

ABSTRACT

Reviewing the Maternal Mortality Surveillance System in South Eastern Regional Health Authority in Jamaica

Noel Gordon Holder

Background: Ministry of Health Jamaica through the reproductive health quality assurance programme in 1993-1995 conducted a review of maternal deaths in public hospitals. The public hospitals were attending to 80% of all births in Jamaica.

The Ministry of Health in 1998 made a policy decision for all maternal deaths to be a class 1 notifiable disease and establish a maternal mortality surveillance system. The surveillance unit has reported a decline in maternal deaths. This research seeks to explore the evidence of this report in SERHA in Jamaica.

Method: Deaths among female 10-50 years in public hospitals were reviewed for the period 1998-2003 to identify the pregnancy - related deaths. Causes of death and access to care were compared with the island wide study 1993-1995 and the reported cases from the maternal mortality surveillance system.

Results: The leading causes of maternal death were no different from the 1993-1995 review: Pre-eclampsia /eclampsia and haemorrhage were still the main causes of death. There is an increase in the maternal death ratios for ruptured ectopic pregnancy and abortions when compared with the 1993-1995 findings. In the 1998-2003 study in (SERHA) the maternal mortality ratio of 95.8 per 100,000 live births showed significant difference when compared with the corresponding period of review where SERHA reported 57.0 per 100,000 live births. The risk of dying from gestational hypertension remains the same, while a marginal difference was observed with haemorrhage, which seemed to occur more in the type A & B hospital where most of the obstetricians are assigned. More women in the older age group seem to be dying, the 34-39 years age group accounts for 30.6% of all deaths with a RR-1.7 and CI of 1.0-2.6. This is an indication for further assessment of the quality given and timeliness of access to care at the facility.

Conclusion: The reported reduction of the maternal mortality ratio in the SERHA was not accurate since many cases were misclassified and were not reported as maternal deaths. At least 20% of the cases were missed at the casualty, medicine and surgical departments. The management of a pregnancy with

complication and care after discharge must be improved. Since a great proportion of maternal death were avoidable.

KEY WORDS: Maternal mortality surveillance system, Misclassification and underreporting,