SHORT COMMUNICATION

Stillbirth — a neglected priority: Understanding its social meaning in Pakistan

Saima Hamid,[1] Asmat Ullah Malik,[2] Fabienne Richard[3]

Abstract

Despite being ranked 3rd among the countries having highest burden of stillbirths, it remains a neglected priority in Pakistan. We review the evidence regarding social and biomedical understanding of stillbirths by both communities and healthcare providers. The terminology used to define stillbirth worldwide remains inconsistent. Not only do the health professionals mis-classify and under-report stillbirths, but also the parents and families are unclear about the difference between miscarriage, stillbirth and early neonatal deaths. Stillbirths occur more in poor families and are not recognised by tradition and religion as a loss comparable to a newborn who was born alive. There is need to understand perspective of communities and healthcare providers to identify prevention and management strategies along with providing support for coping with the implications of stillbirths. Future government policies on stillbirths must be informed by the influence of culture on the attitudes, beliefs and practices of the communities and the healthcare providers.

Keywords: Stillbirth, Pakistan, Developing countries.

Introduction

Pakistan is ranked 3rd among the countries having the highest burden of stillbirths.[1] Despite being a major public health problem, discussion around stillbirths is largely missing from health policies and programmes. In this short communication we review the evidence regarding the social and biomedical understanding of stillbirths by both communities and healthcare providers. We highlight the importance of the disconnect between the two viewpoints which have implications on the design and implementation of interventions for reducing their burden.

High disease burden related to stillbirths goes unnoticed in Pakistan

Globally, 2.6 million stillbirths occur every year of which 98% occur in low-income countries with a large proportion of stillbirths potentially preventable.[2] Findings of a large multi-country study indicate that the stillbirth rate in Pakistan is 32 per thousand deliveries[3] that means an estimated number of 167,040 stillbirths took place in Pakistan in the year 2012 (This number is based on total population of Pakistan, 180 million[4] and expected number of deliveries, 2.9% of the total population[5]). Although improving maternal and neonatal health appears as core element in the government's agenda on development, the evidence from Pakistan Demographic Household Survey (2007) reveals that the gap between the health indicators for the poor women and children and those better off is widening.[6] Despite considerable initiatives undertaken over decades (for example, Lady Health Workers Programme - 1993 to date, Women Health Project - 2000-05, National Maternal, Neonatal and Child Health Programme 2006 to date), progress with respect to maternal and neonatal health indicators remains poor. It is, thus, not surprising that Pakistan has been categorised among the countries that are clearly 'off track' in their global commitments on maternal and child health to achieve the targets set under the Millennium Development Goals (MDGs) by 2015.[7]

Stillbirths are inseparable from maternal health problems. However, like many other countries, the government policies in Pakistan have primarily targeted at reducing maternal and infant mortality, ignoring the importance of stillbirths in the overall disease burden related to maternal and neonatal health.

For stillbirths to be amply reflected in the government policies, they first need to be recognised as a significant problem. The causes of stillbirth are frequently and directly associated with women's poor access to and quality of care and poor follow-up of the labour.[8,9] In Pakistan, the major barriers that prevent women from accessing health and other services are deeply rooted in the socio-cultural structures (e.g. gender disparities, poverty, low social status and lack of decision-making powers in the household) and societal practices discriminating against women particularly belonging to poor and marginalised groups.[10]

Why is it difficult to understand stillbirths?

The terminology used to define stillbirth worldwide

[1]Health Services Academy, Ministry of Health, Government of Pakistan, Chak Shahzad, Islamabad, [2]Research and Development, Integrated Health Services (IHS), Islamabad, [3]Maternal and Reproductive Health Unit, Department of Public Health, Institute of Tropical Medicine, Antwerpen 2000, Belgium.
Correspondence: Saima Hamid. Email: saima_hamid@yahoo.com

remains inconsistent and confusing. The International Classification of Diseases (ICD 10) refers to foetal deaths but not to stillbirths, and classifies late foetal deaths (greater than 1000 gms or after 28 weeks) and early foetal deaths (500 to 1000gms or 22-28 weeks).[3] A stillbirth refers to all pregnancy losses after 16-28 weeks of gestation. In developed countries such as in UK it is 24 weeks, in Australia and USA 20 weeks, whereas in Germany, