JULY 2016

POLICY BRIEF

National MDSR Task Force

Nº IV

ETHIOPIA MATERNAL DEATH SURVEILLANCE AND RESPONSE REVIEW

STRENGTHENING SURVEILLANCE IN THE MATERNAL DEATH SURVEILLANCE AND RESPONSE SYSTEM

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

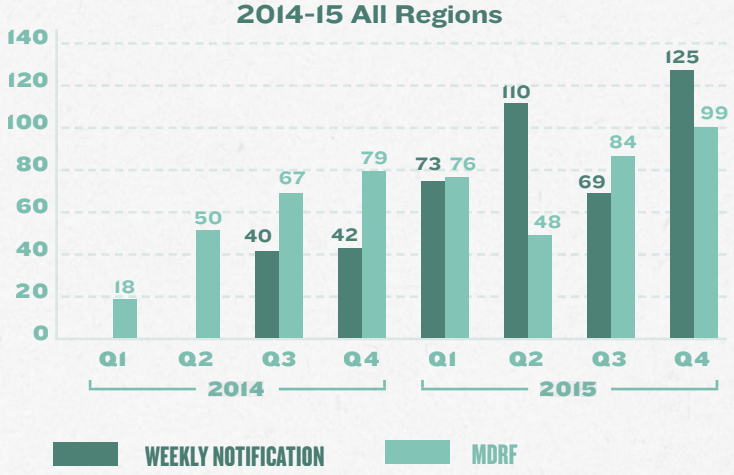
The objective of MDSR is to prevent future similar maternal deaths by responding to its causes and contributing factors, and to count every maternal death at national and subnational levels. In 2014 maternal deaths were integrated into the pre-existing Public Health Emergency Management (PHEM) structures, and was added as one of the 14 immediately reportable events in the country.

KEY FINDINGS

- ✓ Weekly reported maternal deaths are entered alongside all reportable conditions into the national PHEM database
- ✓ All regions have now started weekly reporting of maternal deaths, including "zero reporting"
- ✓ A separate MDSR database for case based data following maternal death reviews has been set up at EPHI.
- ✓ The number of maternal death reports through the case-based Maternal Death Reporting Form (MDRF) and weekly notification showed discrepancies. In 2015, 19% of weekly notified maternal deaths were not reviewed nor reported to national level.
- ✓ There is regional variability in discrepancies of weekly notification and MDRF reporting.
- ✓ Maternal death notification and reporting performance has been improving but still far from capturing the national estimated maternal deaths
- ✓ Maternal deaths reported through MDRF in 2014-15 covered only 2.5% of the estimated maternal deaths for the same period.

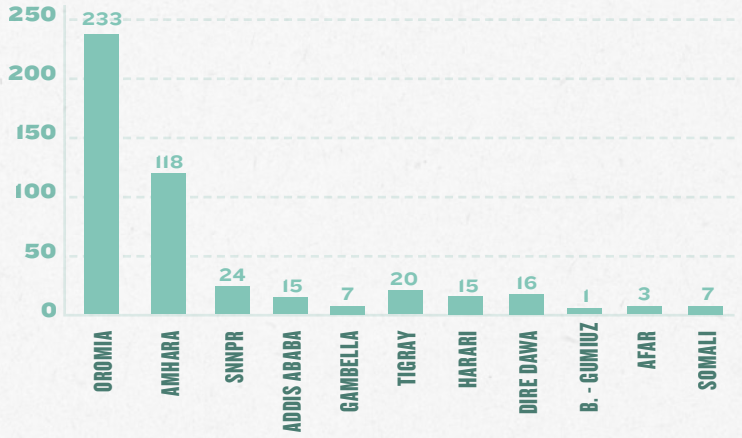
COMPARISON OF MD WEEKLY NOTIFICATION AND CASE BASED REPORTING

2014-15 All Regions



WEEKLY MD NOTIFICATIONS BY REGION

2014-15, N=459



PERCENTAGE OF INCOMPLETENESS OF CASE BASED REPORTS, N=539

S.N	Reporting health facility	Incompleteness
1	Date of MDRF reporting (from Facility)	3.2%
2	Deceased ID	3.2%
3	Date of Death	2.6%
4	Age at Death	3.7%
5	Place of death	1.3%
6	Death Place other specified	0.0%
7	Marital Status	4.5%
8	Religion of the deceased	10.8%
9	Ethinicity of the deceased	12.1%
10	Level of Education	4.5%
11	Gravidity	4.6%
12	Parity	5.2%
13	Timing in relation to the pregnancy	5.2%
14	Attended ANC	100.0%
15	Causes of death	4.3%
16	Other direct causes specified	7.8%
17	Other In direct causes specified	7.4%
18	Is the Death Preventable	8.5%
19	Specified missing supplies and equipment	4.1%

EVIDENCE SHOWS THAT

✓ According to the UN 2015 estimation for Ethiopia there were 11000 maternal deaths in 2015. Maternal death case based reporting however, included only 2.5% of this number in the same period

✓ The global experience indicates that MDSR systems take at least 10-15 years to mature (South African confidential inquiry of MD)

✓ Generally the PHEM System has more than 80% completeness and timeliness of weekly reported data, but to date maternal death has not been fully captured by the system

POLICY RECOMMENDATIONS

1. Gap filling training for PHEM staff at all levels needs to address the MDSR implementation process, particularly at woreda level.

2. All training needs to be supported by ongoing supervision to ensure full reporting with good data quality.

3. PHEM should liaise with the Health Extension Directorate to ensure IRT for HEW is in line with MDSR implementation procedures.

4. Quality and reporting issues specific to MDSR need to be routinely integrated into PHEM feedback mechanisms.

5. Availability of MDSR manuals and reporting tools are critical to the functioning of the MDSR system and PHEM should prioritize ensuring full distribution.

6. Planned bi-annual joint supervision should focus on assessing and strengthening integration between MNCH and PHEM directorates at every level.

For more information see Ethiopian Public Health Institute:
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