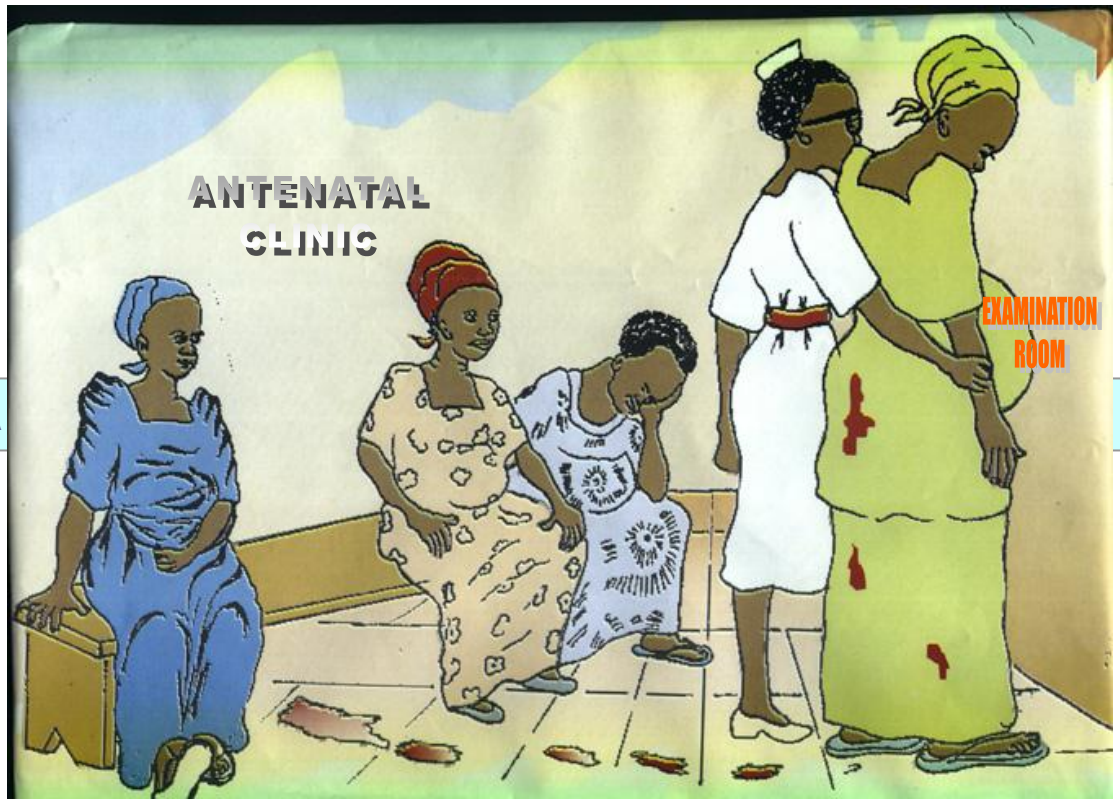
REPUBLIC OF UGANDA

STRATEGIC PLAN

MATERNAL, PERINATAL AND CHILD DEATH REVIEW



2009/10 - 2014/15

Reproductive Health Division

Ministry of Health

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GLOSSARY

The broad definitions of maternal death together with the current classifications of direct and indirect causes as defined in the International Classification of Diseases 10th edition (ICD-10)[2] are almost universally used.

Maternal death (*ICD 10)*

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

Pregnancy-related death

A pregnancy-related death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death

Late maternal death

A late maternal death is the death of a woman from direct or indirect causes more than 42 days but less than one year after termination of pregnancy

Maternal deaths are subdivided into two groups

1. **Direct obstetric deaths**: Direct obstetric deaths are those resulting from obstetric complications of the pregnancy state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above
2. **Indirect obstetric deaths**: Indirect obstetric deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy

Maternal Mortality Ratio: The number of maternal deaths from pregnancy-related causes per 100,000 live births.

Still births: babies born dead after 28 weeks of gestation

Still birth rate: The annual number of babies born dead after 28 weeks of gestation (late fetal deaths) per 1,000 total births.

Neonatal deaths: Number of neonatal deaths (deaths in the first 28 days of life) per 1,000 live births.

Neonatal Mortality Rate: the number of neonatal deaths per 1,000 live births.

