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| **World Health Organisation (WHO) Safe Childbirth Checklist as a tool to understand the ability of hospitals reduces preventable stillbirths and neonatal deaths by delivering high quality care: an ethnography from three Malawian facilities.** |
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| **Introduction** The WHO launched the safe childbirth checklist to encourage improved quality of care for institutional deliveries. High quality care around the time of delivery has the potential to reduce preventable stillbirths and neonatal deaths. It therefore provides a useful tool with which to consider the performance of a health system throughout a woman’s journey from admission to discharge home postnatally.  **Material and Methods** Ethnographic observations were undertaken over a period of 9 months in three settings. A high-risk postnatal ward of a large district referral centre, a district hospital maternity and postnatal ward and a community hospital. The ethnographic observations were then analysed through the lens of the WHO Safe Childbirth Checklist.  **Results** The Checklist is not currently implemented in any of these settings, therefore the potential to meet the checklist criteria is considered here. There are some areas of the checklist in which all facilities could perform well, for example the starting of partograms on admission to the ward, ensuring that a delivery pack is prepared for the mother, and having a hospital attendant on standby to assist if necessary. There is also often quick identification of bleeding after birth and excellent initiation of neonates on antibiotics. All mothers remain in the hospital for at least 24 hours and health talks are given daily explaining danger signs and follow up. However, there are areas where these three facilities would struggle to implement the Safe Childbirth Checklist. Referral is often driven by resource constraints and safe transfer hindered by financial constraints, such as lack of fuel. The vital signs of patients are seldom taken more than once per day and therefore it becomes challenging to identify when to administer antibiotics or anti-hypertensives. This extends to intrapartum care where fetal and maternal monitoring takes place infrequently. Whilst in some facilities companionship throughout the admission is encouraged, in other facilities it is actively discouraged by the staff due to space constraints and personal preference to “not work within guardians (relatives)”.  **Conclusions** The WHO checklist has not been implemented in these hospitals, suggesting a possible gap between the development and implementation of the tool. Whilst the facilities already perform well in some areas of the checklist, the consistent delivery of all aspects of the checklist would require some system level changes, and would help them to tackle preventable stillbirths and neonatal deaths. There needs to be appropriate resources available to adequately assess and monitor |
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