progress meeting, by which time they should be completed. This meeting will be an opportunity to learn from strategies employed in other health facilities and communities. The community and health facility representatives will feedback the comments to their teams. All suggestions should be completed before the next bimonthly progress meeting.

A summary of all strategies and action points will be sent to all TAs and health facilities in the district to update them and inspire them about maternal health.

Contributing factors

After a woman dies, it can be hard to know why this happened. But we need to identify all the factors that contributed to her death so that we can work out how to prevent other women from dying.

Why did this woman die? To identify the factors that contributed to the death, try asking the question ‘**but why?**’ again and again until you find all the contributing factors.

Examples of community contributing factors:

Example of community factors that may contribute to death
Women not eating nutritious foods
Not sleeping under mosquito net
Lack of clean water and sanitation
Women not empowered to make decisions
Women not receiving education
Difficulty talking openly about women’s health, contraception, HIV, abortion
Lack of knowledge about post-abortion care available at the health facility
Not using contraception
Early marriage
Late pregnancies
Having too many children
Domestic violence
Not attending antenatal clinic regularly or not taking treatments given
Not knowing HIV status, or not going for couples testing
Poor awareness of danger signs during pregnancy/childbirth/post-partum
Women not going to health facility for delivery early
Women delivering at home/with the TBA
Women delaying with the TBA or traditional healer with a problem
Taking local medicine during childbirth
Family delaying the woman seeking help due to traditional cultural beliefs
Poor transport for a woman having problems during pregnancy/childbirth/post-partum
Poor roads to health facility
Negative attitude towards health care or health workers
Lack of confidence to ask questions and demand good quality health care
Not following advice of healthworkers

Examples of health facility contributing factors:

Example of health facility factors that may contribute to a death
Shortage of health workers
Lack of skills or up-to-date training
Poor supervision system
Unfriendly or judgmental attitude towards women
Health service not appealing to adolescents
Not involving men in maternal health or not encouraging couples testing
Poor communication skills ie, not probing during history-taking
Poor assessment (ie vital signs and examination)
Inadequate investigation
Failing to give women adequate information
Exhausted or poorly-motivated staff
Poor handovers and communication between staff
Poor documentation
Poor confidentiality discouraging women from using health service
Poor systems for monitoring women ie, during labour or post-operatively
Delaying in provision of care to see women
Poor facilities discouraging women from using health centre
Poor family planning services
Lack of equipment
Shortage of drugs and supplies
Poor hygiene during deliveries
Lack of blood for transfusion
Poor systems for requesting drugs and supplies
Delayed decision-making
Delayed referrals
Slow or unreliable transport for referrals
Not accessing fuel during crisis (for ambulance and generator)
Not feeling able to improve the health facility
Poorly organised work environment

Making great strategies.... and putting them into action.... to prevent maternal deaths

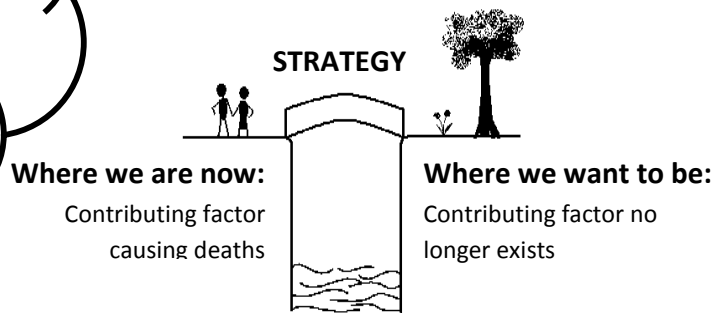
Why did this woman die?

Ask yourself...

but why?... but why?...
but why?... but why?...
but why?... but why?...

...until you have found all the factors that contributed to the death.

For each **contributing factor** imagine what **STRATEGY** could help us get from where we are now to where we want to be?



Now take your **STRATEGY** and break it into **ACTION POINTS**:
Definite actions that can be done by an individual in your team or delegated to someone else.
Think about everything they need to make it happen and plan a time frame for each action point:

Who, how, when?..

If it hasn't happened, think **why?** Maybe it needs to be modified. Go back to thinking about strategies...

