Lagos State Government

USING EVIDENCE TO SAVE MOTHERS AND BABIES IN LAGOS STATE

KEY FINDINGS FROM THE STATE MATERNAL & PERINATAL DEATH SURVEILLANCE & RESPONSE ANNUAL REPORT (2018)

INTRODUCTION

This document summarises key findings from the first Lagos State Annual Maternal and Perinatal Death Surveillance and Response (MPDSR) report. Produced by the Lagos Ministry of Health together with the State MPDSR Steering Committee, this is the first report to systematically analyse the number of deaths recorded and reviewed in 2018, their causes and examples of response to findings. It identifies gaps and recommendations to inform planning and decision-making on how to improve the MPDSR process further.

WHY MPDSR?

The day of birth is potentially the most dangerous day for mothers and their babies in Nigeria. Across Nigeria, 58,000 mothers and 750,000 babies die each year before they are born or in the week after birth . Most of these losses are preventable with high-quality, evidence-based interventions.

It is important to count the number of maternal deaths, stillbirths and neonatal deaths, gather information on where and why these deaths occurred and try to understand the underlying contributing causes and avoidable factors. With this information, health-care providers, programme managers, administrators and policy-makers can help to prevent future deaths and grief for families, and improve the quality of care provided throughout the health system.

The Lagos State Maternal and Perinatal Death Surveillance and Response (MPDSR) System is the mechanism that does this. A committee of health professionals meet regularly at hospitals and at State level to examine the information about the circumstances around every death and make recommendations about what actions need to be taken to prevent future deaths happening due to similar reasons.

A MATERNAL DEATH

is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

A PERINATAL DEATH

is a foetal death (stillbirth) or an early neonatal death within the first week of life.

HOW MANY MOTHERS AND BABIES' DEATHS WERE NOTIFIED AND REVIEWED IN 2018?

- Among 279 maternal deaths notified across the State, 222 (80%) were reviewed.
- Among 1,128 perinatal deaths notified, 839 (74%) were reviewed.

ON AVERAGE, 5 MATERNAL DEATHS & 22 PERINATAL DEATHS WERE RECORDED EACH WEEK IN 2018.

WHO WERE THE MOTHERS?

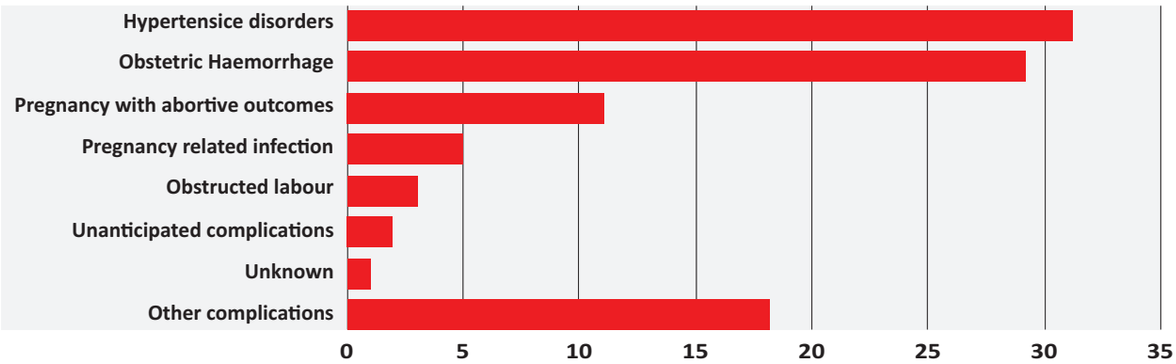
The majority of women were married **(95%)** and most lived in urban **(52%)** or peri-urban areas **(23%)**. Close to a quarter lived in rural areas **(23%)**. Level of education was unknown for half of the women, and half had completed primary school education at minimum.

While only **10%** of the maternal deaths reviewed were among women in their first trimester (≤12 weeks) of pregnancy, only a third of women **(28%)** had any antenatal care recorded and information on antenatal care was missing for more than a third **(36%)** of the records.

