Learn | Annotated Bibliography

Legislation and policies that support MDS

Key findings from the bibliography on how legislative and policy frameworks can support or hinder effective implementation of MDSR and perinatal audit:

- There is a paucity of evidence on the effectiveness of legal and policy frameworks.
- Fear of blame and legal repercussions are key barriers to effective MDSR and perinatal audit.
- Whilst policy and training documents can emphasise "avoiding blame", a lack of legal protection in practice jeopardises sustainability of MDSR systems.
- Legal frameworks can mandate notification, support enforcement of reporting and ensure confidentiality, guaranteeing information is not used for medico-legal or disciplinary purposes.
- Adequate legislation and supportive policy frameworks are key drivers of success, but alone are not sufficient for effective implementation.
- Policy can promote a no-blame, no-shame culture, mandate professionals to participate, define institutional responsibilities and ensure resource allocation.
- Political commitment and strong leadership that champion personal and institutional accountability are essential components of successful implementation of MDSR and perinatal audit.
- Integrating MDSR within an existing surveillance system supports effective implementation.
- Malpractice liability is a barrier to reporting on deaths.
- There is a lack of information on the on lessons learned about improving the response component of MDSRs.

As we continue our research looking at how laws and policies support maternal death surveillance and response (MDSR), we follow the release of two case studies - an in-depth account in Jamaica and a synthesis comparing legal and policy frameworks across five countries with MDSR systems in South America and the Caribbean - to end our three-part series with an annotated bibliography of relevant literature.

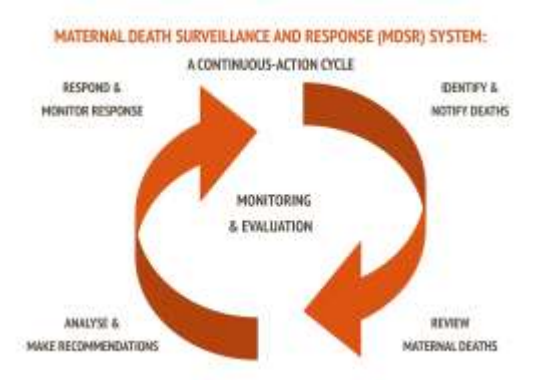
This annotated bibliography presents recent literature discussing the importance of legal and policy frameworks in relation to successful implementation of MDSR and perinatal audit.

This resource intends to orient policy makers, managers and practitioners, on relevant publications, but is not an exhaustive review on the topic. See endnotes for the search strategy used, which included looking at literature around maternal death reviews (MDRs) and perinatal audits. We provide an overview of the main findings relevant to the implementation of MDSR and then present key publications individually and in chronological order. For these publications that met the search criteria, we outline the aim and methods, key findings and authors' interpretations relevant to the topic of the bibliography.

Highlights from the literature

What is MDSR?

MDSR is a continuous cycle of identifying, reporting and investigating deaths, and using the findings from the reviews of deaths to identify what actions need to be taken to prevent other deaths happening in similar circumstances. Importantly, the cycle should include ensuring recommendations are responded to and tracking these responses.



Source: WHO, 2013

The evidence suggests that legislation mandating maternal death as a reportable event is critical for supporting MDSR implementation and has been linked to improved reporting. This raises questions about whether making perinatal deaths a reportable event would have a similar impact. Given that this would add a considerable strain on health systems, an assessment of capacity to implement and enforce such legislation should be done before the introduction of any such laws.

Why is MDSR important?

Most maternal and newborn deaths, and the majority of stillbirths are preventable.

Understanding the circumstances around each death can help identify contributing factors, and enable recommendations to be made and actions to be taken to prevent future deaths from similar reasons.

To do this, each death must to be counted through surveillance systems and investigated (*reviewed*) by clinicians with the help of family or community members of the deceased.

MDSR and perinatal audit can provide the essential information to stimulate and guide actions to prevent future events and improve the measurement of maternal and perinatal mortality.

The evidence also points to the critical role of legislative and policy frameworks in supporting a "no-blame culture", which is essential for success. Legislation to ensure inquiries are confidential and anonymous and to safeguard health workers against litigation could provide a solution. However, studies reveal that, even in the presence of such conducive frameworks, fear of repercussions may persist among health workers and at the community level, underscoring the importance of leaders and champions at all levels to foster an enabling environment.

