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Status of Maternal Death Reviews in Health Facilities of a Hard to Reach Sub-Region: A Case Study of Karamoja in Uganda.

Facility Based Maternal Death Review (FBMDR) is a qualitative, in-depth investigation of the causes and circumstances surrounding maternal deaths occurring at health facilities. It focuses particularly on tracing the path of the women who died through the health care system and within the facility. The aim is to identify any avoidable or remediable factors, which could be changed, in order to improve maternal care in the future. This then calls for an established Maternal Death Review (MDR) - committee team that regularly meets to review all maternal deaths at the facility. The number and the frequency of Maternal Deaths determines the number and frequency of MDRs in the facility. Reviewing maternal deaths and telling the story of how individual women died is essential in understanding why women could have died. The process explores gaps within the health facility and those outside the health facility that could have contributed to the deaths of pregnant women. Addressing these gaps will subsequently lead to reduction in numbers of women dying from preventable pregnancy related causes. The purpose of this study was to determine the status of facility-based maternal death reviews in health facilities of a hard to reach sub-region in order to contribute to the reduction of maternal deaths. A cross- sectional study that utilised both quantitative and qualitative methods of data collection and analysis was used to determine MDR. The study examined the implementation of MDR, lessons learnt and challenges encountered during implementation respectively. Data was obtained from health facilities providing Comprehensive Emergency Obstetric Care (CEmOC) in Karamoja. The findings showed low MDR coverage 8.11% (9/111) in these hard to reach health facilities. Maternal death review implemented according to World Health Organization (WHO) and adopted by Ministry of Health (MoH) recommended cycle was 22.22% (2/9) with evidence of documentation. It was observed that poor record management, poor documentation culture, lack of implementation of recommended action as well as the negative health workers attitude and behaviour towards the MDR affected the implementation of the process. Having a copy of MDR report submitted to the presidents‟ office creates fear associated with low MDR implementation as the office was associated with arrests, dismissal threats and health workers harassments. There were also knowledge and skill gaps for the committee for FBMDR. There is an urgent need for good record management and documentation culture, a change in health workers attitude and behaviour towards FBMDR. Resources should be set aside for implementation of MDR recommended actions and inclusion of MDR process in the training syllabuses of Medical and Nurses training institutions and facilities‟ Continuous Medical Education (CMEs).

Key Words: **Maternal Death Reviews, Health Facilities, Hard to Reach Sub-Region, Karamoja**