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

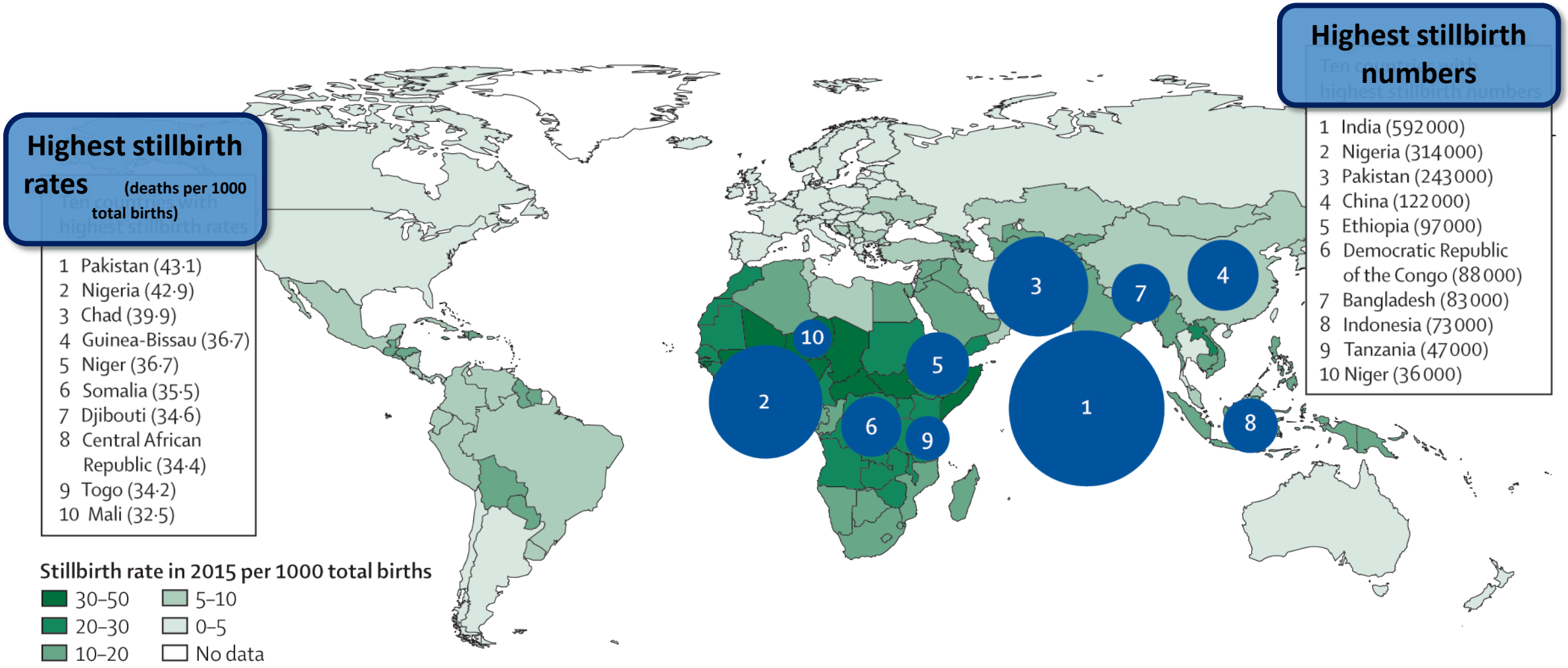
Unfinished Agenda

- **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



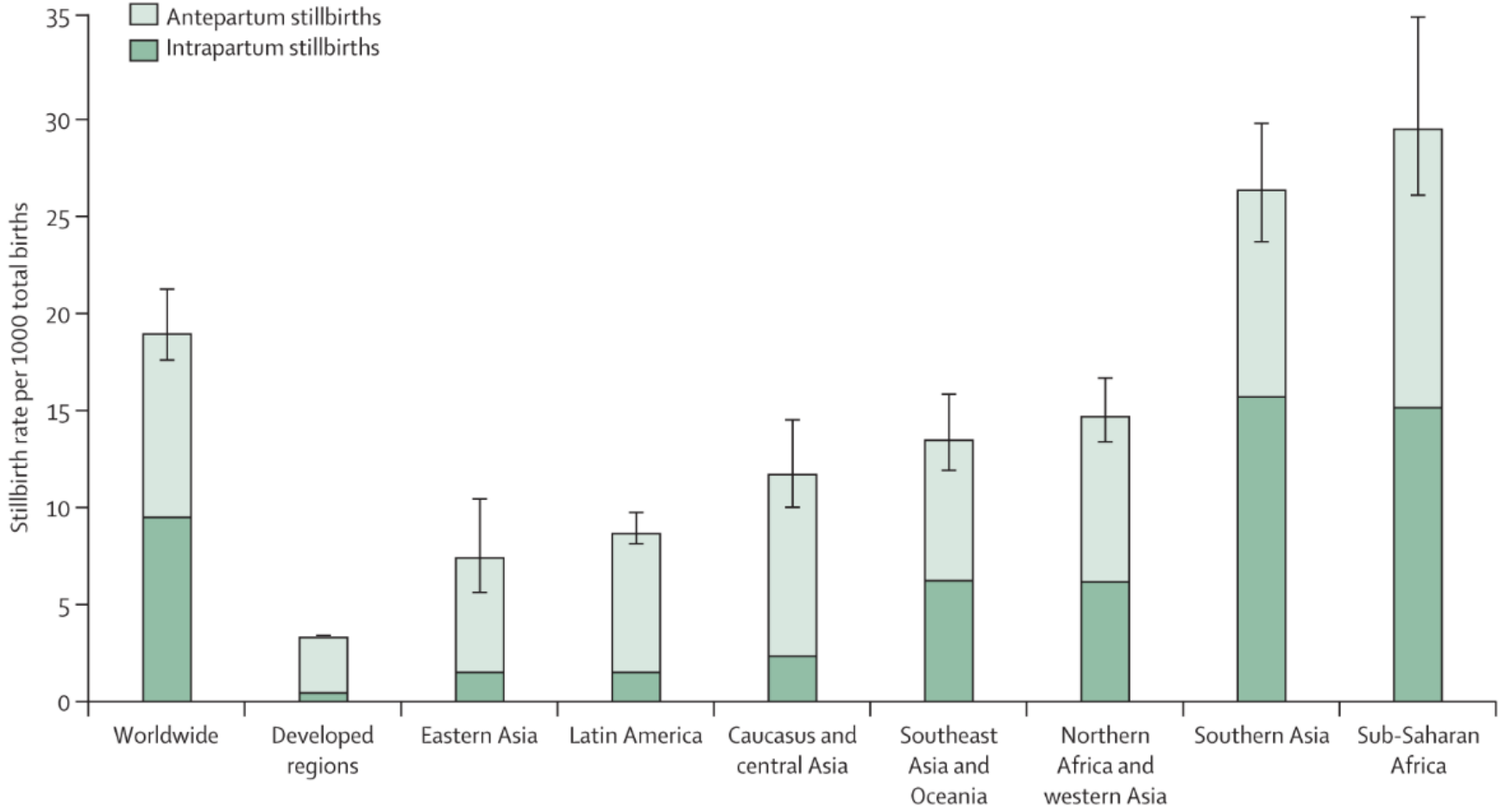
