ESTABLISHING A MATERNAL DEATH REVIEW SYSTEM – KEEPING IT FUNCTIONAL AND EFFECTIVE

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WHY REVIEW MATERNAL DEATHS

- **IMPORTANT FOR THE FAMILY AND THE DOCTORS AND NURSES**
- **INFORMS POLICY**
- **PROGRAM MANAGERS CAN IMPROVE PRACTICE**

CHALLENGES

- DEATH IS AN EMOTIONAL EVENT

- **FAMILY IS ANGRY**
- **CARERS ARE DISTRESSED**
- **BOSSES WANT TO BLAME**

REVIEW STRATEGIES

- VERBAL AUTOPSY
- FACILITY BASED REVIEW
- CONFIDENTIAL ENQUIRY
- CLINICAL AUDIT

WHAT IS NEEDED?

- **CONFIDENTIALITY**
- **EDUCATE DON'T BLAME**
- **DIG DEEP TO FIND REAL CAUSES**
- **GOOD RECORDS**
- **TRAINING IN ROOT CAUSE ANALYSIS**

A CASE STUDY

- **MATERNAL DEATH IN 2011**
- **DIVISIONAL MEDICAL OFFICER CALLS FOR RCA**
- **TEAM IDENTIFIED**
- **FACILITY VISITED AND A WORKSHOP CONDUCTED**
- **GAIN TRUST, FIND FACTS, ANALYSE**
- **REPORT & ACTION**

ACTION

- **INFRASTRUCTURE IMPROVEMENTS**
- **ROSTERING CHANGED**
- **REFERRAL SYSTEM STRENGTHENED**
- **BLOOD BANK IMPROVED**
- **IN SERVICE TRAINING STRENGTHENED**

WAY FORWARDS

- **PSRH DEVELOP A SIMPLE, DOABLE, MDR SYSTEM WHICH IS USER FRIENDLY**
- **THIS SHOULD BE DONE IN COLLABORATION WITH DEVELOPMENT PARTNERS & STAKEHOLDERS**
- **SHARE LESSONS LEARNT WIDELY**

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RECOMMENDATION FROM PSRH

PORT VILA 2017

STEPS

- **IDENTIFY CHAMPIONS**
- **ESTABLISH WORKING GROUP**
- **DEVELOP TOR**
- **GET FUNDER BUY IN**
- **CONSULT STAKEHOLDERS**
- **WRITE PROTOCOL**
- **FIELD TEST/REVISE/ROLL OUT**