



UNHCR

United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

Guideline for Reviewing Maternal Deaths

The purpose of this guideline is to support country programs in:

- A) The *process of reviewing* a maternal death, and
- B) The *requirements for reporting* a maternal death

A) THE PROCESS OF REVIEWING A MATERNAL DEATH

What is a maternal death?

A maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Should each maternal death be reviewed?

Yes. Every maternal death that occurs within a refugee camp (of a refugee or a national) or at a referral health facility should be systematically reviewed.

What is the purpose of reviewing a maternal death?

A maternal death review provides a rare opportunity for a group of health staff and community members to learn from a tragic – and often preventable - event. Maternal death reviews should be conducted as learning exercises that do not include finger-pointing or punishment. The purpose of a maternal death review is to improve the quality of safe motherhood programming to prevent future maternal and neonatal morbidity and mortality.

What process should be used to review a maternal death?

There are 2 main methodologies for reviewing maternal deaths that are relevant to a refugee setting:

1) Community-Based Maternal Death Review / Verbal Autopsy

Definition: A method of finding out the medical causes of death and ascertaining the personal, family or community factors that may have contributed to the death of a woman who died outside of a medical facility

Requirements: Cooperation from the family of the woman who died and sensitivity is needed in discussing the circumstances of the death

Advantages: Provides means to arrive at medical cause of death when a woman dies at home, allows both medical and non-medical factors to be explored, and provides the opportunity to include the family's perspective on health services

Disadvantages: Different assessors may arrive at different causes of death, deaths from indirect causes may be overlooked / underreported

2) Facility-Based Maternal Death Review

Definition: A qualitative, in-depth investigation of the causes of and circumstances surrounding a maternal death at a health facility; the death is initially identified at the facility level but such reviews are also concerned with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable

Requirements: Cooperation from those who provided care to the woman who died, and their willingness to report accurately on the management of the case

Advantages: Is a well-understood process in some settings, allows for complete review of medical aspects, provides a learning opportunity for all staff, and can stimulate improvements to medical care

Disadvantages: Requires committed leadership at the facility level, does not provide information about deaths occurring in the community

A 3rd, additional methodology for improving safe motherhood programs is optional for country programs with the necessary capacity:

3) “Near Miss” Review

Definition: The identification and assessment of cases in which a pregnant woman survives an obstetric complication; there is no universally acceptable definition for such cases and it is important that the definition used be appropriate to local circumstances to enable local improvements in maternal care

Requirements: Good-quality medical record system, a management culture where life-threatening events can be discussed freely without fear of blame, and a commitment from management and clinical staff to act upon findings

Advantages: A “near-miss” may occur more frequently than a maternal death, it is possible to interview the woman herself during the review process, and can reduce the likelihood of future maternal deaths through quality improvement

Disadvantages: Requires clear definition of severe maternal morbidity, selection criteria are required for settings with a high volume of life-threatening events

B) THE PROCESS OF REPORTING A MATERNAL DEATH

Should each maternal death be reported?

Yes. The accompanying report form (or a substitute format available in your location) should be completed electronically for each maternal death review and e-mailed (at minimum) to:

- The UNHCR Health Coordinator, and
- The UNHCR Regional Reproductive Health Officer, and
- Other relevant staff (e.g. IP Health Coordinator, other partner agencies, etc.)

How do I complete the REVIEWERS section of the form?

It is important to include multiple people in the process of reviewing a maternal death, regardless of whether the death occurred in the community or in a health facility. Some examples of people you might want to include are:

- Relevant family members (sister, husband, boyfriend, parent(s), friend(s), etc.)
- Relevant health staff (TBAs, midwives, doctors, managers, coordinators, etc.)
- Relevant community leaders (religious, elders, women’s association, youth, etc.)

How do I complete the INFORMATION sections of the form?

These three sections (summary information, information on pregnancy, information on death) allow you to document basic information pertaining to the woman who died. There might be additional factors specific to your location that you discuss during the review (e.g. the woman’s address, her religion, etc.) that you do not need to document in the summary report.

How do I complete the SUMMARIZED HISTORY section of the form?

This section allows you to summarize the story of what happened. It is intentionally open-ended so that you can include the immediate events surrounding different types of maternal deaths. Some elements you might want to include (in both the review process and the report) are:

- Timeline of relevant events that have not already been documented
- Summary of the interventions / treatment provided prior to the death
- Relevant patient history not already documented

How do I complete the RELEVANT DELAY FACTORS section of the form?

This section encourages you to review and document the relevant delay factors by using the *Three Delay Model* for maternal mortality. Remember that there may be important community-level factors related to a death in a health facility, just as there may be important facility-level factors related to a death in the community.

How do I complete the CAUSE OF DEATH section of the form?

Some examples of direct causes of maternal death are:

Ectopic pregnancy	Eclampsia	Sepsis
Obstructed labour	Antepartum hemorrhage	Post-partum hemorrhage
Abortion complications	Anaesthetic complications	Embolism

Some examples of indirect causes of maternal death are:

Anaemia	Malaria	HIV/AIDS
Heart disease	Substance abuse	Diabetes

How do I complete the LESSONS LEARNED & ACTION TO BE TAKEN section of the form?

This will likely be the most important component of your maternal death review. After analyzing all of the relevant information, individuals involved need to agree on key lessons learned from the process and commit to action that will improve these areas in the future. It is important to consider lessons and action related to both the community and to the health facility.