At your next monthly meeting **EVALUATE** each action point:

At the **bimonthly review meeting** you will need to describe your **PROGRESS** on each action point and any modifications you have made to your strategies

If it has been completed **congratulate** the person who did it!

Role of the Community Maternal Death Review Team

The Community MDR team is an essential part of the project. Their main role is to identify a maternal death in their village and to set in motion the MDR process. The Community MDR team has the role of gathering information from the woman's family, considering the contributing factors, representing the community at the health facility MDR meeting and feeding back this information to the community and the TA. They are responsible for overseeing the ongoing process of evaluation and modification of the strategies employed by the community to prevent further deaths.

Responsibilities:

The whole MDR process relies on 2 responsibilities for everyone involved:

To maintain the confidentiality of the woman and her family.

Information can only be shared with the family's consent and must not be spoken about outside the MDR team until the community meeting, when only consented information can be shared.

To maintain the BLAME-FREE ethic of the MDR process.

The purpose of this project is NOT to find fault with any individual or to put blame on the woman, the family, the community or health staff. The purpose is to give everyone an opportunity to think about how things could be improved IN FUTURE. The whole project relies on maintaining a BLAME-FREE environment so that people can be honest and thoughtful rather than defensive.

Every member of the community MDR team should:

- Know the names and contact details of all members of the community MDR team
- Be available to the rest of the team if they are not sure what to do
- Be present always during CMDR meetings and community feedback meetings
- Actively participate in the MDR process
- Be open-minded to learn about the factors underlying each maternal death
- Consider the MDR process as an opportunity to improve the health centre and community
- Act as a role model in relation to maternal health in the community
- Fulfill any action points they have agreed to do
- Monitor the community strategies and help ensure they are being put into action

Role of the Group Village Headman in the MDR process

The GVH is the chairperson of the community MDR team. The GVH is also responsible for organizing and chairing all meetings in the community. The GVH has the responsibility of speaking to the TA to inform him about any maternal death and to invite him to the Community Feedback Meeting as well as encouraging him to prioritize maternal health within the community. The GVH is also responsible for ensuring that community strategies and action points are put in to place. If the health facility is delaying the process the GVH may need to encourage them also.

Stage 1: Community Maternal Verbal Autopsy 2 weeks after death

During stage 1 the role of the GVH is:

1. If the GVH is the first person to hear about a maternal death he/she should inform the other members of the community MDR team.
2. The GVH should ensure that the volunteer and HSA has conducted the interview with the woman's relative 2 weeks after death.

Stage 2: Community Maternal Death Review 2 weeks after death

During stage 2 the role of the GVH is:

1. 2 weeks after death, the GVH should invite members for the community MDR meeting (HSAs and the volunteers)
2. The GVH should be the chairman of the community MDR meeting, encouraging everyone's participation and discouraging anyone from blaming either the woman, her family, the community or the health workers
3. The GVH should invite the volunteer to read the questions and answers from section 1, the woman's health passport and TTV card
4. The GVH should delegate the HSA to complete section 2
5. The GVH should inform the TA about the maternal death, to forewarn him about the community feedback meeting within 1 month of the death
6. If the GVH is unsure what to do, he should contact the MDR management team for advice

Technique for a community maternal death review team meeting

- All members of the community MDR team should go to the GVH's house
- **Everyone** should be encouraged to participate in the discussions
- **Use the manual and the strategy diagram to help discussions about contributing factors and strategies**
- At all times, try to encourage a BLAME-FREE discussion

Stage 3: Health Facility Maternal Death Review 3 weeks after death

During stage 3 the role of the GVH is:

1. If the health facility delays in arranging the health facility MDR meeting, the GVH should contact the chairperson of the health facility MDR team to encourage them to arrange the meeting promptly

Stage 4: Community Feedback Meeting 4 weeks after death

During stage 4 the role of the GVH is:

