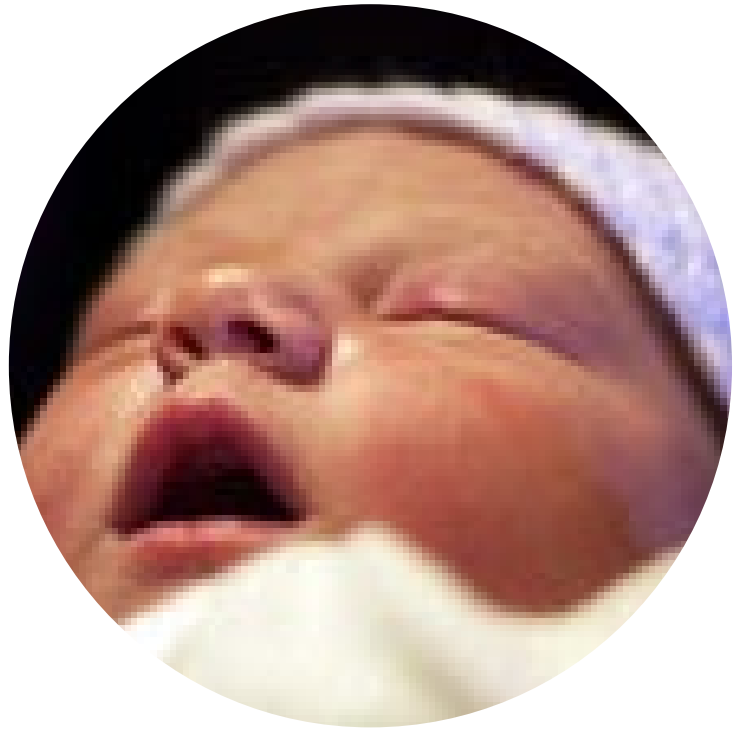
Skills Building Workshop on Perinatal Death Reviews for Health Facility Teams



Day 1. Session 1.

Welcome and Introduction

And almost a similar number of still births….

Session Objectives

- Describe the training format
- Explain how to use the learners guide
- Clarify goals and objectives for the perinatal death review
- Identify the audience for this training
- Discuss guiding principles for perinatal death reviews

Goals of Perinatal Mortality Reviews

- End preventable neonatal deaths and stillbirths by learning lessons and avoiding repetitive mistakes
- With regular reviews of perinatal deaths, and an analysis of the causes of deaths could inform corrective action and reduce the preventable perinatal deaths

Primary Objectives

1. To establish a framework to assess the burden of perinatal deaths including trends in numbers and causes of death
1. To generate information about modifiable factors
2. To use the findings to improve quality of perinatal care
3. To use the findings to develop appropriate actions to end preventable deaths at the facility level
4. To provide accountability for results and compel decision-makers (district, sub-national and national levels) to take appropriate and informed decisions

Every child should survive and thrive

Secondary Objectives

1. Generate accurate and timely perinatal mortality data at the facility, district and national levels
2. Identify major medical and non-medical causes of perinatal mortality

1. To raise awareness among key stakeholders about the modifiable factors
2. Support improvements in Quality of Care for maternal and perinatal health

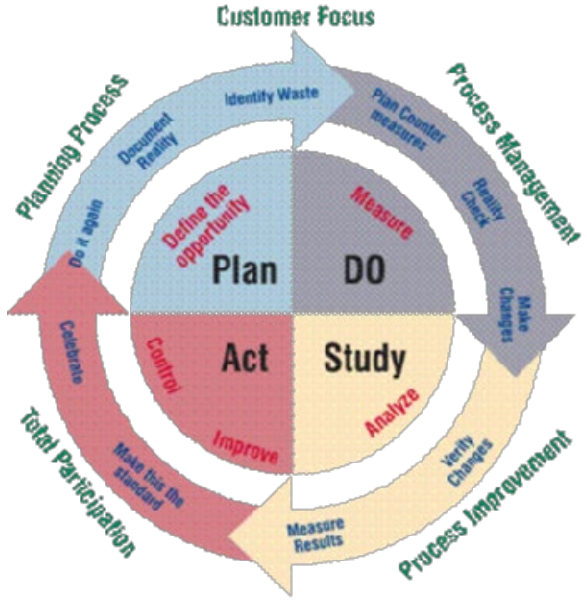
Who is the Audience?

Stakeholders at all levels who can drive positive change should be involved in the process of setting up mortality audit systems

- **Ministry of Health**: health planners, managers, policy makers
- Hospital authorities and hospital administrators
- **Clinicians** (doctors, nurses, midwives, paraclinical staff)
- **Professional associations**: obstetric, pediatrics, perinatal, neonatology, midwifery, nursing associations and councils, anesthetists.
- **Researchers:** social scientists, epidemiologists, public health researchers
- **Health information system specialists** and monitoring and evaluation personnel
- **Civil society representatives**, parent groups and community leaders

Guiding Principles- 1

- “No blame” and “No Name” policy
- Death reviews focus on health systems not individuals
- Review meetings are a learning opportunity for all participants to improve quality of care and end preventable deaths
- Builds on existing QI committees and existing MPDSR platforms
- A zero-reporting principle is adopted (to report regularly even if no death)
- Documentation from patient case notes is the main source of information



Guiding Principles- 2

- Perinatal mortality reviews are similar to MDSR
- Data are anonymized and cannot be used for disciplinary purposes
- The death reviews are **incomplete without response** to prevent modifiable factors
- The response (action plan) often involves a multi-sectoral approach
- It is better to start small, learn from the experience, refine and adapt as we scale up
- Training on perinatal death reviews should also be incorporated in the curricula of medical, nursing and midwifery institutions

Workshop format

- Two days skills-building workshop
- Lectures, small group work, exercises
- Lunch (1 hour)
- Two Breaks (15-minute breaks)