MDSR Newsletters Displayed at the 16th Annual Review Meeting in Dire Dawa

MDSR Newsletter

November 2014

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MDSR ACTIONS FROM AROUND THE COUNTRY

An independent survey was conducted on MDSR between September 2006 and October 2007 Interviews were conducted with 182 staff members from all levels of the health system (national, regional, zonal, woreda, and facilities). One of the 21 questions asked for examples of how MDSR data are being used. These were some of the responses:

'The mother had no ANC and came late, she died on the way to hospital. We used this case as an example to provide education to the community'

SNNPR Health Centre

'We have changed the HR structure and patient flow to improve care of labouring mothers'

Harari Hospital

'There are standby professionals at the maternity ward all the time to avoid delay, a responsible focal person is assigned who checks all activities are run as per the plan, algorithms for case management are posted on walls for quick reference'

Amhara Hospital

'Based on the MDSR data, the office decided to build a mothers' waiting room in the health facilities'

SNNPR Zonal office

Comments on MDSR from around the country

'MDSR increases awareness of maternal deaths and decreases maternal deaths'
Tigray HC

'In this area all people are aware of the causes of deaths occurring in our catchment, and the community decided to stop home delivery after MDSR was implemented in our woreda'.
Oromia woreda office

'MDSR shows that death reviews can be conducted more professionally. Case identification and learning process can be improved. Action plan and response can be explained according to the findings'
Addis Ababa Health centre

'MDSR helps improve linkage from facilities to the community'
Dire Dawa Health centre

'Before there was a tendency of hiding maternal death because of fear of the consequences, but after MDSR started we report and use data with confidence. Even health centre staff discuss with political leaders without fear'
SNNPR Health centre

'Before MDSR we didn't investigate a mother's death. Based on the findings now we develop action plans to prevent further cases.'
SNNPR Health centre

'MDSR alerts the community in general about maternal death and increases the responsibility of all stakeholders'
Amhara Regional Health Bureau

'MDSR encourages teamwork and experience sharing, it creates good relationships and better communication'
Tigray Hospital

Maternal Deaths: a series of cases of uterine rupture that demonstrate the need for pattern recognition as part of the MDSR process

Case 1 Maternal Death: Uterine Rupture

A 35 year old old woman in her fifth pregnancy was induced with a cervical balloon followed by an oxytocin infusion. She had a precipitate labour and collapsed after delivering a 3.2 kg baby. An attempt was made to resuscitate her, but she died.

Case 2 Maternal Death: Uterine Rupture

A 44 year old old woman in her eighth pregnancy was admitted for induction of labour as she was thought to be post-term. Fetal bradycardia was noted and she was delivered of a dead fetus secondary to uterine rupture. She died in the recovery period.

Case 3 Maternal Death: Uterine Rupture

A 35 year old in her fifth pregnancy developed severe pre-eclampsia. She was treated appropriately with hydralazine and magnesium sulphate and then induced with misoprostol. An oxytocin drip was also started but the contractions became tetanic and the fetal heart rate dropped. She underwent a total abdominal hysterectomy for ruptured uterus but died on day 3.

Comment

All cases involved highly parous women and induction of labour. Case 3 is complicated by severe pre-eclampsia, but all women suffered a ruptured uterus.

Actions taken

- The hospital MDSR committee reviewed the guideline for induction and augmentation of labour and ensured that the revised guideline was available on the labour ward.
- The correct follow up of patients on oxytocin with regular pulse, blood pressure, fetal heart and assessment of contractions was emphasised.
- The need for a high level of clinical suspicion of uterine rupture in women who are being induced was included in discussions with all medical and midwifery staff.
- Improvements in the recovery care and post-op follow up were made.
- Awareness of the danger of induction of labour in highly parous women has resulted in caesarean section being considered as an alternative mode of delivery in these women.

Maternal Death: Combining Verbal Autopsy Data with Hospital Notes

A 22 year old woman in her first pregnancy was admitted to a referral hospital at 33 weeks of pregnancy with severe pre-eclampsia. She was treated with hydralazine and magnesium sulphate and spontaneously went into labour, delivering a dead fetus weighing 2.3 kg.

She was monitored for 48 hours afterwards, during which time her blood pressure became normal and her platelet count and other biochemistry returned to normal. She was sent home on day 4 after delivery but complained of severe epigastric pain the following day. She was taken to a private clinic where she collapsed and died suddenly.

Comment

The case was notified through the HEW and the health centre staff carried out a verbal autopsy. This suggested that the cause of death could have been either pulmonary embolism, or a complication of severe pre-eclampsia called HELLP (haemolysis, elevated liver enzymes and low platelets).

However, when the hospital notes were reviewed, the monitoring of vital signs and biochemistry and blood results had been very good and it was highly unlikely that HELLP was the cause of death.

The MDSR follow up in this case was very good and the verbal autopsy was combined with the hospital notes to establish the cause of death.

Every effort should be made to combine the information from the verbal autopsy and the hospital. If this is not done to cross-check information, the wrong conclusion can easily be drawn from the verbal autopsy.

It was commendable that the hospital notes were easily retrieved, showing that the hospital has a good medical record system. The quality of the note keeping at the hospital was excellent and included detailed recording of observations while the patient was on magnesium sulphate and hydrallazine.

This death was probably unavoidable. It is not current practice in Ethiopia to use anti-coagulation in the post-partum period.

Actions

The hospital was congratulated on its standard of care and record keeping.