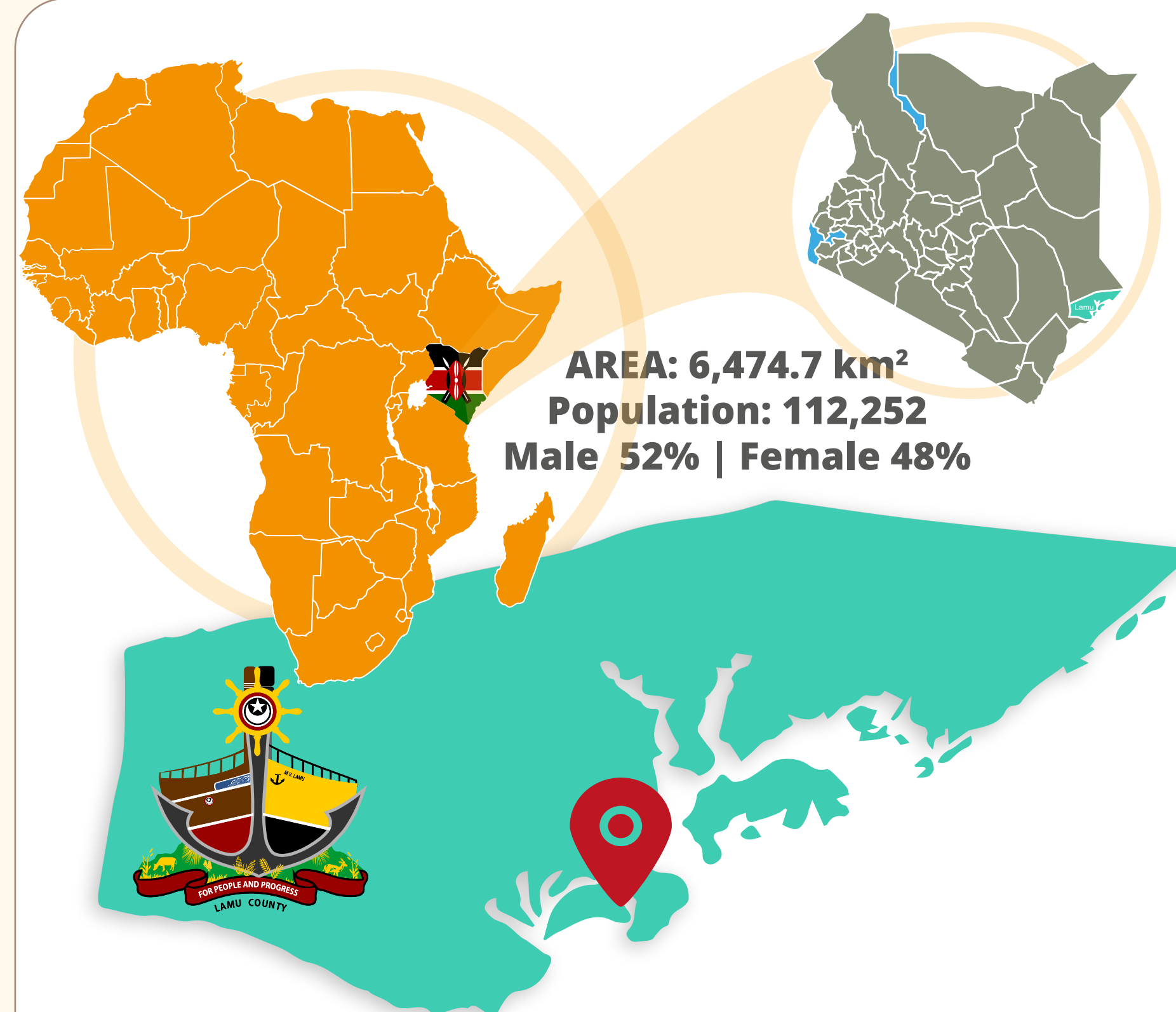


The qualitative content analysis of MPDSR audit meetings in Lamu County Referral Hospital, Kenya.

