Social Autopsy - A method to examine barriers to health care, risky behaviours and missed opportunities for health interventions

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Improving data improving health: Verbal Autopsy for health systems strengthening
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Content

- Defining social autopsy
- Social autopsy methodology and tools
- Results from studies
- Challenges and limitations
- Opportunites
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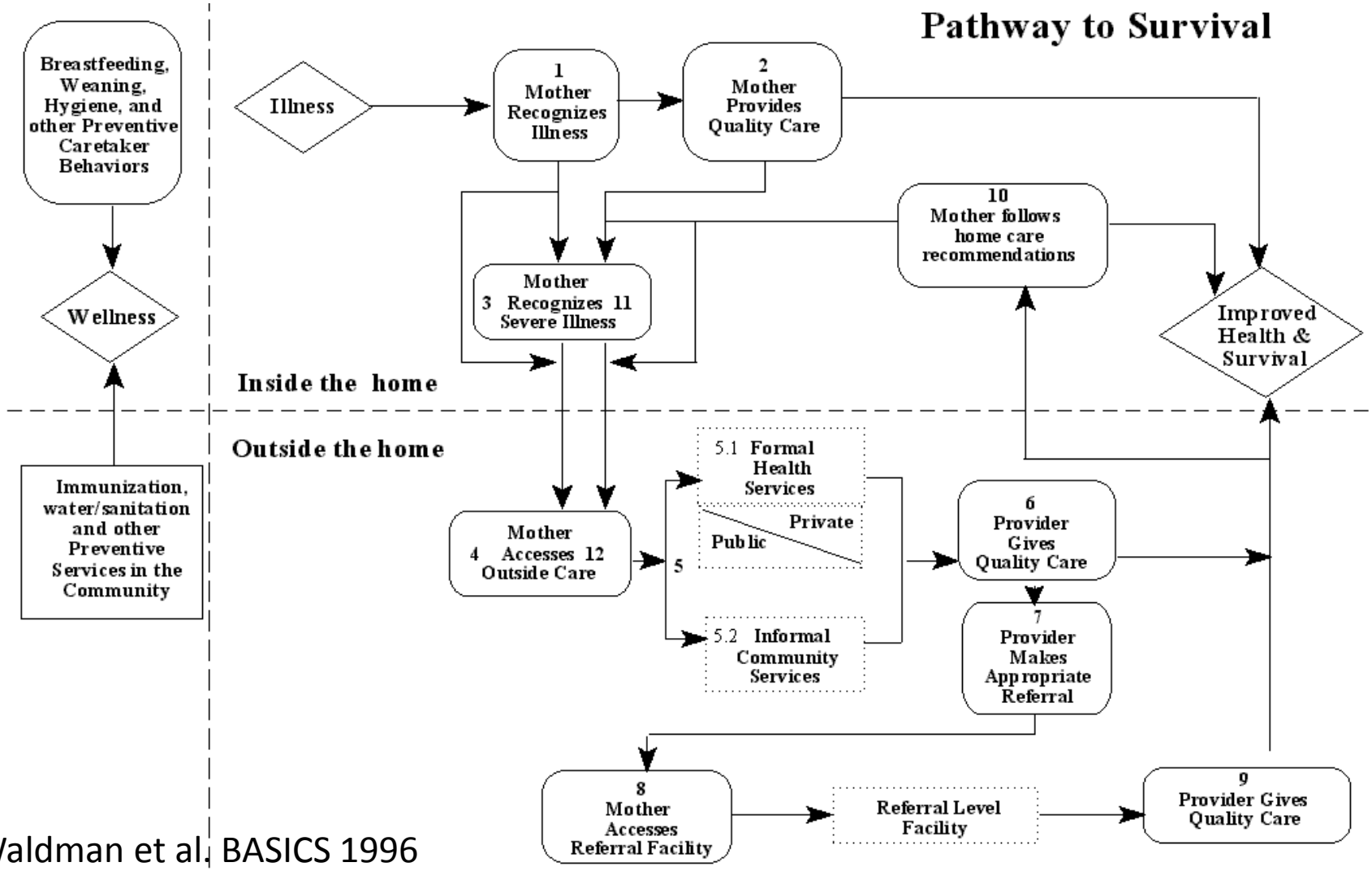
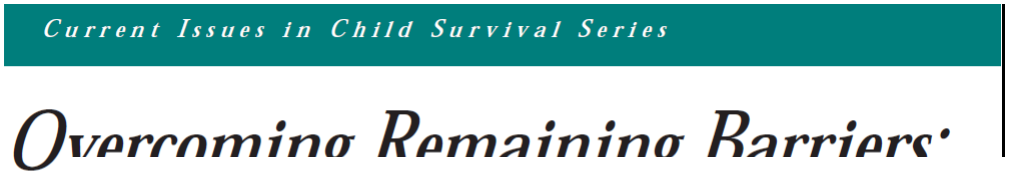
Defining social autopsy



