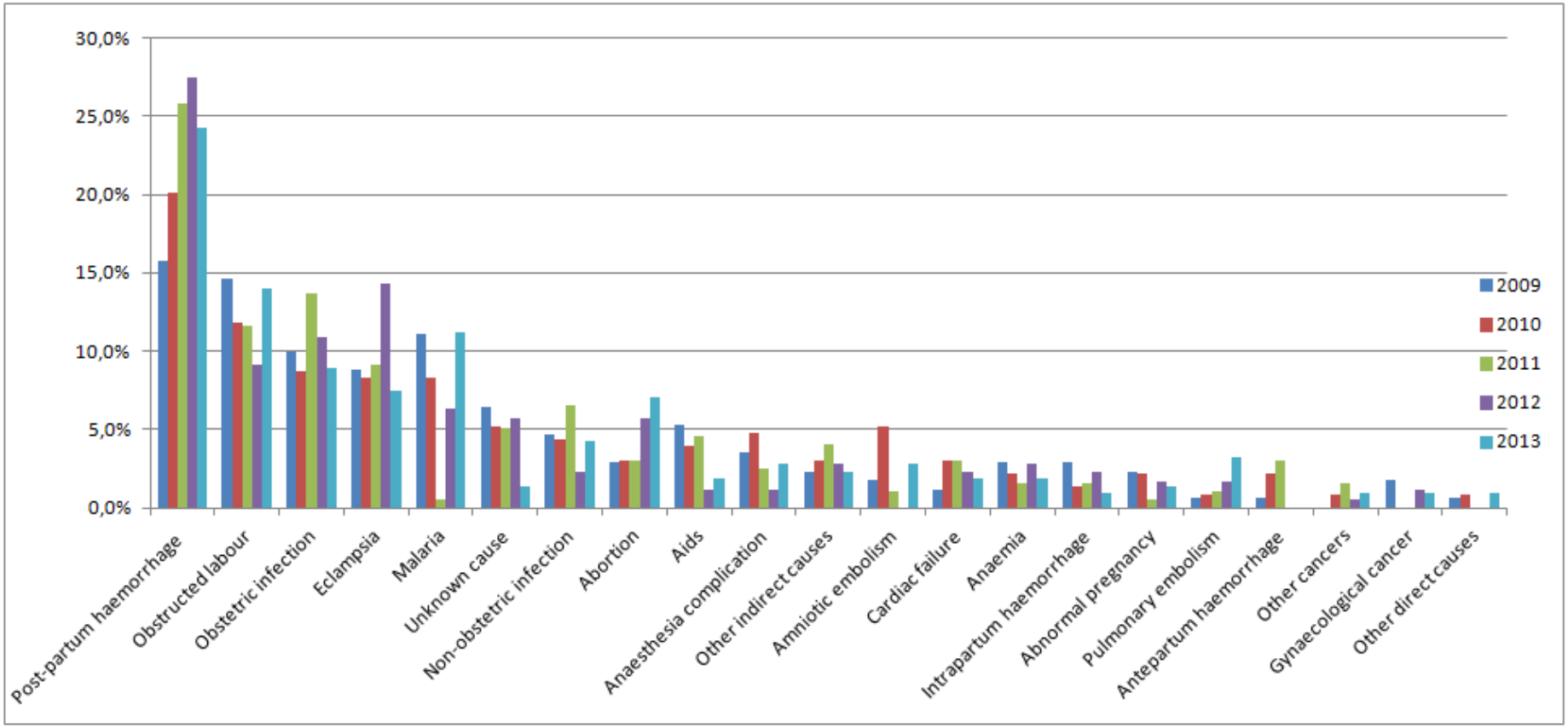
Figure 1: Trends in maternal death causes, from 2009 to 2013 (N=987)



APPENDIX

Box 2. Substandard factors identified in maternal death audits

61.1% Health system factors (N=603)	**30.3% Patient/community factors (N=299)**
• Poor case management (248) • Delay to refer the patient at high level (105) • Lack of skilled staff (48) • Insufficient diagnostic means (40) • Inadequate monitoring of labour and/or use of partograph (33) • Delay to recognize the complication (28) • Insufficient follow up in post-operative period (22) • Delay of the ambulance to reach the health centre (14) • No respect of asepsis (14) • Insufficient follow up in post-partum period (8) • Lack of isogroup blood (8) • Inadequate post-partum follow up (6) • Not following protocol (6) • Inadequate resuscitation (5) • Insufficient follow-up of anaesthesia induction (4) • Delay to administer the correct treatment (3) • Insufficient pre- operative preparation (2) • Poor quality of ANC visit (2) • Other factors (7)	• Delay to consult the health facility (183) • Poor maternal compliance (77) • No use of health facility (8) • Refusal to comply with treatment (7) • Poor hygiene (6) • Refusal to be referred at high level (6) • No use of mosquito nets (5) • Refusal blood transfusion (3) • Consulted traditional healers (2) • No respect of ANC visit (1) • Patient refusal to be operated (1)

Figure 2: Distribution of substandard case management and poor maternal compliance identified in maternal death audits, 2009-2013