Source: Blencowe et al. Lancet. 2016

Myth 3

Stillbirths are inevitable

Half of stillbirths occur during labour

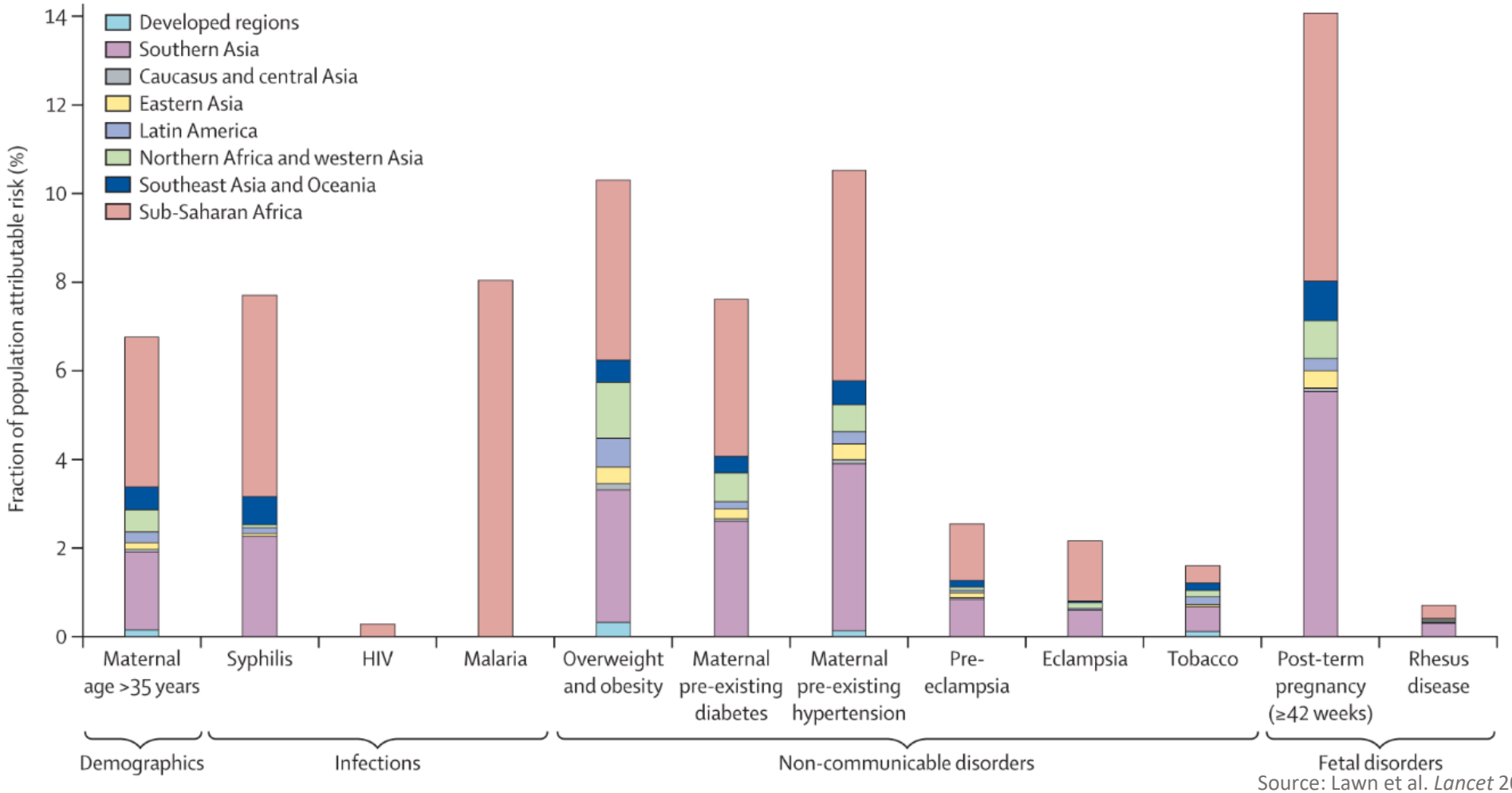
Regional stillbirth rate, showing % that are intrapartum



Source: Lawn et al. *Lancet* 2016.

Risk factors for stillbirth show preventability

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



Source: Lawn et al. *Lancet* 2016.

Most stillbirths are

preventable

notably from maternal infections (e.g. syphilis and malaria), non-communicable diseases.

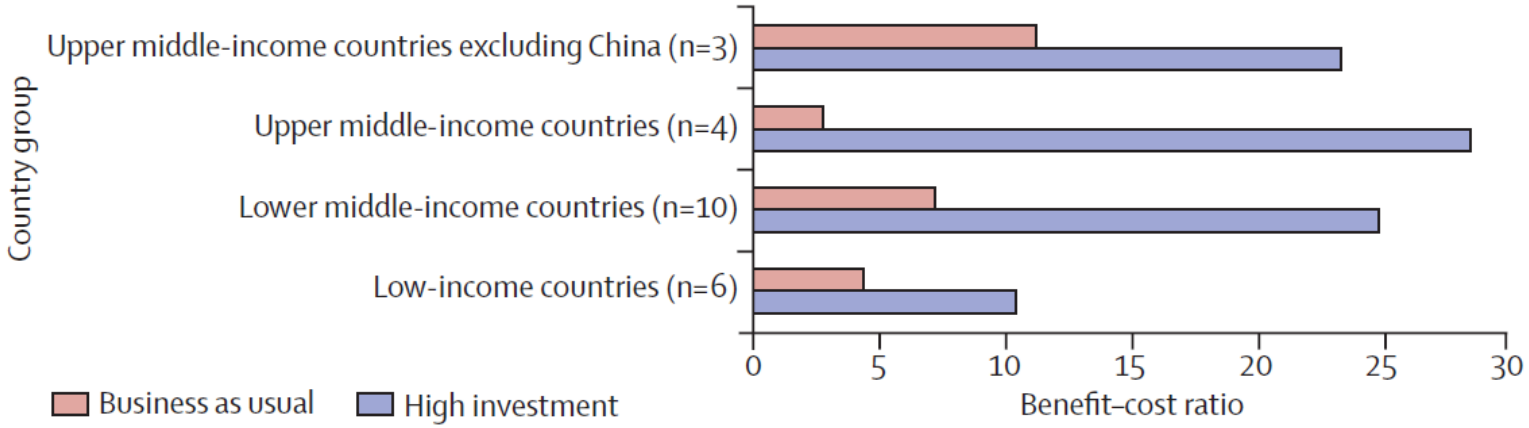
Few are due to congenital disorders.

Myth 4

Preventing stillbirths is expensive

Return on investment

- 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



Sources: de Bernis et al. Lancet 2016; ten Hoope-Bender et al. Lancet 2016.

Interventions that prevent stillbirths in continuum of care for RMNCH:

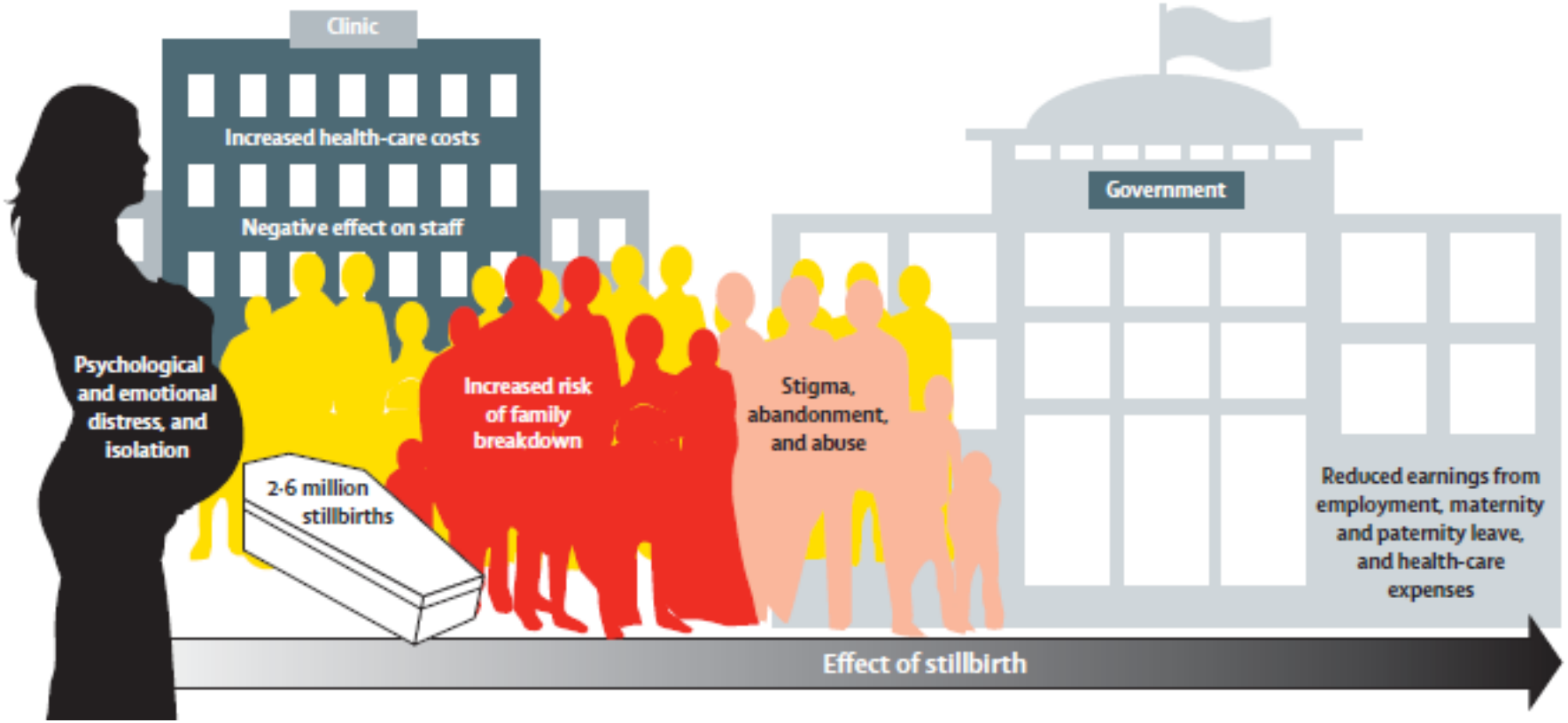
PRECONCEPTION
- Family planning
- Folic acid supplementation/fortification

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

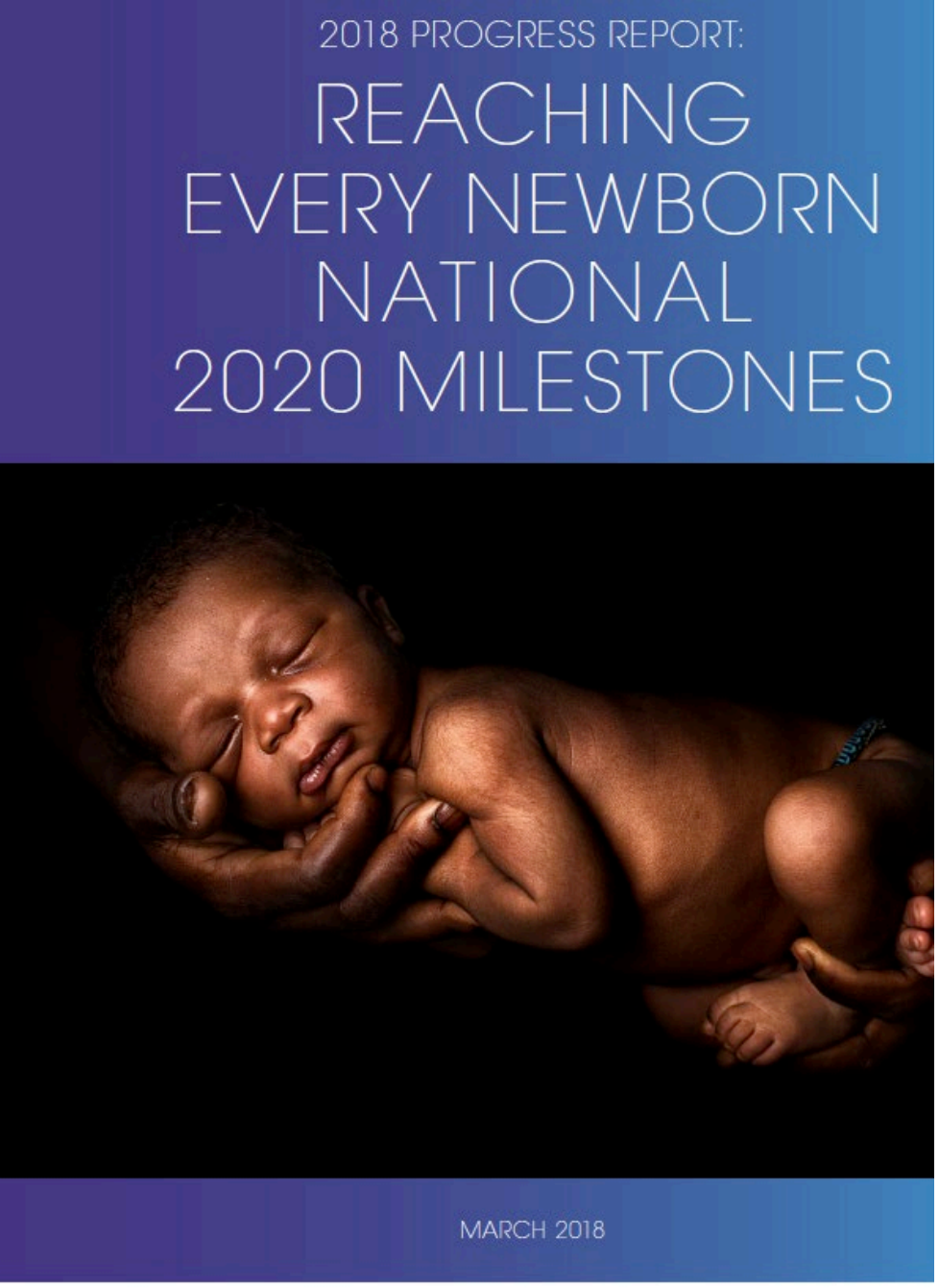
Stillbirth affects mothers, their families, health services, society, and governments



Source: Heazell A et al. *Lancet* 2016.