Waldman et al. BASICS 1996

Social autopsy in the peer-reviewed literature



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Tropical Medicine and International Health doi:10.1111/j.1365-3156.2007.01963.x

VOLUME 12 NO 12 PP 1545–1552 DECEMBER 2007

The relative contribution of case management and inadequate care-seeking behaviour to childhood deaths from diarrhoea and acute resp

Rossana Bojalil[1,2],

Care-seeking for fatal illnesses in young children in Indramayu, West Java, Indonesia

Bamban,

Policy and Practice

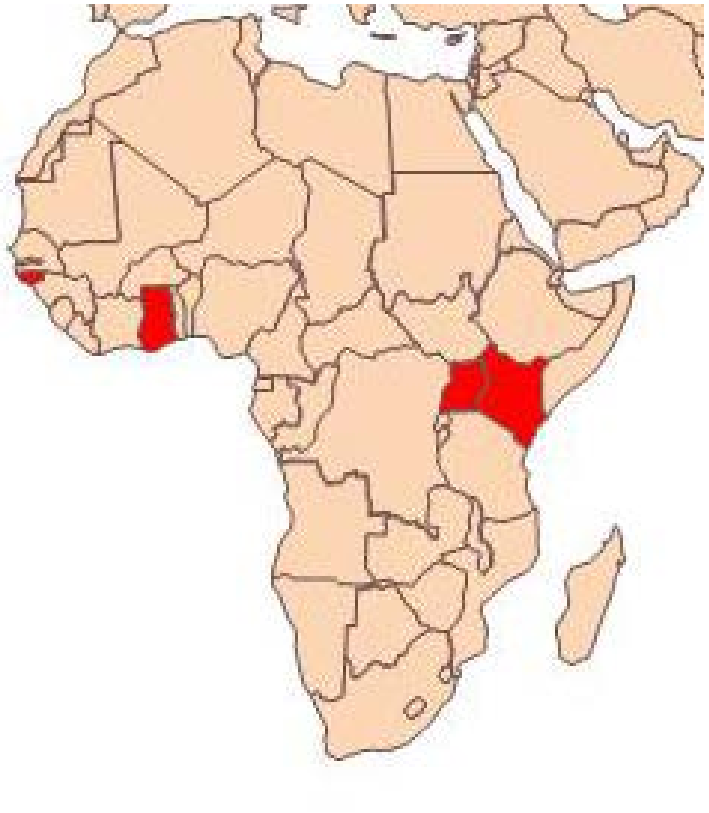
Confidential inquiry into malaria deaths

D.N. Dürrheim[1] S. Frieremans[2] P. Kruger[3] A. Mabuza[4] & J.C. de Bruyn[5]

