A SYSTEMATIC REVIEW OF THE IMPLEMENTATION AND FUNCTIONALITY OF MPDSR COMMITTEES IN AFRICA

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ABSTRACT

Introduction: Maternal and perinatal death surveillance and response is a key strategy to reduce preventable maternal and newborn deaths. Maternal mortality ratio reflects health system performance and women's well-being. In 2012, the World Health Organization and partners introduced the Maternal Death Surveillance and Response system to address high MMRs in low- and middle-income African countries. This review evaluates the implementation of the MPDSR committee and its impact on maternal and perinatal outcomes in Africa. **Methods:** A total of 23 relevant studies published between 2002 and 2025 were identified through a comprehensive search of academic databases using PRISMA criteria and the PICOS framework. The AACODS checklist (authority, accuracy, coverage, objectivity, date, significance) was applied to assess study quality. **Results:** The review assessed the establishment and functioning of MPDSR committees across African countries. Implementation varied from national systems in South Africa and Ghana to facility-level audits in Nigeria and Kenya. Functional systems were associated with action-oriented responses, structured feedback, and regular evaluations. Challenges included blame culture, underreporting, staffing shortages, poor recordkeeping, and limited community involvement. Despite these barriers, studies have shown that effective MPDSR adoption has led to reduced maternal mortality and improved clinical accountability. Supportive leadership, standardized processes, and a learning-oriented culture were key to success. **Conclusion:** MPDSR committees are widely implemented in Africa, but structural, cultural, and institutional challenges continue to limit their impact. Countries emphasizing effective responses, regular feedback, and blame-free environments achieve better maternal and perinatal outcomes. Strengthened leadership, enhanced health worker capacity, and community engagement are essential to fully realize the potential of MPDSR systems in reducing preventable deaths

Keywords: MPDSR; maternal mortality; perinatal mortality; Africa; maternal health outcomes

INTRODUCTION

Maternal and perinatal death surveillance and response (MPDSR) is a critical quality improvement intervention aimed at reducing preventable maternal and neonatal deaths, including stillbirths. It involves systematic identification, notification, quantification, and review of deaths, with the goal of understanding the underlying causes and avoidability and implementing targeted actions to prevent future occurrences. MPDSR encompasses various methodologies, including maternal death reviews, perinatal death reviews, confidential enquiries, and maternal and perinatal audits (WHO, 2021).

Globally, the maternal mortality ratio (MMR) remains a key indicator of health system performance, gender equity, and women's overall status. In response to persistently high MMRs in many low- and middle-income countries, including those in Africa, the World Health Organization (WHO) and partners introduced the Maternal Death Surveillance and Response (MPDSR) system in 2012. This framework provides a continuous cycle of death identification, notification, review, analysis, and response. In 2013, WHO released formal guidance to support countries in implementing MPDSR as part of their national health strategies (WHO, 2013).

The primary aim of MPDSR is to reduce preventable maternal and perinatal deaths through a cyclical process of surveillance and response. The surveillance component involves consistent tracking and reporting of deaths, and the integration of the data into the health information system. The response component focuses on identifying root causes, formulating actionable recommendations, implementing those actions, and ensuring they are carried out.

When effectively implemented, MPDSR provides comprehensive insight into the sequence of events leading to maternal and perinatal deaths. It highlights systemic gaps from the community level to the point of care and informs appropriate interventions to strengthen the health system. Additionally, MPDSR contributes to improving the quality of maternal and newborn health services by promoting accountability, continuous learning, and a culture of no blame, where healthcare workers can candidly engage in the review process without fear of punishment (WHO, 2016).

In Zambia, Tanzania, Kenya, and many other African countries, MPDSR is increasingly being adopted as a strategy to improve maternal outcomes. However, its implementation varies across contexts due to differences in health system capacities, leadership, and institutional support. This systematic review explores the implementation of MPDSR across the African continent, examining how it contributes to improved maternal outcomes and identifying factors that facilitate or hinder its effectiveness.