Early neonatal deaths: deaths that occur in the first week of life.

Late neonatal deaths: deaths that occur between the second and fourth weeks, i.e. from days 7 to 28.

Newborn refers to newborn baby and does not have a specific time period definition, but is often assumed to refer to the first few days but sometimes up to one month of life.

Perinatal death: death of a baby from 28 weeks gestation up to the first 7 days of life

Under Five Mortality: death between birth and exactly five years of age.

Under Five Mortality Rate: Probability of dying between birth and exactly five years of age, expressed per 1,000 live births.

Maternal death notification. This is confidential information sent to the Ministry of Health. A maternal death notification form is completed as soon as a death is confirmed and the person responsible for department or health unit is notified within 24 hours. The notification form is completed by a health care provider who is registered and licensed to practice by any of the Health Care Professional Councils. In exceptional circumstances, notification may be done by other person mandated by the local authorities but the form is countersigned by a supervisor. The DHO and the Ministry of Health are notified of a maternal death within 7 days. In Uganda, maternal death notification is a requirement as per the bill passed in Parliament in December 2006. Maternal deaths are also reported through HMIS system.

Facility maternal, perinatal and child death audits. This is an impartial procedure. All health workers in the facility where a maternal, perinatal or child death occurs participate in reviewing circumstances around the death using audit guidelines and tools. The head of department/ unit and Health Unit Management are represented at the audit meeting. Participation of health workers involved in care of

the deceased has the potential to make them learn from omissions leading to the death and is likely to lead to better management of similar cases in future.

Confidential enquiry into maternal and perinatal deaths (no names, no blame) is usually carried out for only a proportion of maternal/ perinatal deaths. The regional audit team or the National Committee makes the arrangements for the confidential inquiry. It involves:

- Use of completed notification form, completed audit form and photocopies of all clinical or case notes with all health personnel identifications blotted out (white washed) but replaced by their professional titles such as doctor, nurse, midwife, anaesthetic officer etc. These are given to (two) independent assessors
- Assessors make independent assessment of the case by studying all these documents and working closely with the members of the MPDR committee at the appropriate level (district, HSD and facility level)Additional information may be obtained by visiting the health facility or telephone contact with health facility management and /or the team involved in patient care
- The Assessors then submit report to health facility (feedback), the district and to the regional and national committees to make take appropriate action.
- All photo copied clinical notes with the independent assessors are submitted to the regional audit team (for destruction).

Medical legal issues

It is important to note that the purpose of audits and confidential enquiry (peer review) is **NOT** to identify individuals who have made mistakes in the management of the client/ patient. Therefore information obtained from audits and confidential enquiry **cannot** be used for medical legal purposes. Issues of professional negligence are handled and dealt with by the health facility management, at district and other appropriate bodies such as the professional councils, courts of law etc.

CHAPTER 1

1.1 INTRODUCTION

The occurrence of maternal, neonatal, perinatal and child deaths in Uganda is a major concern of the Government and all stakeholders. Three quarters of the neonatal deaths occur in the first week of life while the highest risk of death is in the first 24 hours of life. The major causes of newborn deaths include asphyxia, infections and complications of preterm birth. Generally, perinatal mortality has been linked to poor quality of intra-partum care.

