



EVERY WOMAN
EVERY CHILD

Global
**MATERNAL
NEWBORN**
Health Conference

*reaching every mother and newborn
with quality care*

EVERY NEWBORN

An Action Plan To End Preventable Deaths

Measurement improvement roadmap



World Health
Organization

unicef 



COMMITTING TO CHILD SURVIVAL
A PROMISE RENEWED

#globalmnh #EveryNewborn

Overview of panel

	Moderator	Suzanne Fournier	5mins
1	Count every newborn: a 5-year measurement improvement roadmap	Joy Lawn	15 min
	IMPACT		
2	Counting births, neonatal deaths and cause of death: Improving measurement especially in vital registration	Peter Waiswa	15 min
	COUNTING COVERAGE AND QUALITY AND LINKING TO ACTION		
3	Care for all mothers and newborns: Measuring coverage and content of care	Agbessi Amouzou	12mins
4	Care for newborns with complications: Measuring coverage and content of care	Sarah Moxon	12 mins
5	Counting every stillbirth and neonatal death: Perinatal audit tools and implementation for improving quality of care linked to maternal death surveillance and response	Kate Kerber	10 mins
	DISCUSSION PANEL Tanzania and improving and using the data, links to scorecards Bangladesh and improving and using the data WHO's role in co-ordinating maternal and newborn metrics	Georgina Msemo Shams El Arifeen Matthews Mathai	3 mins each
	Discussion from the floor		10mins
	Close		5 mins

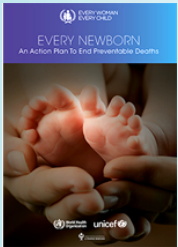
Where to get more information



Lancet *Every Newborn* series: <http://www.thelancet.com/series/everynewborn>

Every Newborn Action Plan (ENAP):

http://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/

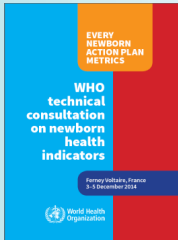


BMC Pregnancy and Childbirth series:

<http://www.biomedcentral.com/bmcpregnancychildbirth/supplements/15/s2>

ENAP WHO meeting report:

http://www.who.int/maternal_child_adolescent/documents/newborn-health-indicators/en/



MARCH MOOC:

<http://www.lshtm.ac.uk/study/freeonlinecourses/women-children-health/index.html>



UNICEF: www.childmortality.org

Healthy Newborn Network:

<http://www.healthynewbornnetwork.org/page/newborn-numbers>



INDEPTH: <http://www.indepth-network.org/>



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Counting every stillbirth
and neonatal death:
Perinatal audit for improving quality
of care linked to maternal death
surveillance and response

Kate Kerber
[@katekerber](https://twitter.com/katekerber)



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Kerber et al. *BMC Pregnancy and Childbirth* 2015, **15**(Suppl 2):S9
<http://www.biomedcentral.com/1471-2393/15/S2/S9>

