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Maternal Deaths Review in Refugee Settings
Analysis in 10 countries, 2008-2010



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Introduction



Analysis involved 10 countries: Bangladesh, Nepal, Chad, Ethiopia, Kenya, Sudan, Uganda, Rwanda, Tanzania, and Zambia

A refugee population size of 25,000 individuals and more as a selection criteria. 25 refugee camps involved.

Maternal death recorded in HIS and active inquiries by the research team: **144 maternal deaths identified** over period 2008-Sept. 2010. Of these, **108 maternal deaths were investigated.**

Completion of the Maternal Death Review Form:



- 15% of cases were not reported in the HIS.
- 74 % were investigated less than one week after the death occurred.
- Most maternal death reviews were facility-based with limited involvement of the community.
- Little information on circumstances surrounding the death.
- No critical review (diagnosis? Treatment? capacities of the structure in case management?)
- Discrepancies and inaccurate information
- No practical corrective actions

Demographics:

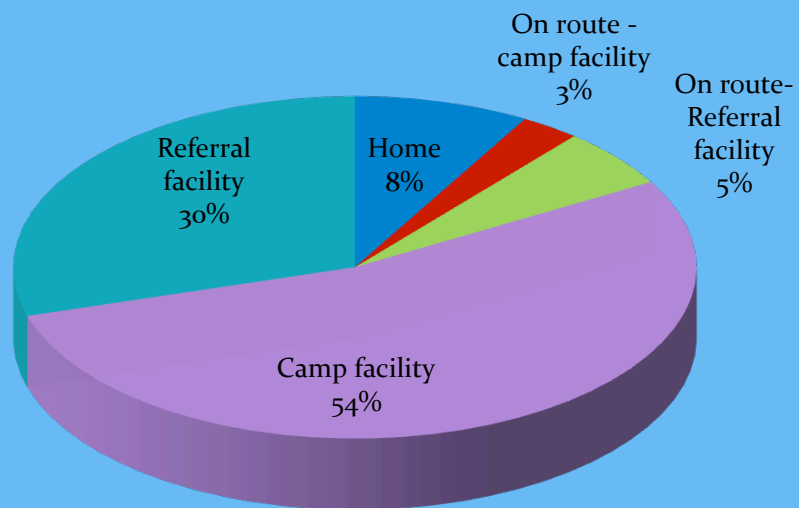
- Mean age of all women was **26.7** years with a range of 15 to 41 years of age.
- **11%** of women were 18 years old or younger and **8 %** women were older than 35 years.
- Median gravida: **4 (range 0 to 13)**
- Median of 3 antenatal care visits with 90% attended by a nurse/midwife.

Direct and indirect causes of death for all camps:

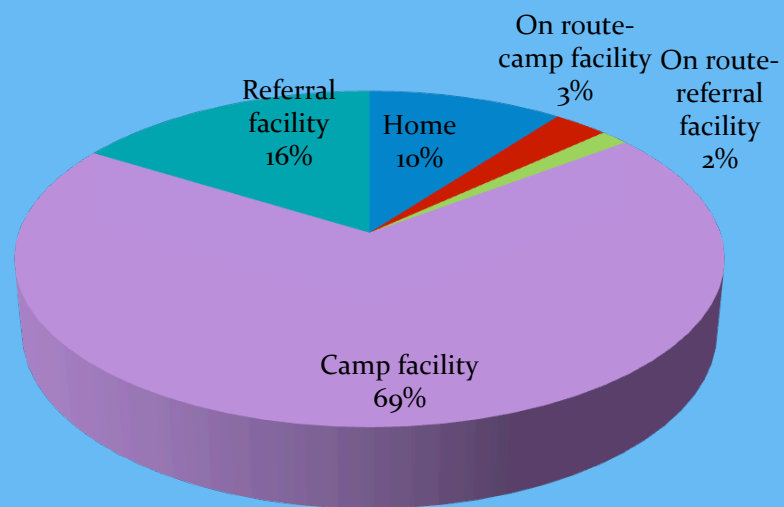


- Top direct causes of death were similar to those found globally.
 - Obstetric hemorrhage (**31%**),
 - Hypertensive disorders (**25%**)
 - Non-obstetric complications (**19%**).
- 99 cases listed indirect causes of death: Anemia (**43%**), multi gravida (**41%**), and history of hypertension (**31%**). In **56%**, women died within 24h.
- Regional estimates for sub-Saharan Africa: hemorrhage (**34%**), hypertension during pregnancy (**19%**), and indirect causes (**17%**).
- Most MDs (**73%**) occurred within one week after delivery/abortion (childbirth and immediate puerperium +++) ----→ timely recognition of complications and access to EmOC , adequate diagnosis and correct treatment----→ skilled attendance & PNC

Location of Deaths, All Camps 2008-2010



Location of Deaths, Kenya 2008-2010





Location of maternal deaths:

Most MDs (>80%) occurred at health facilities (slight increase at referral facilities).

Types of Delays:

- Seeking care was a significant delay both singly and in combination with other delays for all camps.
- Delay in reaching care is less common among all countries and challenges in reaching care seemed less of an issue than the other delays.
- Deaths which had all three delays present were more common in all countries.

While this is an indication that many refugee women are reaching care, various delays and other avoidable factors may contribute to unsuccessful interventions.



Limitations

- There is likely underreporting .
- There may be missing of who deliver at home/women in early in pregnancy.
- Other delays and avoidable factors may have played a role but were not mentioned by the review team.
- Great variation in the length of narratives/relevant information omitted in more succinct reports.
- MD outside health system: Less details about circumstances surrounding death (difficulty in accessing family and birth attendants).

- Kenya (63% of the sample)- Avoidable Factors:
 - Within community level factors: delay in recognizing severity of conditions (38%) , refusal to seek/accept care (29%); No/poor ANC (21%).
 - Camp health facility: diagnosis failure (32%) ; inadequate/delayed treatment (29%) ; lack of blood for transfusion (12%).
 - These top avoidable factors decreased between 2008 and 2010 while the other factors increased over this same period (facility centered factors)
 - In less 6%, avoidable factors were noted at the referral level health facilities.
 - Conclusion for Kenya: Focus should be on improving community health seeking
 - behaviour and the quality of EmONC services at the camp health facility.

Recommendations



- Revision of MMDR form and guidance note to strengthen the investigation process and content (more uniform completion).
- A re-orientation of the field staff and IPs on revised tools (correct investigation and timely reporting to HIS).
- Involvement of family and key community members in the MDR.
- Discuss maternal death cases within the health WG to clarify stakeholders' role in improving EmONC services.
- Strengthening coordination in the referral network (community, camp facility and referral health facility).
- Short-term practical actions and long-term recommendations to improve access to quality of EmONC services for refugees.

Thank you !

