Posted on August 24th 2011

Evaluating the quality of care for severe pregnancy complications: the WHO near-miss approach for maternal health.

Published by WHO, 2011

Download the full PDF publication from: http://whqlibdoc.who.int/publications/2011/9789241502221_eng.pdf

"A maternal near-miss case is defined as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy" (7,11). In practical terms, women are considered nearmiss cases when they survive life-threatening conditions (i.e. organ dysfunction)."

The report briefing is presented below.

Summary

"In any setting, women who develop severe acutecomplications during pregnancy share many pathological and circumstantial factors. While some of these women die, a proportion of them narrowly escape death. By evaluating these cases with severe maternal outcomes (both "near-miss" cases and maternal deaths), much can be learnt about the processes in place (or lack of them) for the care of pregnant women. This guide is intended to be used by health-care workers, programme managers and policy-makers who are responsible for quality of maternal health care within a health-care facility or the health system. It presents the WHO maternal near-miss approach for monitoring the implementation of critical interventions in maternal health care and proposes a systematic process for assessing the quality of care…………………………………..."

"…………………………..However, given the lack of financial resources and skilled health-care professionals in many low and middle-income countries, there is a risk that such policies may lead to overloading of healthcare facilities, which could have serious implications for the overall quality of care provided by those facilities. In addition, for many low- and middle-income countries, the model of facilitybased care for all births is still unrealistic and unaffordable in the short to medium term. A more feasible and cost-effective approach might be to aim at reducing delays in the provision of effective care (including community-based actions) for all pregnant women with complications……… In order to ensure that the evaluation of quality of care with the near-miss approach is comprehensive, a set of process indicators has been developed or adapted based on the concept of criterion based clinical audit, which is considered to be a feasible and beneficial method of auditing the quality of maternal health care (*9*). These process indicators assess the gap between the actual use and optimal use of high-priority effective interventions in the prevention and management of severe complications related to pregnancy and childbirth……………………"

"……………..It presents a standard approach for monitoring the implementation of critical interventions in maternal health care and proposes a systematic process for assessing the quality of care. In its entirety, the included methods and related processes constitute the WHO maternal near-miss approach………….. Implementation of this approach in health services will serve to: • determine the frequency of severe maternal complications, maternal near-miss cases and maternal deaths; • evaluate a health-care facility's or the health system's performance (depending on the health-care level at which the approach is implemented) in reducing severe maternal outcomes; • determine the frequency of use of key interventions for the prevention and management of severe complications related to pregnancy and childbirth; and • raise awareness about, and promote reflection of, quality-of-care issues and foster changes towards the improvement of maternal health care…………………"

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Cuban Maternity Homes: A Model to Address At-Risk Pregnancy

Author: Conner Gorry MA

Published in *MEDICC Review*, July 2011, Vol 13, No 3.

Download the entire article from: http://www.medicc.org/mediccreview/articles/mr_203.pdf

"Like a tropical lullaby, the rocking chairs lay down a languid rhythm accompanied by laughter, bits of gossip, and gripes about the heat. Olga Lydia, 39, anemic, and preparing to give birth to her first child, wonders aloud what it will be like to have a son, when in her heart of hearts she wanted a daughter. Meanwhile, Loreta, 18, and expecting twins, rocks quietly alongside, a smile on her flawless face.

Olga Lydia and Loreta are two of the more than 67,000 at-risk expectant mothers[1] served by Cuba's network of over 300 maternity homes, receiving comprehensive care and childbirth education in either live-in or ambulatory modalities. Since the first 15 such homes were founded in 1962 in the eastern part of the country, the system has evolved into a national program employing a uniform practice for women presenting certain risk factors during pregnancy. The strategy has helped the country achieve a nearly 100% in-hospital birth rate[2] and lower infant and maternal mortality rates, and partly explains why Save the Children ranks Cuba as the number one developing country in which to be a mother…."

