Summary of findings in 12 intrapartum stillbirths out of 6471 deliveries (1.85/1000)

Comments on 3 intrapartum stillbirths from MTMH.

One mother aged 44 years had complications of vaginal breech delivery that led to stillbirth namely the baby's head becoming stuck in the pelvis during delivery. More efforts needed to convert breech to cephalic presentation when safe to do so before labour begins.
One baby was born prematurely (28 weeks, 1.9Kg) and the mother had severe preeclampsia.
One was showing no changes in FHR for the first 11 contractions and then a Dr undertook ultrasound scan and found no FHR.

Comments on 3 intrapartum stillbirths from Sinje CEmOC

Three were born by Caesarean section and all 3 had major obstetric problems. Two had obstructed labour including in one ruptured uterus. One fetus had a major congenital anomaly and could not have survived. All 3 were referred from clinics or homes where they had previously laboured. Mothers are still labouring in their communities where there are unqualified birth attendants or in clinics where midwives are inadequately trained to manage and/or refer complicated obstetric emergency cases. There are regular delays in referral processes either by health workers in clinics or lack of fuel for ambulances which families cannot afford to purchase or ambulances which have been broken down for some time without repair. Need for obstetric outreach (see later), rehearsal for neonatal resuscitation for birth attendants in clinics where babies are still born, more awareness on malaria prevention, and home deliveries/labouring to be discouraged or banned.

Comments on one intrapartum stillbirth from Tellewoyan Hospital.

There was no preceding FHR abnormality but cord entanglement at delivery, obstructed labour, fetal distress and delivery by CS.

Comments on 5 intrapartum stillbirths from CB Dunbar Hospital

- One had no change in FHR and the other 4 showed FHR changes prior to the stillbirths.
- The first patient had a normal FHR, but a breech malpresentation. Delivery was accompanied by an episiotomy but was recorded as difficult during which the fetus became stuck in the birth canal and died. There is a regular occurrence of problems relating to a link between birth asphyxia and breech delivery. There is a need to identify breech malpresentation in late pregnancy and consider external version to a cephalic presentation or CS depending on circumstances.
- The second patient had marked FHR changes which despite CS resulted in stillbirth. There was a previous history of a CS in an earlier pregnancy and HIV infection.
- The third patient's death was undoubtedly related to the long-standing "stock out" of drugs and materials needed for emergency obstetric care. There is a so-called "revolving system" that provides drugs and materials for emergencies at CB Dunbar Hospital. However, the system frequently doesn't work with major delays, especially for the vast majority of families who do not have immediately available money to purchase the drugs and supplies. Also, the hospital pharmacy frequently runs out of emergency drugs and supplies and families need to go to a nearby pharmacy and buy them. These dangerous delays in providing emergency care can result in both maternal and fetal deaths (especially if the family do not have the funds: approximately 90% of the community). There is a need for community and donor awareness of this problem and advocacy at all levels to overcome it.
- The 4th patient had a malpresentation (face) and an emergency CS was undertaken.
- The 5th patient was carrying a twin pregnancy with prolonged labour and one of the baby's died. However, the second twin did well. The mother considered that all that could have been done was undertaken.

Summary of comments on total of 12 Intrapartum Stillbirths from 3 hospitals and 1 CEmOC facility

9 of 12 had FHR abnormalities prior to stillbirth. 2 difficult breech deliveries (antepartum external version, when possible, or CS, may have avoided these stillbirths). One had a major congenital anomaly (anencephaly).

Major stock-out of essential emergency drugs and supplies in clinics and hospitals over last 2 years is especially relevant for poverty-stricken families. (a high risk for both maternal and fetal deaths). Delay in reaching hospital, especially after prolonged obstructed labour (including one woman with ruptured uterus). In one patient arriving at hospital, FHR abnormality identified but no oxygen, drugs or supplies available and no laboratory materials to screen blood from relatives for transfusion.

Mothers are still labouring in homes where unqualified birth attendants, or in clinics where midwives are not trained adequately to manage complicated obstetric emergencies. There are delays in referrals, either from health workers in clinics or the lack of fuel for ambulances (which families cannot afford to purchase) or ambulances are broken down.

Need for obstetric outreach to far-to-reach clinics to identify and manage high risk cases (click here for information on obstetric outreach)