



EPHI takes a leading role in managing national MDSR Data

As of 2014, maternal death became the 21st weekly reportable condition included in Ethiopia's Public Health Emergency (PHEM) system. All deaths – whether they have occurred at home, in transit, or within a health centre or hospital – are now included on the weekly PHEM reports compiled by HEW and facility staff and then sent upwards through the system. By the end of every week, the central PHEM team receives all the

surveillance reports from throughout the country .

Just as important, however, are the case-based reports that follow maternal death reviews (known as the MDRF – maternal death review form) as these provide the crucial details of every death, including preventable contributing factors. EPHI has developed a special national MDSR database that is separate from the surveillance system, and

MDSR

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records the information from MDRFs.

Within the busy EPHI PHEM directorate, there are several focal persons tasked with managing the database, conducting regular analysis, and providing data in a useful format to the MDSR task force at FMOH. EPHI is also working closely with both PHEM and MCH teams at every RHB in order to strengthen their capacity to collect, record, and manage regional level data.

Good Practice Corner



New Collaborative Initiative in East Harege/ Dire Dawa/Harar

A special meeting of East Harege Zone representatives together with CEOs and Medical Directors from all 5 referral hospitals in Dire Dawa and Harar was coordinated and hosted by Ato Ali, Head of East Harege Zone, to discuss maternal deaths in the locality. Many of the women who die at hospitals in Dire Dawa and Harar are from East Harege Zone.

The MDSR system has thus catalysed a historic collaboration between the 3 regions/zones. Representatives from each crossed their borders to discuss the problem of maternal mortality.

After a presentation of maternal death data by the PHEM officer from East Harege Zone, a fruitful discussion took place. It was agreed that there will be quarterly meetings of the group to ensure regular feedback and information sharing. In addition, 22 recommendations were made, including:

- Improve the referral process such as pre transfer discussion by phone between clinicians
- Early transfer of critical patients
- All transfers to be accompanied by relevant referral note
- Stop ambulance abuse and prioritise maternity patients
- Orientate ambulance drivers to maternity patients' needs including smooth transfer

ESOG launches MDSR CME Module at Annual Conference



MDSR now has its own ESOG CME (Continuing Medical Education) module, which will be used across the country to educate Obstetricians and other senior clinicians about the process of MDSR.

The module was launched at the ESOG Annual Conference with 68 participants. These included senior gynaecologists, who graduated long before the development of the MDSR system, alongside O&G residents who will be leading the system in the future.

The seminar included the latest Maternal death data from the National database, the global context of MDSR, an overview of the surveillance system as well as practical exercises that guide SMART responses.

Participants acknowledged the need to improve documentation in clinical notes and vowed to integrate this into their own practice.

There are plans to take the seminars to the Regions in the near future.

Lessons learnt Case 1 : A pregnant teenager dies of sepsis.

A 16 year old with no previous pregnancies was admitted to a referral hospital following 2 days of labour but no fetal movements for one month. She had been referred from her local health centre. She was married and the pregnancy was planned and wanted but she had had no ANC.

On admission she was dehydrated but with a BP of 110/60 and a pulse of 96 per min. Intravenous cephalosporin and metronidazole were given. A macerated stillborn baby was delivered following craniotomy. Pus was seen following delivery and within minutes of delivery her BP dropped to 70/30 and pulse increased to 150 bpm. Despite all resuscitation she died 6 hours later.

Comment

Marriage under the age of 18 is illegal in Ethiopia and therefore families with underage members may be very reluctant to engage with health services. It is important that all health professionals including HEWs behave respectfully with such vulnerable patients.

It is probable that this baby had been dead for a few weeks and so sepsis is highly probable.

Ideally antibiotics should have been started at the health centre, and at the referral hospital gentamycin should have been added to the Metronidazole and Cephalosporin. This is in keeping with the guidance in the FMOH Selected Obstetric Topics.

Case 2 Near Miss: Delayed management in woman with Scarred uterus

A 38 year old para 4+1 was referred from a health centre after being in labour for 12 hours. Previously she had been to the health centre but was thought not to be in labour and sent home. She had had 3 normal deliveries, and in her most recent previous pregnancy had undergone a Caesarean section for placenta praevia. She had had no ANC for this pregnancy.

On arrival at the Referral Hospital she had a BP of 70/30 and a pulse rate of 150, she was cold and clammy and very pale. On examination of her abdomen fetal parts were easily felt and a diagnosis of ruptured uterus was made.

She was resuscitated with intravenous fluids and antibiotics. Laparotomy showed a left sided uterine rupture with 3 litres of blood in the peritoneal cavity. She was transfused 6 units of blood. She was fit for discharge home after 13 days.

Comment: This woman's life was saved by the prompt action of the Hospital staff.

Feedback was given to the health centre including the need for early referral of women with scarred uterus. Telephone discussion of cases is now encouraged from the health