CENTER FOR PREVENTION AND HEALTH PROMOTION
Maternal and Child Health
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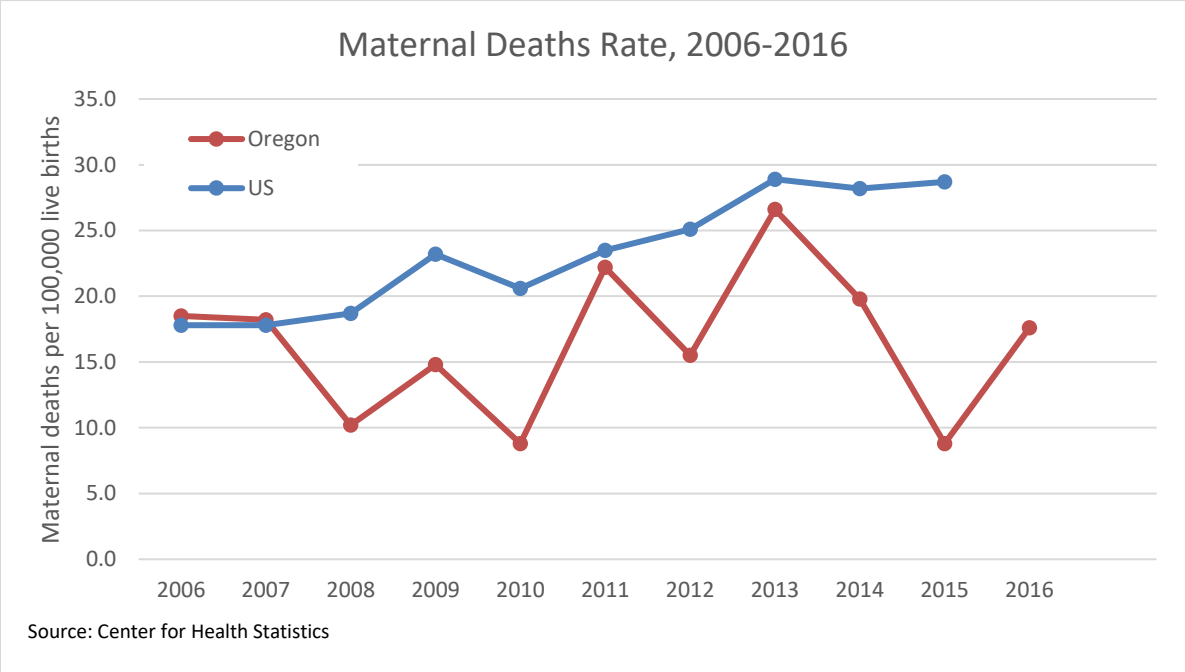
Maternal Mortality

The death of a woman during pregnancy, childbirth, or the year postpartum is a rare and tragic event. Maternal health experts are actively searching for answers about why the ratio of pregnancy-related deaths in the United States is higher than other developed nations, why it is increasing, and why the disparity by race/ethnicity is widening.

In Oregon, over the past 10 years, the number of maternal deaths per year has ranged from 4 to 12; however, the current method of case finding may undercount actual deaths by as much as one-third. It is also important to note that for every woman who dies, there are approximately 50 who suffer severe maternal morbidity--very severe complications of pregnancy, labor, and delivery that bring them close to death. Oregon's maternal death rate, measured as the number of maternal deaths per 100,000 live births varies from year to year due to the overall small number of deaths, is typically at or below that of the U.S. overall.



Source: Center for Health Statistics

Maternal Mortality Surveillance in Oregon

Beginning in 2006, Oregon Vital Statistics modified the reporting of maternal deaths by adding a new item to the death certificate. For all female decedents between 10 and 60 years of age, the medical certifier indicates if the decedent was pregnant at death, pregnant within 42 days

before death, or pregnant within one year before death. Maternal deaths are tracked and reported on annually. The data provide basic information about the causes of death of women during pregnancy and postpartum. However, this type of surveillance can't point to specific factors that contributed to individual deaths, it doesn't determine whether the death could have been prevented, and it can't document opportunities from individual cases in order to act to prevent further occurrences of maternal mortality. It is for these reasons that state or jurisdiction-wide maternal mortality review committees (MMRCs) are seen as important tools in the prevention of maternal mortality. Oregon does not have a maternal mortality review process in place.

Maternal Mortality Review

Maternal mortality review is a standard and comprehensive system primarily operating at the state level. Approximately half the states in the U.S. have a comprehensive maternal mortality review process. MMRCs identify, review, categorize, and analyze maternal deaths; disseminate findings; and act on the results. The maternal mortality review process helps prioritize interventions to improve maternal health. The ultimate purpose of this surveillance process is to stimulate action.

A MMRC gathers extensive information about each individual case of maternal death selected for review, and this information is synthesized into a story for that case. The committee convenes to further fill in the story and, for each case, answer the question, "What happened?" The committee then determines if the death was related to or aggravated by pregnancy. If so, the death is one counted in the state's pregnancy-related mortality ratio. Committee members also will craft recommendations specific to the case. Nationally, nearly 60% of maternal deaths investigated by maternal mortality review committees have been classified as being due to preventable causes.

Preventing Maternal Mortality and Morbidity

Maternal mortality reviews are key tools that allow states to characterize and intervene in maternal mortality and morbidity. These interventions must also connect with efforts to identify upstream root causes of morbidity, including social determinants of health, to effectively develop and implement prioritized strategies for primary, secondary, and tertiary prevention. Preventing maternal mortality and morbidity can only be accomplished if the social, economic and healthcare issues that impact women's health are addressed at multiple levels.

The Association of Maternal and Child Health Programs (AMCHP) has laid out six core elements of a comprehensive maternal health initiative:

1| Strengthen Maternal Data Systems
2| Increase the Value of Investments in Maternal Health
3| Enable Healthy Living
4| Improve Access to Care
5| Ensure High Quality Health Care for Women
6| Ensure Readiness and Response to Obstetric Emergencies