The importance of broader legal and policy frameworks surrounding the provision of maternal and newborn health services is also evident as well as potential tensions originating from restrictive laws and policies that have a bearing on the reporting of maternal deaths and the opportunities for open dialogue on theirs causes, for example in settings were pregnancy termination is illegal. Adopting a human-right based approach and examining the broader legal and policy framework can maximise the effectiveness of MDSR implementation.

Peer-reviewed articles

1. Implementing maternal death surveillance and response: a review of lessons from country case studies, by Smith, H., Ameh, C., Roos, N., Mathai, M., Broek, N.V.D. (2017) in *BMC Pregnancy and Childbirth BMC series*, 17(233).

The study aimed to identify the extent to which countries implement the essential components of MDSR and lessons learned for improving implementation by examining ten case studies including countries with established systems and where MDSR had recently been introduced. The authors use a policy triangle framework to illustrate how actors, context, processes and implementation lessons in relation to maternal death review policies interact to create an enabling environment for MDSR.

The authors found that legislation and supportive policy frameworks are key drivers of success. Legal frameworks can mandate notification, support enforcement of reporting and ensure confidentiality, guaranteeing information is not used for litigation. However, the study notes little evidence on the effectiveness of such frameworks and how they are maintained. Policy can promote a no-blame, no-shame culture, mandate professionals to participate, define institutional responsibilities and ensure resource allocation. A key study limitation is that case studies did not offer specific lessons on how to improve the response component of MDSR.

2. 'We identify, discuss, act and promise to prevent similar deaths': a qualitative study of Ethiopia's Maternal Death Surveillance and Response system, by Abebe, B., Busza, J., Hadush, A., Usmael, A., Belew Zeleke, A., Sita, S., Hailu, S., Graham, W.J. (2017) in *BMJ Global Health*, 2 (2) e000199.

Focusing on the first two years of MDSR implementation in Ethiopia from 2013-15, this

study aimed to identify facilitators and barriers to implementation and assess outcomes through a qualitative policy assessment with data collected via interviews. The findings stress the importance of political commitment and benefit of integrating MDSR within an existing surveillance system.

The authors emphasise the importance of maternal mortality being a reportable event. They found however, widespread fear about reporting deaths at the community level and among health providers concerned about potential legal repercussions or disciplinary actions. While policy and training documents emphasise "avoiding blame", respondents reported a lack of legal protection in practice jeopardising the sustainability of the system.

3. Drivers of maternity care in high-income countries: can health systems support woman-centred care? By Shaw, D., Guise, J.M., Shah, N., Gemzell-Danielsson, K., Joseph, K.S., Levy, B., Wong, F., Woodd, S., Main, E.K. (2016) in *the Lancet*, published online.

This paper from the Lancet Maternal Health Series presents the main delivery care models in high-income countries (HICs), and examines the main drivers of these models. Of relevance to the topic of this bibliography, the study underscores the role of confidential enquiries into maternal deaths to improve care quality and safety, and notes that most HICs lack robust surveillance systems for ascertainment of maternal deaths, and for accurate identification of the underlying causes of death and preventable cases. The authors argue that a policy change should enable institutionalisation of national- or sub-national-level audits of maternal deaths, which include the collation and dissemination of results on social circumstances and clinical contexts alongside recommendations for prevention of future deaths. Furthermore, the authors identify malpractice liability as a barrier to optimal care in several high-income settings, and provide examples of state support provision and insurance regulatory frameworks to minimise such a barrier.

4. Counting every stillbirth and neonatal death through mortality audit to improve quality of care for every pregnant woman and her baby, by Kerber, K. J., Mathai, M., Lewis, G., Flenady, V., Erwich, J. J. H. M., Segun, T., Aliganyira, P., Abdelmegeid, A., Allanson, E., Roos, N., Rhoda, N., Lawn, J. E., Pattinson, R. (2015) in *BMC Pregnancy and Childbirth BMC series*, 15(Suppl 2):S9.

This study investigates progress institutionalising facility-based maternal and perinatal death audits, synthesises the main challenges using the World Health Organization (WHO) health system building blocks, and proposes solutions for scaling up audits for stillbirths and neonatal deaths. Methods include a review of literature on facility-based perinatal and maternal mortality audits with a focus on high-burden countries.