1. The GVH should ensure that the HSA has given feedback to the members of the CMDR (from the Health facility maternal death review)
2. The GVH should lead the CMDR team to the deceased family to return the Health passport and TTV card, feed back health facility findings and seek consent for a community feedback meeting
3. The GVH should ensure that the TA attends the community feedback meeting
4. The GVH should encourage influential people, men, women and young people to attend the meeting
5. At the community feedback meeting the GVH should act as chairperson
6. The GVH should encourage everyone to listen whilst the HSA reads out the summary of events, planned health facility strategies and suggested community contributing factors and strategies
7. The GVH should encourage everyone to discuss community factors that may have contributed to the death
8. The GVH should encourage everyone's contribution, not just influential people
9. The GVH should encourage people to think of strategies that could help prevent women dying in the future
10. The GVH should encourage the identification of action points and ask individuals to sign to show their responsibility for putting them in to action
11. The GVH should ensure that all contributing factors, strategies and action points are recorded on the evaluation form
12. The GVH must ensure that this process is BLAME-FREE and does not blame the woman, her family, the community or the health staff.
13. The GVH should support the community in completing action points.
14. The GVH should organise monthly community evaluation meetings to review the effectiveness of strategies they have employed and to modify these strategies as necessary.

Technique for conducting a community feedback meeting

- After the volunteer and HSA have conducted an interview to the relatives of the deceased woman, GVH notifies the TA to give him plenty of notice
- Arrange the meeting 1-month after the woman has died, so there is time for the community MDR and health facility MDR to take place
- Inform **everyone** in the community, including TA, village headmen, influential people, men, women and young people
- Ask **everyone** what community factors might have contributed to the woman's death
- Record the factors everyone agrees may have contributed on Section 4
- Ask **everyone** for their ideas about community strategies which could prevent deaths in the future and break these in to action points
- Record the strategies and action points everyone agrees on Section 4, and invite individuals to sign
- Ensure that the contributing factors, strategies and action points are recorded on the evaluation form
- Plan a meeting in 1 month's time to **evaluate** the strategies
- Try to encourage participation of everyone present, not just people of influence
- At all times discourage people from blaming individuals and encourage them to think about positive changes that could improve things in future

Technique for holding a monthly strategy evaluation meeting

- The GVH should arrange monthly evaluation meetings to review progress towards the strategies and action points planned at the community feedback meeting
- The GVH should invite community members, influential people, women, men and young people
- The GVH should invite one member of the community MDR team to read the evaluation form
- The GVH should invite **everyone** to consider any successes and challenges in relation to the planned strategies
- Where action points have been achieved, the GVH should congratulate those that have completed them
- Where strategies are not being achieved, encourage participants to think about how they can achieve them.
- This may require breaking the strategies into simple actions, identifying obstacles, and thinking of ways around them.
- Consistently encourage everyone to think positively: to focus on where they are trying to get to rather than dwelling on problems and obstacles
- The GVH should encourage those present to think broadly about alternative strategies if their original strategies are not going to plan
- The GVH should ensure that an individual is responsible for each of the action points
- The GVH should set a date for the next monthly strategy evaluation meeting

Stage 5: District Hospital Bimonthly Review Meeting every 2 months

During stage 5 the role of the GVH is:

1. Following this meeting the HSA will bring the evaluation form back to the community with feedback from the district hospital MDR team.
2. The GVH should disseminate this feedback to the community via a community meeting
3. If the district hospital MDR team has suggested further strategies for the community the GVH should ensure that these strategies are put into action before the next bimonthly meeting

The role of the HSA in the MDR process

The HSA is the only member of the community MDR team who goes to the health facility MDR meeting, so they have a huge responsibility to represent the community at this meeting. The HSA also holds the responsibility of representing the community at the district hospital bimonthly review meeting to update them on the community's progress with the strategies. The HSA has a wider role of communicating between the health facility and the community about maternal health issues in general.

