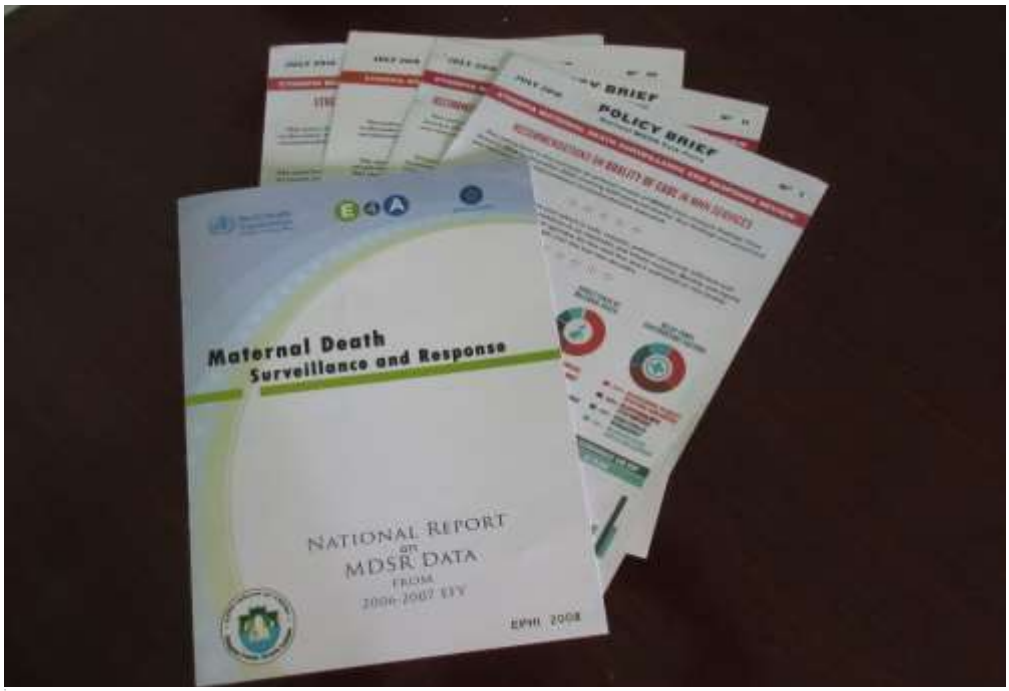


# MDSR Newsletter

September 2016

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# Ethiopia's 1st National Report on Maternal Death published

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## The first ever

National Report on Maternal Death Data was presented at the FMOH Annual RMNCH meeting in August in Addis Ababa.

The report summarises the numbers of maternal death reported by region and also gives details of the causes of death, timing and place of death and key demographic data.

Recommendations address future implementation of MDSR nationwide and appropriate responses to maternal death data. These recommendations include

*The need to use MDSR data at all levels from community to MOH to prevent further deaths and improve the quality of maternity care

*The need for all health facilities to actively participate in the MDSR system via the surveillance officer

*Recognising that haemorrhage is the major cause of maternal death, all pregnant women should be encouraged to engage with early ANC and be offered iron in pregnancy

*All health facilities should have trained staff and equipment to deal with Obstetric Haemorrhage

In addition a series of 4 policy briefs were released at the meeting. Both the Report and the policy Briefs are available on MOH /EPHI websites.

## Good Practice Corner

# Policy Briefs

**Four policy briefs developed in response to MDSR data have been published by the National MDSR task force**

The **first policy brief** makes recommendations on **Quality of Care** in MNH services. These include practical actions such as

- Institutionalizing regular multiprofessional training on management of obstetric emergencies particularly haemorrhage and pre eclampsia/eclampsia
- Emergency drug box/ cabinet on all labour/delivery units
- Availability of iron, essential antibiotics and bed nets in all health facilities

The **second policy brief** makes recommendations on **Community participation and engagement,** for example

- Improving HEW capacity to deliver ANC and recognize older, high parity , poorly educated women as being at particular risk of poor maternal outcome
- Supporting HEW to deliver Postnatal care with timely referral of women with complications

The **third policy brief** addresses **appropriate clinical use of blood and blood products.** Examples of the recommendations made include

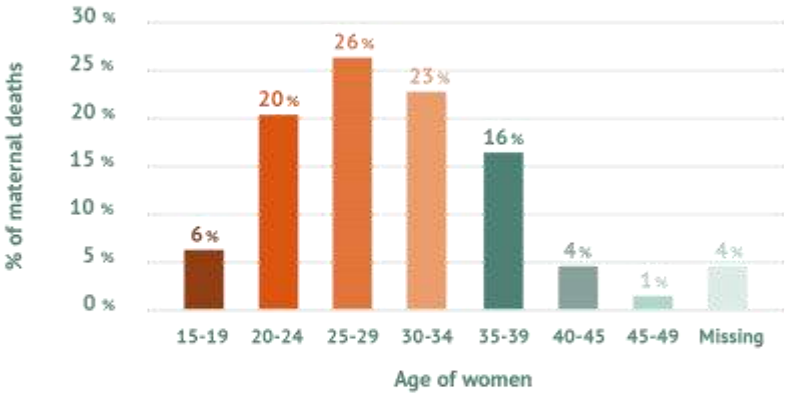
- The need for all CEmONC facilities to have constant access to safe blood products, and assign a qualified, focal person to be responsible for the service
- Mobilisation of blood donation through existing community structures eg Health Development Army

The **fourth policy brief** relates to **strengthening surveillance** in the MDSR system.

