Maternal near miss reviews at facility level: "beyond the numbers"

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Introduction

Sri Lanka has long been a forerunner in maintaining low maternal mortality ratios (MMRs) in the South Asian region. The vision of revolutionising maternal health together with clever initiatives made Sri Lanka a success story in how a low-middle income country (LMIC) can achieve impressive maternal outcomes with limited resources[1]. However, beneath the success, there are questions that remain unanswered as to why the downward trend of MMR has plateaued in the past decade. Since 2010, the MMR has been fluctuating between 29-39 deaths per 100,000 live births[2], despite the ever-increasing interest in the subject and the advancement of knowledge and technology. It has come to a point whereby Sri Lanka need to address the root causes of the stagnation of MMR through practical and evidence-based methods.

Evaluating the lessons generated from maternal deaths and severe morbidities in pregnancy is a systematic way of identifying effective and country appropriate interventions. It requires in-depth analysis of the cases, honesty in challenging routine practices, openness in staff attitudes and benchmarking current practices with evidence-based and internationally accepted standards.

Recently, Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) spearheaded a pilot programme of confidential enquiries into maternal death together with the Family Health Bureau (FHB) to include it as a component of the existing review mechanism[3]. This launch was highly commended as it encourages a blame-free culture when investigating events leading to maternal deaths which is a positive step forward in addressing this issue. However, desired maternal outcomes in LMICs cannot be completely achieved without incorporating a fundamental process called "maternal near miss reviews"[4].

Maternal near miss (MNM) is defined as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy"[5]. One of the tertiary maternity hospitals in Sri Lanka was found to have a

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relatively high number of MNM cases[6] whilst another study highlighted that the near miss to maternal mortality ratio was 18 in a different tertiary care setting[7]. Concerningly, this figure could be even greater in areas lacking resources and multidisciplinary input. These studies reflect the need for a robust system on a national and local level for the Sri Lankan healthcare services to consistently follow in relation to near misses.

The WHO has outlined a simple 12-step process in conducting MNM reviews that can be adopted by local institutes. This guide includes templates for documentations, examples of what a near miss case review (NMCR) should assess and ways to ensure the quality of these reviews[8]. Unfortunately, not all hospitals officially carry out NMCR cycles in a manner recommended by the World Health Organisation (WHO)[8], yet within hospitals that do take part there are disparities and deficiencies in this process.

Many countries have initiated NMCRs since the introduction of the WHO manual in 2011. Notable challenges that these countries experienced were a lack of applicability of diagnostic criteria, difficulty in developing recommendations, poor implementation and sustainability[9]. Other key barriers that hamper an effective NMCR cycle are the absence of protocols at a national and hospital level, lack of proactiveness following the reviews and poor follow-ups[4].

In Sri Lanka, the FHB have carried out excellent work in data collection of MNMs and in recognising its importance[10] but falls short of subsequently utilising the information gathered to devise policies and guidelines to facilitate an overall improvement in near miss cases. Furthermore, at a facility level the heavy work burden in obstetric units may inadvertently lead to the delegation and completion of the relevant MNM documents to junior members of the team. It is well known that burnout rates are high amongst doctors[11] which may ultimately affect the quality of the information provided.

With the recent launching of confidential enquiry into maternal deaths, now would be the ideal time to officially introduce confidential enquiries into MNM which will promote a shift in attitude and welcome a non-threatening environment amongst the multidisciplinary team as advocated by WHO's "beyond the numbers" principle[8]. Moreover, we believe that staff members other than doctors must be empowered to speak up during NMCRs for a productive outcome[12]. It is also vital that patients feedback is obtained on their birthing experience and is incorporated into NMCRs to be able to improve the quality of care[12].

One can appreciate the challenges that may arise in successfully integrating and implementing NMCR cycles at a national level, but this cannot be an excuse for complacency. By focusing our efforts into reducing the cases of near misses, we are confident that Sri Lanka will lead by example in further reducing maternal mortality and morbidity in the country.

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