MDSR Newsletter

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MDSR system celebrated at 1st National Symposium

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National and Regional delegates

joined Partners and Donors at the National Symposium on MDSR held on April 20th & 21st.

The MDSR system was launched in 2013 and now 3-5% of maternal deaths have been entered into the National database. All Regions have now reported some maternal deaths to the national database.

At the symposium it was agreed that the system will now be rolled out across the country.

Dr Ephrem , Head of MNCH at the FMOH recognised the contribution of Professor Wendy Graham , Emeritus Professor of Aberdeen University in supporting the MDSR system in Ethiopia from its inception.

Following presentation of the National Data all Regions presented an update of the MDSR data from their Region. As the database increases in size the analyses that can be made improve in quality.

The major cause of maternal death in Ethiopia is Haemorrhage (48%) and the high risk of death from haemorrhage in grand multipara was recognised.

In response to this data each Region devised their response in the form of an Action plan. This action plan will be followed at the forthcoming Annual RMNCH meeting.

Good Practice Corner

FMOH embeds MDSR in the Quality Improvement programme

To become a lead hospital in Ethiopia is a big achievement associated with a financial reward. Any Hospital which aspires to Lead Hospital status must have a functional MDSR system and be able to demonstrate that they have regular meetings, report and review all cases and as a result make improvements that will improve the quality of care in their institution.

From the MDSR system perspective this is an important contribution to the sustainability of the MDSR system and demonstrates the FMOH commitment to the programme.

National Blood Bank joins the National Task Force for MDSR

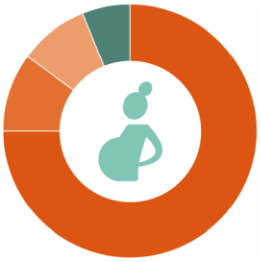
As of March 2016 the National blood bank has become part of the National MDSR system. This will be mutually beneficial as it will ensure that real time information about blood shortages are available to the National Blood Bank but also that those working in the facilities are more informed of the status of the National Blood Transfusion service and some of the safety aspects of use of blood.

For example fresh frozen plasma is now available in Ethiopia but not requested by many hospitals. One litre of fresh frozen plasma can be safely given and contains many of the coagulation factors needed in major haemorrhage.

Maternal deaths in Ethiopia: preventability and causes

The following results are from the first 539 maternal deaths entered into the national Maternal Death Surveillance and Response (MDSR) database. These deaths occurred between January 2014 and December 2015.

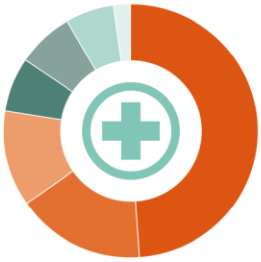
Preventability of maternal deaths



THE MAJORITY OF MATERNAL DEATHS ARE PREVENTABLE AND DUE TO DIRECT OBSTETRIC CAUSES

- 75 % Preventable
- 10 % Unknown preventability
- 9 % No data
- 6 % Not preventable

Causes of maternal deaths



- 48 % Haemorrhage
- 16 % Indirect
- 12 % Hypertensive disorders
- 9 % Obstructed labour
- 7 % Other direct
- 6 % Sepsis
- 2 % Abortion

48 % of maternal deaths were caused by haemorrhage. The largest indirect cause of death was anaemia, contributing to 14 % of deaths.

Timing of maternal deaths in relation to pregnancy

Almost two thirds of deaths occurred postpartum

The findings from this data emphasise the importance of every birth happening with a skilled provider and in a facility. Giving birth in facilities with skilled providers can prevent many of these maternal deaths.

Source: Ethiopian National MDSR Database: Maternal Death Review Forms, January 2014 – December 2015, Ethiopian Public Health Institute.

Lessons learnt when a woman dies or nearly dies of Haemorrhage

Good quality antenatal care should encourage women to deliver in the best level of facility for their needs

A woman who had a Caesarean Section in her first pregnancy was admitted to a general hospital after a second vaginal delivery. She was unconscious and bleeding after a long labour and delivery. She had delivered at a health centre 8 kms from the hospital. She had had antenatal care but had not been advised to deliver at a facility where blood transfusion and emergency Caesarean Section were available.

She regained consciousness after application of an anti shock garment and intravenous fluids. She had a 2 unit transfusion and made a good recovery.

Comment

Many of the deaths reviewed in Ethiopia have a similar story. Women who are at increased risk of needing support during delivery either because of their previous history or because of a specific factor in the index pregnancy are unaware of the danger of delivery in an unequipped health facility.

Haemorrhage is the major cause of maternal death in Ethiopia- 48% of all maternal deaths are caused by haemorrhage.

Many of these women have antenatal risk factors, high parity, previous haemorrhage, anaemia, multiple pregnancy etc but although they attend for antenatal care the need to deliver in a hospital with a blood bank and access to Caesarean Section is not discussed.

All hospitals including primary hospitals should have a mini blood bank, a transfusion committee and a focal person for blood transfusion.

It is the responsibility of the focal person to communicate with their local blood bank in a timely fashion to avoid stock outs of blood.

Fresh frozen plasma (FFP) is now available in Ethiopia. This has the advantage of lasting up to one year in storage and should therefore be ordered by all hospitals as a back up. I litre of Fresh frozen plasma can be given if there is a delay in obtaining blood. It is important to ask for FFP early as it will need to be defrosted and warmed before administration.

In any death review where there has been a shortage of blood products a spotlight should be shone on the reason for this stock out and action taken.

E4A Evidence for Action
Evidence for Action to Reduce Maternal & Neonatal Mortality in Africa