Stage 1: Community Maternal Verbal Autopsy 2 weeks after death

During stage 1 the role of the HSA is:

1. If the HSA is the first person to hear about the death, they should immediately inform the other members of the community MDR team
2. The HSA should bring the combined form and go to the deceased family with the volunteer for the community maternal verbal autopsy
1. 2 weeks after death, the volunteer and HSA should visit the family of the woman who has died. They should talk to a close member of the woman's family (i.e. husband, mother, sister). It is essential to gain their consent to take part in the study. This involves reading the consent statement on the front of the Community Maternal Verbal Autopsy (Section 1).
2. They should ask all the questions in Section 1 and probe for information as necessary.
3. They should also collect the woman's health passport and TTV card if the family gives their consent and attach this to the form.
4. If they are not sure what to do they should contact the nearest health facility or the MDR management team
5. The HSA should take hold of the form until the CMDR meeting

Interview technique

- Greet and **condole** the respondent
- Ask for a private place to sit and talk away from other people
- Ask the respondent to bring the woman's health passport and TTV card (if available)
- Engage the respondent in a general discussion e.g. about weather to make them feel relaxed
- Sit at the **same level** so that they feel comfortable
- Maintaining **eye contact**, and **nodding** will help them to talk to you (avoid **smiling** during the interview)
- Get **consent** for the interview
- Encourage them to tell you **everything** they can remember for each question by using prompts
- This may require asking questions to probe them for more information
- Record their answers in the boxes during the interview, not afterwards
- Answer any **questions** they may have as best as you can and refer difficult ones to the CMDR team/health facility or MDR management team
- **At all times discourage them from blaming individuals for the death**
- Thank them for the cooperation and responses

Stage 2: Community Maternal Death Review 2 weeks after death

During stage 2 the role of the HSA is:

1. The HSA should go to the GVHs house for the community MDR meeting
2. The HSA should assist the volunteer in reading the verbal autopsy which is in section 1, the health passport and TTV card and participate in the discussions about community and health facility factors that may have contributed to the death, as well as making suggestions about strategies that could help to prevent future deaths
3. The HSA should complete Section 2 and ensure everyone agrees with what he/she has written
4. The HSA is now responsible for keeping the form, the health passport and TTV card safely.
5. If the woman died in the district hospital, the HSA should pick a member of the health centre MDR team, and go together to the Safe Motherhood Co-ordinator at the district hospital for the district hospital MDR meeting to be held the same day.
6. If the woman died in the community or at the nearest health centre, the HSA should go to the nearest health centre and handover the form to the chairperson of the health centre MDR team booking for health centre maternal death review meeting
7. The HSA should make a note of the date of the health centre MDR meeting

Stage 3: Health Facility Maternal Death Review 3 weeks after death

During stage 3 the role of the HSA is:

1. The HSA should attend the health facility MDR
2. The HSA should read out the information on the form in Section 1, Section 2, the health passport and the TTV card
3. The HSA should participate in the health facility MDR discussions and make sure that he/she represents the community perspective in these discussions
4. The HSA should try to ensure that the process is BLAME-FREE
5. The HSA should ensure that the health facility contributing factors, strategies and action points are copied on to the health facility evaluation form.
6. The HSA should take the combined form, the health passport and the TTV card back to the community to discuss with the CMDR team and the woman's family prior to the community feedback meeting
7. The HSA should inform the health facility MDR team of the date of the planned community feedback meeting

Stage 4: Community Feedback Meeting 4 weeks after death

During stage 4 the role of the HSA is:

1. Following the health facility MDR meeting the HSA should meet with the Community MDR team to discuss the findings of the health facility MDR team
2. The HSA should summarise the events leading up to the death on to section 4, using only information consented by the family
3. The HSA should visit the woman's family with the GVH and the volunteer to return the health passport and TTV card, feed back the deceased family and gain their consent to share the information at the Community Feedback Meeting.
4. The HSA should encourage everyone to attend the community feedback meeting, including the deceased family, traditional leaders, influential people, men, women and young people
5. The HSA should attend the community feedback meeting
6. The HSA should read out the summary of events
7. The HSA should read out the health centre contributing factors, planned strategies and action points identified by health facility MDR Team (Section 3, Part 3)

8. The HSA should read out the district hospital contributing factors, planned strategies and action points identified by health facility MDR Team (Section 3, Part 4)
9. The HSA should read out the community contributing factors and suggested strategies identified by the community MDR team (Section 2, Part 1) and the health facility MDR team (Section 3, Part 2)
10. The HSA should participate in the community discussions about contributing factors and possible strategies
11. The HSA should help to encourage a BLAME-FREE discussion
12. The HSA should complete Section 4 and ensure that the community agrees about contributing factors, planned strategies and action points. The HSA should ensure that those responsible for implementing action points sign the form
13. The HSA should copy the community contributing factors, strategies and action points on to the evaluation form
14. The HSA should support community strategies and complete any strategies he/she has agreed to complete
15. The HSA should participate in monthly community evaluation meetings to review the effectiveness of strategies they have employed and to modify these strategies as necessary, recording all progress and modifications on the evaluation form.