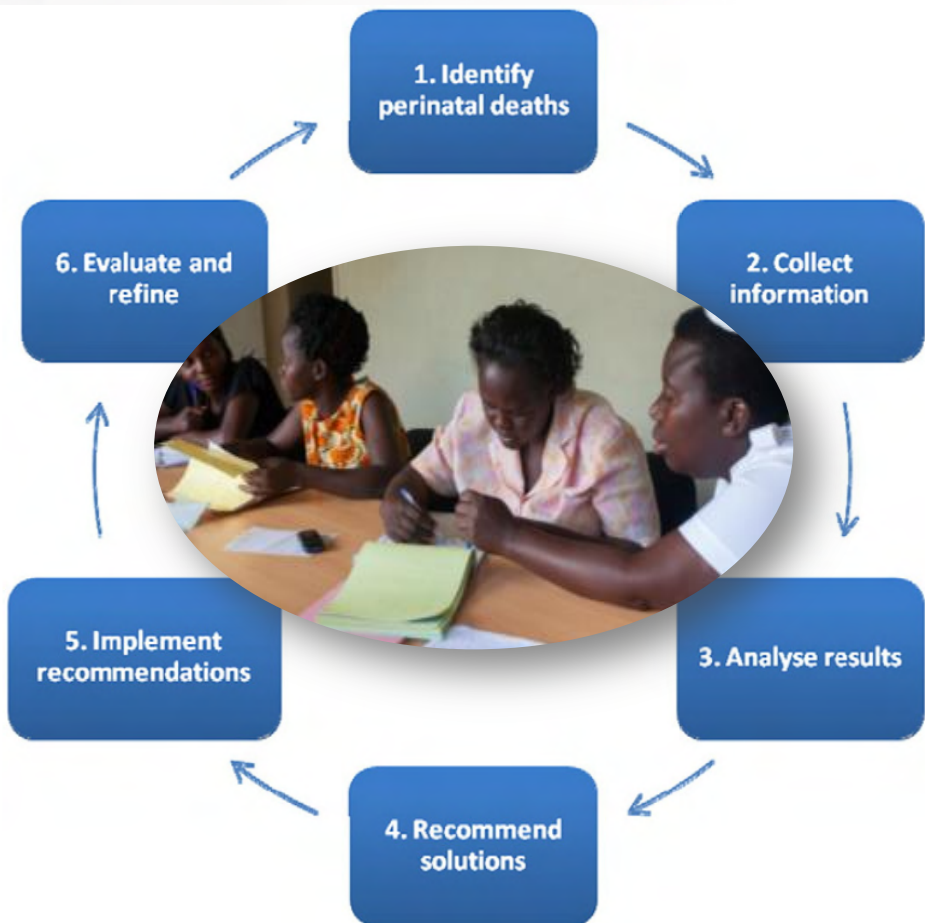
**RESEARCH****Open Access**

Counting every stillbirth and neonatal death through mortality audit to improve quality of care for every pregnant woman and her baby

Kate J Kerber^{1*}, Matthews Mathai², Gwyneth Lewis³, Vicki Flenady⁴, Jan Jaap HM Erwich⁵, Tunde Segun⁶, Patrick Aliganyira⁷, Ali Abdelmegeid⁸, Emma Allanson^{9,10}, Nathalie Roos², Natasha Rhoda¹¹, Joy E Lawn^{1,12,13}, Robert Pattinson¹⁴

@katekerber

What is mortality audit?



Mortality audit is a process to document the medical causes of each death and contributing systemic failures in order to identify solutions and take action.

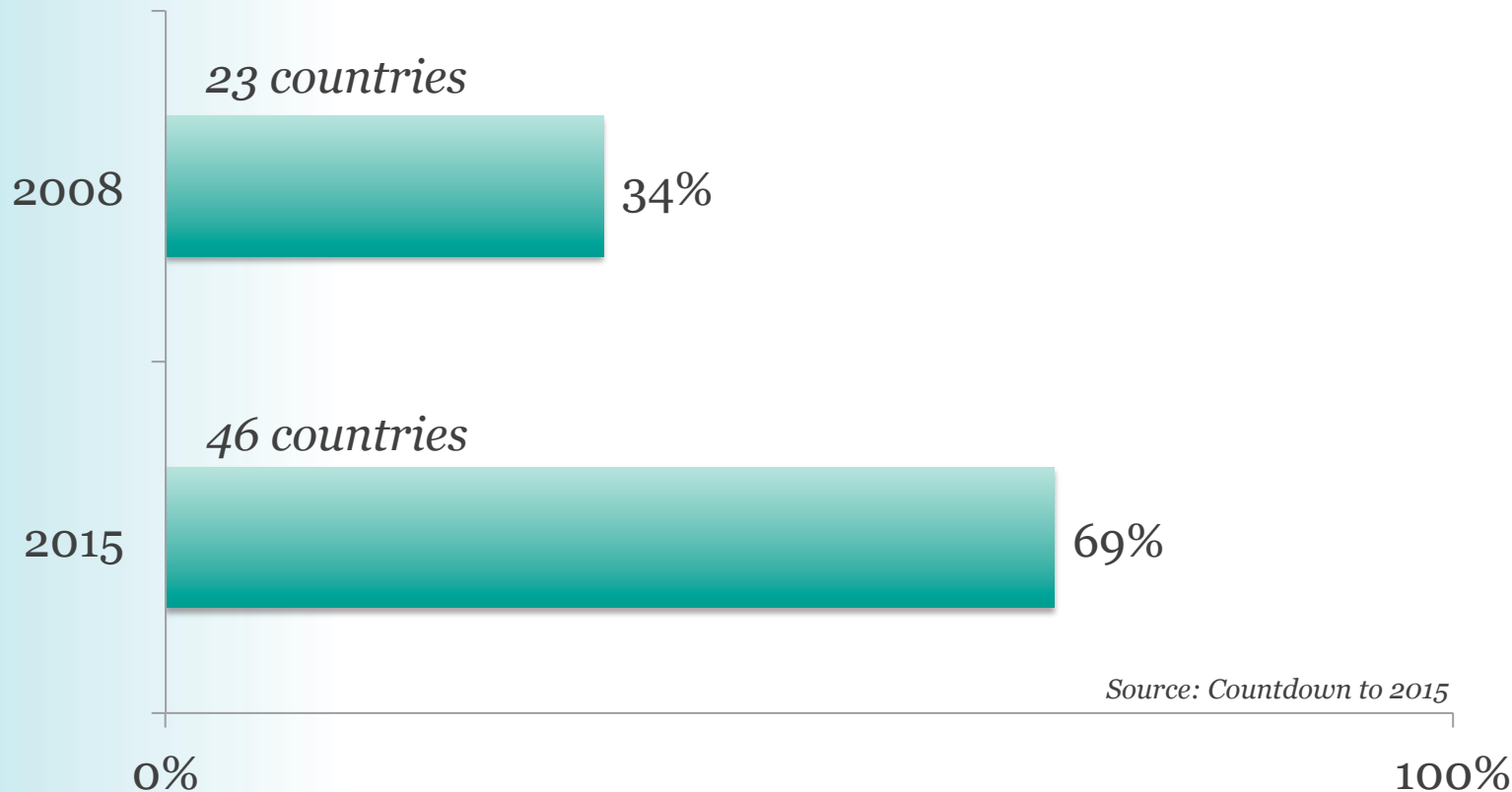
It is not a solution in itself. It is a systematic way of improving quality of care through collecting and analysing data, linking solutions and ensuring accountability for changes in care.