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INTRODUCTION

MPDSR constitutes a quality improvement approach to identify how many maternal deaths occur (Surveillance), what the underlying causes of death and associated factors are (Review), and how to implement actions to reduce the number of preventable stillbirths and maternal and neonatal deaths (Response)

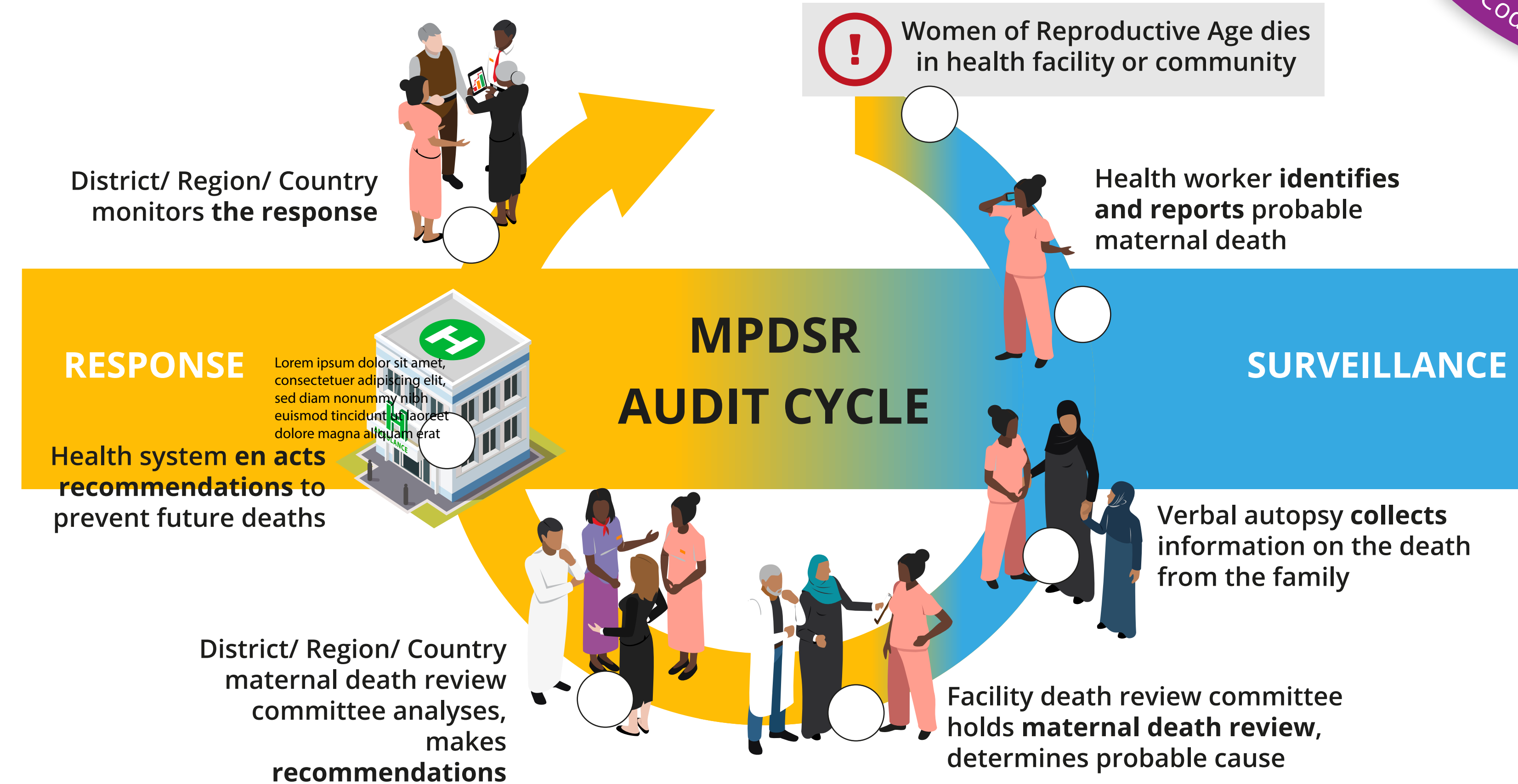
Currently in Kenya the maternal mortality ratio is 362/100,000 live births perinatal mortality rate and the neonatal mortality 29/1000 live births and 22/1000 live births respectively

Kenya made maternal death notification mandatory in 2004. The National guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) were launched in 2016 and the first Confidential Enquiry into Maternal Deaths (CEMD) was published 2017

The author served in Lamu County for 3years(2019-2022) and kept wondering why there is no shift in the MPDSR. Here some answers are shared.



