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 on 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%

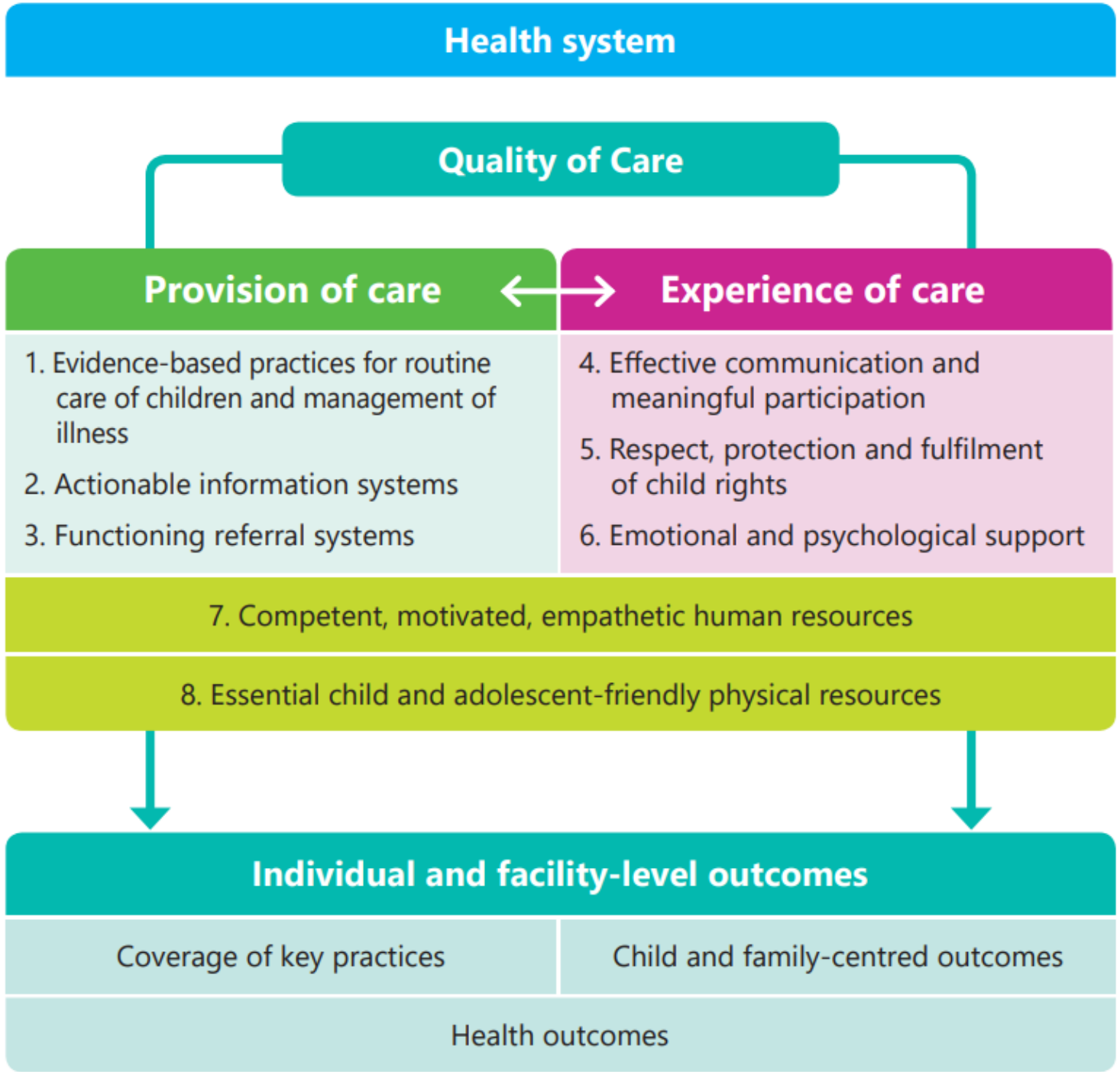
Institututional deliveries 85%

However

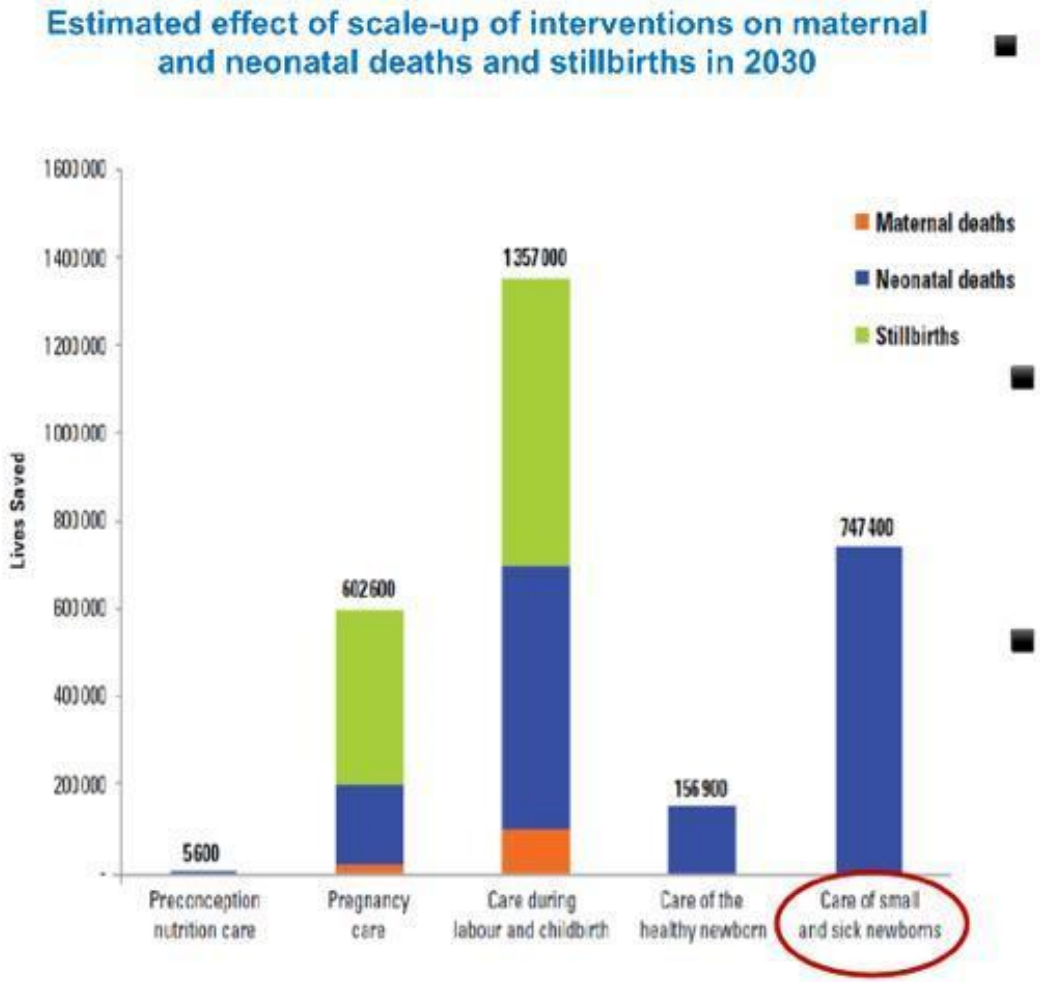
Institutional maternal rate 132 from 101

Perinatal mortality rate 32 from 28

Being there but not being there……


Health system
Quality of Care
Provision of care
Experience of care
1. Evidence-based practices for routine care of children and management of illness
2. Actionable information systems
3. Functioning referral systems
4. Effective communication and meaningful participation
5. Respect, protection and fulfilment of child rights
6. Emotional and psychological support
7. Competent, motivated, empathetic human resources
8. Essential child and adolescent-friendly physical resources
Individual and facility-level outcomes
Coverage of key practices
Child and family-centred outcomes
Health outcomes

Where Do We Need to Invest?