Among the maternal deaths reviewed, more than a third of mothers died during pregnancy **(35%)**, and **63%** died during labour **(11%)** or in the postpartum period **(51%)**. Whilst **48%** were attended to by a skilled health professional, **6%** did not have a skilled birth attendant with them during delivery or were delivered by a Traditional Birth Attendant. The birth attendant was unknown or not recorded for **46%** of cases.

The leading primary underlying cause of death was related to hypertensive disorders during pregnancy childbirth and the puerperium **(31%)**, followed by obstetric hemorrhage **(29%)**. Pregnancy with abortive outcomes was the third most common cause of maternal mortality **(11%)**. 'Other complications of pregnancies' such as anaemia, sickle cell anaemia, tuberculosis, HIV/AIDS, malaria and diabetes' were cited for **18%** of deaths.

CAUSES OF MATERNAL DEATHS (%)



WHY ARE BABIES DYING?

Among the perinatal cases for which we have records, more than a tenth of deaths **(13%)** were among newborn babies and **7%** were stillbirths. For **8** out of **10** cases, the timing of the death was not recorded. We do know that at least **40** of the stillbirths occurred during labour.

Birth asphyxia was the leading cause of perinatal mortality in over a third **(35%)** of the live births. Prematurity was a leading complication among **17%** of the deaths, and neonatal sepsis and jaundice were causes of death among **7%** and **6%** of babies, respectively. Other conditions recorded as causes among **17%** of babies included maternal complications (such as heavy bleeding, anaemia or hypertensive disorders), prolonged labour or cord prolapse.

OF ALL THE PERINATAL DEATHS CAPTURED IN MPDSR IN 2018:

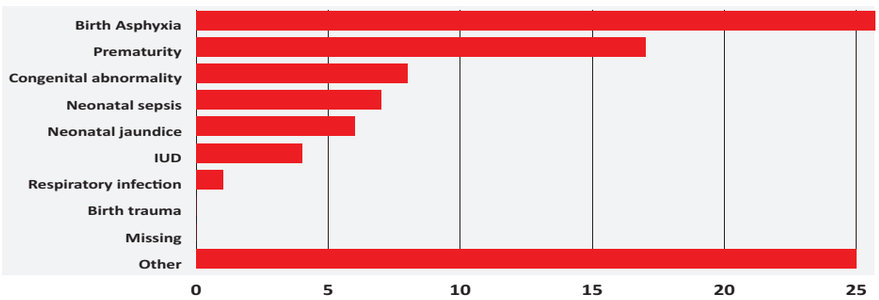
74%
of deaths notified, were reviewed

18%
faced delays in decision making to seek care

46%
faced delays in receiving care

35%
died from birth asphyxia

CAUSES OF PERINATAL DEATHS (%)



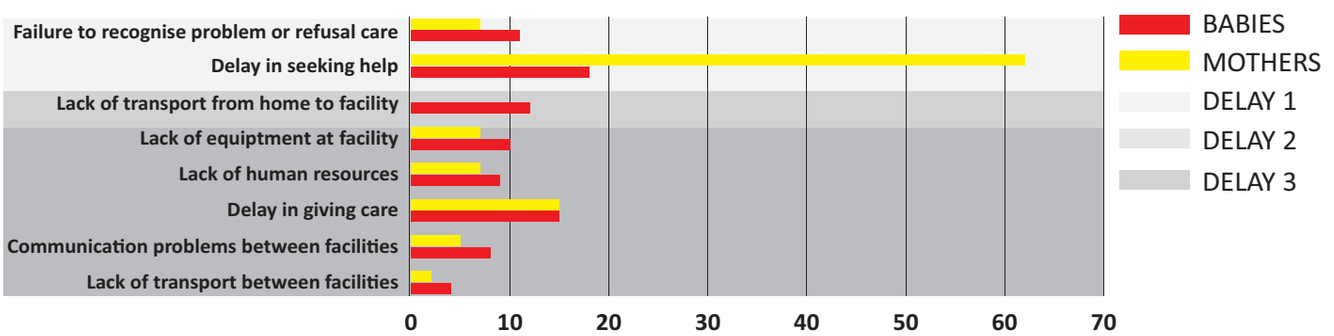
DELAYS IN ACCESSING CARE

Causes of maternal and perinatal deaths are often linked to a delay in accessing skilled health care due to one of three delays:

1. Delay in deciding to seek care
2. Delay in reaching adequate care
3. Delay in receiving adequate care.

Delays in seeking or accessing care were reported in all maternal and perinatal cases. Most often due to a delay in the mother seeking care.