Seventeen countries out of 71 were identified with policies providing a national mandate for perinatal death reviews and only51 for maternal deaths. Key challenges were found in the leadership domain. The authors identify that a policy framework is a necessary condition to commence implementation but policy alone is not sufficient for effective implementation. Fear of blame and legal repercussions are cited as key barriers, which can be potentially overcome by the development of an ethos of safety through a supportive, non-punitive policy and legal environment at national level, and having leaders champion personal and institutional accountability.

5. The cultural environment behind successful maternal death and morbidity reviews, by Lewis,

G. (2014) in *BJOG: An International Journal of Obstetrics & Gynaecology*, 121 (Suppl. 4): 24–31.

This expert piece, based on experience of instituting reviews of maternal deaths and near misses worldwide, suggests that a positive and enabling environment for successful maternal death reviews results from: A culture of individual responsibility, a proactive institutional ethos, and a supportive political and policy environment at national and/or local level. The authors outline that providing legal protection for those participating in maternal death reviews can remove fear of participation. In contrast, linking maternal death notification with police reporting has led to the stalling of the process in a few countries. The article also notes that a requirement for anonymising reviews can ensure that any cases of malpractice continue to be dealt with using existing legal procedures.

6. The confidential enquiry into maternal deaths in South Africa: a case study, by Moodley, J., Pattinson, R.C., Fawcus, S., Schoon, M.G., Moran, N., Shweni, P.M. (2014) in *BJOG: An International Journal of Obstetrics & Gynaecology*, 121 (Suppl. 4): 53–60.

This article presents the process, findings and impact of the Confidential Enquiry into Maternal Deaths (CEMD) in South Africa which has been operational since 1998. The article places the CEMD process in the context of enabling legislation specifically mandatory notification of maternal death but also, more broadly, legislation granting free health care to pregnant women and children, and enabling elective pregnancy terminations. It also provides a rare example in the literature of how the principles of confidentiality and anonymity are applied in the CEMD system in practice so that findings from the CEMD process cannot be used for medico-legal or disciplinary purposes. It further points to the fact that medico-legal processes do continue to occur, protecting patients from clinical malpractice, but they are completely separate and parallel processes, which has been ratified by relevant judicial bodies.

7. Easier said than done!: methodological challenges with conducting maternal death review research in Malawi, by Thorsen, V. C., Sundby, J., Meguid, T., Malata, A. (2014) in *BMC Medical Research Methodology*, 14:29.

This article describes the methodological challenges experienced when conducting maternal death review research. It draws observations from a study using facility-based maternal death review to assess cause of death. Study methods include review of case audits and participant interviews. Fear of blame and potential repercussions are cited as barriers affecting the completeness and accuracy of data recorded. To ensure participation in reviews, the authors needed to reassure participants that their contributions would not be used for litigation. The study underscores the importance of ensuring anonymity and confidentiality during reviews and demonstrates the complexity involved in conducting facility-based audits.

Reports: Global and regional

1. Time to respond: a report on the global implementation of maternal death surveillance and response (MDSR), WHO, 2016.

This report presents the findings of a global survey conducted by the WHO and UNFPA to determine the status of MDSR implementation in countries where there is a national system, and provides overall implementation insights and case studies. Individual MDSR country profiles are available in the report with information about national policies for maternal death notification and review.

In relation to policy frameworks, the report suggests a gap between policy and practice. Most participating countries (86%) reported having a national policy to notify and review all maternal deaths, but only 46% reported that a National Maternal Death Review Committee meets biannually (twice a year). In relation to legal frameworks, the study identified little in the literature that considers MDSR from a legal perspective, suggesting more research is required.

It also suggests that the legal environment within which MDSR is implemented, such as country laws for the rights of women and by extension for their reproductive rights, can either assist or hinder the effectiveness of MDSR as a tool for reducing maternal mortality. For example, the existence of an efficiently run MDSR system cannot fully mitigate the risks to girls who marry and conceive at a young age, or to women who seek to terminate a pregnancy in a country where abortion is illegal. Conversely, taking a human-rights-based approach to health, making maternal death a notifiable event in law and supporting this legislation with policies for maternal death review, analysis and follow-up action, creates the preconditions necessary for successful implementation of MDSR.