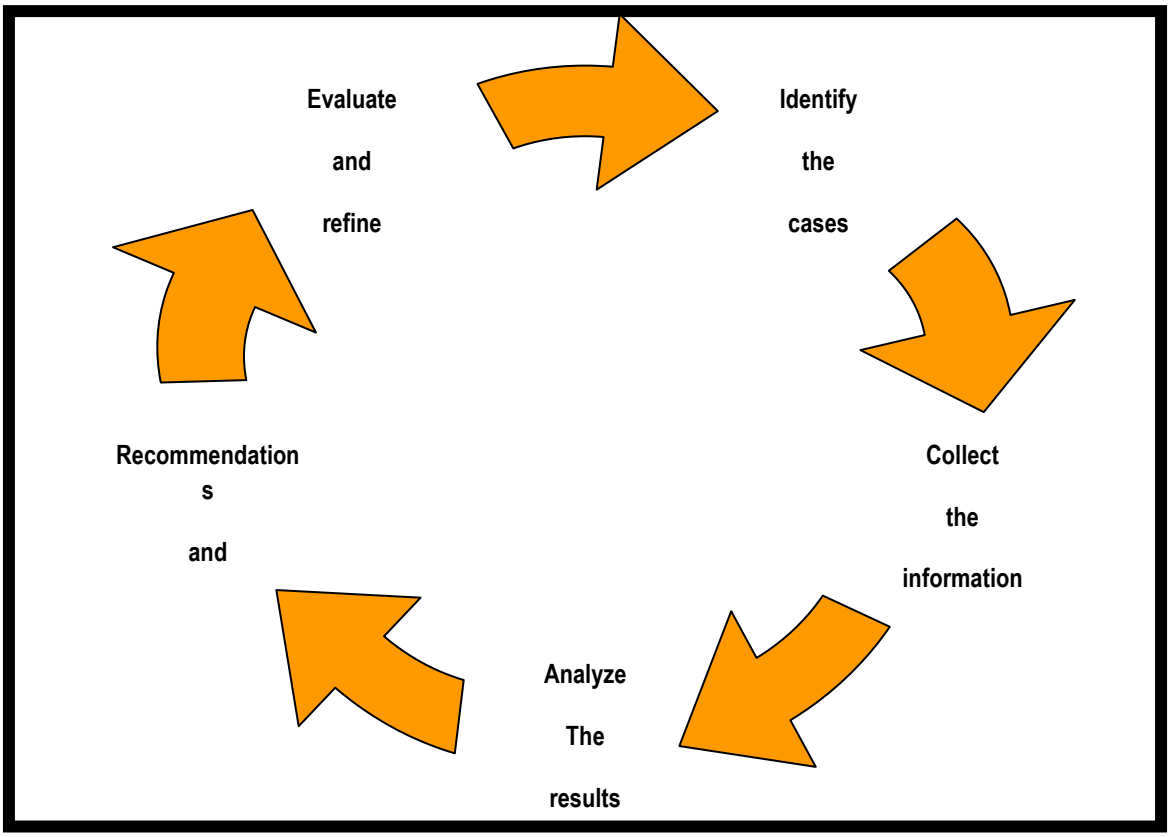
Maternal death is caused by either complications that develop directly as a result of pregnancy, delivery or the postpartum period (a "direct obstetric death"), or due to an existing medical condition (an "indirect obstetric cause"). The major direct obstetric complications responsible for maternal deaths in Uganda include bleeding, infection, obstructed labour, unsafe abortion and hypertensive diseases. About 15% of all pregnancies develop life-threatening complications and require emergency obstetric care. If these mothers do not access appropriate medical attention in time, they die.

There are several avoidable factors that contribute to the above maternal complications. These have been grouped into:

- Socio-economic and cultural factors (especially related to the household/ family level).
- Factors relating to accessibility of health facilities by pregnant women with pregnancy/ labour complications.
- Factors around Quality of care which includes timeliness in receiving care at the health facilities.

A critical analysis of the above issues after every maternal death should guide the health facilities, districts and the Ministry of Health to pin point the major factors contributing to maternal deaths and design appropriate interventions to prevent or contain future maternal, perinatal and child deaths and morbidity.

Figure 1: **AUDIT (Surveillance) CYCLE**



1.2. JUSTIFICATION

Auditing of deaths is an important way of monitoring quality of health care. A systematic review of deaths (audits and confidential enquiry) can facilitate identification of health systems failures/gaps and social cultural issues that contribute to death. Actions to address the gaps can reduce on the burden of mortality.

The purpose of Maternal, Perinatal and Child Death Reviews (MPCDR) is to identify major causes of death and the associated risks and /or avoidable factors. Solutions to the avoidable factors can be then be worked out jointly by all those involved in caring for mothers and children. An effective audit process leads to better health care, improved accountability for the health of babies and mothers and reduction in Maternal and perinatal morbidity and mortality.

