

# Improving quality of care in Ethiopian district hospitals through maternal death surveillance and response

*Evidence for Action-MamaYe was established in 2011 with UK aid from the UK government and continues with funding from the Bill & Melinda Gates Foundation. Our goal is to save maternal and newborn lives in Africa, through better resource allocation and improved quality of care.*

*This case is an excerpt from a collection of 22 case studies based on the experiences of the E4A-MamaYe programme, which brings to light new learning about the specific ways in which evidence, advocacy and accountability reinforce each other to bring about change.*



*Our staff and a head of hospital stand next to an ambulance received in response to an MDSR report*

Access to health care in Ethiopia has greatly improved over the past decade, with over 3,000 new health centres. More recently, some of these health centres have been upgraded to primary hospitals, making them responsible for the other health centres in their catchment area. As a result of this rapid expansion in the number of health facilities as well as women being encouraged by health extension workers to use maternity services, the skilled birth attendance rate has rapidly risen from 11%<sup>1</sup> to as high as 60% in some regions<sup>2</sup>.

Health providers in these new primary and district hospitals are under pressure to accelerate improvements in the quality of care provided, in order to convert greater skilled birth attendance into a reduction in maternal mortality. The quality of care challenge is compounded by the fact that many of these new facilities are staffed by recently qualified doctors, emergency surgical officers,

midwives and nurses - direct access to a senior obstetrician is rare.

## Description of the case

Against this background, our Ethiopia country team has supported the introduction of the National Maternal Death Surveillance and Response (MDSR) system to one selected zone in each of the Oromia and Amhara Regions, where there are three district hospitals.

MDSR is a useful tool for identifying weaknesses in the management of patients and contributing factors to maternal death. Following the analysis of cases, the changes made in response to each maternal death can improve quality of care within the health facility and the health system as a whole. Following a two day training programme using the national training package in May 2013, which we delivered alongside the Federal Ministry of Health, all three hospitals were assisted in forming MDSR committees between May and October 2013. Our regional and national advisors also participated in inaugural committee meetings, providing guidance on the identification of maternal deaths and prioritisation of responses.

Over a year later, these committees are now independent, meet regularly, keep comprehensive minutes, and have successfully embedded the MDSR process within the hospital culture. Beyond the remedial actions catalysed by better communication within the health facility itself, medical directors find that having concrete evidence of problems supports them in their request for additional resources from

health administrators. Thanks to real cases and concrete examples of gaps in referral services, they are also empowered to discuss problems with facilities in their referral system, such as inappropriate or late referrals, or poor communication between referring health centres and hospital staff.

Another unexpected effect of MDSR has been to strengthen collaboration and teamwork between different types of health professionals in the same facility, thanks to the multi-professional training and communication which MDSR requires.

## Results

At **Hospital A**, many of the deaths first reviewed were from haemorrhage, and all involved problems accessing blood for transfusion. Anti-shock garments had been available, but had not been used due to the lack of staff training. Early responses included appointing a focal person to coordinate blood supplies with the local blood bank, organising blood donation days, and training all maternity staff on the use of the anti-shock garments. More recently, the hospital has been allocated a new ambulance following the use of MDSR evidence to request improved transport.

At **Hospital B**, an early death from peripartum cardiomyopathy was reviewed and led to a multi-professional education session on cardiomyopathy, which increased awareness of the condition and the need for early diagnosis and appropriate treatment. Because this condition had previously been labelled as “unpreventable”, this case captured the interest of sceptical medical staff who became enthusiastic advocates of the MDSR system. This hospital has also constructively used information from MDSR reviews to discuss cases with its referral hospital and improve the referral system between the two. The referral hospital has been stimulated to develop its own MDSR system following the experience of Hospitals A and B.

At **Hospital C**, information from the MDSR system has been used to inform discussions at catchment area meetings between the hospital and its surrounding health centres. This in turn led to an

improved referral system, strengthening the health centres through a mentoring process. In addition, Hospital C has extended its death reviews beyond maternal deaths to include all hospital deaths and maternity near misses.

## Challenges and lessons learned

Implementing MDSR successfully and sustainably in health facilities requires a change in culture. One of the most important aspects of this is enabling a no-blame environment. The national training materials emphasise the importance of this, but ultimately, adopting an “MDSR culture” in relation to this and other aspects requires strong leadership. The medical directors in all three of these hospitals have recognised the potential of MDSR and spearheaded its implementation in their own facility.

We also noted that it may be easier and more efficient to introduce MDSR at district hospital level than at referral hospitals. At district hospitals there are fewer members of staff to engage and the inexperienced staff have less strongly developed working practices. Unfortunately, frequent staff turnover is a challenge for the continued practice of MDSR, particularly when the systems are not yet fully embedded at national level. The three hospitals described in this article are all being used as role models as the MDSR system is rolled out across Ethiopia, at all levels of the health system.

*This case study is based on data from the Ethiopia Demographic and Health Survey, Regional Health Bureau and Federal Ministry of Health, and observations of our Ethiopia team staff.*

To read the collection of E4A case studies visit: [www.mamaye.org/en/evidence/mamaye-evidence-action-stories-change-selected-case-studies](http://www.mamaye.org/en/evidence/mamaye-evidence-action-stories-change-selected-case-studies)

<sup>1</sup>EDHS. (2012). Ethiopia Demographic and Health Survey 2011. Addis Ababa/ Maryland: Central Statistical Agency/ ICF International.

<sup>2</sup>Regional Health Bureau and Federal Ministry of Health data, own analysis