The Lamu archipalaego is a small group of islands situated on Kenya's Northern Coastline, near Somalia. It is made up of Lamu, Manda, Pate and Kiwayuu Islands.



OBJECTIVES

1

To decipher the impact of "R" of Maternal and Perinatal Death and Surveillance (MPDSR) audit meetings in Lamu County Referral Hospital

2

To identify challenges and barriers in implementing MPDSR

DESIGN

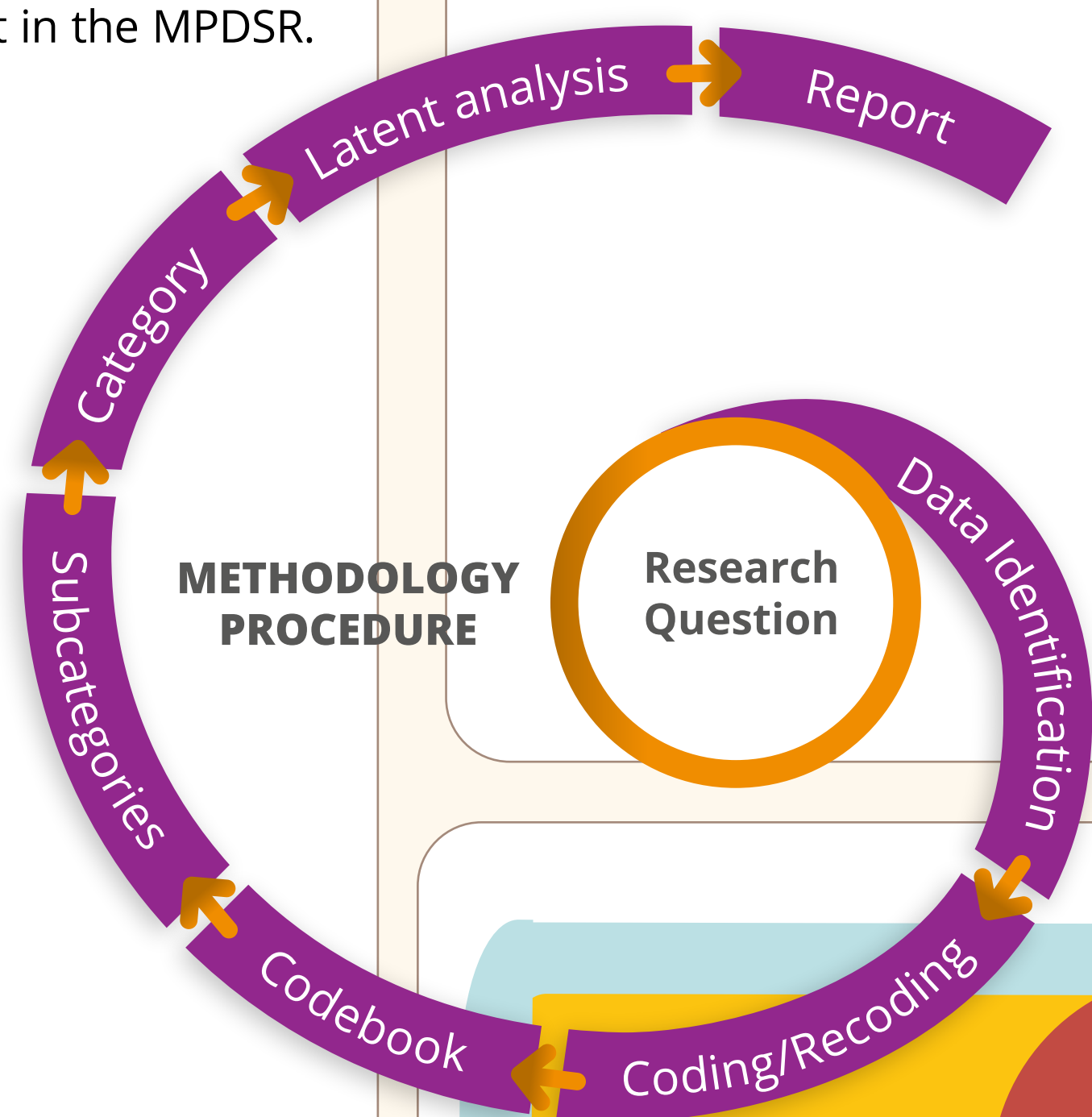
Retrospective qualitative content analysis of 64 audit meetings held from 2015 to 2022 at Lamu County Referral Hospital, Lamu.

