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ASSESSMENT OF MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE IMPLEMENTATION IN NIGERIA

Background

With a focus on achieving the Sustainable Development Goals, Nigeria is looking to accelerate efforts to improve outcomes for women and babies.[1] There is global consensus that accurate information about causes of death through mortality audits is needed to help inform efforts to end preventable maternal and perinatal deaths. Maternal and Perinatal Death Surveillance and Response (MPDSR) is a continuous cycle of identification, notification, and review of maternal and perinatal deaths, followed by actions to improve quality of care and prevent future deaths.[2] It is an established mechanism to examine the circumstances surrounding each death, including any breakdowns in care from the household to the health facility that may have been preventable. There is global consensus that this process is an important part of the continuous action cycle for quality improvement that can link data from the local to the national level.

The Nigerian Federal Ministry of Health (FMOH) adopted the Maternal and Perinatal Death Surveillance and Response policy and guidelines in 2016.[3] Since other maternal and perinatal death audit models had been practiced in the country, the FMOH and supporting partners sought to understand these models in order to improve implementation of the policy.

Study objective

The objective was to conduct a national assessment that would provide an understanding of the characteristics of past and current maternal and perinatal death audit processes, including their operational enhancers and challenges. The assessment was done by Save the Children's Saving Newborn Lives project and USAID's Maternal and Child Survival Program, with support from the FMOH, state ministries of health, and professional associations.

Methodology

The assessment was conducted in two phases during September and October 2016. The first phase was a telephone survey that captured the landscape of past and current MPDR processes in all 36 states and the Federal Capital Territory (FCT). The second phase, an in-depth assessment of functional processes, involved visits to selected facilities in one state in each of the six geopolitical zones, as well as interviews with key informants at national, state, and facility levels. The study was reviewed by the Nigeria Health Research Ethical Committee, the Johns Hopkins School of Public Health Institutional Review Board, and Save the Children, and was designated "non-human subject research."

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Findings

History of audit practice

The desk review identified 10 programmes implementing death audit models across Nigeria dating to 2008 (Table 1). These programmes applied a variety of audit types, including confidential enquiry, maternal death review and verbal autopsy, and clinical audit. Most of the programmes were implemented in geopolitical zones with the highest burden of maternal and perinatal mortalities, all focused on maternal deaths, and only three included perinatal mortality. All of the programmes, except the clinical audit, provided specific guidelines and tools, produced reports, and worked in partnership with states and local and international partners. The programme audit models varied in structures and outcomes, with some using local structures while others were specific to programmes, which inhibited institutionalization of the audit model into the existing systems.

Table 1. Landscape results of maternal and perinatal death audit processes prior to MPDSR

Programme Title (Partner support)	Components: Audit Type(s)	Implementation Level(s)	Start Year	Geographic Coverage (full/partial)	Current Status
1. Ondo State "Alive" Programme: Confidential Enquiry into Maternal Deaths in Ondo State (Ondo State Government)	CE, MDR	State, Facility, Community	2009	Ondo State (Full)	Transitioning to MPDSR
2. Delta State MDR Programme (Delta State Government)	MDR	State, Facility	2014	Delta State (Partial)	Transitioning to MPDSR
3. Quality Assurance in Obstetrics (Rotary International)	CE (Maternal & Fetal)	Facility	2008	Kaduna, Kano, FCT, Ondo (Partial)	Ended 2015
4. Facility Maternal Death Review (PPRINN-MNCH)	CE, MDR	State, Facility	2010	Yobe and Zamfara (Full) Katsina (Partial)	Ended 2013
5. Maternal Death Review in the Northern States under the Midwifery Service Scheme (NPHCDA)	MDR, VA	Facility, Community	2011	19+1 Northern States (Partial)	Ended 2013
6. Maternal Death Review Programme in the Federal Capital Territory (SOGON)	MDR VA	State, Facility, Community	2014	FCT Only (Partial)	Ongoing
7. Community-Based Health Information System (CHAI)	MDR, PDR, VA	Community	2015	Kaduna, Kano, Katsina (Partial)	Ongoing
8. Maternal Death Review Programme in Lagos State (WHARC)	MDR	State, Facility	2014	Lagos State (Partial)	Ongoing
9. The Nigerian Maternal, Newborn and Health Maternal Death Review Programme (MNCH2-MDR)	MDR, VA	State, Facility, Community	2014	Kaduna, Kano, Katsina, Jigawa, Yobe, Zamfara (Full)	Ongoing
10. N/A	Clinical Audit	Facility	N/A	Entire Country	Ongoing

Key: CE – confidential enquiry; CHAI – Clinton Health Access Initiative; MDR – maternal death review; NPHCDA – National Primary Health Care Development Agency; PPRINN-MNCH – Partnership for Reviving Routine Immunisation in Northern Nigeria and Maternal Newborn and Child Health; SOGON – Society of Gynaecology & Obstetrics of Nigeria; WHARC – Women's Health and Action Research Centre

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Scale of MPDSR

At the time of the assessment, state-level stakeholders reported widespread orientation and dissemination of the national MPDSR guidelines to the state ministry of health level. However, there was moderate to limited scale in terms of setting up the processes needed to implement MPDSR across the states (Table 2).