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

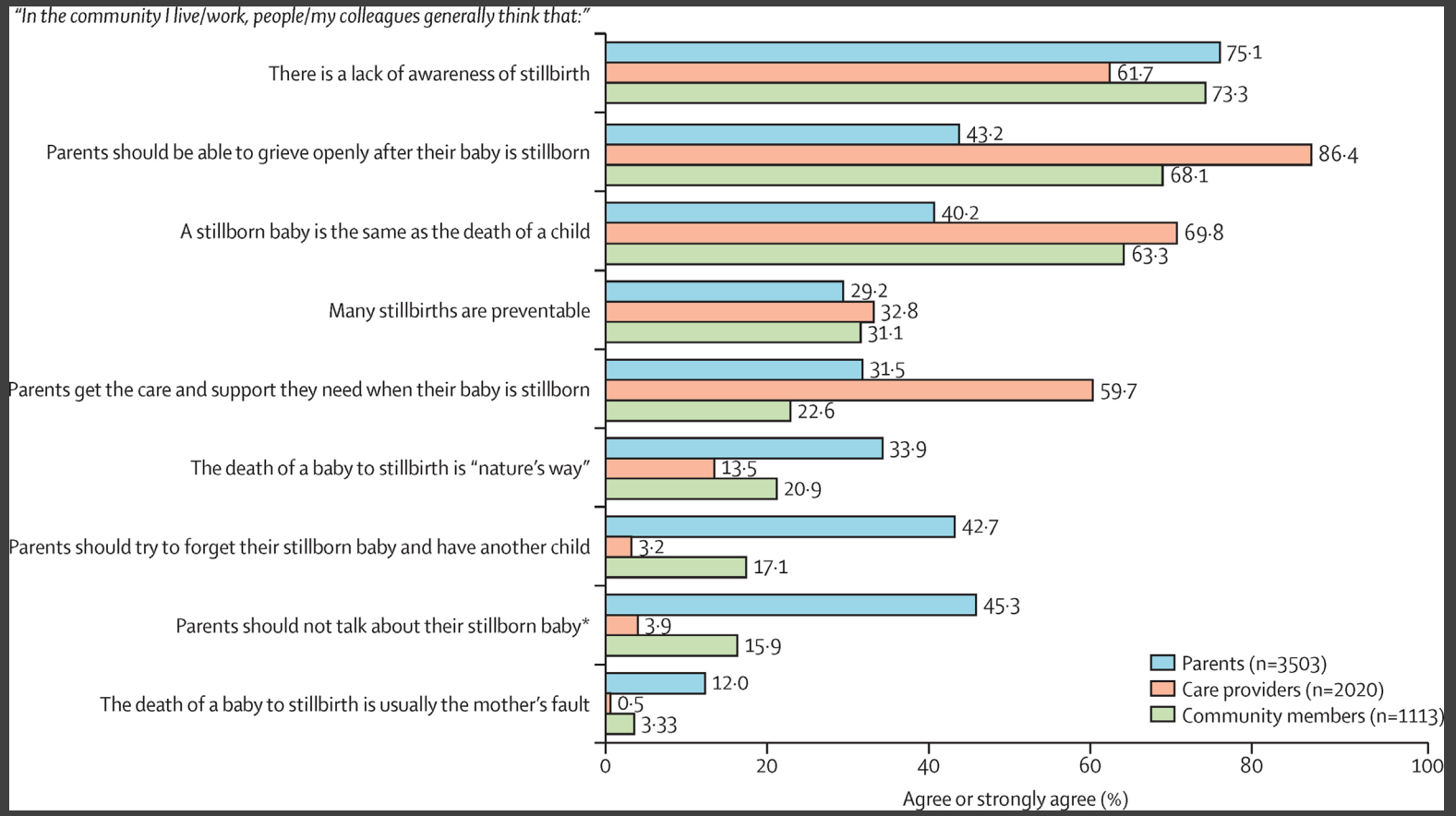
BY 2020 (additional milestones)

- 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
Source: The Lancet Ending preventable stillbirths Series 2016:
http://www.thelancet.com/ series/ending-preventablestillbirths

Myth 5: Talking about stillbirth is insensitive?

