MPDSR Implementation Lessons: A scoping review of 58 studies in 24 countries spanning 15 years

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Outline

• Scoping Review
• Conceptual framework
• Key findings
• Conclusions

https://bmjopen.bmj.com/content/9/11/e031328

https://doi.org/10.1093/heapol/czab011
Scoping review

Why
• Growing momentum to strengthen, expand and study the intervention
• Some reviews on implementation factors but not using framework or including both maternal and perinatal death audits or all LMIC

What
• Scoping review
  ➢ To map and synthesize the available literature to identify and describe factors that support or hinder M/PDSR implementation
  ➢ To develop a conceptual implementation framework that considers critical dynamic linkages and triggers of change.

How
• Systematic screening process of 1027 studies
• Data collection and analysis for 72 resources, including 58 studies

Inclusion criteria for screening:
• Published in English between 2004-July 2018
• Concept component: enablers and barriers of MPDSR implementation (all forms of maternal and perinatal death audit considered)
• Context component: LMIC only

Screening methods
• 2 reviewers independently screened
• All discrepancies between reviewers resolved by a 3rd party.
• The reviewers regularly met during process

Data collection
• Extraction tool developed & piloted
• Data extracted by one team member and then reviewed by another team member
• Regular meetings and workshop to review and revise
Theoretical framework for studying MPDSR implementation

4 domains
- Intervention
- Individual
- Inner setting
- Outer setting

3 lenses
- Service delivery
- Societal
- Systems

24 constructs in total
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Service delivery lens (inputs needed for implementation)

Societal lens (interactions between those involved in the implementation)

Systems lens (things that trigger change)
Key findings: Record characteristics & data points (n=58)

- **WHERE** - 24 LMIC; mostly Sub-Saharan Africa: 66% Sub-Saharan Africa; 12% South East Asia; 12% international; 6% other; Few from humanitarian and fragile settings: 16% (4 countries)

- **WHAT** - Maternal death reviews & MDSR. 53% maternal only; 39% maternal and perinatal; 9% perinatal only; Mostly combination of levels few meso or micro studies & few studies at sub-national level.

- **HOW** - Mostly qualitative. 45% qualitative; 28% mixed methods; 5% quantitative; 22% no methods indicated

- **WHOM** – Academia and government: 52% mixed including government; 26% University
  - First authors from LMIC: 69% but top 2 countries: UK (21%) & US (9%)

- **601 data points extracted and analyzed**
  - The outer setting, intervention and inner setting domains have the most data (27%, 29% and 30% respectively).
  - The domain focused on the role of individuals has the fewest data (13%)
Key findings: many assumptions vs. actual systematic documentation

• **Most studies describe tangible inputs** addressed by the service delivery lens, but these are often measured inadequately or through incomparable ways.

• While studies document belief of individuals that MPDSR leads to change **little evidence presented on “closing the loop”** ie the response/action.

• **Studies state that people and their relationships**, motivations, implementation climate and ability to communicate influence implementation processes, but individual subjective experiences and relationships are inadequately explored.

• MPDSR implementation **contributes to accountability and benefits from a culture of learning**, but few have studied the change dynamics involved.
**Intervention**: characteristics of the intervention being implemented in a particular setting

- **No consistency in reporting on MPDSR** (e.g. including all steps of the audit cycle)
  - No differences in implementation factors between different types of reviews

- **Cost**: Funds for training, transport and dissemination of results, human resources
  - Few studies actually reported costing data and no standard approach

- **Framing of intervention** source and evidence strength explored but not relative advantage
  - Countries adapt from WHO guidelines but context specific changes not documented or examined
  - Stakeholder perceptions of legitimacy not explored; some literature around belief MPDSR leads to change with little evidence

- **Phasing and pilots used** - local leadership was noted as a critical enabling factor; 9 pilots identified
  - No reporting on modification or expansion after these pilots,
  - Challenge of sustained implementation beyond projects

- **Processes have adapted and changed over time** in specific contexts and to the intervention itself, but we are not applying learning from previous literature/experience
Individuals: characteristics of the individuals involved in implementation

- **Technical skills are required** BUT no list of required competencies needed; few studies
- Individual confidence to implement MPDSR supported by supportive supervision, appropriate tools and oversight from sub-national management or health specialists.
- Motivation to implement driven by
  - **extrinsic motivation**: expectations from sub-national teams, skills or knowledge and incentives, improved quality;
  - **intrinsic motivation**: consciousness for self-improvement & value of life.
- Individual perception of the MPDSR process described as helpful, especially for learning.
- Few studies examined reasons for ownership or commitment to MPDSR; ownership may come over time as people see the benefits of change
- Individual orientation to collaborate not explored
**Inner Setting:** factors internal to the organization

- Required **inputs to implement validated** e.g. focal person, committees, regularly scheduled meetings; available tools; audit charters, training, HR challenges

- Teams mostly described as **multidisciplinary**; challenges include high staff turnover, competing priorities, lack of interest, hierarchy

- **Incentives** mentioned (i.e. training, per diems, refreshments) but not investigated for impact. **No research identified on sanctions** or consequences of not implementing audit

- **Team approach and organizational culture matters**: a culture of accountability, learning and improvement; blame culture perceived as barriers with mixed results.

- **Engaged leaders recognized widely as enabler** yet little is known about the necessary individual leadership traits and critical thinking or problem solving skills.
  - Skills in facilitation one trait identified but not investigated
**Outer Setting:** factors external to the organization that influence implementation

- Policies and guidelines in place; few studies on impact of legal frameworks or protocols around death notification
- **Funding source mostly from governments or development partners**; lack of a budget line identified as a barrier with mixed findings on need for allocated resources
- **Important role of external actors** identified at all levels – development partners, professional associations, civil society – esp for developing guidelines and supporting implementation; sub-national actors for supportive supervision are critical
- Pressures to implement depends on level of implementation e.g. national level - political commitments; facility level - sub-national structures – but few studies investigate perceptions around how & why
- **Interlinkages exist across domains and constructs are important** ie better data and reporting improves communication across the health system as well as between team members
Conclusion

- M/PDSR is a complex intervention process and using a theory-based implementation framework helps to unpack the various components needed for implementation.

- **How do we go beyond what we think we know works?**
  - *Do we know enough* about the “blue prints” for implementation?
  - What do we know about *how to sustain such a process* in systems that are under strain and with other competing time commitments?
  - We need to do better at *comparably learning* what works or doesn’t for MPDSR implementation.
  - Many *research* gaps especially of
    - individual perceptions & skills needed
    - sub-national level engagement, which plays a vital role in implementation for accountability, information flow and quality control
    - Adaption including in humanitarian and fragile settings

- Health policy and systems research looking *at how and why people adopt, adapt and sustain collective action* will strengthen our understanding of implementation.
Thank you!

Access the paper:
https://bmjopen.bmj.com/content/9/11/e031328