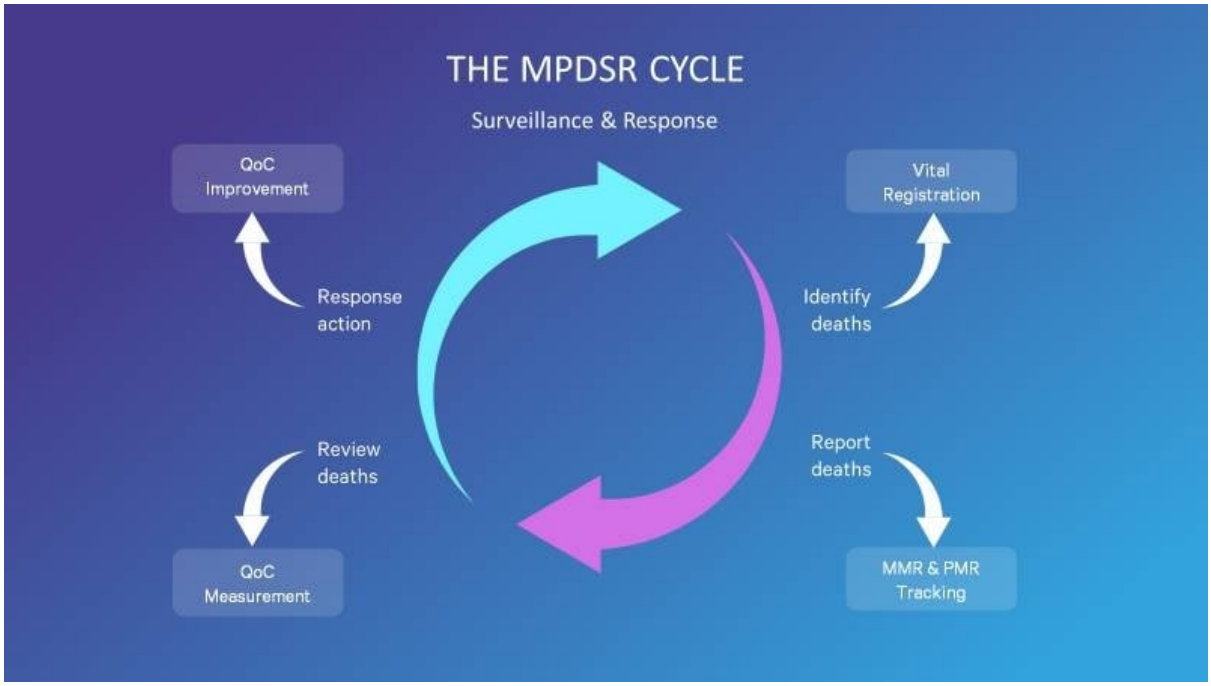

Figure 1: *Maternal and Perinatal Death Surveillance and Response (MPDSR) Cycle* (Adapted from World Health Organization, 2013)

A key intervention for improving maternal, perinatal, and neonatal survival is the ability to understand both the number and causes of these deaths. Systematic analysis of overall mortality trends, along with a detailed examination of the events and contributing factors leading to individual deaths, can uncover health system weaknesses and inform local solutions to prevent similar deaths in the future.

MPDSR is a structured approach promoted by the WHO and international partners as a critical health systems strategy (WHO, 2021). It is designed to improve data availability, increase accountability for maternal and newborn health, and enhance the quality of care during pregnancy and childbirth. MPDSR aims not only to identify and review maternal and perinatal deaths but also to ensure that the findings translate into timely and effective responses across all levels of the health system.

This article systematically reviews the implementation of MPDSR in hospitals across Africa. It explores barriers and facilitators to its adoption and identifies best practices that can be replicated in other healthcare settings on the continent.

Although maternal death review has long been used as an approach to improving maternal health and reducing preventable deaths in various countries, the implementation, coverage, and quality of MPDSR processes vary significantly across regions.

