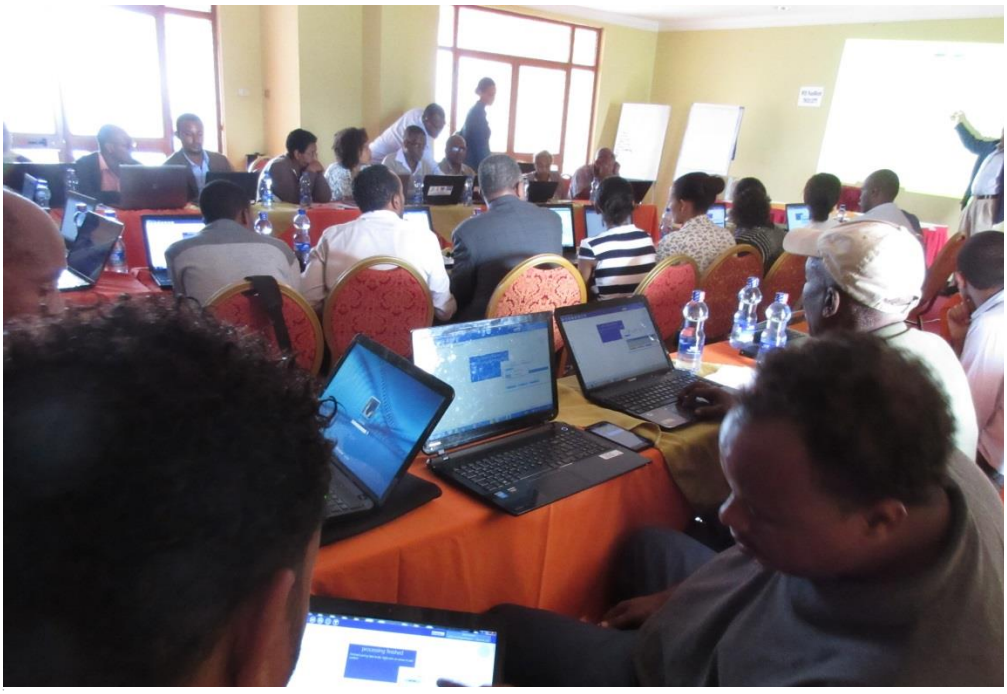


MDSR *Newsletter*

January 2017

E4A/WHO, ECA Compound
Telephone:
0115531550
Addis Ababa
Ethiopia

All Agrarian Regions now report maternal death data for analysis

IN THIS ISSUE

- The MDSR system in Ethiopia has matured to the point where all Agrarian regions have their own data to interpret and present. This should lead to informed planning and policy-making using real data.

- National and Regional teams from PHEM and MNCH recently worked together with expert facilitator Dr Negussie of Addis Ababa University at 2 Data Management workshops. Each three day workshop used data from Regional and National MDSR databases to compile reports that can make recommendations about how to most effectively respond to the high maternal death rate in Ethiopia. 76 staff from all major regions, EPHI and MNCH at FMOH participated.

- The PHEM Implementation Manual for MDSR is available online!
  See:
  http://www.ephi.gov.et/images/pictures/download2009/PHEM_Implementation__Manual_July%202016.pdf

MDSR Informs Quality of Care Improvements

A 3 day conference was convened by FMOH and supported by WHO with Dr Anthony Costello, WHO Global Director of MNCH, attending from Geneva. WHO are launching a new global network and learning platform to improve Quality of Care for women, newborns and children.

Ethiopia is one of the first wave of 8 countries involved in this learning platform and participants at the conference went on to prepare for country engagement by developing a country road map.

MDSR is a key component of Quality of Care, providing real time information that helps to identify the gaps in the maternal health care system from community to facility to administrative levels. The development of MDSR in Ethiopia was described by Dr Ephrem, Director of MNCH at FMOH, as ' a unique achievement'.

Dr Amsalu from Amhara gave an excellent presentation of the benefits of MDSR at health centre level by describing the actions taken at Awunt HC in response to two deaths from PPH. The responses included developing a waiting room and improving communication with both the local district hospital and the community, as well as improving skills of staff to deal with haemorrhage, thereby improving quality of care

Dr Costello commended the rapid development of the MNCH service in Ethiopia and also the proactive approach to improving quality of care with the development of the National Quality of Care Directorate.