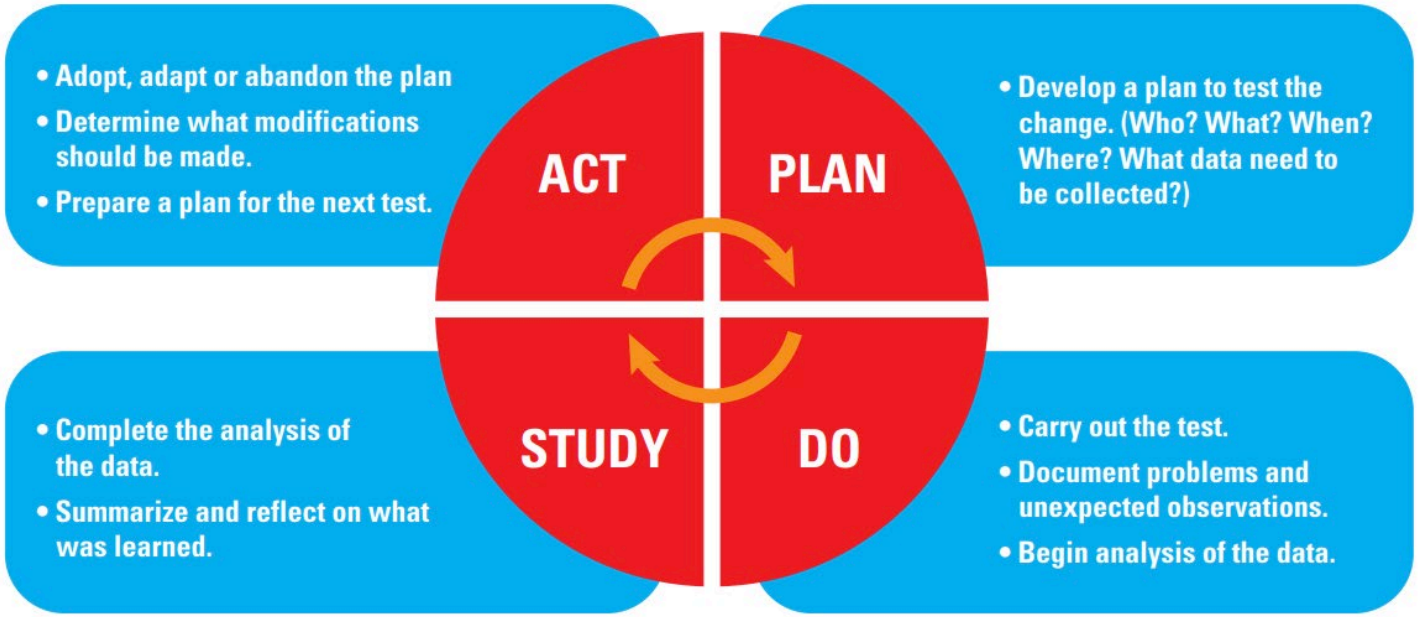
When you ask women (and men) who have suffered a stillbirth, they will tell you that breaking the silence is one of their most urgent and heartfelt wishes.

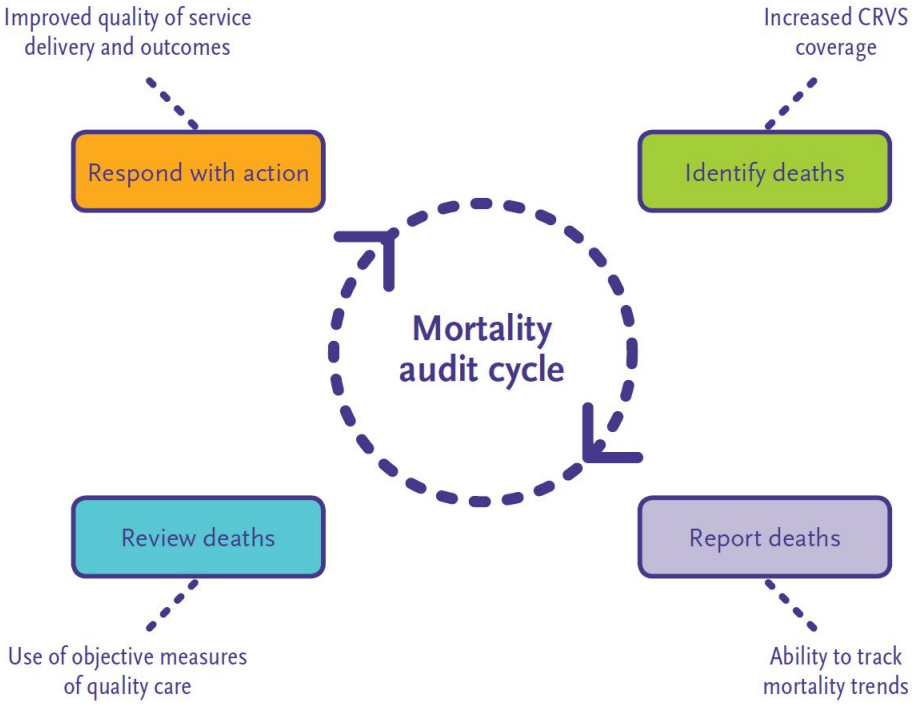


The Lancet 2016 387, 691-702DOI: (10.1016/S0140-6736(15)01020-X)