1.3 SWOT ANALYSIS

Table 1 : Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT Analysis) for MPCD auditing

Strength	**Weakness**
Coordination: • National Maternal Perinatal Death Review (NMPDR) Committee is functional • In some health facilities MPDR committees have been established and some are active Institutional framework: • Commitment and support from MOH Top and Senior management Maternal and Child health cluster provides a good forum for discussion and follow up of MPCDA issues Training: • Some health workers are already sensitized and trained in some form of death audits Policy environment, strategies and guidelines: • Accountability for poor maternal and perinatal indicators required by legislators • Existence of other supporting strategies (Roadmap, HSSP, Child Survival Strategy) • HMIS functional in all health facilities • Some guidelines and protocols exist (on management of maternal complications, child survival) • Newborn care standards exist MPDR Tools • Perinatal death audit tool not user friendly	Coordination: • Some permanent members of National MPDR committee do not regularly attend meetings • MPDR committees are not yet existing at district level Institutional framework: • Poor Health systems inadequate qualified personnel medicines, supplies, basic equipment instruments, tools e.g partograph) Policy environment, strategies and guidelines: • Standards of care not detailed enough • Some Management protocols not up to date • Partogragh use is poor 1% in facilities and limited in training schools Implementation • Where maternal audits have been conducted there has been limited follow up action/intervention to address the avoidable factors • Funding for implementing some of the recommendations is usually lacking • Failure by the service providers to use the guidelines • Many maternal deaths are neither notified nor audited • Many service providers have a poor attitude towards auditing Data Management: • Poor documentation of health care particularly for the babies • Poor record storage (patient files) Training: • Many health workers are not yet trained on auditing :MPDR tools • Irregular supply of tools for notification and auditing
Opportunities	**Threats**
Advocacy: • Interest and commitment from H.E the President and	Institutional framework: • Lack of resources (Human resource for health, receding funding allocation

parliamentarians, civil society and professional associations • Strong international momentum on continuum of care for Maternal Newborn and Child care and increased resources • Advocacy for increased funding of RH is beginning to bear fruit Partnerships: • Sensitized stakeholders (Professional associations, Parliament, Pop Sec, WHO, UNFPA, UNICEF, HCPAs, civil society including the media etc) • International interest and support towards the attainment of the MDGs • Existence of global initiatives with funding (Global fund, PEPFAR, PIM)	to the health sector inspite of growing population) • Human resources shortages and poor distribution • Numbers of deaths very high; therefore big volume of auditing especially for newborns Community: • The Community expectations of the audit outcomes tends towards criminal persecution. Pressure to apportion blame • Inaccessibility of some communities to health facilities based services

CHAPTER 2

2.1 : GOAL

The overall goal is to accelerate reduction of maternal , newborn and perinatal mortality and morbidity.

2.2 : VISION

No woman in pregnancy, childbirth or postpartum period nor newborns or children in Uganda should die from avoidable factors within the next 5 years**.**

2.2.1: MISSION

Through audits of maternal, perinatal and child deaths, lessons learnt are used to provide information to be used to improve health care for the most vulnerable members of the community and to reduce morbidity and mortality.

2.3 OBJECTIVE

1. To increase the availability, accessibility and utilization of quality skilled care during pregnancy, childbirth and postnatal and childhood.

2.4 STRATEGIES

- Strengthen capacity for delivery of quality MCH care services including auditing of deaths
- Advocate for increased resources for maternal perinatal and child death auditing
- Establish monitoring and evaluation mechanisms for perinatal , child and and maternal death notification and auditing

2.6 ACTIVITIES/ PRIORITIES

- Review MPDR guidelines and tools
- Procure audit and notification tools, guidelines, job aides, protocols, MNCH tools e,g partographs,
- Conduct training on maternal and perinatal death auditing and notification at all levels of health care.
- Review , produce and distribute guidelines/protocols for delivery of quality MNCH services
- Develop, produce and disseminate minimum standards for newborn care and Emergency Obstetric care.
- Update skills of Service providers in MNCH service delivery/ Conduct CMEs and apprentiship for key MNCH staff
    - LSS, Care of newborn, use of partographs, logistics management
- Develop, produce and disseminate MNCH IEC materials
    - -Cascade training on maternal and perinatal death audits and notification
- Procure office equipment, vehicles, telephone, internet linkages to support MPDR at the appropriate levels.
- Establish MPDR budget line for implementing recommended remedial actions of MPDR
- Establish Maternal and Perinatal Death Review committees at all levels (National, regional and facility)
- Conduct Health facility based perinatal death audits and maternal death notification and audits.
- Implement remedial interventions/ measures to prevent avoidable deaths as per MPDR recommendations
- Procure and distribute essential medical equipment, medicines and supplies

