

Its Everybody's
business...

Introduction

- Usually maternal deaths and perinatal deaths are reported as ratios
- There is a lot of work being done, and many mothers babies are going home....
- But there is still a lot to be done for those who do not...
- Making each death count....
- We need to have systems...

Maternal Deaths (January to August)

Province	Maternal deaths
Bulawayo	37 (14%)
Harare	105 (40%)
Manicaland	22 (8.4%)
Mash Central	10 (3.8%)
Mash East	16 (6%)
Midlands	35 (13.3%)
Mat North	6 (2%)
Mat South	7 (2.7%)
Masvingo	7 (2.7%)
Mash west	17 (6.5%)
Total	262

- Audit findings from a few of the cases.....
- Our house is on fire
- It can not be business as usual
- All hands of deck....

Summary of cases audited at institutions

Failure to detect uterine rupture while
admitted

Poor communication within the team on
escalating critical cases

Delay in the management of some cases
due to lack of fetal dopplers to decide on
either induction or c/section

Junior doctor failed to establish
haemostasis after a c/section for
antepartum haemorrhage

Patient had a c/section for fetal distress
and the junior doctor failed to establish
haemostasis



Audit findings cont.....

Patient had PPH secondary to c/section for 2 previous c/section

Patient who was P4G5 had induction of labour done based on the results of an USS the month before and ruptured. Baby at delivery was 3900g

Patient had a c/section and team failed to achieve haemostasis

Patient had a ruptured uterus secondary to a trial of scar at a peripheral hospital

Patient with one previous c/section and failed to achieve haemostasis

Ruptured ectopic pregnancy was missed at the district hospital



Stillbirths (Fresh)

Bulawayo	41 (4%)
Harare	234 (22%)
Manicaland	118 (11%)
Mash Central	111(10%)
Mash East	97 (9%)
Midlands	110 (10%)
Mat North	45 (4%)
Mat South	35 (3%)
Masvingo	113 (11%)
Mash West	163(15%)
Total	1067



Early Neonatal Deaths (Jan - Aug 2024)

Province	Neonatal deaths			
	>2.5kg	<2.5kg	Total	Proportion >2.5kg
Bulawayo	82	316	398 (13%)	21%
Harare	405	659	1064 (35%)	38%
Manicaland	127	154	281(9%)	45%
Mash Central	95	67	162 (5%)	59%
Mash East	85	70	155 (5%)	55%
Midlands	126	171	297 (10%)	42%
Mat North	49	35	84 (3%)	58%
Mat South	36	43	79 (3%)	46%
Masvingo	92	86	178 (6%)	52%
Mash west	129	171	300 (10%)	43%
Total	1226	1772	2998	

Perinatal deaths

Province	Total ENND	Total with sB	SB + >2.5/total
Bulawayo	398 (13%)	(41) 439	28%
Harare	1064 (35%)	(234) 1298	49%
Manicaland	281(9%)	(118) 399	61%
Mash Central	162 (5%)	(111) 273	75%
Mash East	155 (5%)	(97) 252	72%
Midlands	297 (10%)	(110) 407	58%
Mat North	84 (3%)	(45) 129	72%
Mat South	79 (3%)	(35)114	62%
Masvingo	178 (6%)	(113) 301	68%
Mash west	300 (10%)	(163) 334	87%

There is lack of quality of care, the paradox....