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

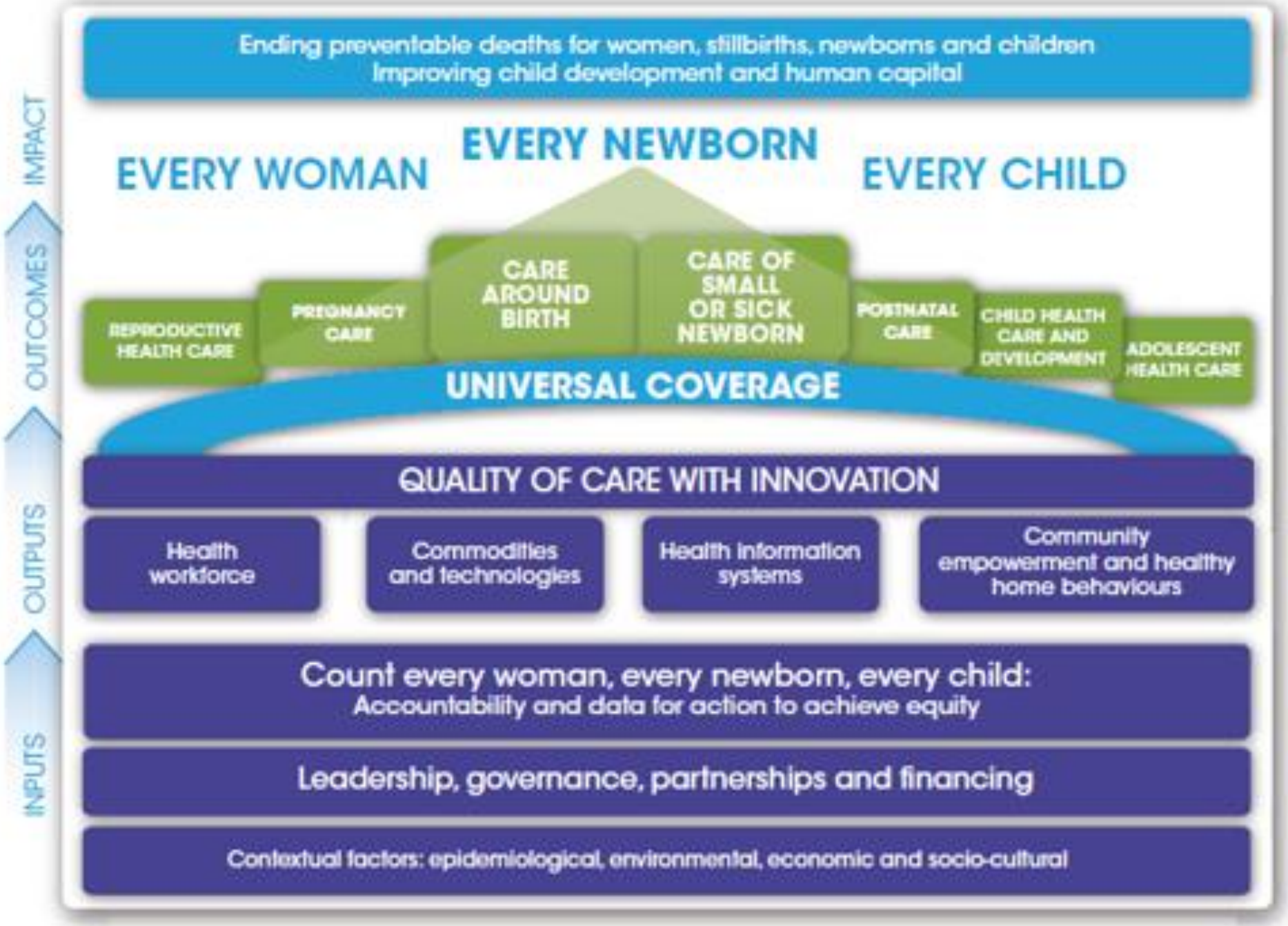
We have relatives in the provinces

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 than10 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

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!