Common Myths and Misconceptions - Perinatal Death Reviews

Day One Session Two
Session Objectives

By the end of this session, learners will be able to:

1. Understand common myths and misconceptions related to perinatal death reviews

2. Learn about the relationship between quality improvement processes and perinatal death reviews
Myth 1

Pregnancy and Childbirth are no Longer Dangerous
Unfinished Agenda

• Almost 6 million deaths related to pregnancy and birth
• 303,000 mothers die
• 2.6 million stillbirths – 50% of whom were alive at the start of labour
• 2.5 million newborn deaths, of which 1 million newborn deaths on the day of delivery
• Majority of these deaths are preventable through simple interventions
Myth 2

Stillbirths mostly occur in high-income settings
2.6 million stillbirths in 2015, 98% in LMIC


Highest stillbirth rates (deaths per 1000 total births)

1. Pakistan (43.1)
2. Nigeria (42.9)
3. Chad (39.9)
4. Guinea-Bissau (36.7)
5. Niger (36.7)
6. Somalia (35.5)
7. Djibouti (34.6)
8. Central African Republic (34.4)
9. Togo (34.2)
10. Mali (32.5)

Stillbirth rate in 2015 per 1000 total births
- Dark green: 30-50
- Green: 20-30
- Light green: 10-20
- Light grey: 0-5
- Dark grey: 5-10
- No data

Myth 3

Stillbirths are inevitable
Half of stillbirths occur during labour

Regional stillbirth rate, showing % that are intrapartum

Risk factors for stillbirth show preventability

Most stillbirths are preventable notably from maternal infections (e.g. syphilis and malaria), non-communicable diseases. Few are due to congenital disorders.

Population attributable risk for stillbirth, by region, for 12 potentially modifiable risk factors

Myth 4
Preventing stillbirths is expensive
• Investment to prevent stillbirth also improve women’s health, generating substantial economic & social benefits

• The cost of averting stillbirth in LMIC is returned almost 25 times by the economic and social value these live children would provide their families and nations

Interventions that prevent stillbirths in continuum of care for RMNCH:

PRECONCEPTION
• Family planning
• Folic acid supplementation/fortification

ANTENATAL CARE WITH QUALITY
• Addressing infections especially syphilis and malaria
• Management of hypertension, diabetes
• Fetal growth monitoring

LABOUR AND BIRTH CARE
• Fetal surveillance and response
• induction of labour for pregnancies lasting more than 41 weeks

Quadruple return ...fewer stillbirths, and fewer maternal & newborn deaths, plus improved child development

Stillbirth affects mothers, their families, health services, society, and governments

Myth 5
There are no global targets focused on reduction of stillbirths and neonatal deaths
Newborn mortality targets for 2030 as set in the Every Newborn Action Plan (ENAP)

- NMR target: 12 or fewer neonatal deaths per 1000 live births in every country by 2030
- A global Annual Rate of Reduction (ARR) of 4.3% needed to achieve the global NMR target, but this varies between countries, with 29 countries needing to at least double their ARR.
- Progress is tracked and reported in the ENAP progress tracking report launched at the World Health Assembly annually.
- In 2018- 75 countries tracked progress on NMR
Call to Action for Ending Preventable Stillbirths in Every Country

Mortality targets (included in ENAP):
- 12 stillbirths or fewer per 1000 total births in all countries
- All countries to set and meet equity targets within countries by 2030

Universal health care coverage targets: family planning, antenatal care and care during labour and birth

BY 2020 (additional milestones)
- ENAP global and national milestones e.g.: Measurement Improvement Roadmap and perinatal audit linked to maternal audit
- Respectful care, including bereavement support after a neonatal death or stillbirth: global consensus on a package of care after a death in pregnancy or childbirth for the affected family, community, and caregivers in all settings
- Reduce stigma: all countries to identify mechanisms to reduce stigma associated with stillbirth among all stakeholders, particularly health workers and communities

Fig: Stillbirth is largely invisible in the discourse on maternal and newborn health
Myth 5: Talking about stillbirth is insensitive?

