Optimizing MDSR reviews. What are we learning about PPH and what more could we learn?

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Outline

Maternal Death Surveillance and Response
MDSR process

• One of the global strategies in ending preventable maternal mortality
• Continuous surveillance response cycle
  • Identification
  • Notification
  • Case review of maternal deaths
  • Commitment to real time ACTIONABLE data
    • Preventing future similar deaths
  • Analysis @ national level- data aggregation and interpretation
  • Response
  • Dissemination of results, recommendations, and responses
  • Monitoring and Evaluation (M&E) for MDSR system
  • MDSR implementation plan

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Hiccups to Implementation of a sound MDSR

- Lack of awareness of the purpose and principles by stakeholders
- No political commitment @ national level
- Lack of financial resources to support MDSR committees
- Existence of blame culture during reviews
- Mindset to reflect and effect change not present
- Insufficient number of trained health workers
Why discussing maternal deaths?

• 295 000 maternal deaths in 2017 - Globally

• Sub-Saharan Africa (SSA) contributed 66% of burden
  • SSA Life time risk of maternal death - 1 in 37 for a 15 year old

"In countries that provide everyone with safe, affordable, high-quality health services, women and babies survive and thrive."

Dr Tedros Adhanom Ghebreyesus, Director-General of WHO
Synergy between MDSR & EMOC assessments
Big Five causes maternal deaths

• Haemorrhage - 27%

• Sepsis – 11%

• Pre-eclampsia and eclampsia – 14%

• Complications from delivery - 10%

• Complications from unsafe abortion – 8%
What are we learning so far?

• PPH- leading cause of maternal death
• Problem recognition still an issue
• Availability of blood products still a challenge
• Data capturing process of cases not efficient
• Uptake of medical / surgical interventions to control PPH still a huge gap
  • Lower c section rates in LMIC
  • uterotonics supplies erratic
  • Life saving surgical interventions for PPH not readily utilized in hard to reach areas

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What more could we learn?

• Invest in the data capturing process- HMIS

• Integrate health processes that captures both morbidity & mortality
  • evaluating maternal near miss reviews together with maternal deaths
  • The inclusion of maternal near misses in death review is necessary for a number of reasons:
    • Maternal near miss cases occur more frequently than maternal deaths which makes it easier to track progress in the quality of service delivery
    • Surviving a near miss is mainly because of the care provided such that reviewing near misses has the potential of highlighting deficiencies and positive elements in the obstetric care of any health system
    • Because the mother survives, she can provide valuable details on what she experienced
  • Blood products usage can be tailored to clinical outcomes
  • Create clinical dashboards that can reflect quality of care & workload