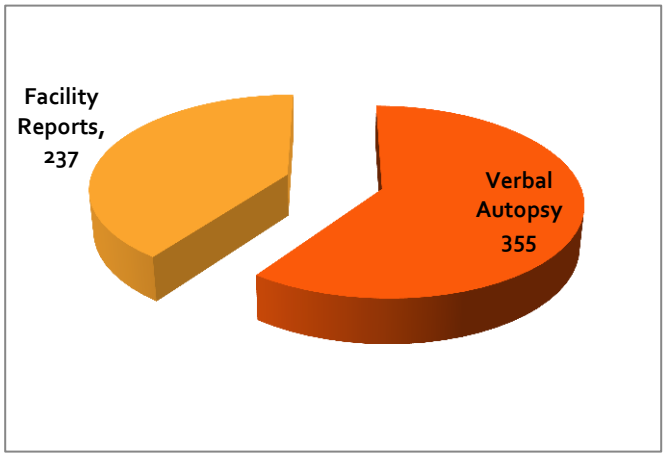
Get to know the MDSR Database

2008 Overview:

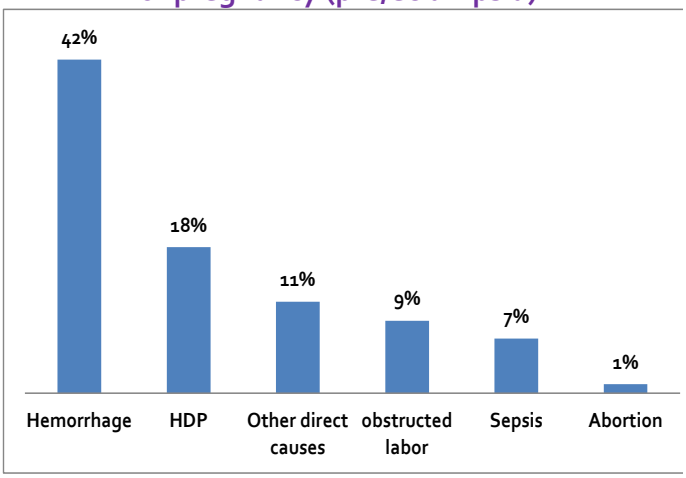
The 2006-2007 National Report was the first time Ethiopia's MDSR data were analysed and presented. If you haven't seen the report it is available on the EPHI website here: http://www.ephi.gov.et/images/pictures/download2009/First%20NationalMDSR%20Report%202007%20EFY.pdf

Now that the Ethiopian 2008 fiscal year is finished, a new report will be available soon. Here we present some key statistics from the 631 maternal deaths reported for 2008.

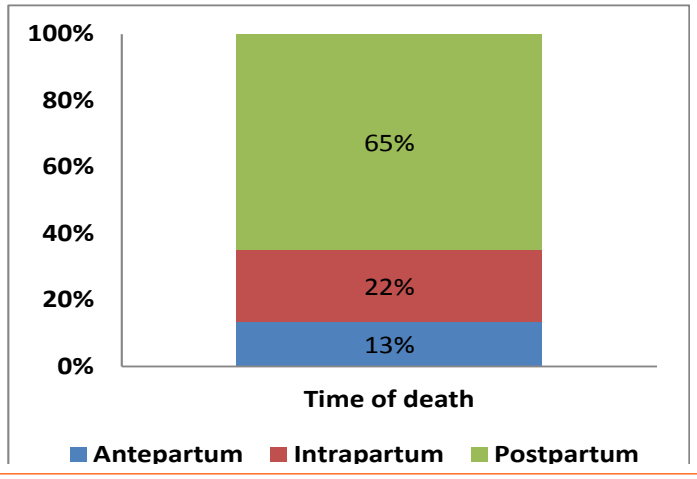
60 % of reported deaths came from Verbal Autopsies and 40 % from facilities. This reflects increased reporting from facilities in 2008.



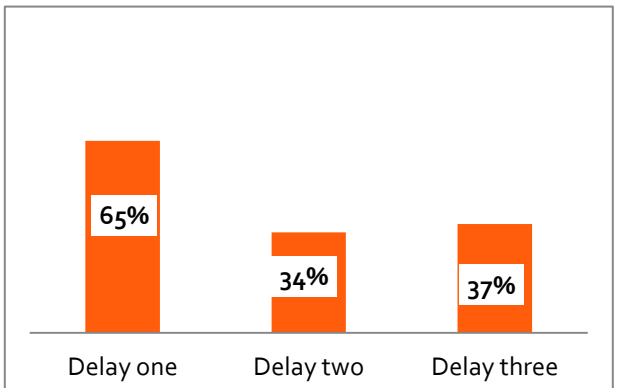
As previously, the main cause of death was hemorrhage, followed by Hypertensive diseases of pregnancy (pre/eclampsia).



Most maternal deaths occurred in the postpartum period suggesting the need for good postnatal monitoring and care



Delays in seeking care, reaching a facility, and receiving services contribute to the "pathway to death" meaning that action is needed to raise community awareness, strengthen transport and referrals and improve quality of obstetric care



Precipitate labour and PPH: Can Hospital facilities reduce the night-time mortality rate?

A 30 year old woman in her 3rd pregnancy had attended 4 ANC visits. When she was 40 weeks pregnant she was admitted to the referral hospital at 9 a.m. when she was contracting regularly, but her cervix was not dilated. Her BP was normal at 110/70.

She was re-assessed at 9 p.m. when she was 4 cm dilated and transferred to the delivery room. She delivered a live 3 kg baby at 10.50 p.m. The placenta delivered at 11.05 p.m. with 1.9 litres of blood. The placenta was complete and there were no perineal tears. Her BP post-delivery was 100/70.

Because of the bleeding she was given intravenous normal saline with 20 units of oxytocin added and blood was sent for cross match. At no time was her pulse rate recorded. The doctor was in OR and was asked to review her, which he did at 11.30 p.m. He ordered 2 units of fresh frozen plasma and 2 units of blood and arranged for her to go to OR for examination under anaesthesia. She was taken to OR at 2.10 a.m. but was gasping so was returned to the ward where she was declared dead.

Comment

The PPH should have been anticipated after her precipitate labour.

The response to her haemorrhage at the time of delivery was inadequate. The fact that she maintained her blood pressure masked the severity of her condition. Her pulse should have been taken.

More fluids should have been given more quickly. The fluids were not immediately available on the delivery ward and there was delay in accessing them. There was no attempt made to bimanually compress the uterus which may have slowed the blood loss.

A second OR could have been made available.

Responses

It was agreed that there should be more willingness to open a second OR especially when a patient is actively bleeding .

Refresher training for resuscitation procedures, major haemorrhage and active management of third stage will take place regularly. All trainings will be multi professional to improve teamwork in emergency situations.

Proper stocking of emergency boxes is the responsibility of the lead midwife. Checks should be made at every change of staff.

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