JULY 2016

POLICY BRIEF

National MDSR Task Force

Nº 1

ETHIOPIA MATERNAL DEATH SURVEILLANCE AND RESPONSE REVIEW

RECOMMENDATIONS ON QUALITY OF CARE IN MNH SERVICES

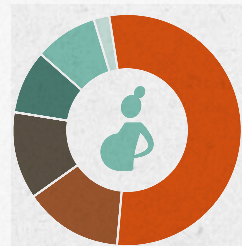
This policy brief is the outcome of national review of MDSR data analysis findings from January 2014 to December 2015 covering 539 maternal deaths. Key findings are presented and relevant quality improvement recommendations indicated.

Quality MNH care refers to care which is safe, reliable, patient-centered, efficient and provided to all mothers and newborns in an equitable and timely manner. Quality and equity in health care are transformation agendas for the next five years and build on the health systems' gain in improving coverage over the last two decades.

KEY FINDINGS

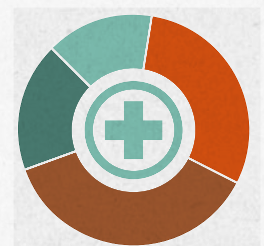
- √ Direct obstetric causes account for 87% of maternal deaths and hemorrhage is the leading cause
- √ Anemia is the leading indirect cause of death
- √ Delay one contributes to the majority of deaths (71%)
- √ Delay 2 contributes to 37% of deaths
- √ Delay 3 , which relates to quality of care at health facilities contributes to 35% of deaths
- √ Among supplies and equipment, lack of blood was the leading contributing factor (45%) followed by lack of ICU service (18%)
- √ Majority of deaths due to hemorrhage (77%) and hypertensive disease in pregnancy (HDP)(57%) occurred in the postpartum period
- √ MDSR reviews found that the majority of deaths (82%) were preventable

DIRECT CAUSE OF MATERNAL DEATH



- 54% HEMORRHAGE
- 14% OTHER DIRECT
- 12% HDP
- 9% OBSTRUCTED LABOUR
- 9% SEPSIS
- 2% ABORTION

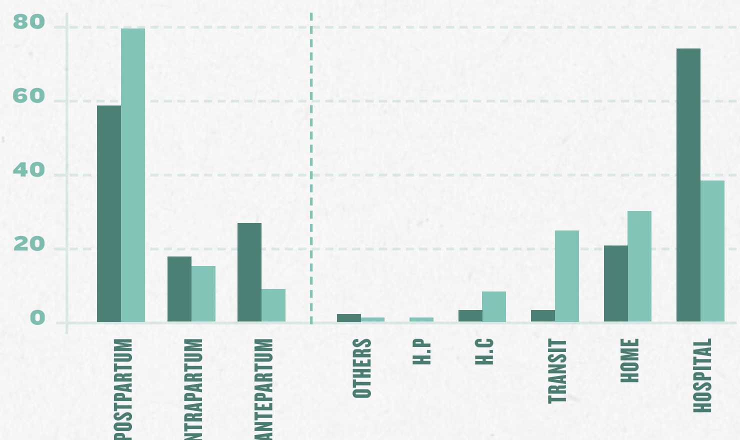
DELAY THREE CONTRIBUTORY FACTORS



- 37% DELAYED ARRIVAL TO FACILITY ON REFERRAL FROM ANOTHER
- 30% DELAYED MANAGMENT AFTER ADMISSION
- 18% HUMAN ERROR OR MISMANAGMENT
- 15% DELAYED OR LACKING SUPPLIES AND EQUIPMENT

MATERNAL DEATHS DUE TO HEMORRHAGE AND HDP

BY TIME | BY PLACE



DEATHS DUE TO HDP | DEATHS DUE TO HEMORRHAGE

EVIDENCE SHOWS THAT

- √ Attendance significantly decreases across the continuum of care from the first ANC visit, which is universal, through the fourth visit to having a safe birth attendant at delivery or receiving postnatal care
- √ The quality of ANC in terms of the full package of care (including birth preparedness and complication readiness plans) remains very low, with late initiation of ANC
- √ Delay three is directly related to service quality in facilities.
- √ Post partum care coverage is the poorest section of maternity care although the majority of maternal deaths occur during this time
- √ Effective referral systems to address delay II and hospital ICU care are critical to curtail deaths due to hemorrhage/PPH and HDP

Reference: (EDHS 2011, Mini EDHS 2014)

POLICY RECOMMENDATIONS

1. Regular multidisciplinary training on management of emergency obstetrics, particularly hemorrhage and pre-eclampsia/ eclampsia should be institutionalized.
2. Internal quality assurance through conducting QOC assessment for all MNC and particularly hemorrhage and preeclampsia/ eclampsia should be done at least quarterly followed by quality planning and improvement.
3. Post partum care should be a priority for HEW and they should have regular supervision from midwives at health centres.
4. HEW should ensure that all women having ANC at health post are linked to health centers for intrapartum care.
5. QOC initiatives should be owned by health facilities supported by RHBs and the existing hospital based QOC initiative should be cascaded to health centers.
6. Pre-service and in-service trainings on EMONC should target the major drivers of maternal mortality such as PPH and HDP.
7. The use of the Safe Childbirth Checklist and Partograph should be expanded and monitored to overcome human error and mismanagement and ensure patient safety.
8. Blood transfusion committees should be established at hospitals to assure quality of transfusion services.
9. All labor and delivery units should have an emergency drug box/cabinet with IV fluids, Oxytocin, Misoprostol, Hydralazine and Magnesium Sulphate.
10. Iron, essential antibiotics and bed nets should be available in all health facilities.
11. Liaison officers for referrals should be assigned at every health center and clear procedures for emergency obstetric referral between catchment health facilities put in place in all zones.
12. All tertiary/referral hospitals should have ICU care or HDU for obstetric complications to significantly reduce deaths from HDP and hemorrhage.
13. All facilities should assess the timeliness of management of admitted obstetric patients and take action accordingly.
14. There should be early engagement of senior staff in the management of critically ill maternity patients.

For more information see Ethiopian Public Health Institute:
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