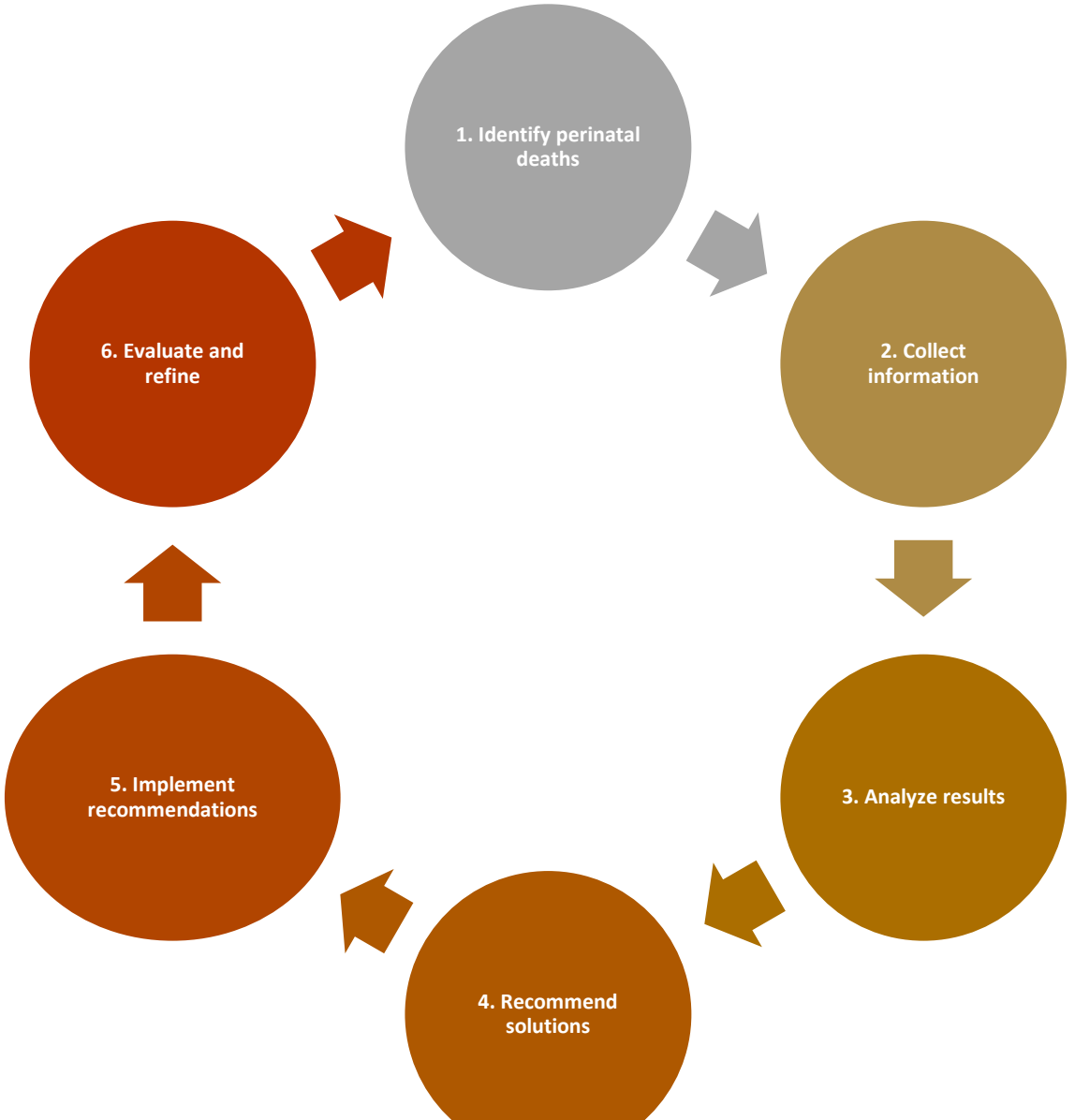
Myth 6

Perinatal and neonatal death review are very complex to introduce in my setting





Myth 6
Perinatal and neonatal death review are very complex to introduce in my setting

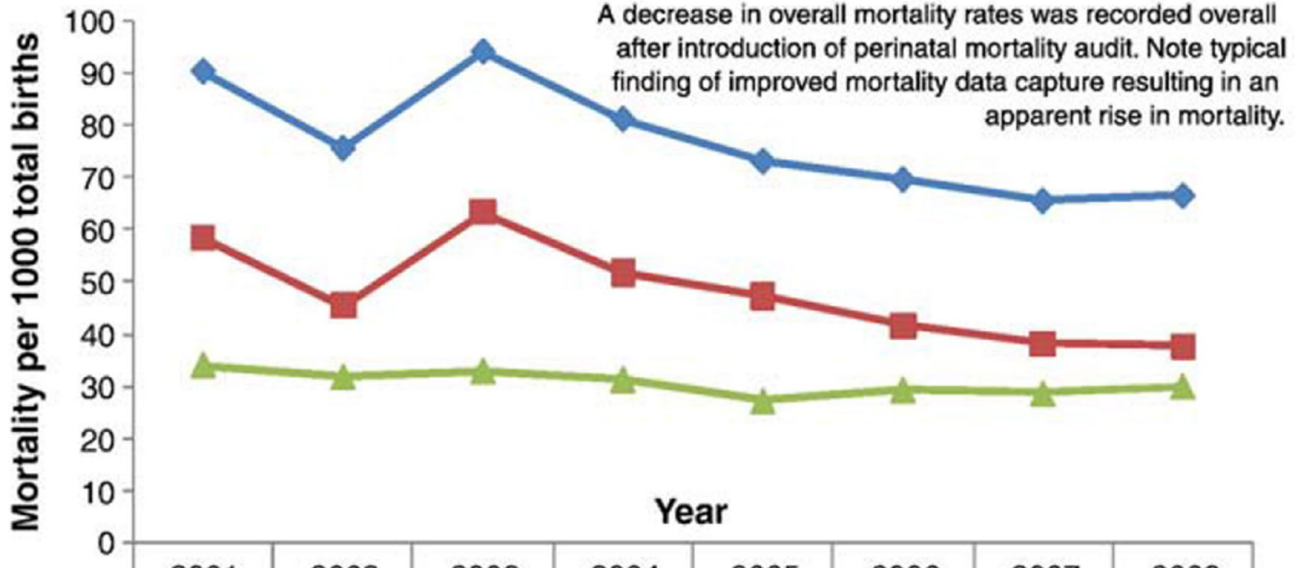


Misconception 1: Perinatal death reviews are impossible in my setting as there are too many neonatal deaths and stillbirths

There are ways to select a sample of perinatal deaths

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

Fig: Perinatal and early neonatal mortality rate and stillbirth rate at LAMB Hospital, Bangladesh.