METHODS

Study design

A systematic review was conducted in accordance with Arksey and O'Malley's methodological framework for systematic reviews, incorporating subsequent enhancements. The review focused on original research articles related to the implementation of maternal and perinatal death surveillance and response to improve maternal outcomes in Africa from January 2002 to March 2025. It followed the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) guidelines. The included studies were appraised using the AACODS checklist (assessing authority, accuracy, coverage, objectivity, date, and significance), the STROBE checklist for observational studies, and the Joanna Briggs Institute's appraisal tool (Tyndall j, 2010; Von Elm et al, 2007; Joanna Briggs Institute, 2017)

Research Question

The research question was: How are MPDSR committees implemented, and how functional are they in improving maternal and perinatal health outcomes across African countries?

Review Design

Following the PRISMA reporting framework, a systematic review was conducted to assess the implementation of Maternal and Perinatal Death Surveillance Response in Hospitals, review the barriers, facilitators, and suggest best practices that can be replicated in other hospital settings in Africa.

Study design

Online bibliographic databases (Medline, CINAHL, Embase, PubMed, and ProQuest Dissertations) were searched. All studies reporting Maternal, Perinatal, and Death Surveillance Response barriers, practices, facilitators, and functionality were included.

Definitions

For our review, we defined Maternal and perinatal surveillance and response as an essential quality improvement intervention that enables the identification, notification, quantification, and determination of the causes and avoidability of maternal, neonatal deaths, and stillbirth, with the goal of orienting the measures necessary for their prevention. This definition also includes confidential enquiries, maternal death reviews, perinatal death reviews, maternal and perinatal death reviews, maternal death surveillance and response (WHO,2013).

Inclusion and Exclusion criteria

The review included peer-reviewed studies published between January 2002 and March 2025 that reported the barriers and facilitators of implementation of Maternal and Perinatal Death Surveillance Response in Hospitals. The timeframe was selected to maximize the relevance of the study findings to

public health practice and to have a broad understanding of the implementation of MPDSR. Studies conducted in low, middle-, and high-income countries were included if they were published in peer-reviewed journals and written in English. We excluded the commentaries, letters, and viewpoints.

Search strategy and selection process

Eligible peer-reviewed studies were identified by searching four databases (Medline, CINAHL, Embase, PubMed, and ProQuest Dissertations & Theses) that provide wider coverage of the relevant literature and are widely used by the global health community. The search was conducted using a search term that combined key elements :(1) MPDSR;(2) the site of interest (Hospitals);(3) Barriers and Facilitators;(4) functionality;(5) the outcome of interest (mortality), using Boolean terms (AND/OR). Reference lists of included papers were also reviewed for relevant materials; we did not search for grey literature, such as websites of conferences, etc.

Criteria for including Studies in the Review

The PICOS model for defining the eligibility of studies for the primary research question

Table 1: PICOS model

PICOS Criteria	Details
Population	Healthcare workers; Health faciltites
Intervention	Maternal, Perinatal, Death and Surveillance Response
Comparison	Settings without MPDSR committees, or before implementation of MPDSR
Outcome measure	Functionality of MPDSR committee
Setting	Cross sectional studies, in Africa setting

Table 1.0 demonstrates the PICOS model used to define the eligibility of studies for the primary research question.

Search Strategy

In accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2019 guidelines, a systematic review of peer-reviewed literature published from 2002 to 2025 was conducted in three phases. The investigation team used the Population, Intervention, Comparison, Outcome, and Setting (PICOS) framework developed by the Joanna Briggs Institute (2017) to assess the eligibility of the primary research topic. The search strategy keywords were based on healthcare workers (population) and the integrated disease surveillance system, including core, support, and attribute surveillance functions (phenomenon of interest). The evaluation focused on Africa, aiming to propose enhancements for surveillance functions based on health professionals' opinions.