Stage 5: District Hospital Progress Meeting every 2 months

During stage 5 the role of the HSA is:

1. The HSA should attend the next District Hospital Progress Meeting which will be organised by the district hospital MDR team every 2 months
2. The HSA should bring the evaluation form from the community
3. The HSA will present the contributing factors, strategies and action points that the community identified during the community feedback meeting and report the progress on each action point.
4. If action points have not been completed the HSA should record the feedback on the evaluation form and report back to the CMDR team
5. The HSA should ensure that all suggestions are followed up before the next bimonthly meeting

The role of the volunteer during the MDR process

Selection criteria

Criteria for choosing community MDR volunteer

1. Matured 35yrs and above
2. Able to read and write in local language
3. Has given birth before or fathered a child
4. Respected and acceptable to the community
5. Lives within the community

Stage 1: Community Maternal Verbal Autopsy 2 weeks after death

During stage 1 the role of the volunteer is:

6. If the volunteer is the first person to hear about a maternal death, they should immediately inform the rest of the community MDR team
7. 2 weeks after death, the volunteer and HSA should visit the family of the woman who has died. They should talk to a close member of the woman's family (i.e. husband, mother, sister). It is essential to gain their consent to take part in the study. This involves reading the consent statement on the front of the Community Maternal Verbal Autopsy (Section 1).
8. They should ask all the questions in Section 1 and probe for information as necessary.
9. They should also collect the woman's health passport and TTV card if the family gives their consent and attach this to the combined form.
10. If they are not sure what to do they should contact the MDR management team

Interview technique

- Greet and **condole** the respondent
- Ask for a private place to sit and talk away from other people
- Ask the respondent to bring the woman's health passport and TTV card (if available)
- Engage the respondent in a general discussion e.g. about weather to make them feel relaxed
- Sit at the **same level** so that they feel comfortable
- Maintaining **eye contact**, and **nodding** will help them to talk to you (avoid **smiling** during the interview)
- Get **consent** for the interview
- Encourage them to tell you **everything** they can remember for each question by using prompts
- This may require asking questions to probe them for more information
- Record their answers in the boxes during the interview, not afterwards
- Answer any **questions** they may have as best as you can and refer difficult ones to the CMDR team/MDR management team
- **At all times discourage them from blaming individuals for the death**
- Thank them for the cooperation and responses

Stage 2: Community Maternal Death Review 2 weeks after death

During stage 2 the role of the volunteer is:

1. 2 weeks following the death, all the volunteers in the community MDR team should go to the home of the GVH for the community MDR meeting.

2. The volunteer should read the information in section 1, the health passport and TTV card to the rest of the community MDR team
3. The volunteer should participate in discussions about the factors that may have contributed to the death and possible community and health facility strategies that could prevent deaths in the future
4. The volunteer should help to make sure these discussions are BLAME-FREE

Stage 3: Health Facility Maternal Death Review 2-3 weeks after death

During stage 3 the role of the volunteer is:

1. The volunteer does not have a role during stage 3

Stage 4: Community Feedback Meeting 4 weeks after death

During stage 4 the role of the volunteer is:

1. The volunteer should meet the community MDR team before the meeting
2. The volunteer should visit the woman's family with the GVH and the HSA to return the health passport and TTV card, show them the information and gain their consent to share it at the Community Feedback Meeting.
3. The volunteer should attend the community feedback meeting
4. The volunteer should participate in the community discussions about contributing factors , strategies and action points
5. The volunteer should help to encourage a BLAME-FREE discussion
6. The volunteer should support the community strategies and action points and fulfill any they have agreed to complete
7. The volunteer should participate in monthly community evaluation meetings to review the progress of the community strategies and to modify these strategies as necessary.