Saving children — an audit system to assess under-5 health care

A Krug, R C Pattinson, D J Power

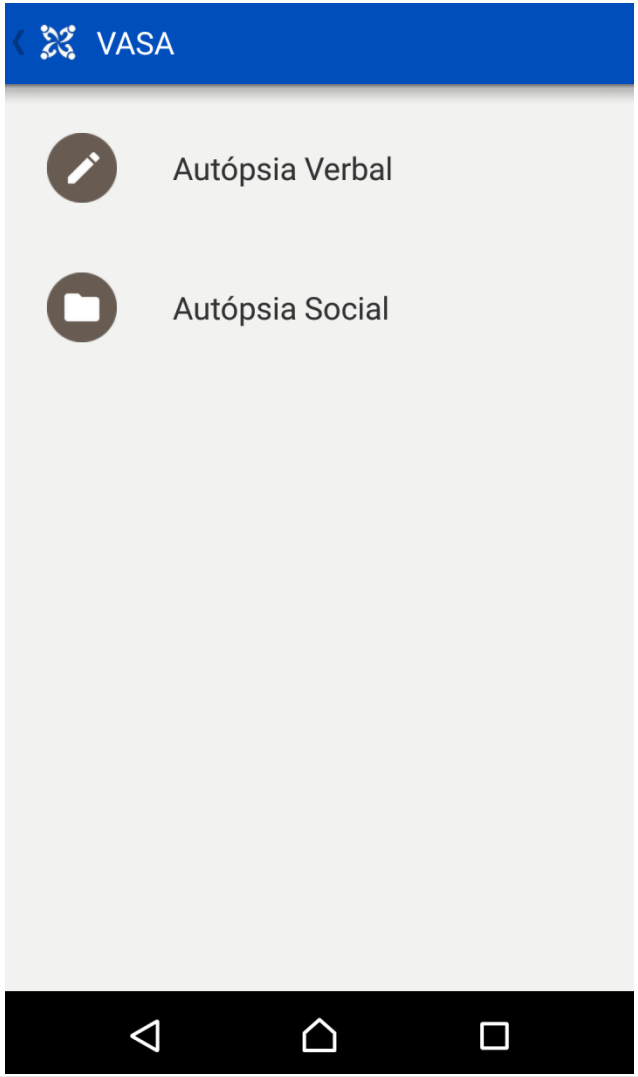
The INDEPTH Network social autopsy tool



- Consensus process from a 3-year effort by an expert group of researchers, paediatricians, statisticians, and other stakeholders
- The group systematically reviewed, debated, and refined the accumulated experience and evidence from the most widely-used social autopsy tools and procedures
  - standard social autopsy questionnaires for two age groups (neonatal and child deaths)

Kallander K et al: Social autopsy: INDEPTH Network experiences of utility, process, practices, and challenges in investigating causes and contributors to mortality. *Popul Health Metr* 2011, 9:44.