Data synthesis and analysis

We synthesized the results of the included studies using the PRISMA Strategy

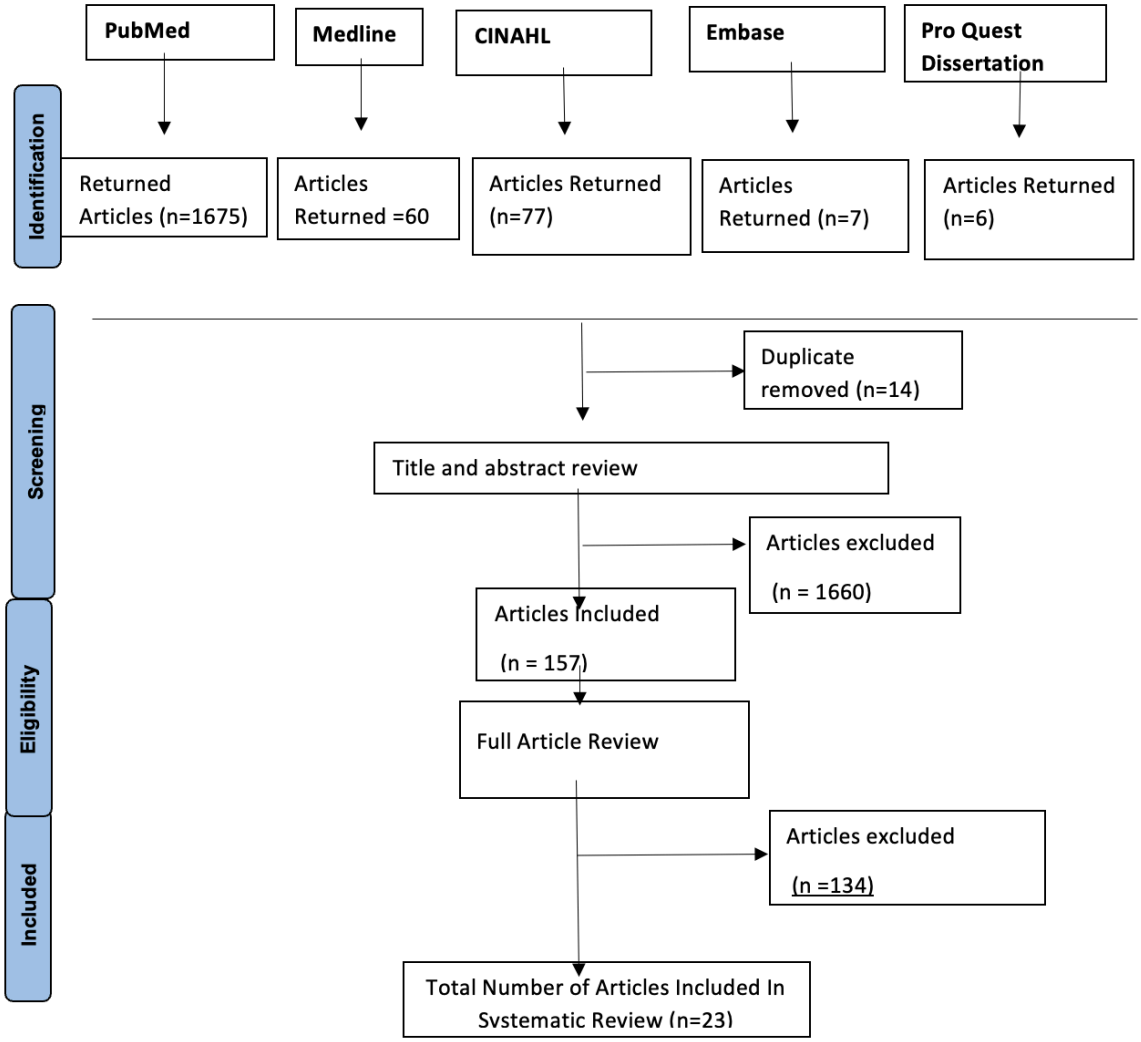

Figure 1: Presentation of Results using this PRISMA Strategy

RESULTS

Search results and study inclusion.

A total of 1,825 potentially relevant studies were identified in our initial literature search (Fig. 1). After removing duplicates and screening titles and abstracts, full-length papers from 157 studies were retrieved and assessed for eligibility. Of the retrieved studies, 23 met our inclusion criteria and were included in our systematic review (Table 2). The remaining 134 studies were excluded because they did not meet the inclusion criteria. No additional studies were identified through our hand search of references from published studies, relevant reviews, and previous meta-analyses. All included studies were published since 2002.