When you ask women (and men) who have suffered a stillbirth, they will tell you that breaking the silence is one of their most urgent and heartfelt wishes.
Myth 6
Perinatal and neonatal death review are very complex to introduce in my setting
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Misconception 1: Perinatal death reviews are impossible in my setting as there are too many neonatal deaths and stillbirths

There are ways to select a sample of perinatal deaths

A meta-analysis of before and after effects associated with the introduction of perinatal audits in LMIC countries demonstrated a 30% (95% CI, 21%–38%) reduction in mortality. (Ref: Pattison et al. 2009)

Misconception 2: Death reviews are useless and a waste of time as no one takes any action

- By conducting death reviews correctly we can identify health system, provider-related and patient-related factors.
- Facility teams can immediately act on the provider-related factors
- Get useful insights from patient-related factors
- Can demand support from management and district authorities on system-related factors

Fig: A facility committee in Rwanda conduct their mortality audit meeting
Misconception 3: Death review committees do not meet regularly so the process is difficult to implement

- Involve senior leadership and management (hospital and district)
- Having a fixed day/month- for e.g.: every last Monday can be useful to make the process regular
- Providing tea/ coffee to participants can make the process relaxed and inviting
- The meetings should be focused and last upto one hour
- Preparing well in advance about cases to be presented
Misconception 4: Perinatal death reviews can expose the providers to punitive or disciplinary action

• Anonymized and the committee should talk about case X
• Don’t discuss specific identifiers for any individual case
• Confidential
• Help staff understand that errors are unintentional and that learning from any adverse event is useful
Misconception 5: It is difficult to create confidence amongst providers that information will not be leaked to the press and the public

- legal backing to prevent the use of findings for litigation purposes.

- Review findings are for improvement of QoC and will not be used as evidence in any legal proceedings or settlement of a complaint

- In case of legal enquiries, there should be a separate investigation, which is for a different purpose intended to assign responsibility or ascertain neglect.
Misconception 5: It is difficult to create confidence amongst providers that information will not be leaked to the press and the public

• Consent forms should be administered prior to interviewing family members.

• Having a code of conduct that participants sign at each meeting may help reinforce the goal of the review meeting being a safe space.

• After the committee meeting, all case review notes with identifying information collected for the purposes of the audit should be destroyed.

• Any case review notes with identifying information should not be shared by electronic means, such as email.
Misconception 6: Quality improvement PDSA cycles and perinatal death reviews are not linked.

• Once cases for perinatal death review are identified and reviewed, we will be able to identify modifiable factors and failures in care processes.

• This leads to development of action plans which generally take two forms: provider level actions and/or a QI project to address systematic issues.

• Hence, perinatal death review findings help facility teams to formulate realistic problem statements for a PDSA cycle.

• Testing of these solutions can also help in effective implementation of change ideas.
Misconceptions 7: Perinatal death review cannot be implemented unless there is budget allocated to the process

- Many problems (system, provider) can be fixed by changing management practices and making efficient use of resources

- Do not wait for change to come from outside

- For example: South Africa’s Perinatal Problem Identification Programme (PPIP) started as a research project in 1990 using paper based forms. Now it capture 75.6% of all births in institutions (2014)

- The PPIP software is available to download freely at: https://www.ppip.co.za/
Misconception 8: Everything is a problem so where should we start?

- First step is to review your data carefully

- For stillbirths:
  - In how many women, was foetal heart rate checked at the time of admission?
  - How many babies were alive at the time of admission but died as labour progressed
  - What could have been done differently?

- For neonatal deaths:
  - Classify by birth weight and gestational age
  - Start with deaths amongst term babies and those with birth weight of less than 2500 grams to identify modifiable factors
  - Once we achieve success in this group we can go to lower weight categories
An example from EMEN QI project in Bangladesh using MPDSR

Newborn Deaths in Kurigram District Hospital Period- Jan 2017 – Feb 2018

Total Newborn deaths - 299 (10% reviewed)

- 1000-1500 gms (58)
- 1500-2000 gms (36)
- 2000-2500 gms (10)
- >2500 gms (21)

Bacterial sepsis + Septicemia (5)
Birth Asphyxia (16)

Delivery by Skilled/Unskilled provider
Bad Obstetric condition
Inborn/Outborn
Facility/Home
Summary

• Perinatal mortality more prevalent than maternal mortality
• Where MDSR systems exist, conduct both together
• “No blame”, “No name”
• Review findings must be separate from legal processes
• Start small, learn in detail, test ideas and scale up
• Even one case can provide good learning
• Getting a count on all deaths that occur in the facility and creating a culture around the importance of reporting all births and deaths is also a good place to start
Summary

• Don’t be overwhelmed- choose a sample
• Freely available software such as the PPIP can be a useful tool
• Showing good success in the beginning motivates the team
• Start with things under your control, demonstrate success

Celebrate small successes — celebrate big successes — celebrate each other!