Methodology

The study used a qualitative design on inductive content analysis and latent analysis.

Data collection: Data was collected from 64 perinatal audit meeting reports, from LAMU County and Referral Hospital between 2015-2022. Data on gaps identified, challenges, recommendations, and action plans were recorded.

Analysis: The data was coded per transcript and additional new aspects that came up in the process of coding resulted to the recoding of previous reports to include all new codes. The codes were categorized and subcategorized based on similarities to form content category and a code book generated. A latent analysis of the content category and the subcategories was created to help understand the deeper meaning of the texts in the report.



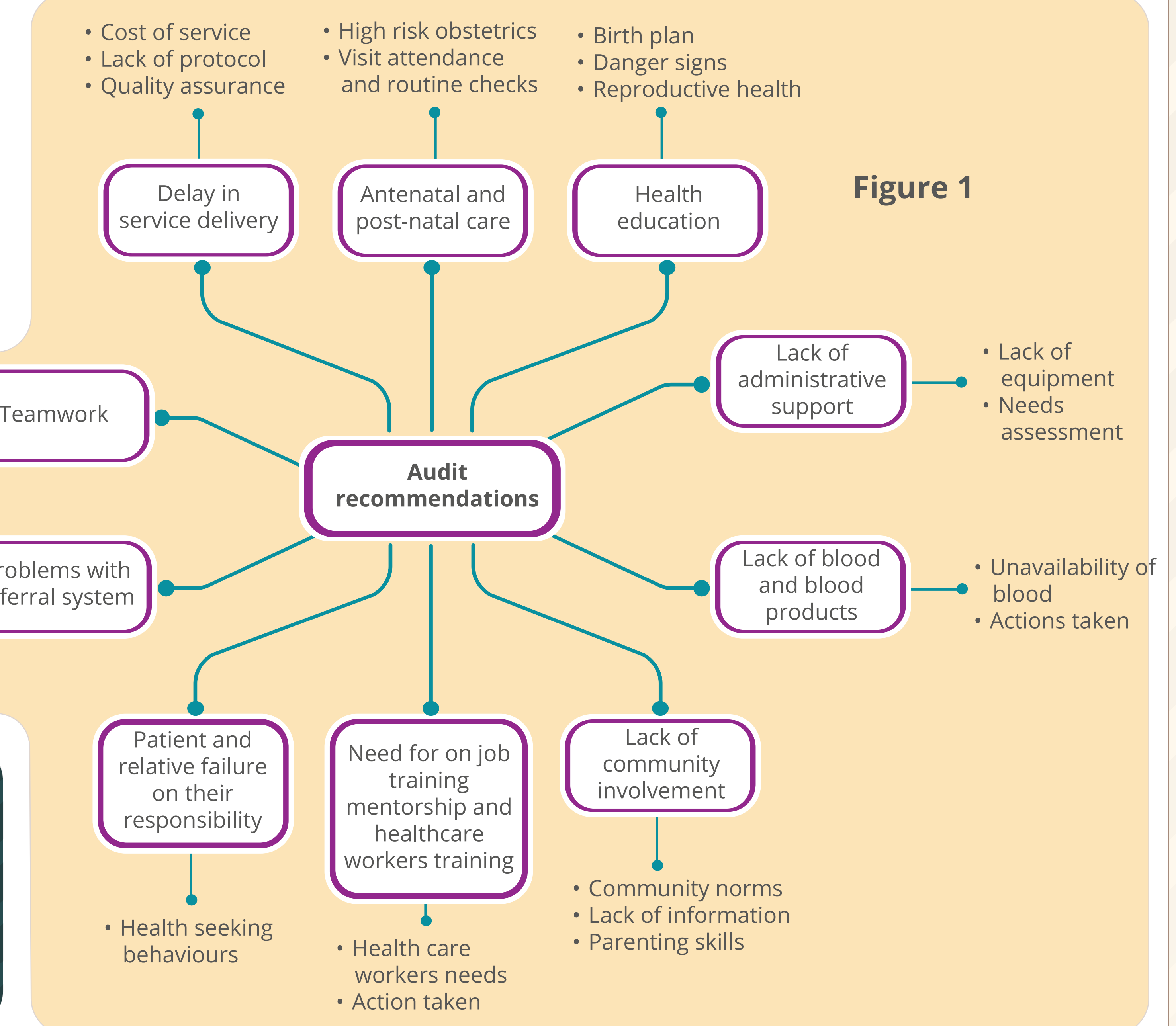
RESULTS

Three registers maintained at the maternity wing from 2015-2022 were reviewed, 64 audit meeting reports from 2015-2022 were analyzed. Recurrent categories (10) were identified; antenatal and postnatal care, delays in service delivery, health education needs, lack of administrative support, lack of blood and blood products, lack of community involvement, need for on job training and mentorship, Patient and relative failure on their responsibility, Problems with referral system, Teamwork, and actions taken. (figure 1).