Table 2: Summary of Characteristics of Included Studies on Maternal and Perinatal Death Surveillance and Response (MPDSR)

	Author (s)	**year**	**country**	**Study**	**Level of MPDSR**	**Implementation Description**	**Functionality Indicators**	Challenges Identified	Key outcomes/ Impact
1	Volk	2002	Zambia	Descriptive review, Kalabo Hospital	Facility	15 case reviews with documented meeting notes	Recommendation follow-up, training value	Care quality, no standard follow-up	Educational benefits noted among staff
2	Nyamtema et al	2010	Tanzania	Cross-sectional	Facility & District-level	Evaluated structure and processes of maternal and perinatal audits in tertiary hospitals	Existence of audit systems; staff awareness; implementation of audit recommendations	Few hospitals had functioning audit committees; poor awareness; no systematic action from audits; lack of leadership involvement	Audit systems weak or absent in many hospitals; lack of follow-through on recommendations; urgent need for structural reform
3	Agaro et al	2016	Uganda	Descriptive cross-sectional study	District & Facility	Health worker surveys (n=66) and key informant interviews (n=10)	Existence of MPDR committees; attendance and participation rates;	Only 34.8% of health workers had participated; lack of committee	MPDR conducted in facilities was low; functioning review systems correlated

						assessed conduct of MPDR meetings in district hospital + lower-level centers	implementation of recommendations; provision of feedback	formation/training; poor support supervision; no financial incentives; heavy workload; non-implementation of recommendations	with feedback provision and perceived improvements in maternal-newborn care; need for stronger initiation, training, and supervision to improve uptake
4	Kalua et al.	2017	Malawi	Retrospective audit, district hospitals	District	Maternal death reviews with community verbal autopsies	Timeliness of death notification	Resource constraints, transport delays	Reduced maternal mortality ratio in study districts
5	Awoonor-Williams et al.	2018	Ghana	Qualitative study, regional hospitals	Regional	Regional MPDSR committees with government support	Implementation rates, feedback to facilities	Political will and funding constraints	Better policy alignment and maternal death reductions
6	Okonofua et al.	2018	Nigeria	Cross-sectional study, tertiary hospitals in Nigeria	Facility	Implemented facility-based MPDSR with audit committees	Review meetings held, case reviews documented	Staff attitude, poor record-keeping	Improved identification of modifiable factors; reduction in delays
7	Melberg et al	2019	Ethiopia	Multi-sited ethnographic fieldwork	National MPDSR system	In-depth interviews (n = 35) and document review exploring maternal death reporting and review practices	Extent of reporting undercount; health workers' rationale for under-reporting; nature of review procedures	Political pressure to report zero maternal deaths; fear of blame or litigation; defensive reporting; shifting blame onto women or communiti	Revealed that maternal death reporting is highly politicized; health workers often avoid reporting or falsify data to

								es; organizational concealment of system failures	meet political expectations; undermines MPDSR credibility and coverage
8	Gebrehiwot et al	2019	Ethiopia	Mixed-methods, rural district hospitals	District	MPDSR integrated into routine health systems	Proportion of maternal deaths reviewed	Low community engagement, weak feedback loops	Increased death review rates; improved response planning
9	Mbaruku et al.	2019	Tanzania	Mixed-methods, district and facility level	District/Facility	MPDSR committee formation and training of health workers	Completeness of death reporting and review	Inadequate training, poor data quality	Strengthened data use and local response systems
10	Bandali, et al	2019	Kenya	Mixed-methods	County & Facility	Strengthened perinatal audit ("P" in MPDSR) via harmonised tools, audits, supportive supervision	Perinatal death review coverage rate; proportion of cases audited; actions taken; CME sessions delivered	Nationally low perinatal review rate; documentation gaps; unclear roles; low motivation	Bungoma reviewed 59% of perinatal deaths in 2017 (51% of all Kenyan perinatal audits), driven by feedback, tools and supervision
11	Muvuka	2019	Democratic Republic of the Congo (DRC)		District & Facility	Qualitative case study assessing MPDSR structure, process and outcomes integration	Completeness of death notification /review; linkage to IDSR; response implementation	Weak community /private-sector linkage; gaps in implementing responses; fear of disciplinary action; data quality concerns	MPDSR institutionalised in integrated health facilities; timely notification/review; limited higher-level response and impact