ANC coverage 95%

Institutional deliveries 85%

However

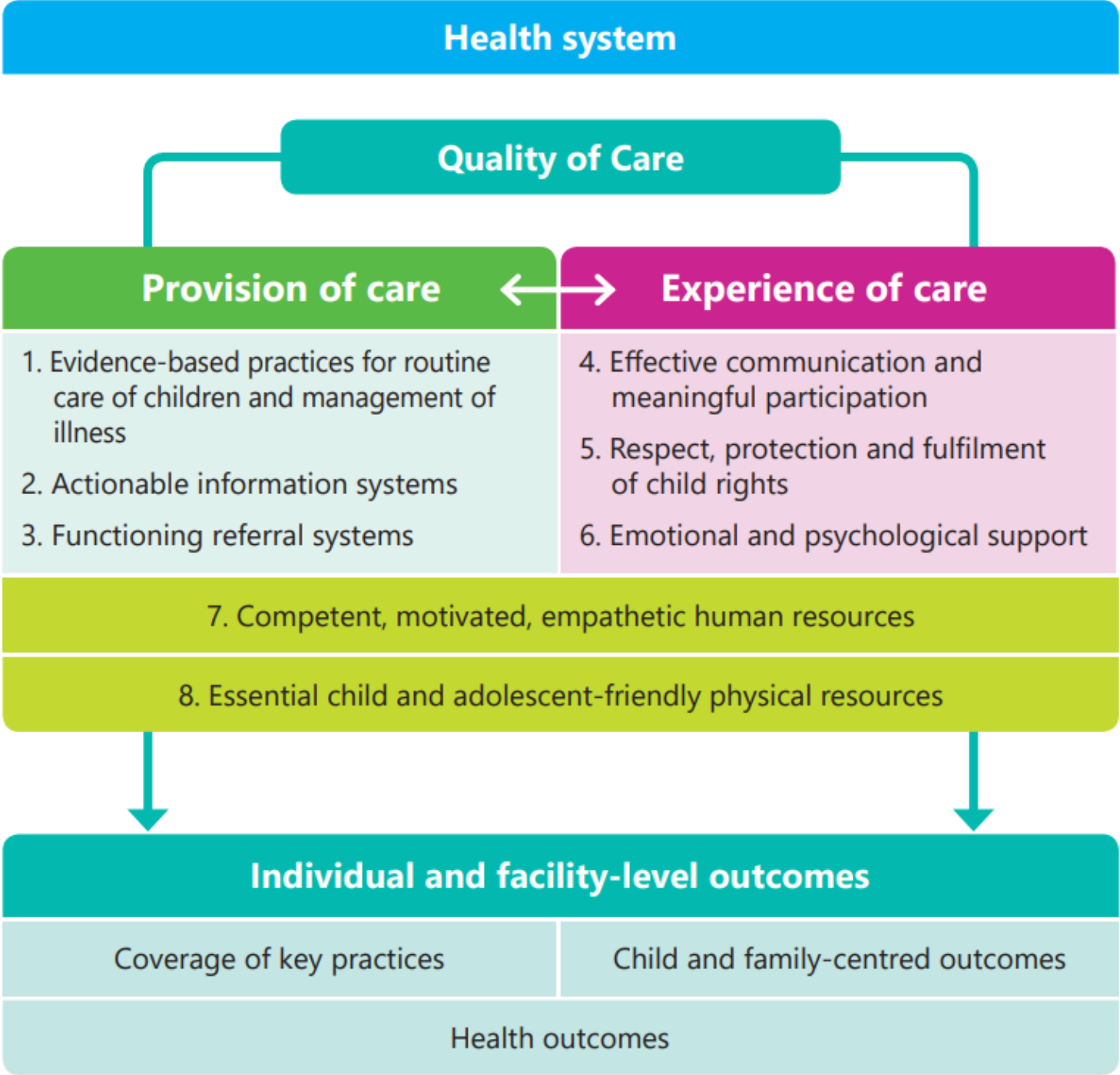
Institutional maternal rate 132
from 101

Perinatal mortality rate 32 from
28



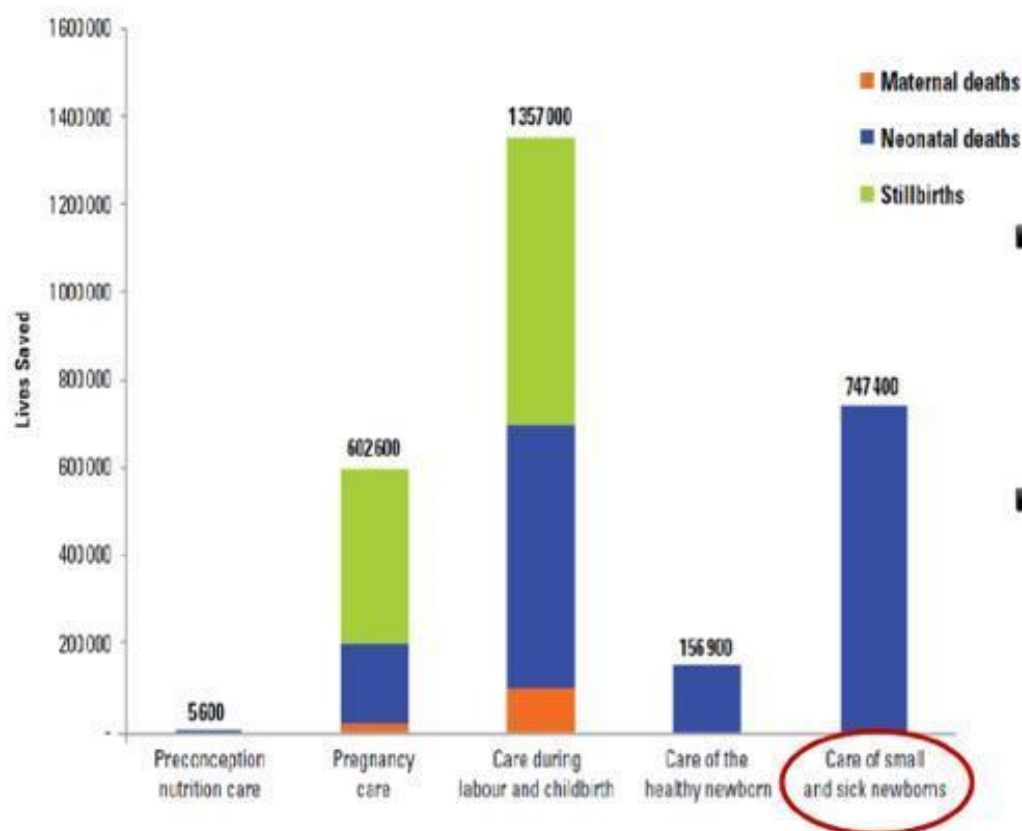
Being there but not being there.....