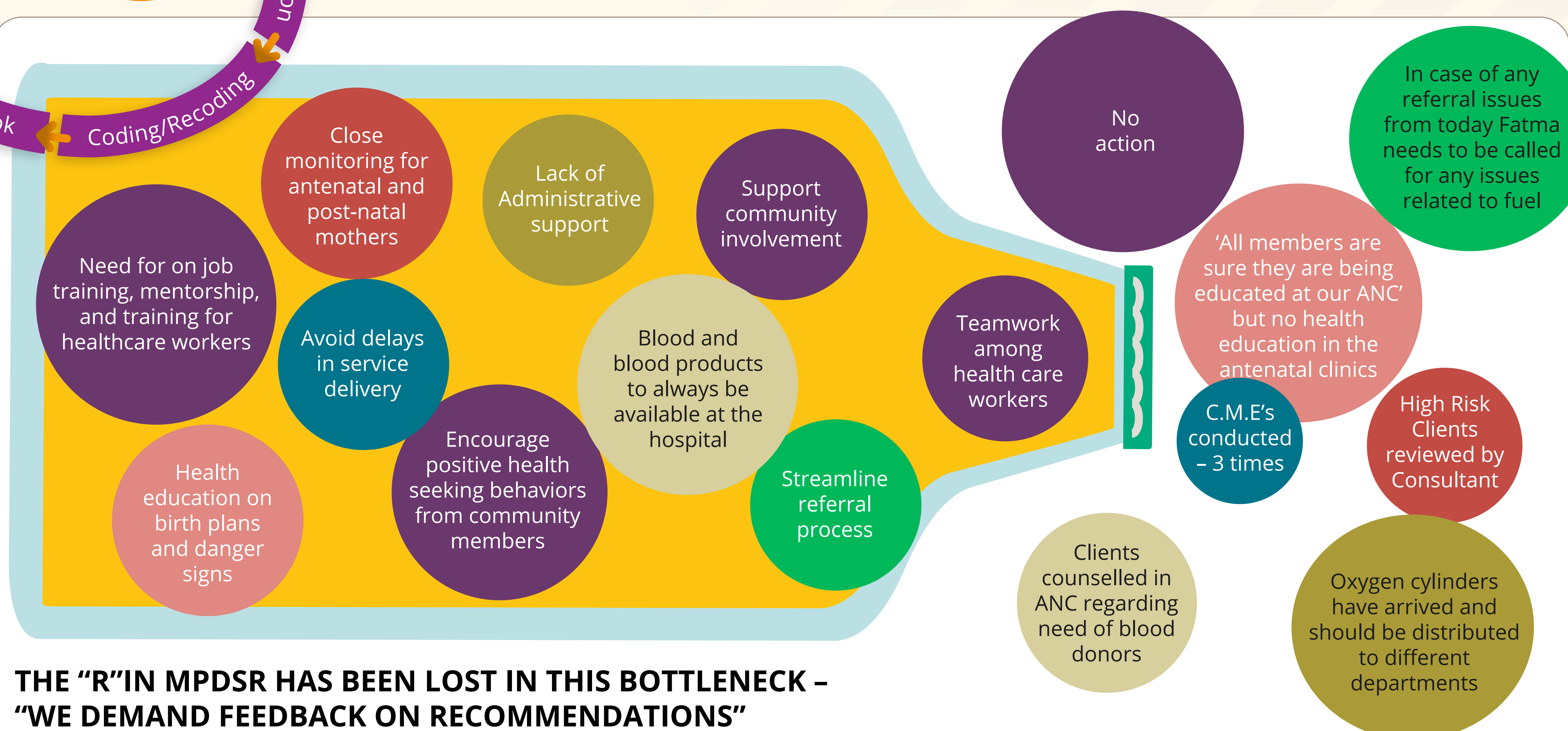
Subcategories had different reference intensities based on the recommendations. The order of the subcategories with the references is as shown: Lack of protocol (55 references), lack of administrative support (38 references), Antenatal and postnatal care(29 references), lack of health information by community(26 references), health system referral challenges (25 references),health education on danger signs (21 references),team work and communication among health providers(18 references),poor health seeking behaviors among community members(16 references),need for healthcare workers training and mentorship(15 references) and lack of blood and blood products at the facility(9 references). The number of responses/actions carried out documented in the 64 meetings were 3CMEs, High Risk Obstetrics reviewed by Consultant, arrival of oxygen cylinders reported, clients counselled regarding the need for blood donors, Fatima to be informed regarding fuel issues for referrals. Out of 237 references for the ten categories, a mere 7 references to actions actually taken were noted.

STATEMENTS THAT SHOW NO ACTIONS TAKEN

- 'Previous mortality meeting there have been recommendations but no evidence of implementation of such.'
- 'We demand feedback on recommendation!!'
- 'Ambush the CHMT'



THE "R"IN MPDSR HAS BEEN LOST IN THIS BOTTLENECK - "WE DEMAND FEEDBACK ON RECOMMENDATIONS"



DISCUSSION