Social autopsy methodology



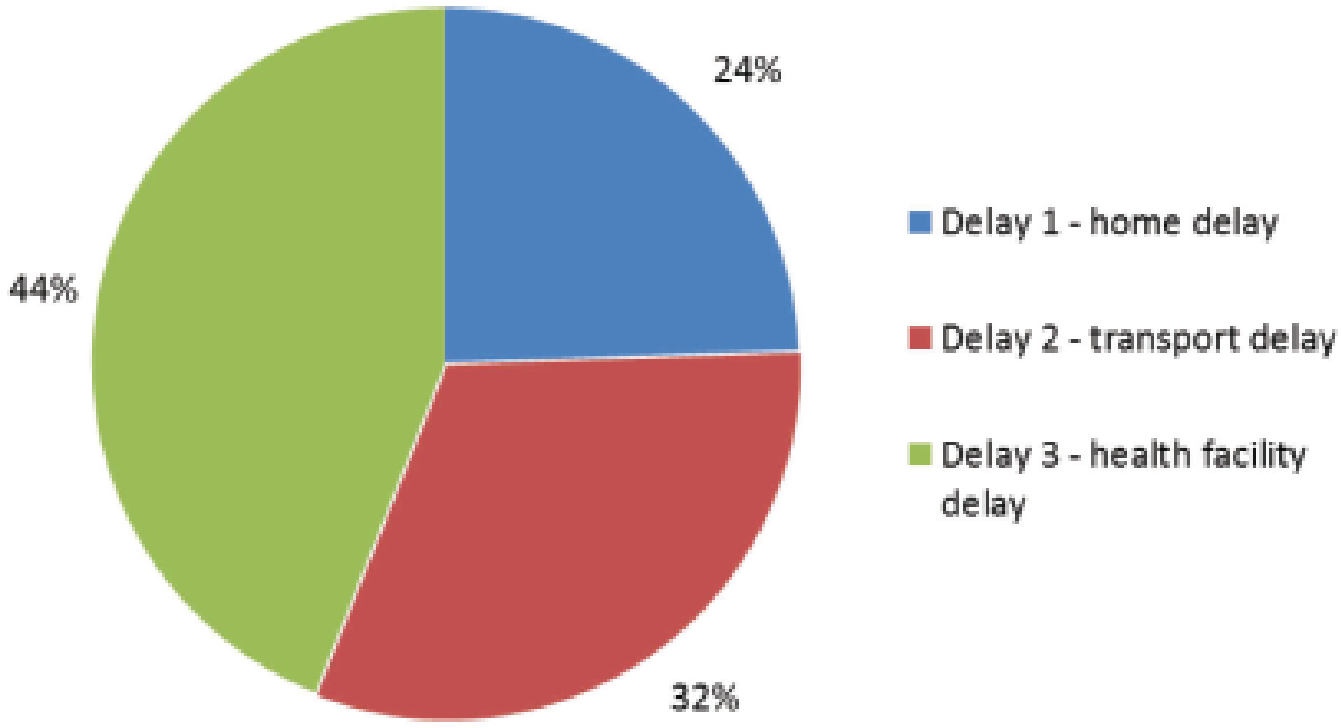
Add numbers in the yellow shaded areas

		Number	Overall proportion	Conditional proportion
	Recognition			
1	# children who were mildly or moderately sick (status 1-2) when caregiver detected that they were ill	89	86%	
	Home care			
2	# who gave treatment at home	46	45%	
2.1	# Who did not give home treatment and did not seek care outside the home	16	16%	
3	# who only gave treatment at home without going outside for care	6	6%	13%
4	# caretakers with severely ill child who treated at home without going for outside care	2	2%	
	Seeking outside care			
5	# who sought care outside the home	79	77%	
5.1	# who did not seek care outside the home	23	22%	
6	# who did not provide care at home but sought care outside the home	33	32%	
6.1	# who provided care at home and sought care outside the home	40	39%	
	Informal health services			
7	# who went to informal first source of care	9	9%	3%
8	# who went to informal last source of care	9	9%	14%
	Formal private health services			
9	# who went to formal private first source of care	0	0%	0%
10	# who went to formal private last source of care	0	0%	0%
	Formal public health services			
11	# who went to formal public first source of care	70	68%	22%
12	# who went to formal public last source of care	56	54%	85%