Where Do We Need to Invest?

Estimated effect of scale-up of interventions on maternal and neonatal deaths and stillbirths in 2030



Graph Source: Lancet newborn survival series

- **Care around Birth (SBA + EmONC) Quadruple return**
 - 46% reduction of maternal deaths
 - 40% reduction of still Births
 - 40% reduction of neonatal deaths
- **Care of Small and Sick Newborn**
 - KMC and level 2 newborn care
 - 30% reduction in NMR
- **Follow up care in community**
 - Home visits and referrals
 - Post discharge care of small and sick babies
 - Early childhood development linkages

Where is the problem?

There are known including

Infrastructure

Equipment

Medicines

But Especially

Human Resources



Human Resources

Human resources are a significant contributor to quality of care



Am I my brothers' keeper?

Every one is related to everyone

We have relatives in the provinces

Their only source of health care is public institutions

For the sake of our relatives.....



Zimbabwe Every Newborn Action Plan



- Goal 1: Ending preventable newborn deaths to achieve the target of less than 10 newborn deaths per 1 000 live births by 2035 and continue to reduce death and disability, ensuring that no newborn is left behind.
- Goal 2: Ending preventable stillbirths to achieve the target of less than 10 stillbirths per 1 000 total births by 2035 and continue to close equity gaps.

IMPACT
OUTCOMES
OUTPUTS
INPUTS

Ending preventable deaths for women, stillbirths, newborns and children
Improving child development and human capital

EVERY WOMAN **EVERY NEWBORN** EVERY CHILD

REPRODUCTIVE
HEALTH CARE

PREGNANCY
CARE

CARE
AROUND
BIRTH

CARE OF
SMALL
OR SICK
NEWBORN

POSTNATAL
CARE

CHILD HEALTH
CARE AND
DEVELOPMENT

ADOLESCENT
HEALTH CARE

UNIVERSAL COVERAGE

QUALITY OF CARE WITH INNOVATION

Health
workforce

Commodities
and technologies

Health information
systems

Community
empowerment and healthy
home behaviours

Count every woman, every newborn, every child:
Accountability and data for action to achieve equity

Leadership, governance, partnerships and financing

Contextual factors: epidemiological, environmental, economic and socio-cultural

Accelerated Implementation Plan

1.Improve access to quality Emergency Obstetric and Neonatal Care - Updated EMONC guidelines

mental health
teenage pregnancy
nutrition
eclampsia prevention

2.Health workforce

3.Implement Evidence-Based High impact Interventions

4. Strengthen continuous quality improvement(CQI) - weekly audits

5.Strengthen Supply Chains

6.Advocate for Policy Support

7.Domestic funding

8.Foster Partnerships



Quality improvement through audits (systems vs individuals)

Most audits were focused on maternal and few on perinatal deaths

Perinatal cases are “too many”

Quality of the audits are poor

Do not address issues within institutions sphere of influence

Ultimately there is no change in practice after an audit hence no impact.....

THE WORST EXCUSE Is A GOOD EXCUSE!



a)Term still births and birth asphyxia (25%)

1. Improve intrapartum care (Deliver well babies who do not need much support)
2. Count our deaths (Measure the work that is being done)
3. Account for each death (audit for continuous quality improvement)
4. Audit as a team including labour ward as this is largely related to intrapartum care.

b)Prematurity/ LBW (45%)

1. Appropriately trained health workers to look after sick and small newborns
2. Appropriate areas to manage sick and small newborns
3. Adequate equipment
4. Count and account for deaths in the various weight bands



When two elephants fight, its the grass that suffers...

Employers vs employees

Paediatricians vs Obstetricians

Doctors and midwives

Referring and receiving
institutions

Management dynamics
(accountant/ administration etc)



Which way to go....



ZSOG

Leadership and governance

Accountability

Custodians

Mentors

Visibility



It is possible...

Ngwenya *BMC Res Notes* (2017) 10:246
DOI 10.1186/s13104-017-2567-z

BMC Research Notes

RESEARCH ARTICLE

Open Access



Reducing fresh full term intrapartum stillbirths through leadership and accountability in a low-resource setting, Mpilo Central Hospital, Bulawayo, Zimbabwe

Solwayo Ngwenya^{1,2,3*}

Where there is a will, there is a way.....

Lastly

Looking at the mother and baby dyad...

Measure our work - Introduction of weekly audits. introduction of empdns

Hold each other accountable

Starting where we are....

Success comes from doing the small things well...

Together we can

Thank you!

