Subnational and facility leadership as drivers of maternal and perinatal death surveillance and response in four Sub-Saharan Countries

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Background
- Maternal and perinatal death surveillance and response (MPDSR) systems are an important component of quality improvement strategies to prevent preventable maternal and perinatal mortality and strengthen health systems.
- Few sub-Saharan African countries have robust MPDSR systems.

Assessment and objectives
From 2016-2017, USAID’s Maternal and Child Survival Program (MCSP) conducted an assessment of MPDSR implementation in four sub-Saharan African countries: Nigeria, Rwanda, Tanzania and Zimbabwe. The assessment assessed the implementation status of MPDSR processes at subnational and facility levels and to describe factors influencing sustainable MPDSR practices.

Methods
- A desktop review of MPDSR-related national policies, guidelines, and tools.
- 41 national and sub-national key informants semi-structured interviews.
- 55 health facilities visits (41 hospitals and 14 health centres) to conduct semi-structured interviews with managers and providers, review documents for MPDSR processes, and assess the implementation status of each facility’s MPDSR system. Facility inclusion criteria included provision of child births services and current or previous experience conducting maternal or perinatal deaths audits.

Results
- 47 facilities demonstrated implementation or institutionalization of MPDSR. The most commonly observed enabling factors of MPDSR included
  - Leadership and regular meeting conducted with participation from a multidisciplinary team.
  - National and sub-national support through MPDSR training support.
  - Evidence of MPDSR process leading to change or having improved health services.

Proportion of facilities practicing MPDSR with evidence of leaders and multidisciplinary teams (N=47):
- 98% had a special persons who take specific effort in promoting death reviews
- 89% had clear leader(s) involved in establishing and championing death reviews (past or future)
- 91% had steering committees or death review teams established
- 86% had multidisciplinary teams including staff from different disciplines and management teams

Country specific highlights
- In Tanzania, the participation of district coordinators in facility MPDSR meetings improved the quality of meetings and built capacity of facility staff.
- In Zimbabwe, the interdisciplinary nature of audit meetings was ensured by the strong facility leadership and demonstrated wider buy-in and ownership in the process.
- In Rwanda, all of the facilities assessed had MDSR teams in place and most mentioned strong facility leadership as an important element of the process.
- In Nigeria, national and sub-national champions and decision-makers, especially professional associations, helped to build momentum for establishing and disseminating the new MPDSR policy.

“MPDSR helps us not to repeat the same mistakes—we see what was lacking and want to improve quality of care.”—Facility interview

Leadership
Nearly all facilities practicing MPDSR had designated staff members assigned as MPDSR coordinators. Common positions for coordinators were:
- Facility-in-charge, mostly at health centers and hospitals with less than 100 deliveries per month
- Regional or district health officer (or equivalent), at provincial, regional and district hospitals
- Head of the hospital OB-GYN, Pediatric or Neonatology department, at the tertiary, government and private hospitals with high level of deliveries (over 100 per month)

Multidisciplinary Teamwork
Nearly all of these facilities had established steering committees or review teams with representation of a range of health workers from different units, especially in larger facilities. The frequency of formal meetings varied between and within countries from weekly to monthly to quarterly, but most committees met regularly.

“Everyone attends our maternal and perinatal meetings, all the way to the driver. Because when we have a case to transfer, he knows why we need to move now.”—Facility interview

Coordinating and reporting structures and sub-national support
The national MPDSR-related guidelines in all four countries specify national and sub-national structures in support of MPDSR. In practice the functionality of such structures varies within and across countries as determined by sub-national stakeholder interviews. In Tanzania, MPDSR district coordinators were in place and sent quarterly district reports to regional level. In Zimbabwe, most sub-national MDSR coordinators were in place but fewer PDSR coordinators, and most stakeholders (86%) reported compiling central reports. In Nigeria, 2 of 7 stakeholder reported a MDSR coordinator in place at subnational level and none reported compiling sub-national reports.

Conclusion
The findings demonstrate that the facilities practicing MPDSR have designed leaders, established multi-disciplinary steering committees and sub-national support. Designated leadership and supervision within a supportive environment are essential components to completion of the audit cycle. Engagement from sub-national level promotes accountability and supports MPDSR practice at facility level through cross facility/district learning, capacity building on data use for decision making, and mentorship. Successful implementation of MPDSR requires leaders to champion the process, and to access change agents at other levels to address larger, systemic concerns identified through MPDSR.

This study did not unpack “champions” or measurement of strong leadership or teams, which will require further investigation. The practice of MPDSR should continue to be assessed and monitored to deepen understanding of the quality of MPDSR processes and further inform country implementation and global recommendations.