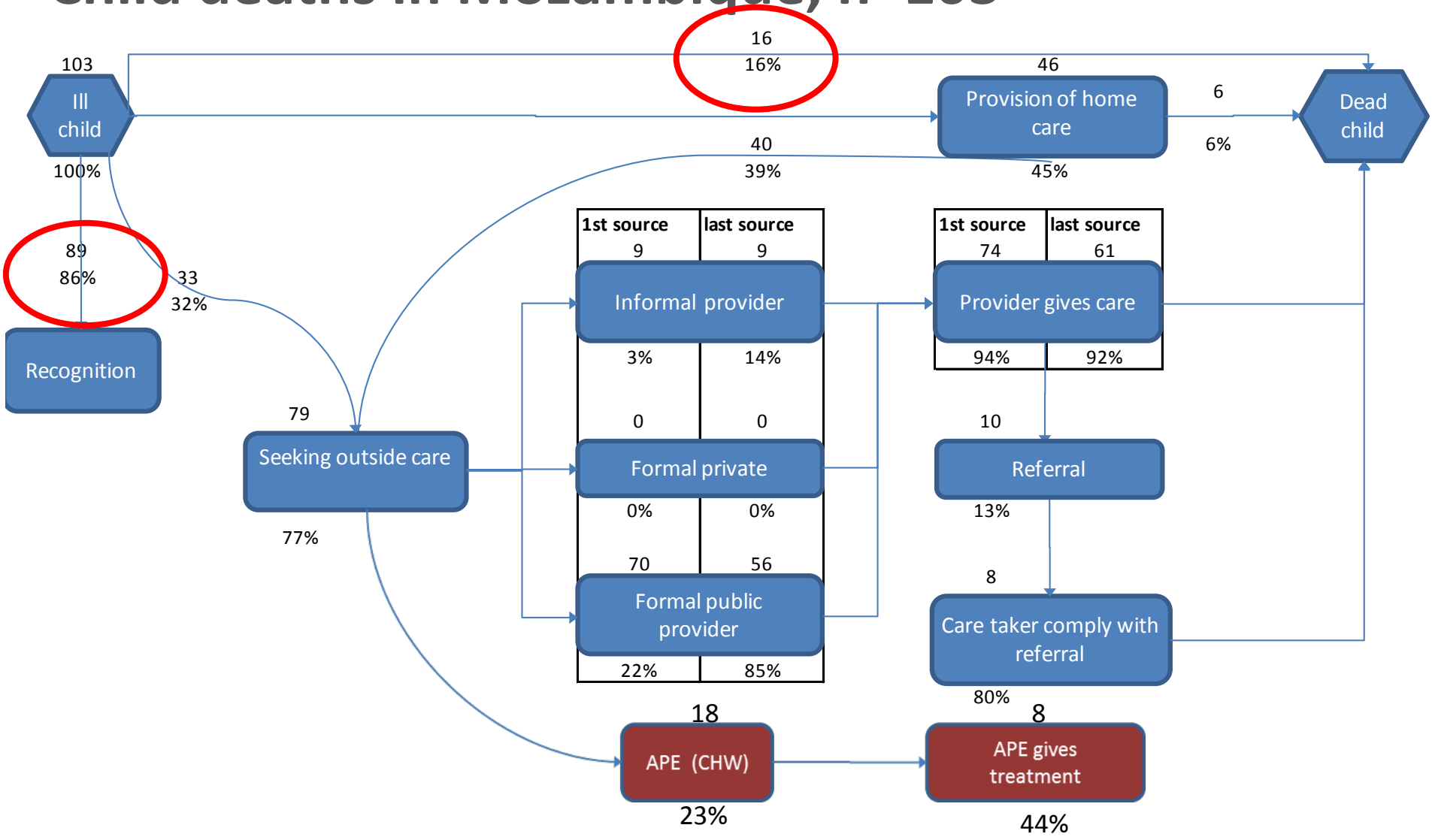
Three-delay model

	Number of children	Denominator	Overall proportion	Relative Weight¤	Cluster Total weigth*	Proportional contribution
Delay 1 - home delay				1/7	0.18	41%
# caregivers who only detected that the child was ill when the child was severely ill (status 3)	14	f	14%	0.02		
# children not taken outside for care	23	f	22%	0.03		
# children delaying to seek care>1 day when child was moderately (status 2) or severely (status 3) sick.	33	d	39%			
# children with moderate or severe illness who recevied treatment at home	44	d	52%	0.07		
# children who delayed >3 hours to seek care after decision had been taken due to reasons other than lack of transport	29	a	37%	0.05		
# children who only received **informal** health care for their fatal illnesses as both first and last source of care	0	a	0%	0.00		
# not going for referral because of care taker decision making	0	e	0%	0.00		
Delay 2 - transport delay				1/3	0.09	20%
# delaying >2 hrs to reach first or last provider	17	a	26%	0.09		
# children who delayed >3 hours to seek care after decision had been taken due to lack of transport	5	a	8%	0.03		
# not going for referral because of transport or money problem	0	e	0%	0.00		
Delay 3 - health facility delay				1/3	0.17	39%
# children obtaining treatment from provider after >1 hr from first or last provider	21	a	27%	0.09		
# children referred because of lack of equipment or lack of drugs	2	e	20%	0.07		
# deceased children who did not receive any treatment after visiting first or last formal provider	2	b	3%	0.01		

