Measurement improvement roadmap
# Overview of panel

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Moderator</strong></td>
<td>Suzanne Fournier</td>
<td>5mins</td>
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<tr>
<td><strong>Count every newborn: a 5-year measurement improvement roadmap</strong></td>
<td>Joy Lawn</td>
<td>15 min</td>
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<tr>
<td><strong>IMPACT</strong></td>
<td>Peter Waiswa</td>
<td>15 min</td>
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<tr>
<td><strong>COUNTING COVERAGE AND QUALITY AND LINKING TO ACTION</strong></td>
<td>Agbessi Amouzou</td>
<td>12 mins</td>
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<tr>
<td><strong>Care for all mothers and newborns: Measuring coverage and content of care</strong></td>
<td>Sarah Moxon</td>
<td>12 mins</td>
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<tr>
<td><strong>Care for newborns with complications: Measuring coverage and content of care</strong></td>
<td>Kate Kerber</td>
<td>10 mins</td>
</tr>
<tr>
<td><strong>Counting every stillbirth and neonatal death: Perinatal audit tools and implementation for improving quality of care linked to maternal death surveillance and response</strong></td>
<td>Georgina Msemo Shams El Arifeen Matthews Mathai</td>
<td>3 mins each</td>
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<tr>
<td><strong>DISCUSSION PANEL</strong></td>
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<tr>
<td>Tanzania and improving and using the data, links to scorecards</td>
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<tr>
<td>Bangladesh and improving and using the data</td>
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<tr>
<td>WHO’s role in co-ordinating maternal and newborn metrics</td>
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<tr>
<td><strong>Discussion from the floor</strong></td>
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<td><strong>Close</strong></td>
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Where to get more information

**Lancet Every Newborn series:** [http://www.thelancet.com/series/everynewborn](http://www.thelancet.com/series/everynewborn)


**BMC Pregnancy and Childbirth series:** [http://www.biomedcentral.com/bmcpregnancychildbirth/supplements/15/s2](http://www.biomedcentral.com/bmcpregnancychildbirth/supplements/15/s2)


**MARCH MOOC:** [http://www.lshtm.ac.uk/study/freeonlinecourses/women-children-health/index.html](http://www.lshtm.ac.uk/study/freeonlinecourses/women-children-health/index.html)

**UNICEF:** [www.childmortality.org](http://www.childmortality.org)

**Healthy Newborn Network:** [http://www.healthynewbornnetwork.org/page/newborn-numbers](http://www.healthynewbornnetwork.org/page/newborn-numbers)

**INDEPTH:** [http://www.indepth-network.org/](http://www.indepth-network.org/)
Counting every stillbirth and neonatal death: Perinatal audit for improving quality of care linked to maternal death surveillance and response

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

Kate J Kerber1*, Matthews Mathai2, Gwyneth Lewis3, Vicki Flenady4, Jan Jaap HM Erwich5, Tunde Segun6, Patrick Aliganyira7, Ali Abdelmegid8, Emma Allanson9,10, Nathalie Roos2, Natasha Rhoda11, Joy E Lawn1,12,13, 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.
Priority countries with maternal death notification policy

2008: 23 countries (34%)
2015: 46 countries (69%)

Source: Countdown to 2015

- 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

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

## Challenges and solutions

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