Table 2. Scale of MPDSR implementation activities as reported by the state-level key informants with the state ministry of health

Indicator	Total # States (%)
States participating in national orientation on MPDSR	36+1 (100)
States with established MPDSR steering committees	31 (84)
States with developed MPDSR action plans	28 (76)
States with established facility MPDSR committees*	12 (32)
States with established community MPDSR committees*	8 (22)
States with established tracking mechanism for rollout of MPDSR	8 (22)
States with system for collating state-wide MPDSR reports	7 (19)

** Signifies at least one facility or community MPDSR committee established*

In-depth assessment

The assessments showed a range of awareness and implementation of MPDSR and other audit models for maternal and perinatal deaths. There was general awareness of the importance of collecting mortality data and notifying authorities regarding maternal deaths. However, the practice of reviewing the causes and avoidable factors related to maternal deaths and recommending changes was not widespread. Overall, there was very little integration of stillbirths and neonatal deaths into data collection and notification, and almost no review of the care received prior to these deaths. Many facilities were unaware of or not using the new national MPDSR guidelines. In all but one state, tertiary, secondary, and primary health facilities had either not implemented or were still at the level of creating awareness of MPDSR; yet nearly two-thirds of facilities demonstrated the existence or institutionalization of other death audit processes.

"You don't regularly hear about stillbirths. They are considered not as grievous."

- Facility Interview

"The positive changes are evident; however, the documentation of the process was poor."

- Facility Interview

"Review meetings are where people learn to 'stick to the rules.' … Some staff are reprimanded verbally and [receive] other punishments."

- Facility Interview

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Perspectives of national stakeholders

National stakeholders reported that MPDSR is a FMOH priority, noting its inclusion in major policy documents, such as the National Strategic Health Development Plan. Despite the challenges identified, national stakeholders, including FMOH, are confident that, with stronger political commitment at the state level, MPDSR has the potential to improve quality of care and data generation in the health sector.

Challenges reported by national key informants include:

- MPDSR is poorly funded and largely donor dependent; generally there is inadequate funding for RMNCH.
- Health workers are resistant to change and are ignorant of or misinformed about the "no name, no blame" mortality audit approach.
- Written standards and protocols for newborn resuscitation are lacking at various levels of health system.
- Harmful traditional practices persist.
- MPDSR tools are voluminous and the language is too technical.
- Political commitment is low. There is no strategic implementation plan for MPDSR and no link to the quality improvement framework.
- Inadequate health personnel persists.
- Poor documentation on patients results from poor recordkeeping and poor reporting of deaths.
- MPDSR committees do not respond to recommendations.
- There are a large number of deaths for review in some settings.

Conclusion

Each death that is carefully documented and reviewed has the potential to tell a story about what could have been done differently to improve the care available and health outcomes for each woman and baby. Box 1 presents recommendations for all stakeholders based on the results of this assessment.

The practice of mortality audit in Nigeria requires leaders to champion the process – especially to ensure a no-blame environment – and to motivate change agents at other levels to address systemic concerns. The existence, and in some cases institutionalization of practice, of the older death audit processes in many facilities assessed reveals a system in place to strengthen MPDSR implementation. The information from this assessment can serve as a baseline for monitoring the implementation of MPDSR and to advocate for greater investments to ensure smooth and effective institutionalization of MPDSR across Nigeria.

> *"Poor understanding of the tools and terminologies therein lead to poor quality of data and incomplete data."*
>
> **- Stakeholder Interview**

> *"Reviews are meant to bring things to the forefront. It's about accountability, checks and balances."*
>
> **- Stakeholder Interview**

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Box 1. Recommendations

- **Strengthen or establish tracking of MPDSR implementation** at national, state, and facility levels, with regular meetings to discuss and adjust implementation if necessary.
- **Improve MPDSR reporting requirements** by ensuring all stakeholders understand required reporting channels between facility, state, and national levels. The national stakeholders should review the MPDSR report flow from health facility to LGA/state in the current guidelines.
- **Link quality improvement initiatives to MPDSR processes**, especially between the national MPDSR guidelines and the forthcoming national quality improvement guidelines. States and facilities should integrate the new quality improvement initiative into the MPDSR process.
- **Ensure dissemination and use of national MPDSR forms and guidelines** at facility, state, and national levels, and orient all stakeholders. Standardized forms (preferably the national MPDSR forms) should be used for documenting all cases under review.
- **Strengthen leadership and nurture champions of MPDSR at all levels**, especially ensuring that facilities identify an MPDSR focal person and establish MPDSR committees. Leaders should be mentored to ensure a no-blame approach to death review and to document successes.
- **Integrate MPDSR into federal and state data systems, ensuring quality of data capture and analysis** into HMIS, problems identified, and solutions implemented. A standardized classification system for cause of death classification should be considered.
- **Engage communities** through the ward committees to ensure a formal communication process of results from facility-based death reviews. Stakeholders should explore the feasibility of community death notification and, where possible, verbal and social autopsy for community maternal and perinatal deaths.

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2. WHO. Make every baby count: audit and review of stillbirths and neonatal deaths. Geneva: World Health Organization, 2016.
3. Federal Ministry of Health. National guidelines for maternal and perinatal death surveillance and response in Nigeria Abuja: Government of Nigeria, 2015.

Access the full report and state MPDSR profiles at: *www.healthynewbornnetwork.org/resources/NigeriaMPDSRassessment*

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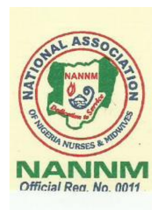

Paediatric Association of Nigeria (PAN)