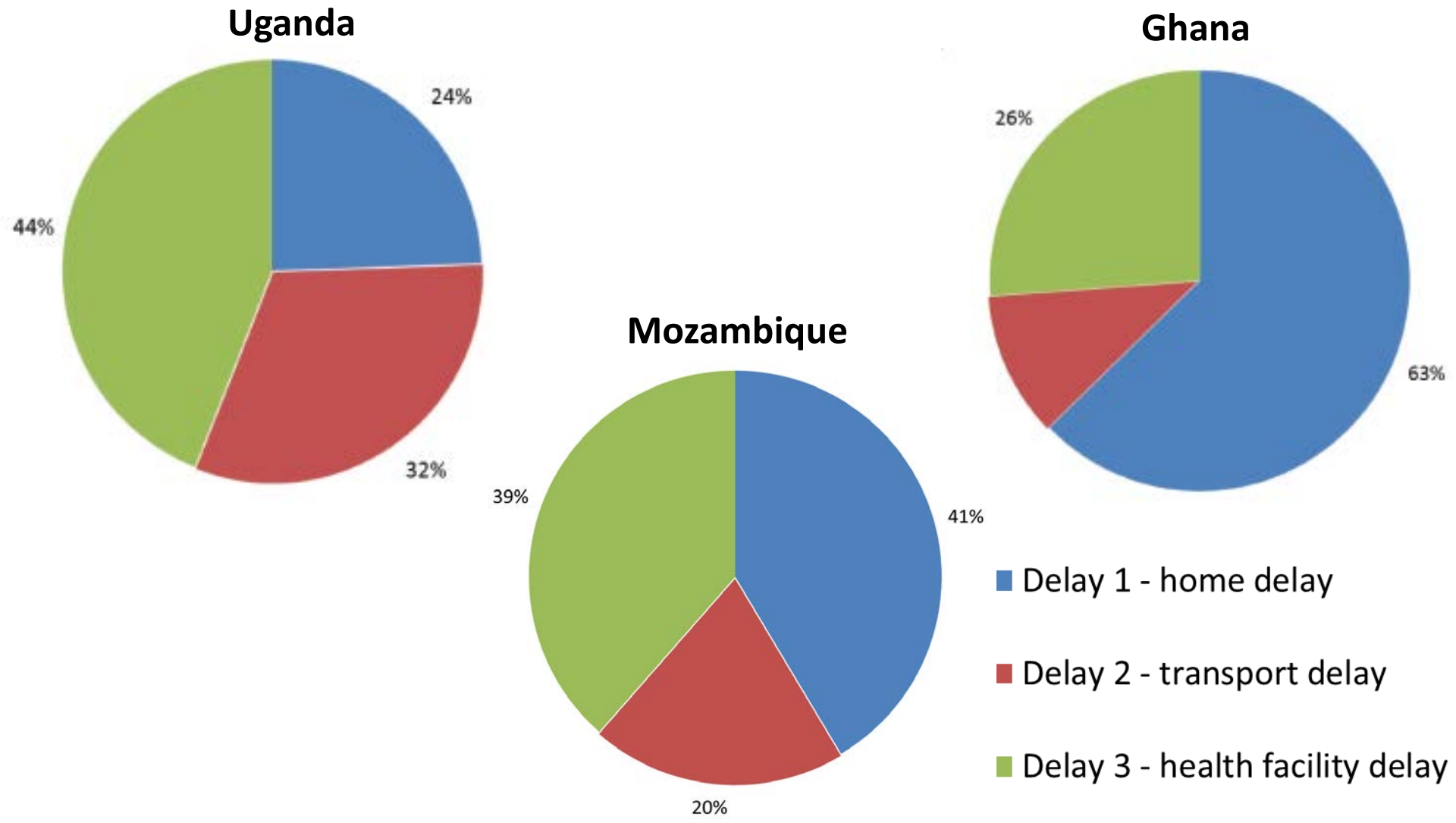
The relative contriubtion of the three delays



Child deaths in Mozambique, n=103



The three delays in Uganda, Mozambique and Ghana



Pneumonia specific SA in Uganda, n=44

- Half of pneumonia deaths occurred in hospital and one-third at home.
- Median duration of pneumonia illness was 7 days, and median time taken to seek care outside the home was 2 days.
- Most first received drugs at home: 52% antimalarials and 27% antibiotics.
- Most were taken for care outside the home, 36% of whom first went to public hospitals.
- One-third of those reaching the district hospital were referred to the regional hospital, and 19% reportedly improved after hospital treatment.
- The median treatment cost for a child with fatal pneumonia was US$ 5.8.

Källander et al. Bulletin of the World Health Organization, May 2008, 86 (5)