12	Kimani et al.	2020	Kenya	Qualitative case study, Nairobi hospitals	Facility	MPDSR committees with multidisciplinary team participation	Number of recommendations implemented	Fear of blame culture	Better clinical practice adherence and accountability
13	Nsubuga et al.	2020	Uganda	Facility-based audit, urban and rural hospitals	Facility	MPDSR committees with community feedback integration	Frequency of reviews and feedback loops	Lack of continuous training	Enhanced community participation and improved outcomes
14	Kabuya et al	2020	Zambia	Mixed-methods, Nchelenge Hospital	Facility	Structured MDR with feedback mechanisms	Meeting frequency, actions implemented	Staffing gaps, late referrals	35% reduction in maternal mortality
15	Tayebwa & Sayinzoga	2020	Rwanda	Mixed-methods cross-sectional survey	Facility & District	Applied the six-step audit cycle for MPDSR, conducted regular maternal audits; perinatal death audit not yet integrated	Regular maternal death audits; action plans developed; recommendation tracking	Staff shortages and low motivation; heavy workloads; incomplete medical records; poor cause-of-death classification; weak community engagement; lack of stillbirth review guidelines; minimal feedback sharing	Uneven MPDSR implementation between sites; clear need to integrate perinatal death reviews into maternal audit systems; facilities which had better staff engagement showed more functional MPDSR processes
16	Pattinson et al.	2021	South Africa	National report, mixed methods	National	Nationwide MPDSR system with electronic reporting	National coverage and review completeness	Variable district capacity	Significant reduction in preventable deaths

17	Said et al	2021	Tanzania	Qualitative case study, Mtwara region	Regional/ Facility	MD surveillance aligned with national MPDSR	Policy-practice gaps	Implementation delays, blame culture	Recommendations for realignment of ambition and execution
18	Bvumbwe	2021	Malawi	Descriptive, Northern Zone hospitals	Facility	Audit documentation and committee roles	Coverage and completeness of reviews	Inconsistent follow-up actions	Evidence of review system weakness in northern Malawi
19	Millogo et al	2022	Burkina Faso	Evaluation study	National	Quality assessment of MDR cycles	Audit completion rates and delays	Capacity and training deficits	Recommendations for audit cycle improvements
20	Millogo et al	2022	Burkina faso	Qualitative, health districts	District	Exploration of implementation barriers	Local governance, staff skills	Blame culture, data use deficits	Need for system redesign and support tools
21	Busogoro, Conombo & Nkurunziza	2022	Burundi	National MPDSR implementation review	National	National rollout of MPDSR system	Audit committee coverage, neonatal inclusion	Weak surveillance, feedback delays	Recommendations for data quality and use improvement
22	Chirwa et al	2022	Malawi	Qualitative	Facility	Midwives' perceptions of MPDSR audits	Staff experiences with audits	Workload burden, emotional toll	Call for improved support structures and mentorship
23	Compaoré et al	2022	Ghana	Qualitative case study	National	System-wide adoption process	Transition indicators, national coverage	Resource and training gaps	System strengthening recommendations offered

DISCUSSION

The systematic review explored the implementation and functionality of Maternal and Perinatal Death Surveillance and Response (MPDSR) committees across African countries. The findings highlighted significant variability in MPDSR practices, systems, and outcomes, as well as key implementation challenges and promising interventions. The reviewed studies, drawn from diverse geographic and health system contexts, offer insights into both the facilitators and barriers influencing MPDSR effectiveness.

Implementation Approaches of MPDSR Committees

Across the reviewed literature, MPDSR implementation took place at different levels of the health system, ranging from national to facility levels. In Nigeria, Okonofua et al. (2018) documented the implementation of MPDSR at the facility level in tertiary hospitals, where structured audit committees conducted regular review meetings. These processes led to improved identification of modifiable factors and helped reduce delays contributing to maternal deaths. Similar facility-level interventions were described by Kimani et al. (2020) in Kenya and Kabuya et al. (2020) in Zambia, both of whom emphasized the importance of structured committee activities and timely feedback.