- Analyze MPDR data and prepare MPDR reports
- HMIS Weekly report on maternal deaths(surveillance)
- Conduct confidential enquiry for selected maternal, perinatal and child deaths
- Document and disseminate findings and experiences of Maternal and perinatal death audits.
- Prepare quarterly and annual MPDR reports at different levels
- Develop advocacy materials
- Conduct advocacy meetings for key stakeholders, policy makers and leaders
- Mobilize resources for MPDR recommended actions
- Mobilize and sensitize communities about MNCH services.
- Conduct technical support supervision , monitoring and follow up
- Conduct regular MPDR coordination committee meetings
- Quarterly briefing meetings for Senior and Top management/ disseminate MPDR/ conf. inquiry findings
- Conduct annual reviews / stakeholders meetings for improving quality of care at all levels

GUIDING PRINCIPLES FOR DEATH AUDITS AND CONFIDENTIAL ENQUIRY

- Death audits are not for apportioning blame
- Confidential enquiry should be based on "No name and no blame" principle
- All stakeholders should be involved in seeking solutions
- All stakeholders should be committed to follow and implement the full audit cycle
- Death audit must promote team work and accountability

CHAPTER 3

3.1 IMPLEMENTATION PLAN

3.1.1 INSTITUTIONAL ARRANGEMENTS

The community Health department, specifically reproductive Health division will coordinate the implementation of this plan in close collaboration with department of Clinical services and Quality Assurance. The Community Health department will ensure that each key player's role is clearly defined and that relationships and linkages are harmonized for maximizing resources.

NATIONAL COMMITTEE FOR MATERNAL, PERINATAL AND CHILD DEATH AUDITS (NCMPCDA)

Roles of the NCMPCDA

- Receive and analyze completed notification forms of all maternal deaths from the Health facilities in Uganda
- Advocate for maternal, newborn and child death audits
- Identify and Facilitate Independent assessors to carry out confidential enquiries
- Facilitate Confidential enquiry of maternal and perinatal deaths
- Compile quarterly and annual audit reports at national level
- Disseminate confidential enquiry and audit reports appropriately
- Mobilize resources for systems strengthening and MPDR

HEALTH FACILITY COMMITTEE FOR MATERNAL, PERINATAL AND CHILD DEATH AUDITS

Roles of the Health Facility Committee for MPDR

- Complete and send notification forms of all maternal deaths from the Health facilities in Uganda
- Conduct maternal, newborn and child death audits
- Compile quarterly and annual audit reports.
- Document experiences of MPDR
- Provide MPDR records to independent assessors when they are required

- Take appropriate action at the facility and within community; based on recommendations from the audit
    a. Identify appropriate departments/stakeholders based on audit findings and recommend to the Health Sub-district, district and National Committee
    b. Provide information to promote health within the communities
    c. Encourage and support health care service providers and other stakeholders to implement recommendations from audit findings

OTHER STAKEHOLDERS

To render the maternal and child health reviews effective, other stakeholders need to bebrought on board to support the process of strengthening care of mothers, newborns and children. These include AOGU, WHO, UNFPA, UNICEF, NGOs, CSO, FBOs, Medical and councils, Parliamentarians, local leaders and cultural leaders. Depending on comparative advantage, stakeholders will be involved in legislation, policy making, mobilization of resources and strengthening capacity for death auditing at the different levels of the health care system but generally roles of stakeholders will be:

- Advocate for supportive policies
- Advocate for provision of increased funding for RH
- Provision of Technical support, funds, materials.
- Sensitize and mobilize communities.
- Implement the MPDR strategic plan

3.1.3 ADVOCACY FOR THE STRATEGIC PLAN

In order to secure technical and financial support for this strategic plan, the plan will be presented to all stakeholders. These will include the Maternal and Child Health (MCH) Cluster, the Minimum Package Working Group, Senior management of the Ministry of Health that are charged with approval and endorsement. It will then be introduced to the Health Policy and Advisory Committee (HPAC) for the purpose of resource mobilization. After that, various fora will be used to market the plan and inform other stakeholders about it.

3.1.4 MONITORING AND EVALUATION OF MPDR STRATEGIC PLAN

Monitoring of this strategic plan will be accomplished partly through regular technical support supervision on all aspects of the Maternal, Perinatal and child death audit implementation at all levels.. There will be systematic collection and analysis of data to render implementation of death reviews useful at all levels. Data analysis will done both manually and electronically in order to obtain information across districts and nationally and to assess trends.