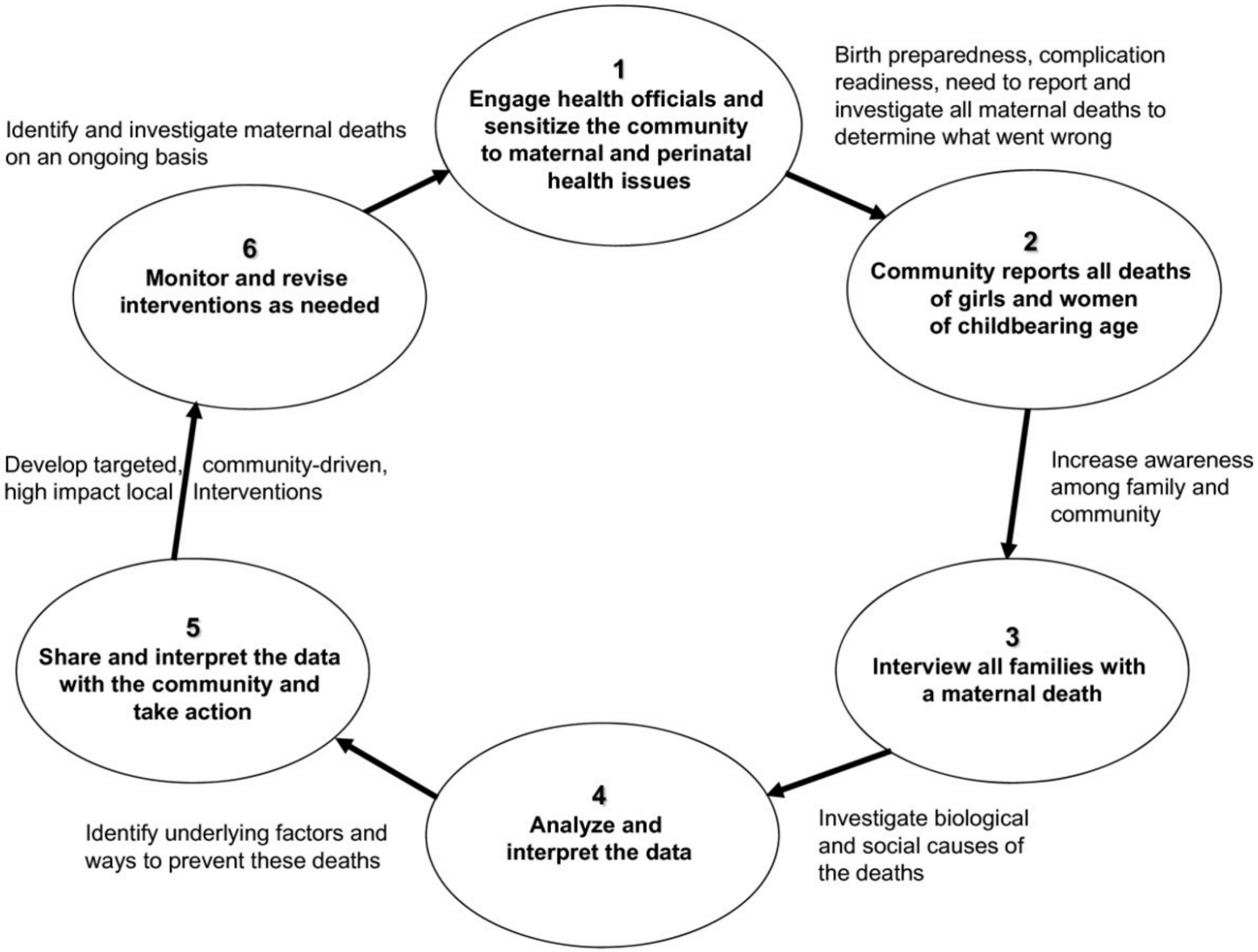
Challenges and limitations

- Care seeking practices are rarely linear and include a diverse mix of treatment options and care providers – SA may simplify complex patterns and behaviours
- Not suitable for chronic conditions or long term illness – therefore currently only used for acute illness in children
- Current SA tools do not take into account the influence of household decision making and social capital – shown to have major impact on child mortality in Ethiopia (Fantahun et al).
- By design, SA cannot determine the association between risk factors and mortality

Opportunities

- SA can be added on to a sample of VA for more indepth understanding of certain death causes or deaths in a specific age group
- Access to this information can help health planners and policymakers prioritise scarce resources appropriately by identifying the most suitable interventions for the specific context
- Potentially promising tool to also investigate maternal mortality

Maternal death inquiry and response in India



Kalter HD et al. Health Res Policy Syst. 2011;9:41

Conclusions

- SA is a useful method to improve the understanding of the common circumstances preceding death
- Evidence from SA show that delays contributing to deaths differ with context, age group, and country
- Important to understand not only of what people die from, but also why
- SA in some form should be added to VA whenever possible

Thank you

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