DELAYS CONTRIBUTING TO DEATHS (%)



ACTIONS IN RESPONSE TO MPDSR DATA

A crucial component of the MPDSR is "response". In 2018, several actions were implemented by health facilities and the State MPDSR Steering Committee to address findings identified during MPDSR review meetings. Anonymized examples include:

- Strengthened collaboration between hospital units: In response to MPDSR data, protocols were established to ensure both Obstetric and Gynecological (O&G) and pediatric units participate in managing high risk deliveries.
- Redistribution of specialist health workers to address identified trends in maternal deaths. In response to data which showed particularly high maternal mortality among sickle cell patients, the State MPDSR Steering Committee recommended that available hematologists at larger hospitals should run weekly clinics in all hospital units and co-manage pregnant sickle cell women with their O&G specialist from the antenatal care stage.
- The introduction of the "catastrophe pack" which includes resuscitation packs, theatre caesarean section packs and 'red tags' to authorize immediate treatment for anyone deemed high risk without asking questions. This pack was introduced after MPDSR review meetings identified significant delays in starting treatments while waiting for relatives to provide blood or pay for treatment.
- Training for Traditional Birth Attendants (TBAs) to recognize the danger signs of pregnancy and when to refer. This was introduced based on MPDSR findings that several deaths faced delays at stage 1 – the decision to seek care. Following investigation, health workers concluded that the lack of knowledge among Traditional Birth Attendants meant they did not refer women for care. Monthly training meetings with TBAs aimed to address this issue. The hospital also made the ambulance available to TBAs to faciliate better referral from the TBA's residence to hospital.

RECOMMENDATIONS

Based on the findings from this report, the Lagos State MPDSR Steering Committee made many recommendations. We present here some of the most important:

INVEST IN HEALTH WORKERS:

- Assess gaps in skills among health professionals to manage emergency obstetric and newborn care and implement certified refresher training of all health professionals who deliver babies in public and private facilities.
- Secure funds and scale-up training of all skilled health personnel on "Helping Babies Breathe" to reduce deaths due to birth asphyxia
- Invest in human capital by addressing shortages of skilled personnel in the maternity and new-born units.

STRENGTHEN LINKS BETWEEN HEALTH PROVIDERS AND COMMUNITIES:

- Review current maternal health promotion approaches to identify where these can be adapted to increase awareness of the importance of attending antenatal care and of risk factors and signs of pregnancy complications.

IMPROVE QUALITY OF CARE AND EMERGENCY SERVICES:

- Strengthen referral linkages between communities including Traditional Birth Attendants, private and public facilities and hospitals including with better referral documentation and communication.
- Explore the cost-effectiveness of facility interventions in response to MPDSR, such as introduction of the 'catastrophe packs'. Based on this decide on scale up to all secondary and tertiary hospitals.
- Strengthen health worker skills to provide post-abortion care to manage complications after abortions.
- Assess and fill gaps in availability of supplies needed to manage obstetric haemorrage and hypertensive disorders in pregnancy.
- Investigate reasons behind women dying from blood loss and decide on interventions to prevent these deaths.

STRENGTHEN THE MPDSR SYSTEM:

- Invest manpower and time to improve reporting of all deaths and to improve the information available from reviews of all maternal and a sample of perinatal deaths, including stillbirths. Reviews among perinatal deaths should include information describing the condition of the mother at the time of death.
- Introduce 'zero' reporting where facilities must confirm if there were no deaths in a given time.
- Conduct routine quality checks on the information inputted in the electronic MPDSR platform for completeness and accuracy.
- Involve budget planners in the death review meetings and system to ensure evidence from reviews informs budget planning and disbursement.
- Expand the death review system to include private health facilities and communities.

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