MDSR Newsletter

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MDSR IS ONE OF THE KEY TOPICS AT A WOMEN'S HEALTH DEVELOPMENT ARMY CONFERENCE IN TIGRAY. THE E4A TECHNICAL ADVISER ADDRESSED OVER 450 WOMEN WHO HAD COME TOGETHER FOR THEIR QUARTERLY CONFERENCE

IN THIS ISSUE

MDSR at Regional level

Case 1: Post partum haemorrhage

Case2 : HELLP syndrome

Case 3 : Dead on arrival

MDSR System celebrates its first birthday!

Where is the Maternal Death Surveillance and Response System one year on?

It is just over a year since the FMOH launched the National Technical Guidelines on MDSR. The first year has seen over 500 health centres and over 30 hospitals in 15 zones and 2 city administrations trained in MDSR. This covers an area with a total estimated population of 20 million people.

Over 150 deaths have been reported, analysed, and responded to. To date, most responses have been implemented at local level following identification of gaps in service provision or quality-of-care. Responses have included a wide range of actions, from replacing essential but broken equipment, restructuring staff rotas and providing further education and training to staff. Improvements in documentation have been observed everywhere following maternal death reviews.

This is the beginning of a process that will take at least 10 years to implement fully. Over time, it will lead to significant improvements in the quality of care provided to mothers, and thus will contribute to reducing maternal mortality in Ethiopia.

Regional update

Addis Ababa

With strong leadership from the Deputy City Bureau Head for Health Promotion and Disease Prevention, Honorable Alemtsehay Paulos. MDSR is firmly on the agenda for 2006-7 in Addis Ababa. Roll out training is now complete with 74 health centres, 10 subcities and 9 hospitals undergoing the 2 day training. Training was delivered by a strong team from the City Health Bureau

The deputy head of Addis CHB addresses participants at the Roll out training

Amhara

Amhara RHB recently extended their MDSR system from West Gojjam and Bahir Dar Town to include South Gondar. Further expansion is planned for the next year. Participants included teaching staff from local health care colleges. In the future further trainings will involve more teaching staff thereby embedding MDSR in the health care culture.

Dire Dawa and Harar

Despite starting up the MDSR system later than other regions, both Dire Dawa and Harar have flown into a strong position with very well organised systems. Strong leadership from the RHB staff will help ensure success.

Oromia

The RHB is enthusiastic about MDSR and have positively demonstrated how MDSR can lead to change. The health facilities in the functional zones have been particularly successful in embracing the MDSR culture to improve care.

SNNPR

Similarly, in SNNPR, the system has been successfully incorporated into health facilities , in one case building on the previous FIGO LOGIC programme.

Tigray This region has developed its own Maternal Audit programme, which is being incorporated into the FMOH MDSR system . MDSR in Tigray is strengthened by RHB leadership and also by the strong Health Development Army.

EXAMPLES FROM THE FIELD

Three cases of maternal death that demonstrate lessons learnt and provide evidence of good practice

Case 1 Maternal Death : Postpartum Haemorrhage

Team work is essential to survival

A woman of 27 years having her second baby was admitted to her local health Centre at 37 weeks of pregnancy. She was transferred to the Referral Hospital because of suspected fetal distress. At the hospital she delivered a healthy baby uneventfully. Following delivery she was transferred to the postnatal ward. 6 hrs after delivery she was found collapsed with a major haemorrhage. Attempts to save her were unsuccessful and she died on the postnatal ward.

The midwife and resident did not consult the gynaecologist.At the time of her collapse there was a staff shortage as several midwives were at a training meeting. There were only 2 nurses/midwives for the entire ward.

This led to a delay in recognizing the haemorrhage .

Actions

1. Feedback was provided to the entire team
2. The need to involve senior members of staff was acknowledged
3. The number of midwives was increased to 5.
4. In the future, ward staffing will be given a priority over training opportunities

Case 2 Maternal Death : HELLP syndrome in Severe Pre Eclampsia.

The need for timely delivery

A 20 year old in her first pregnancy was admitted to Hospital at 32 weeks of her pregnancy following an episode of vaginal bleeding and lower abdominal pain. A diagnosis of mild abruption placentae was made . She was given dexamethasone and iron medication but over the next few days she developed pre eclampsia with a raised blood pressure and proteinuria. She was treated with Magnesium Sulphate and Hydrallazine, but the baby died.

Induction of labour was carried out and she delivered a stillborn baby vaginally. Immediately following delivery she had profuse vaginal bleeding and was promptly treated with fluids, oxytocics and blood transfusion. However the bleeding persisted and a hysterectomy was done by the Senior Gynaecologist. Disseminated Intravascular Coagulation (DIC) occurred with bleeding from all puncture sites and haematuria. She died shortly after completion of surgery.

HELLP syndrome is a well recognized but relatively rare complication of severe pre eclampsia.

HELLP is an acronym for **H**aemolysis, **E**levated **L**iver enzymes and **L**ow **P**latelet count. The maternal mortality rate is estimated to be as high as 25% and early recognition and treatment is essential.

Actions

The case was discussed in detail at the facility MDSR meeting. The woman had been an inpatient at the hospital for more than 1 week.

1. It was agreed that good care was given following delivery and the correct steps were taken in a timely fashion .
2. The decision to deliver her should have been taken earlier in order to avoid the development of HELLP syndrome and DIC.
3. Subsequent cases of severe pre eclampsia have been treated more aggressively.

The hospital has become an 'Institution with a memory', and will treat similar situations differently, having learned from their experience of this case and discussed it in detail across levels of staff.

Case 3 Maternal Death before Arrival

The value of reporting cases of Death on Arrival (DOA)

A 30 year old pregnant woman was bought to a referral hospital but found to be dead on arrival. There was no accompanying health professional and no note of referral although the driver reported that she had been seen at a district hospital prior to transfer.

The staff at the Referral Hospital realized that although they knew no medical details of the case it was important to report the case through the MDSR system.

1. The hospital staff recognized the need to improve the referral system and knew the importance of having evidence to discuss with the referring centres.
2. In addition to improving the referral system in that area, the hospital also has staff and students from the nearby Medical School . The case was used as a talking point to sensitise students, interns and GPs to the MDSR system.