# Maternal deaths in Ethiopia: background characteristics

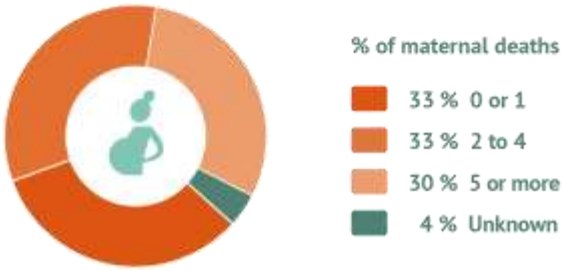
The following results are from the first 539 maternal deaths entered into the national Maternal Death Surveillance and Response (MDSR) database. These deaths occurred between Jan 2014 and Dec 2015.

## Maternal deaths by age



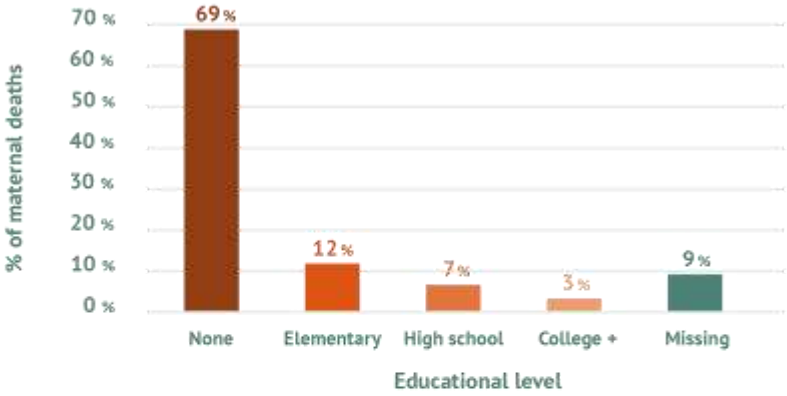

In general, the proportion of maternal deaths at each age follows the proportion of births in each group, peaking in age 25 to 29.

## Maternal deaths by parity




The distribution of maternal deaths across parity groups is generally equal with slightly fewer deaths in the parity 5 or more group.

## Maternal deaths by education




Over two thirds of maternal deaths reported were to women with no education. This is higher than the proportion of women in the wider population with no education (48%), suggesting that women with no education are most at risk of maternal death. This may be confounded by women with low education being the most rural and remote and/or poor.

## 90% of deaths reported were to married women

Married women, women with no education and vulnerable families should be the primary targets for responses to prevent maternal deaths. Vulnerable families are those needing extra support to ensure good pregnancy care, awareness of risks signs, and uptake of institutional delivery and post-natal care. These are likely to be women from remote households, with lower education than other families, or without resources to ensure they can arrange transport to health facilities when required.

**Women are at risk of maternal death each time they become pregnant. Therefore fulfilling the unmet need for family planning should be a priority. Ensure high quality family planning**

# Death at 2 am

# Can Hospital facilities reduce the night time mortality rate?

A 43 year old woman in her 10th pregnancy had 4 living children. She was known to have a fibroid uterus. She started ANC at 13 weeks gestation and had 11 ANC visits. At 39 weeks gestation a BP of 150/90 was recorded, this rose to 160/100 at term and a decision to induce labour with Misoprostil 25 micrograms was made.

After 5 doses of misoprostil, by 10pm she was 5 cm dilated and contracting 3 in 10 mins. Her waters were broken by the doctor on call and 1 hour later she was fully dilated and the fetal heart was absent. Her BP had been steady at 150/90 . She delivered a fresh still born baby at midnight together with a 2 litre blood loss.

The placenta was retained and removal of the placenta was attempted in the labour ward by a doctor. Another patient was undergoing C/S in the OR. She died at 2am.

## Comment

**Risk recognition was not well done. This patient was an elderly grand multip with a fibroid uterus and a poor obstetric history. She had also requested sterilisation. Planned C/S may have been a safer mode of delivery.**

**Documentation of events between midnight when she delivered and 2am when she died was confusing as separate contradictory entries were written by the midwife, intern and doctor. The doctor had had to leave OR to attend to this patient. The absence of good team work was obvious from the entries.**

**The maternity unit was overcrowded with a lack of midwifery, medical and anaesthetic staff.**

## Responses

**It was agreed that in future all decisions to induce labour must be agreed by a senior clinician.**

**Refresher training for resuscitation procedures, major haemorrhage and active management of third stage will take place regularly. All trainings will be multi professional to improve teamwork in emergency situations.**

**The overcrowding problem had been increasing over the last few years with the delivery rate increasing and staff retention a major cause for concern. This problem was referred to the Hospital management board who agreed to increase staff numbers.**



E4A Evidence for Action
Evidence for Action to Reduce Maternal & Neonatal Mortality in Africa