Fostering Equity, Facilitating Access

"…………..In the initial stages of the maternity home program in the 1960s, the single criterion for referral was geographic, with expectant mothers from remote rural areas living in maternity homes located near hospitals for all or part of their pregnancy. Rather than embed these

facilities in traditional health care settings, existing houses were re-purposed and re-conditioned to create a familiar, home-like environment where the health and wellbeing of mother and fetus could be monitored. By providing basic medical services, physical and recreational activities, and health promotion and education in a comfortable setting, the aim was for "expectant mothers to reach their delivery date in optimal health"……………………………. The strategy worked. These first maternity homes, together with aggressive training of doctors and other health professionals and an increase in the number of maternity hospitals, had a signifi cant early impact on maternal and infant mortality……..Another stage in the program began in the 1990s during Cuba's severe economic crisis, when generalized food scarcity translated into insuffi cient weight gain for many pregnant women and a corresponding increase in rates of low birthweight newborns:………………… By 1996, low birth weight babies once again constituted only 7.3% of the total, and the percentage continued to decline over the rest of the decade, standing at 5.4 in 2010; infant mortality, which increased from 9.4 to 9.9 per 1000 live births between 1993 and 1994, began consistently decreasing, reaching 6.5 by 1999 and reaching 4.5 in 2010……….."

Current Approach

"Today, each of the 327 maternity homes across the country follow uniform practice guidelines designed by the Ministry of Public Health's Maternal-Child Health Program, in collaboration with UNICEF…………………… "What's especially important is early detection of at-risk pregnancies and transfer to a maternity home at the appropriate stage so that if complications arise, the mother is close to the services she and her baby need,"."

Caring for Mothers, Preparing for Birth

"Whether she hails from inner city Havana or the remote Sierra Maestra mountains, once a woman steps through the doors of a maternity home, she receives comprehensive care from a multidisciplinary team……..Another fundamental step in the admission process is an in-depth nutritional analysis. Using the woman's clinical history, body mass index, mid-upper arm circumference measurement, and body weight, the nutritionist designs a diet based on the FAO and WHO recommendations for caloric, vitamin, and mineral intake for pregnant and lactating women, adjusted for Cuban norms and the individual needs of each woman……………………………..Social workers also form an integral part of the maternity home team, particularly when women are admitted due to social circumstances including lack of family support for the pregnancy, an overcrowded home, and apparent gender or other inequities within the family unit."

Challenges Ahead

“While infant mortality is now under 5 per 1000 live births—comparable to rates in industrialized countries[9]—and low birth weight newborns are just 5.4%,[1] Cuban health authorities and professionals are less satisfied with progress in consistently reducing maternal mortality. In 2010, the maternal mortality ratio was 43.1 (per 100,000 live births); 29.7 in direct maternal mortality, and 13.3 indirect—well below the 85 registered in 2008 for Latin America and the Caribbean, but still considered unsatisfactory.[10]…………………………………… Over its nearly 50-year trajectory, Cuba’s community-based maternity home network has been found a cost-effective approach contributing to reductions in infant and maternal mortality, and in incidence of low birthweight newborns. Perhaps the day will come when staving off boredom is the biggest worry for pregnant women the world over—especially for expectant mothers in the Global South, where maternal mortality still stands at nearly 300 per 100,000 live births[10] with infant mortality in 2009 running as high as 134 per 1000 live births in Afghanistan and up to 126 in Sub-Saharan Africa.”

Posted on: 18th August 2011

Shared by Mr.Anant, CH Member

Oral misoprostol for preventing postpartum haemorrhage in home births in rural Bangladesh: how effective is it?

Hashima-E Nasreen, Shamsun Nahar, Mahfuz Al Mamun, Kaosar Afsana, Peter Byass
(Published: 10 August 2011)

Source for full article:
http://www.globalhealthaction.net/index.php/gha/article/view/7017/9895

“Evidence exists about prevention of postpartum haemorrhage (PPH) by oral administration of misoprostol in low-income countries, but effectiveness of prevention by lay community health workers (CHW) is not sufficient. This study aimed to investigate whether a single dose (400 μg) of oral misoprostol could prevent PPH in a community home-birth setting and to assess its acceptability and feasibility among rural Bangladeshi women. Methods: This quasi-experimental trial was conducted among 2,017 rural women who had home deliveries between November 2009 and February 2010 in two rural districts of northern Bangladesh. In the intervention district 1,009 women received 400 μg of misoprostol immediately after giving birth by the lay CHWs, and in the control district 1,008 women were followed after giving birth with no specific intervention against PPH. Primary PPH (within 24 hours) was measured by women’s self-reported subjective measures of the normality of blood loss using the ‘cultural consensus model.’ Baseline data provided socio-economic, reproductive, obstetric, and bleeding disorder information. Findings:

The incidence of primary PPH was found to be lower in the intervention group (1.6%) than the control group (6.2%) ($p<0.001$). Misoprostol provided 81% protection (RR: 0.19; 95% CI: 0.08-0.48) against developing primary PPH. The proportion of retained and manually removed placentae was found to be higher in the control group compared to the intervention group. Women in the control group were more likely to need an emergency referral to a higher level facility and blood transfusion than the intervention group. Unexpectedly few women experienced transient side effects of misoprostol. Eighty-seven percent of the women were willing to use the drug in future pregnancy and would recommend to other pregnant women. Conclusion: Community-based distribution of oral misoprostol (400 µg) by CHW appeared to be effective, safe, acceptable, and feasible in reducing the incidence of PPH in rural areas of Bangladesh. This strategy should be scaled up across the country where access to skilled attendance is limited………"

Citation: Global Health Action 2011, *4*: 7017 - DOI: 10.3402/gha.v4i0.7017

Posted on: August 18th 2011

Maternal Health Review Guidebook from NRHM and some of the useful tools from Immpact, that explain the various ways to measure maternal mortality using different tools in different settings such as key informants technique, within institutional settings, and interviewing women where they are present in large numbers, as in a health facility. Please find more details and download corresponding files from the source websites.

Maternal Death Review Guidebook

Source: http://rrcnes.gov.in/pdf_ppt_zip/mdr_handbook.pdf

"This handbook has been developed to assist nodal officers of the states and districts in the implementation of Maternal Death Reviews (MDR), as per the policy of Government of India. It contains a more in depth explanation of the roles and responsibilities at different levels, how to conduct the trainings and orientation sessions of stakeholders and a detailed guide for trainers and interviewers who will conduct interviews with bereaved families in the communities.

This guidebook aims to, establish operational mechanisms/modalities for undertaking MDR at selected institutions and in community level; to disseminate information on data collection tools, data/information flow, analysis and to develop systems for review and remedial follow up actions……"

Immpact: Toolkit A guide and tools for maternal mortality programme assessment, Version 2.

Source: http://www.immpact-international.org/index.php?id=67&top=60

The toolkit tells the story of the evaluations completed in three countries and gives details on the process of defining evaluation questions and agreeing on evaluation designs and data capture approaches and instruments. The Toolkit is a guide designed to be used as a reference document for those who plan to conduct evaluations while also providing useful information for safe motherhood policymakers. The very use of the term Toolkit as a collection of tools with guidance on their selection and use emphasizes the importance of evaluations being tailor-made for specific contexts and using fit-for-purpose study designs and tools…..A brief description is provided beneath on the various tools available in the immpact website.

Module 4, Tool 9: Maternal Death from Informants and Maternal Death Follow-on Review (MADE-IN / MADE-FOR)

"The Maternal Death from Informants / Maternal Death Follow-On Review (MADE-IN / MADE-FOR) is an approach that allows the measurement of maternal mortality down to the community level, together with an analysis of the causes of maternal deaths. Where there are suitable networks of informants available, this tool is not only suitable for intensive surveys or even censuses, but can also be used in large surveys to give precise estimates. In addition, the tool is less costly than household surveys or SSS, especially in lower-fertility, lower-mortality contexts. It goes beyond simply counting deaths, it develops an understanding of why they happened and how they can be averted………………"

Module 4, Tool 1: Sampling at Service Sites (SSS)

"SSS is a survey method for capturing data on maternal deaths which uses opportunistic sampling at health facilities, markets or other sites. The questionnaire uses the Direct Sisterhood Technique to ask about maternal deaths.

The Sisterhood Technique (Graham et al, 1989; WHO, 1997) is similar to modules used to measure maternal mortality in DHS surveys, and involves asking individuals about maternal deaths amongst their sisters who reached age 15 or above, born to the same mother. It is based on the premise that people are likely to know if a sister has died whilst pregnant, during childbirth or soon after being pregnant. It also has the advantage that one respondent can give information about several sisters, the efficiency being greatest in countries with very high fertility.

The Direct Sisterhood Technique attempts to gain current estimates of mortality by asking about deaths during the five years before the survey. It is therefore an adaptation of the original Indirect Sisterhood Technique which asks about any past deaths. Adult women are usually selected as informants but the technique can also be applied with men as informants……"

Module 4, Tool 2: Rapid Ascertainment Process for Institutional Deaths (RAPID)

"RAPID is a tool that reviews institutional records of deaths to identify unreported maternal deaths, and to identify mechanisms for improving the reporting of maternal deaths.

RAPID involves a review of institutional records for all deaths of women aged 15–49 years to identify all pregnancy-related deaths, including those that may have been missed from routine reports. Information is extracted from registers and case notes to determine the level of under-reporting, whether it is possible to improve the reporting using existing sources of data, and, if so, where such an improvement should be targeted……………."