Improving prevention, detection and management PPH in Tanzania

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Outline

- Background
- Gap analysis in PPH prevention and management
- Interventions implemented
- Results
- Challenges
- Key recommendations
Background

• Tanzania MMR
  • is high and stagnant
  • at 524 with annual rate reduction (ARR) 2.9% (WHO, Unicef 2019)

➢ PPH is the leading cause of maternal deaths at 29%

• Proportion of facility births received uterotonics 89.6% (DHIS2 2015)
• PPH incidence 0.8%(DHIS2 2015)
• The national RMNCAH strategic plan indicates improving Quality of Care (QoC) for obstetric emergencies
Key findings of root cause analysis to identify gaps in PPH prevention and management

**Emergency readiness in facility:**
- Team not readily available during emergencies; team roles not clear
- Challenges in availability of emergency commodities 24/7 and ensuring supply
- Suboptimal patient stabilization prior to referral and no prior notification to receiving HFs
- Skills gaps on managing obstetric hemorrhage including caesarean birth
- Serious shortage of human resources for health (HRH)

**Health System:**
- MPDSR process is inadequate at health facilities especially ‘response’
- Shortage of blood and blood products
- Inadequate facility leadership (managing staff, planning, allocating resources based on needs)

**Routine service delivery organization:**
- Inadequate monitoring for immediate postpartum care resulted in delayed early identification of PPH

**Facility- Community linkages:**
- Late referrals from community

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Interventions to improve QoC and reduce PPH burden

1. Adaptation of PPH framework
   - Updated national uterotonic guidelines 2019
   - Improved facility readiness & referral
     - Emergency teams with clear roles and responsibilities
     - Emergency kits and regular checking of emergency commodities & equipment
     - Emergency drills
     - Closed User Group to facilitate communication (prior notification & consultations)

2. Blended learning
   - Use of data to focus intervention
   - On-the-job-training on managing PPH, surgical management of PPH using the B-Lynch suture
   - Structured regular peer practices
   - Targeted supportive supervision and mentorship
   - dLearning

3. Health System Strengthening
   - Accountability:
     - MPDSR,
     - community score card,
     - Strengthening facility leadership
   - Enhancing safe Blood availability and accessibility

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Key Results
Uterotonic use and PPH incidence among births in Geita, Kagera and Mara (n=560 HFs)

- Facilities Deliveries
- Received Uterotonics
- PPH incidence

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CFR for PPH in 52 CEmONC sites (Kagera, Mara and Geita)

38 Hospitals

52 Hospitals

PPH Case fatality rate

- Oct-Dec'16: 4%
- Jan-Mar'17: 4%
- Apr-Jun'17: 2%
- Jul-Sep'17: 2%
- Oct-Dec'17: 1%
- Jan-Mar'18: 5%
- Apr-Jun'18: 9%
- Jul-Sep'18: 6%
- Oct-Dec'18: 6%
- Jan-Mar'19: 9%
- Apr-Jun'19: 6%
- Jul-Sep'19: 6%
- Oct-Dec'19: 5%

Geita added
Annual trend on availability of safe blood Lake Zone (Kagera, Mara, Geita) 2016-2019

- **2016**: 66112 units, 23% of target
- **2017**: 67788 units, 35% of target
- **2018**: 69463 units, 45% of target
- **2019**: 71137 units, 56% of target

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Challenges

• PPH is under reported

• Inadequate implementation MPDSR especially the response part

• Severe shortages of staff

• Suboptimal implementation QoC interventions
Key recommendations

National strategic plan in reduction of MMR should ensure strong focus on PPH:

- Improve quality of care in prevention, detection and management of PPH e.g. use TXA
- Metrics for monitoring QoC (e.g. % PPH clients correctly managed with uterotonics)
- Improving referrals (transport, communication and follow up)
- Improving facility readiness (esp. lifesaving commodities & HRH)
- Surgical management & data on PPH in C/S
- Strengthening response & follow up in MPDSR
- Community engagement/social accountability (Community Score Card)

Pre-service curriculum for midwives and doctors to include updated PPH protocols and clinical simulations/drills for team building to respond to PPH

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