In contrast, Ethiopia demonstrated a more integrated district-level approach. Gebrehiwot et al. (2019) reported that MPDSR was embedded within routine health system activities in rural hospitals. However, they noted challenges, such as limited community engagement and weak feedback loops. These findings align with Melberg et al. (2019), who employed ethnographic methods to reveal that reporting of maternal deaths in Ethiopia was highly politicized, with health workers fearing blame or litigation. This led to underreporting or data falsification, undermining the integrity of the MPDSR system. Such fears were echoed in Rwanda (Tayebwa & Sayinzoga, 2020) and Tanzania (Said et al., 2021), where audit systems were often weakened by staff demotivation and institutional blame cultures.

National-level implementation strategies were evident in countries like South Africa, Ghana, and Burundi. Pattinson et al. (2021) described South Africa's comprehensive MPDSR system, which included electronic reporting and national coverage. Despite variations in district capacities, this system contributed significantly to reducing preventable deaths. Ghana's national transition to MPDSR was examined by Compaoré et al. (2022), who noted that while policy adoption was widespread, resource constraints and training gaps remained. Similarly, Busogoro et al, (2022) highlighted implementation delays and surveillance weaknesses within Burundi's national MPDSR program.

Functionality Indicators and Processes

The review revealed a variety of functionality indicators used across countries to assess the operational effectiveness of Maternal and Perinatal Death Surveillance and Response (MPDSR) systems. These indicators commonly included the frequency and coverage of maternal and perinatal death reviews, the regularity and quality of committee meetings, attendance and participation by relevant stakeholders, the existence and use of feedback mechanisms, and the implementation and monitoring of recommended action plans.

For example, Bandali et al. (2019) documented significant progress in Kenya, where 59% of perinatal deaths were reviewed in 2017. Notably, this accounted for more than half of all national perinatal reviews conducted that year. The study attributed this relatively high performance to several factors, including supportive supervision from county leadership, the availability of harmonized national audit tools, and sustained capacity-building efforts targeting frontline health workers. These components contributed to institutionalizing review processes and facilitated a culture of continuous learning and accountability within health facilities.

In Malawi, Kalua et al (2017) highlighted the beneficial role of maternal death reviews combined with community verbal autopsies. These activities not only improved case ascertainment but also contributed to tangible reductions in maternal mortality in selected districts. The reviews enabled the early identification of systemic weaknesses, such as delays in referral and inadequate emergency obstetric care, which informed corrective actions at both the community and facility levels. These findings reinforce the critical value of extending death review processes beyond hospital walls to involve community structures, a model echoed in Uganda by Nsubuga et al (2020).

In contrast, Nyamtema et al, (2010) conducted a retrospective assessment of maternal and perinatal audits in Dar es Salaam, Tanzania. They reported weak or entirely absent review systems in a number of health facilities. Where reviews did occur, there was often limited documentation and little to no follow-up on recommendations, undermining the potential impact of the audit process. These findings underscore the centrality of not just conducting reviews but ensuring systematic follow-through and evaluation of implemented interventions to improve MPDSR functionality.

Agaro et al (2016) assessed MPDSR conduct in Oyam District, Uganda, and observed that facilities with functional MPDSR committees and structured feedback systems tended to demonstrate improved quality of maternal care. However, the study also noted that only 34.8% of surveyed health workers participated in reviews. The limited involvement was largely due to insufficient training on audit methodologies, lack of incentives to attend committee meetings, and inadequate supervision by district health teams. Chirwa

et al, (2022) reported comparable challenges in Malawi, where midwives expressed emotional distress associated with participating in death reviews, citing high workloads and the psychological burden of repeated exposure to maternal mortality cases. These factors not only contributed to burnout but also discouraged consistent participation in audit processes.

Moreover, Muvuka (2019), in a qualitative study from the Democratic Republic of Congo, emphasized the absence of structured mechanisms to evaluate the implementation status of recommendations arising from death reviews. Health workers frequently cited uncertainty regarding their roles and a lack of clarity on how audit findings were used to inform practice improvements. These implementation gaps point to the need for standardized indicators to monitor both the procedural and outcome dimensions of MPDSR.