A previous meta-analysis found impact of audit on perinatal mortality.

New evidence from long-term implementation suggests the greatest change is possible where health workers identify and focus on issues with *clear modifiable factors within their sphere of control.*

Progress for maternal mortality audit

Priority countries with maternal death notification policy



- Commission for Information & Accountability recommended maternal AND perinatal audit
- 16 countries have stillbirth audit, 30 countries have neonatal death audit
- Few low/middle income countries with wide coverage of perinatal audit, e.g. South Africa



Mortality audit by level of health system

National



- National trends can be used to inform priorities, planning
- At minimum, collation and monitoring includes births, deaths, and cause of death but also may include analysis of modifiable factors and recommendations to address system gaps

Facility



- Mortality data collected on all births, deaths (maternal and perinatal) and cause of death
- Learning cases examined in more detail in regular, mandated audit meetings to identify avoidable factors and specific actions

Community



- Surveillance: Trained community workers visit households following a death and conduct social and/or verbal autopsy to feed back into a local or centralised data collection system
- Facility/community linkage: Facility audit recommendations shared, community avoidable factors addressed together

Challenges and solutions

Challenge	Solution
Lack of mortality audit GUIDELINES and tools	Standardised tools and implementation guide (forthcoming from WHO)
Staff do not have TIME	Record all deaths; audit a selection Highlight successes where audit has led to change; near-miss
Culture of BLAME	Use champions to foster an enabling environment Clearly separate audit from disciplinary and legal processes
Limited data INTERPRETATION	Use electronic systems with graphs that auto-generate Provide in-service support on use of data
No COMMUNITY ENGAGEMENT	Work with community liaison to provide interface and translate recommendations for community implementation

Table adapted from: Kerber et al., *BMC Pregnancy and Childbirth. Supplement 2015*

*WHO Making Every Baby Count:
Audit and review of stillbirths and neonatal deaths*

- Responding to country demand for support
- Implementation guide and tools for establishing a perinatal audit system
- Focused on facility level entry point with national level oversight and collation
- Aimed at low-resource settings with limited capacity for cause of death investigations
- Geared towards midwives and mid-level cadres
- Linked to Maternal Death Surveillance & Response and WHO quality of care framework

**Finalising draft with plans for field testing
and finalization in early 2016**

Thanks to



- This work would not have been possible without more than **80 partners** involved in the Every Newborn Action Plan and particularly those on the ENAP metrics coordination group
- Technical inputs from the Coverage Task teams, participants of the WHO meeting and 33 authors on the paper

Multi-partner plan and will take multi-country, multi partner action to work!



DISCUSSION OPPORTUNITY

- Georgina Msemo: Government of Tanzania
- Shams El Arifeen: ICCDR,B
- Matthews Mathai: World Health Organization

OPEN TO THE FLOOR FOR DISCUSSION

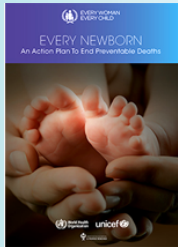
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