Stage 5: District Hospital Bimonthly Progress Meeting every 2 months

During stage 5 the role of the volunteer is:

1. After the bimonthly progress meeting, the volunteer should meet the community MDR team to discuss the recommendations.
2. The volunteer should help to ensure that all suggestions are fulfilled before the next bimonthly meeting.

Using the forms

General advices

All sections have instructions at the beginning explaining who should use them, when and how. please complete all information requested. At the end of each meeting please record key people who were present.

On each page please record the Maternal Death ID, which looks like this:

1609 / |_|_| / |_|_| / |_|_| / |_|_|
Mchinji District / Health centre number / GVH number /HSA number / Woman number

The front page should have the correct numbers when you receive them, but you will need to record the woman number, i.e. 01 for the first maternal death in your community MDR team, 02 for the second maternal death etc.

The community focused MDR form

What is it?

It is a form used to interview a relative of the deceased woman, and then to record the community MDR meeting summary, the health facility MDR meeting, the community feedback meeting and the bimonthly progress meeting. It contains all the information relating to the death so it is very important.

Who is responsible for it?

The HSA will keep the form at his/her house in the plastic wallet. They will be responsible for bringing it to all meetings

Where can you get more?

The HSA can get more copies from the nearest health facility

The evaluation form

What is it?

It is a form used by each MDR team to record their contributing factors, planned strategies and action points. It is then used at all strategy evaluation meetings to review progress on action points. When action points have been completed, this should be recorded. If action points are not completed, they need to be reviewed. Modifications should be recorded on this form.

Who is responsible for it?

The HSA should keep it at his/her house in the plastic wallet. They should bring it to the community feedback meeting, all evaluation meetings and the bimonthly progress meeting

Where can you get more?

The HSA can get more copies from the nearest health facility

Role plays

Case study 1:

Teleza Naphiri 18 years old. Not married. 1st pregnancy. Died On 31st October at Mchinji District hospital, 4 months pregnant. She had not attended antenatal clinic. For 1 week before she died, she had bleeding, fever and vomiting. She was taken to the hospital on the 29th October and was told she needed an operation but she died on the 31st October before this was done.

1. Was this a maternal death?
2. Complete as much of section 1 as possible with the information you have been given. Think about contributing factors from the community and the health facility (think 'but why' and use the contributing factors section to help you). Then consider strategies that the community and the health facility could use to help prevent a similar death in the future (use the strategy flowchart to help you). Record your conclusions in section 2. Then break the strategies in to specific action points that individuals in the health facility and the community could do.

Case study 2:

Agness Nabanda 21years old, married, third pregnancy at 9-months, died on 1st November at home during delivery of the baby with a TBA. She had been healthy during her pregnancy and she attended antenatal clinic twice but she did not find the hospital staff friendly so she decided to give birth at home. In the last week before delivery she had severe headaches and abdominal pain. During the birth she had convulsions and then she died. The baby died soon after birth.

1. Was this a maternal death?
2. Complete as much of section 1 as possible with the information you have been given. Think about contributing factors from the community and the health facility (think 'but why' and use the contributing factors section to help you). Then consider strategies that the community and the health facility could use to help prevent a similar death in the future (use the strategy flowchart to help you). Record your conclusions in section 2. Then break the strategies in to specific action points that individuals in the health facility and the community could do.

Case study 3:

Navileza John 40years old. Married. Ninth pregnancy. Died 2 weeks after delivery. Delivered a baby boy 2-weeks ago at the Mkanda health centre. After the birth she had vaginal bleeding every day and she became very weak. She finally went back to the health centre 10 days after delivery. She was told she needed an operation and a blood transfusion. She waited for transport to the district hospital for 12 hours. She died on arrival at the hospital.

1. Was this a maternal death?
2. Complete as much of section 1 as possible with the information you have been given. Think about contributing factors from the community and the health facility (think 'but why' and use the contributing factors section to help you). Then consider strategies that the community and the health facility could use to help prevent a similar death in the future (use the strategy flowchart to help you). Record your conclusions in section 2. Then break the strategies in to specific action points that individuals in the health facility and the community could do.