2. Making every baby count: audit and review of stillbirths and neonatal deaths, WHO, 2016

This guide discusses the role of perinatal mortality audit as a quality improvement strategy. It makes the case for introducing a system to capture the number and causes of all stillbirths and neonatal deaths, and reviewing a selection of individual cases for more in-depth, systematic and critical analysis of the quality of care received, and provides detailed guidance for it. It notes that in many settings established MDSR systems may present an opportunity to integrate perinatal audits effectively and efficiently, however this is not a precondition. It refers to how the law can contribute to the creation of an enabling environment, particularly when this ensures protection of staff and patients throughout the process. The report recognises that in settings with high malpractice litigation, the fear of law suits can hamper data collection and the use of findings from death audits and thus the importance of separate processes for handling legal misconduct to mitigate this is noted. It also provides a sample code of conduct to be adhered to by all stakeholders, and discusses policy and ethical issues in relation to access to information and use of results.

3. Guidelines for Maternal Death Surveillance and Response (MDSR): Region of the Americas, Regional Task Force for Maternal Mortality Reduction, 2015

This guide contextualises WHO MDSR guidelines in the Latin American and Caribbean context, includes a situation assessment of the maternal mortality context, detailed guidance on each MDSR component, and analysis and recommendations on context specific barriers and solutions for optimal implementation. The report stresses the importance of an enabling legal and policy framework in relation to mandatory reporting of maternal deaths, anonymisation of data, and sharing information on suspected maternal deaths across sectors. It also recommends integrating MDSR into sexual and reproductive health, and general health policy.

The guidelines are accompanied by five case studies on MDSR implementation in Jamaica, Mexico, Brazil, Colombia and El Salvador. Making maternal deaths notifiable by law, enshrining in law rights to quality care, particularly for women, and adopting a policy framework that clearly

identifies institutional responsibilities were reported as enabling factors for successful implementation. More detail on case study country experiences can be found in this synthesis. The case studies from Jamaica and Brazil offer particularly valuable detail on conducive legal frameworks.

4. Maternal death surveillance and response: technical guidance, WHO, 2013

WHO technical guidance on MDSR introduces the concept of MDSR as a continuous action cycle building on established maternal death review systems. It represents a pivotal resource with detailed guidance to implement each surveillance component. In relation to legal frameworks, it stresses that identification and development of regulations and legal protections are crucial pre-requisites to implementation. Notification of a maternal death should be mandatory. A ministerial decree is usually needed to establish the MDSR system. Developing a policy or a code of conduct and standards for conducting maternal death reviews, and orienting all stakeholders on these is essential to create a collaborative rather than blame environment. A legal framework on confidentiality and medical liability should be in place to prevent the use of review findings in litigation, thus aiding the development and dissemination of findings and recommendations.

It also highlights that other legal provisions may have a bearing on MDSR implementation and should be assessed and considered at the start. For example, reviewing patient health records, speaking with family members or friends, and interviewing health-care workers may require the adoption of regulations. Furthermore, dissemination of findings may be affected by legal frameworks surrounding pregnancy terminations.

5. Study on the implementation of maternal death review in five countries in the South-East Asia region of the World Health Organization, WHO, 2014

This report presents the findings of a study on the implementation of maternal death reviews in five countries in South-East Asia, namely India, Indonesia, Myanmar, Nepal, and Sri Lanka, including individual country reports and a regional overview. The studies all used largely qualitative methods. Of relevant to the bibliography topic, the report discusses government policies and directives which provide clear institutional and managerial arrangements in each country. It also identifies fear of possible punitive action among the critical challenges for the conduct of maternal death reviews in the region. Recommendations include improved communication to promote a no-blame culture in implementation.

Endnotes: Search strategy and criteria

The search strategy was not intended to be systematic or exhaustive, but to identify key recent publications on the issue of legal and policy frameworks for MDSR.

The Open University database, subscribed to over 150,000 journals including the British Medical Journal, BioMed Central and the Lancet, was searched for published literature, using the search terms "MDSR", "MDR", "maternal death review", "maternal death surveillance" and "perinatal death surveillance".

References of relevant articles were hand-searched and key stakeholder websites, including WHO and UNFPA, were searched to identify additional publications. Inclusion criteria: Research studies, editorials and reports; English only; published in the last 15 years; specifically discussing legislation and policy frameworks in relation to MDSR implementation. The search was not restricted to specific settings.

Suggested citation

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