Comparatively, studies from other low- and middle-income countries echo similar challenges and successes. For instance, Hussein, Qureshi, and colleagues (2016) emphasized that regular feedback loops and action-oriented recommendations are critical to ensuring that MPDSR systems lead to measurable improvements in maternal and perinatal outcomes. Bergh, Pattinson, and colleagues (2015) also highlighted that conducting audits without adequate mechanisms to implement recommendations fails to yield the desired health system improvements.

Challenges Affecting Implementation and Functionality

Multiple cross-cutting barriers were identified across countries. One major issue was the fear of blame and legal consequences, which led to defensive reporting or data manipulation. This was particularly evident in studies from Ethiopia (Melberg et al., 2019), Kenya (Kimani et al., 2020), and Tanzania (Said et al., 2021). According to Smith et al. (2017), a blame-free environment is critical for the successful implementation of MPDSR, yet this remains a challenge in many low-resource settings.

Documentation gaps, staff shortages, and unclear committee roles were also widely reported. Bandali et al. (2019) noted that poor documentation and low staff motivation undermined the effectiveness of perinatal audits in Kenya. Similarly, Tayebwa and Sayinzoga (2020) found that in Rwanda, audit quality suffered due to incomplete records, weak classification of causes of death, and a lack of guidelines for stillbirth review.

Other challenges included weak community linkages, limited private-sector engagement, and poor data quality (Muvuka, 2019; Millogo et al., 2022). Additionally, political and structural factors such as insufficient funding, lack of leadership commitment, and fragmented health systems impeded implementation in Ghana (Compaoré et al., 2022), Burundi (Busogoro et al., 2022), and Burkina Faso (Millogo et al., 2022).

Key Outcomes and Impact

Despite the challenges, several studies documented positive outcomes from MPDSR implementation. These included reductions in maternal mortality (e.g., Kabuya et al., 2020, in Zambia), improved identification of preventable factors (Okonofua et al., 2018, in Nigeria), and enhanced staff awareness and clinical accountability (Kimani et al., 2020, in Kenya).

In South Africa, Pattinson et al. (2021) linked a significant reduction in avoidable deaths to the widespread adoption of MPDSR and strong government commitment. Similar national gains were observed in Ghana and Burundi, although these were tempered by systemic constraints. At the district and facility levels, Kalua et al. (2017) and Nsubuga et al. (2020) showed that timely death notification and regular committee meetings led to more responsive planning and service improvements.

Importantly, the role of community involvement and feedback was emphasized as a critical component of effective MPDSR. Studies by Gebrehiwot et al. (2019), Agaro et al. (2016), and Nsubuga et al. (2020) all underscored the value of engaging communities in death reviews and in developing culturally appropriate interventions.

Comparative Insights and Recommendations

Compared with the global literature, the African experience with MPDSR reflects both shared and unique challenges. According to WHO (2021), effective MPDSR systems require a culture of learning, clear governance structures, and sustained investment in capacity building. The review findings echo this, demonstrating that systems with strong policy support (e.g., South Africa), integrated data systems (e.g., Kenya's harmonized tools), and regular mentorship (e.g., Malawi's community verbal autopsies) are more likely to function effectively.

In line with studies by Hussein et al. (2016) and Bergh et al. (2015), the current review confirms that the effectiveness of MPDSR hinges not only on audit processes but also on the quality of response actions. Systems that merely document deaths without acting on findings fail to achieve meaningful impact. Thus, emphasis should shift from audit formality to actionable learning, strengthened feedback systems, and transparent leadership engagement.

CONCLUSION

The systematic review highlights considerable diversity in the implementation and functionality of MPDSR committees across African countries. While some settings have made notable progress, persistent challenges such as blame culture, data quality issues, weak feedback loops, and limited community engagement hinder broader system effectiveness. Strengthening MPDSR systems requires multi-level reforms, including better policy-practice alignment, adequate funding, continuous training, and the creation of non-punitive environments that foster transparency and learning. Ultimately, for MPDSR to realize its potential in reducing maternal and perinatal deaths, countries must prioritize supportive supervision, consistent response tracking, and active community participation as integral components of the system.

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Conflicts of Interest

The authors declare no conflicts of interest.

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