Causes of maternal deaths

These are some of the medical complications that may result in a death. In the maternal death review process, the medical cause of death is less important than identifying the factors that have led to the death.

Some maternal deaths are DIRECTLY caused by the pregnancy:

During pregnancy: Vaginal bleeding, convulsions of pregnancy (with swelling, headache and raised blood pressure), unsafe abortion, infection of the womb

During labour and delivery: Vaginal bleeding before or during delivery, convulsions, unable to deliver the baby, rupture of the uterus, unable to deliver the placenta

Up to six weeks after delivery or termination: Heavy vaginal bleeding, convulsions, infection, and anaemia because of losing too much blood

Some maternal deaths are because of conditions that are AGGRAVATED by the pregnancy

Anaemia, Injuries (assault, accident, suicide), **Heart diseases**
Infections: Malaria, AIDS, TB, Tetanus, Hepatitis, Pneumonia

Danger signs

As a member of the MDR team it is important that you act as a role model for maternal health. This includes encouraging women to go to the health facility for antenatal care, for delivery and for post-partum care. You should also encourage them to attend immediately if they recognize any **danger sign**:

Examples of danger signs during Pregnancy: Any vaginal bleeding, looking pale, breathless during housework, fever, abdominal pain, offensive vaginal discharge, headache, swelling, blurred vision, convulsions, passing liquor before onset of labour

Examples of danger signs during Childbirth: Bleeding before or after delivery, long labour, difficult delivery, convulsions, difficulty delivering the placenta, fever

Examples of danger signs during the post-partum period: Heavy vaginal bleeding, fever, offensive vaginal discharge, headache, swelling, blurred vision, convulsions

Timetable for Community MDR team training

TIME	DAY 1	DAY 2
8.00-10.00 am	Welcome Remarks Introductions Group Norms & Expectations Training Objectives Background of the Project	Recap previous day's work Role plays on how to use the CMDR forms
10.30-12.30 pm	Identifying contributing factors of maternal deaths Using the strategy flowchart to make great strategies and break them into action points Dangers signs in pregnancy, delivery and postpartum	Roles of the Community MDR members
1.30-3.30 pm	Introduction of CMDR forms	Roles continue Evaluation
4.00-4.30 pm	FACILITATORS MEETING	Closing remarks and departure

Abbreviations used in the document

ADC	Area Development Committee
AEC	Area Executive committee
AIDS	Acquired Immuno deficiency Syndrome
BFHI	Breast Feeding Health initiative
CMDR	Community Maternal Death Review
DEC	District Executive Committee
DHMDR	District Hospital Maternal Death Review
DHMT	District Health Management Team
DHO	District Health Office /District Health Officer
GVH	Group Village Headman
HFMDR	Health Facility Maternal Death Review
HIMS	Health Information Management Systems
HIV	Human Immunodeficiency Virus
H SA	Health Surveillance Assistant
IEC	Information Education and Communication
MDR	Maternal Death Review
M&E	Monitoring and Evaluation
TA	Traditional Authority
TB	Tuberculosis
TTV	Tetanus Toxoid Vaccine

Contact details for the Mchinji District Maternal Death Review Team		
Mchinji Maternal Death Review Management Team		
Safe Motherhood Co-ordinator:	K.Gondwe	Tel: 0999630755
Reproductive Health Co-ordinator:	E. Chagunda	Tel:0999422348
BFHI co-ordinator:	E. Mitochi	Tel: 0888319208
MaiMwana staff:	H. Chapota	Tel: 0888393486/0999630450
	E. Kainja	Tel: 0888300485/01906175
Your Community Maternal Death Review Team		
Chairperson: GVH:	.....	Tel:.....
Community HSA:	.....	Tel:.....
Community HSA:	.....	Tel:.....
Community HSA:	.....	Tel:.....
Volunteer:	.....	Tel:.....
Volunteer:	.....	Tel:.....
Volunteer:	.....	Tel:.....
Your nearest Health Centre Maternal Death Review Team		
Chairperson:	.....	Tel:.....