MDSR
Newsletter

Ethiopia

November 2013

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MIDWIFE IN OROMIA WITH MDSR COMMITTEE RECORD BOOK

MDSR SYSTEM KICKS OFF!

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Key Highlights…

- The MDSR System is now active in 5 Regions: Addis Ababa, Amhara, Dire Dawa, Oromia and SNNPR.
- Over 1000 healthcare professionals and administrators have been trained.
- HEWs and Community orientations are taking place.
- Hospitals, health centers, Zonal and Regional bureaus are developing action plans and TORs.
- Some facility MDSR committees are active and have already discussed cases and responded to the deaths.
- Some health centers have completed verbal autopsies.

Health Extension Professionals reviewing maternal death identification and notification form (CMC HC, Addis Ababa)

First Verbal Autopsies

The first maternal death verbal autopsies have been carried out in Oromia and Addis Ababa

The families concerned expressed their gratitude that the death of their sisters or daughters were being looked at.

The autopsies took at least 1 hour and it was found that the process was much easier if the families had been informed beforehand.

The information gained has been used to review the case. Follow up actions include availing parenteral antibiotics, strengthening ambulance service, and increasing community awareness on ANC, institutional delivery and PNC through health extension professionals.

Facility MDSR Committee set up

Good practice points

- ☞ Prepare the maternal death case using annexe 2 from the National Guidelines
- ☞ Ensure all committee members sign the non disclosure form (annexe 10 from National Guidelines)
- ☞ Be prepared with a copy of annexes 4 & 5 to document the committees response and recommendation .One copy for each case to be discussed.
- ☞ Appoint someone to take the minutes.
- ☞ A minimum time for each meeting is 1 hour
- ☞ Most facilities meet once a month and discuss near misses as well as Maternal deaths

REVIEW of the first 5 maternal deaths at one hospital led to the conclusion that too much documentation was missing to review the cases.

Action

A staff meeting was held and the details of the MDSR programme were outlined to all staff. The need to document times and dates was highlighted as well as clinical data. Feedback will be provided to staff after the next MDSR review

Peripartum Cardiomyopathy

A 22yr old woman in her first pregnancy was admitted to hospital with mild pre eclampsia and 2 days later went into spontaneous labor. She delivered a live baby weighing 4.6 kg, she was discharged 2 days later. She was readmitted on day 6 after delivery with breathlessness, tachycardia and a loud ejection murmur. Her BP was mildly elevated. Initially she was treated for broncho pneumonia but after a chest X ray and repeat examination suggested heart failure she was treated for cardiac failure. She died 24hrs

Comments from the hospital MDSR Committee meeting

Peripartum cardiomyopathy is a relatively rare condition occurring approximately 1 in 1000 pregnancies. Risk factors include pre eclampsia and glucose intolerance. Presenting symptoms can be very similar to bronchopneumonia.

It is associated with a significant mortality rate in all settings. However early diagnosis and appropriate treatment can reduce this.

Actions

- Feedback to staff at both the private clinic she attended and the hospital
- Raise awareness of Peripartum cardiomyopathy with case presentation at hospital by a GP
- Improve access to oxygen concentrator at hospital
- Raise awareness of the condition at zonal/regional level so that appropriate intensive care facilities can be developed in the zone. It is anticipated 105 women per annum will develop peripartum cardiomyopathy in that zone.

Could these cases happen in your health centre or hospital?

Can you think of other actions?

Sepsis

A 20yr old woman in her first pregnancy had had 2 ANC visits. She was admitted to the Health Centre in false labour.

She stayed overnight at the Health Centre and the following day was in true labour. On day 3 of her admission she was found to be in obstructed labour and transferred to the Hospital. On admission to the hospital she was fully dilated with prolonged ruptured membranes. A vacuum delivery was attempted and unsuccessful so 2 hrs after admission she underwent a C/S. At C/S pus was found and she was given i/v ampicillin. She had a normal temperature until day 4 when she had a temperature of 40 degrees Centigrade and medical review was requested. Metronidazole was commenced but her condition deteriorated and she died on day 6 of her admission.

Comments/discussion at the Hospital MDSR Committee meeting

- There was delay in referral from the Health Centre and the significance of prolonged ruptured membranes was not recognized
- There was good care on arrival at the hospital and she had the C/S done without delay
- The need for triple antibiotics in a woman with obvious infection at delivery was missed.
- This woman was at risk of puerperal sepsis and a routine medical review should have taken place prior to day 4

Actions recommended at the hospital MDSR Committee meeting

- Discussion and feedback to Health Centre staff. Criteria for referral to be agreed with Health Centre staff. Telephone communication to be encouraged between Health centre and hospital. The gynaecologist will visit the health centre in the next 3 weeks.
- Discussion and feedback to hospital staff. National guidelines 2010 FMOH 'Selected Obstetric Topics' to be distributed to all medical staff and a copy made available on labour ward. If this guideline had been followed, the correct antibiotic regime would have started 6 days earlier.
- A Handover Manual has been developed to inform temporary or new staff of Hospital Guidelines and Protocols including review of high risk patients.

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