The number of meetings for 8 years were 64 with an average of 15 participants including midwives, laboratory staff, clinical officers, doctors, theater representatives, nursing officers, Maternity unit in charge, and a member of management team. Every mortality was meticulously documented, gaps identified, recommendations and action points recorded but out of 237 recommendations only 7 references of actions carried out were coded. These results suggest an overarching problem with organizational resistance to change, lack of leadership in owning the MPDSR program, good governance and a total lack of knowledge management, hands on training, mentorship and innovation.

The challenges faced include harsh terrain with lack of transport, political and healthcare corruption including lack of trust and fear of nepotism and tribal repercussions.

Some of the barriers are lack of evidence-based practices, one stop trainings that are unorganized with no monitoring and evaluation, lack of a data base, favoritism and a demotivated human resource.

CONCLUSION

Although this is a snapshot of MPDSR audits in Lamu County, it highlights many outstanding issues. There is a dire need for ownership of MPDSR with an organogram to track roles and responsibilities in order to track implementation. Some of the causes of resistance to change are economic factors, inconvenience, uncertainty, threats to social relationships, resentment to control, group inertia, threat to expertise, to established power relations and established resource allocations. This qualitative content analysis is a starting point for addressing the pitfalls for continuous improvement cycle of MPDSR in Lamu County, Kenya.