This new ambulance at Dodola Hospital was obtained as a result of information provided by MDSR and has improved access to the Hospital.

MDSR integrates with IDSR

MDSR
Newsletter
February 2015

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Training of Surveillance Officers facilitates MDSR system

Throughout December 2014 and January 2015 , MDSR training was provided to 243 Regional and Zonal Public Health Emergency Management (PHEM) Surveillance Officers.

Integration into PHEM will strengthen the MDSR system, enabling data to flow along existing reporting channels from community and health centre levels up through Regional and National levels.

Weekly reporting by HEW will ensure timely identification. More importantly, the story behind each death will be captured on the Maternal Death Reporting Format (MDRF), which will be completed after the verbal autopsy has taken place.

The surveillance focal person at health centres will be responsible for conducting the verbal autopsy and completing the MDRF form.

New HEW will be trained in identifying and notifying deaths of Women of Reproductive age (15-49) and screening these for maternal deaths. This is also included in HEW refresher training.

Story of Change : Dodola Hospital , West Arsi Zone

In 2013 , Dodola District Hospital staff, including the Medical Director, were trained in the use of MDSR. Since that time they have convened a multi professional MDSR committee that meets at least monthly and reviews all maternal deaths and some "near misses".

Many changes and improvements have been made as a result of this process including getting extra ambulances and training GPs and all midwives in the use of anti-shock garments. A focal person now coordinates blood transfusions, ensuring there is enough blood from the local blood bank. He has also coordinated 2 blood donation sessions and a total of 39 staff members have donated blood.

In response to a death following an abortion, the hospital management board agreed to fund a designated room for safe abortion and identify a focal person to oversee the practice.

The hospital also has regular catchment meetings with 15 local health centres and has organized training for these health centres about causes of maternal death, MDSR and pathways of referral.

Since beginning MDSR documentation, hospital notes have improved, but the Medical Director wants further improvements and carries out random assessments three times a week.

The Medical Director says ' MDSR is good. We discuss the deaths and what are our gaps. We detect problems immediately and then plan solutions. We have started a morning session on the delivery ward. We have no Seniors at the hospital, but this is a good opportunity to hand over well between the Emergency Surgical Officer and the day staff. Overall MDSR is improving quality of care at our hospital.'

Is the death preventable?

Each maternal death represents an individual tragedy. Sometimes women die despite excellent care, but in most cases the death could have been avoided. Reviewing maternal deaths requires a sustained effort from professionals to learn lessons from case histories that would otherwise go unreported or unexamined.

It is not an easy task for Doctors, midwives, emergency surgical officers and family members to review fatal cases but this process provides a critical opportunity to learn lessons and improve health services.

A Case History from a referral hospital

A 35 year old woman with a bad obstetric history was admitted for a planned elective Caesarean Section at 39 weeks. She had had 2 previous stillbirths and 1 previous live birth. The last baby had also been delivered by Caesarean Section.

On this occasion, the Caesarean Section was complicated by adhesions and she had a blood loss of 1.3 litres during the procedure.

She stayed in hospital for 4 days after delivery but was very keen to go home and was discharged on day 4. The GP noted that she was afebrile (had a normal temperature) but the wound looked a little infected. She was prescribed antibiotics.

When she got home the wound broke down and she was readmitted on day 7. She collapsed and died following acute central chest pain and acute breathlessness. A presumed diagnosis of Pulmonary Embolism was made.

At the MDSR Committee meeting, the death was initially considered unpreventable as the cause of death was considered to be Pulmonary Embolism. After further discussion it was agreed that because of the blood loss during the caesarean section she had become anaemic. Anaemia predisposes a patient to infection. She had not had a blood transfusion or been put on iron treatment. She had gone home with an infected wound where she had not been mobile. The death therefore had avoidable factors. It was determined that the woman's post-operative care was deficient.

Missing cases of Maternal Death

Cases of maternal death in hospital facilities will only be recognized if all deaths of Women of Reproductive Age are first identified.

A review of all deaths of Women of Reproductive Age was recently completed at 3 hospitals (2 district and 1 referral) in one zone. All registers for admissions and discharges on medical, surgical , gynaecology and maternity wards, and emergency rooms were checked for deaths to females aged 15- 49 yrs.

A total of 52 cases were identified. All 3 hospitals had very efficient record departments and the 52 notes were reviewed to identify cases of maternal death. 3 cases were identified, one following abortion , one from probable gestational trophoblastic disease and one indirect death from pneumonia .

It was noted that several of the other deaths could have been pregnancy related, for example:

- one 37 year old woman died of a stroke but had had no pregnancy test and there was no comment about menstrual pattern
- Two teenage girls had died of poisoning but had had no pregnancy test done

Recommendations include:

- Improved history taking: most notes had no menstrual , obstetric or gynaecology history. Even if a woman is admitted to a medical or surgical ward this is an important component of history-taking
- Pregnancy tests can help to identify maternal death if the woman is admitted unconscious

Action :

The hospital focal person for surveillance should ensure that all deaths in Women of reproductive age are screened for maternal death.