MDSR Newsletter

November 2015

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Ethiopia's MDSR system gains international recognition

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Ethiopia's MDSR system is unique in the international context. No other country has a surveillance system with a community base

Countries including Zimbabwe, Zambia, Nigeria and South Sudan have all expressed interest in the MDSR system being implemented in Ethiopia. Guidelines, tools and the Ethiopian training package have been shared with the above countries and representatives from Ethiopia were recently invited to share their good practice in South Sudan alongside colleagues from Rwanda and Namibia.

At International conferences in Vancouver and Mexico Ethiopia's experience was show cased. In Vancouver the Ethiopian system was recognized for its true Surveillance component as opposed to a facility based Maternal Death Audit system.

In Mexico the strength of the response component was demonstrated with health system strengthening examples including improved teamwork and communication, recognizing and managing emergencies and referral pathways.

Good Practice Corner

T-shirts as advocacy tools

Awunt Health centre in West Gojjam have developed T-shirts aimed at men with the message:

" No mother should die while giving birth"

The T-shirts were prepared and are being sold at Awunt HC to the cluster community for 100 births.

Focussed training in Maternity units

In Amhara one referral hospital has set up a quality improvement programme at surrounding health centres which includes BEmONC and CEmONC training programmes, as well as using the hospital liaison officer to feedback on a regular basis to referring health centres.

In Addis Ababa one referral hospital has suffered a series of deaths from post-partum haemorrhage and has therefore introduced a programme of training for all staff involved in deliveries and postnatal areas to improve the management of PPH.

Another Addis hospital has recognized that its staff needs regular refresher training on resuscitation methods and new staff are particularly important. Onsite training is recommended so that staff are aware of where to find essential equipment and drugs.

Improved Referral Systems

In Dire Dawa and Hareri, 2 hospitals have started to communicate regularly with referring health centres to try to improve the referral process and also quality of care at the health centres.

Problems with the MDRF

The Maternal Death Reporting Format (MDRF) is the key component of the Ethiopian MDSR system. It is the single page document which summarises the most important data about the mother , her pregnancy and her death.

The MDRF is completed at the health facility level following the MDSR Committee meeting and sent to the National database housed at the Ethiopian Public Health Institute.

Currently more than 400 maternal deaths have been entered into the National database and some problems have been identified.

These include

1. Incomplete or illegible unique ID code. This is the most important piece of information on the MDRF. The box on the form is too small for easy use but the code can be written in the empty space above the box.
2. Cause of death – ideally only one box should be completed here. For example if the major cause of death is haemorrhage and the woman is anaemic only haemorrhage should be ticked. If the cause of death is ruptured uterus the 'obstructed labour' box should be ticked rather than haemorrhage.

   Any problems with completion can be discussed with the Zonal / Regional PHEM MDSR focal person or the Regional E4A Technical Adviser.

Lessons learnt after death of a high risk patient in the late postnatal period

A 25yr old 0+2 was admitted with severe pre eclampsia. After treatment with hydralazine, magnesium sulphate and corticosteroids she was delivered by Caesarean Section of a 2kg baby in good condition. Postnatally she had a post-partum haemorrhage which was treated with a 2 unit blood transfusion and she was fit for discharge by day 5.

She returned for postnatal follow up and was complaining of insomnia. There were no abnormal physical signs and she was discharged home but returned a few days later with a history of vomiting and an unrecordable blood pressure. Shortly after admission she suffered a cardiac arrest and died in the OPD area.

Autopsy was denied. Case review suggested a possible diagnosis of Venous Thrombo embolism.

At review by the Hospital MDSR Committee it was agreed there were elements of suboptimal care particularly at the first post natal review and also at the time of the final fatal admission.

Actions in response to this death included:

Strengthening of postnatal care

- **Development of a postnatal follow up clinic in the family planning area**
- **Development of a checklist for postnatal care**
- **Use of a patient information leaflet about danger signs in the postnatal period**
- **Feedback to staff and increased awareness of atypical symptoms in the postnatal period**

Resuscitation training for staff in Emergency OPD and other key areas.

Lessons learnt included the need to take symptoms seriously in the postnatal period. Most maternal deaths occur in the postnatal period and yet this is the stage of pregnancy when women receive the poorest quality health care.

Poor resuscitation skills are unfortunately common in staff working in emergency areas. Ideally all staff should have mandatory regular resuscitation skills training. All new staff should have an induction process which includes orientation to resuscitation equipment. It is helpful for hospitals to have a resuscitation training officer to support this training.


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