	2001	2002	2003	2004	2005	2006	2007	2008
PMR	90	76	94	81	73	70	66	67
SBR	58	45	63	52	47	42	38	38
ENMR	34	32	33	31	27	29	29	30

Ref: Pattison et al. Perinatal mortality audit: Counting, accountability, and overcoming challenges in scaling up in low- and middle-income countries, Volume: 107, Issue: Supplement, Pages: S113-S122, First published: 06 October 2009, DOI: (10.1016/j.ijgo.2009.07.011)

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

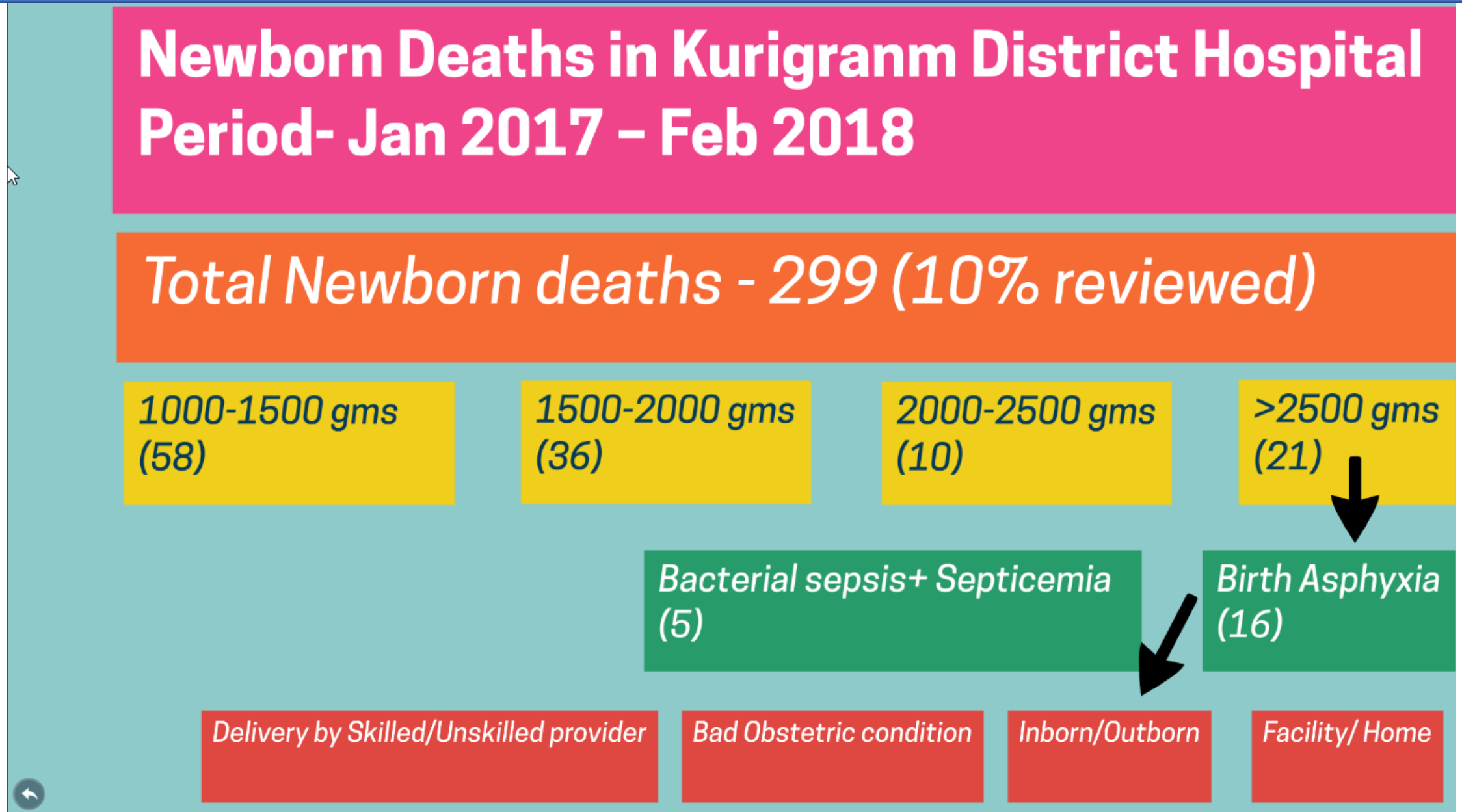
- For example: South Africa's Perinatal Problem Identification Programme (PPIP) started as a research project in 1990 using paper based forms. Now it capture 75.6% of all births in institutions (2014)

- 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



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!