The sources of data for the above indicators will comprise of Routine HMIS, field monitoring and supervision activity reports, confidential enquiry reports, MPDR notifications and maternal and perinatal death review reports and surveys. Regular meetings to review and report on progress on the implementation of the death reviews will be conducted. Quarterly and annual review meetings will be held to use findings of MPDR for improvement in care as well as implementation of Maternal Perinatal Child Death Reviews. The monitoring and evaluation framework of the Health sector strategic plan 111and the road map will be adopted although additional indicators of performance will be monitored.

Core indicators are as follows:

- Number of maternal and Perinatal deaths

- Percentage of maternal deaths notified
- Percentage of maternal and perinatal deaths audited
- Functionality of MPDR Committees at various levels
- Number of recommended remedial interventions implemented
- Availability of MPDR tools

  Quality of care:

  - Percentage of health facilities with recommended human resource in place:
  - Skilled attendant at delivery
  - 24 hour Anaesthesia services available at HC IVs and hospitals
  - Availability and use of EmOC supplies and equipment
  - Percentage of HSDs with functional referral mechanisms
  - Availability of equipment for resuscitation of newborns
  - Availability and use of relevant guidelines and tools (e.g. partographs for monitoring labour, newborn emergencies management guideline)

LOGICAL FRAMEWORK AND BUDGET FOR THE MATERNAL AND PERINATAL DEATH REVIEW STRATEGIC PLAN 2009 / 10- 2014/15

Objective:

To increase availability, accessibility and utilization of quality skilled care during pregnancy, childbirth postnatal and childhood

Strategies:

1. **Strengthen capacity for delivery of quality MNCH care services including auditing of deaths**
2. **Establish monitoring and evaluation mechanisms**
3. **Advocate for increased resources for Emergency obstetric and new born care**

	Activity	**Out put**	**Responsible Agency**	**Funds Required Ug.Shs-(' 000' Millions)**
1	Establish MPDR committees at all levels	MPDR committees in place	MOH, DHOs	
2	Develop, review and produce audit training guidelines	Training guidelines	MOH	50
3	Conduct cascade training on maternal and perinatal death audits and notification	Trainings conducted	MOH, DHT, AOGU	100
4	Follow up trainees through support supervision	Supervision Reports	MOH, DHT, AOGU	75
5	Procure/ distribute audit and notification tools, office equipment, vehicles, telephone, internet linkages at the appropriate levels	Tools, services and equipment procured.	MOH	500

	Activity	**Out put**	**Responsible Agency**	**Funds Required Ug.Shs-(' 000' Millions)**
6	Conduct Health facility based perinatal death audits and maternal death notification and audits.	Audit and notification reports	Health Facilities MPDR committee	100
7	Conduct confidential enquiry for maternal, perinatal and child deaths	Regional and Central Audit reports	Regional and Central teams	75
8	Put in place intervention measures to prevent avoidable deaths (training, procurements, guidelines and protocol development	Action plan reports	HF, DHT, HSD, MOH, NGOs, DPs	1000
9	HMIS Weekly report (surveillance)	Surveillance reports	HF, DHT	20
10	Analyze audit reports	audit reports	HF, DHT, Regional team, MOH	75
11	Document findings of the audits	Reports	MOH, DHT, HF	20
12	Advocacy to key stakeholders, policy makers and leaders	Meetings conducted	MOH, DHT, NGOs, AOGU	20
13	Mobilize and sensitize communities about RH services.	Meetings conducted	HF, DHT, HSD, MOH, NGOs, AOGU	800
14	Develop, produce and disseminate IEC and advocacy materials in RH	IEC materials	MOH	500
15	Conduct technical support supervision	Supervision reports	HSD, DHT, MOH	100

	Activity	**Out put**	**Responsible Agency**	**Funds Required Ug.Shs-(' 000' Millions)**
16	Conduct regular committee meetings	Meeting reports	HF and National MPDR committees	154
17	Monitoring and supervision visits	Activity reports	MOH, DHT, HSD, HF in-charge	80
18	Quarterly and annual review meetings	Activity report	MOH, DPs, DHT, NGOs	10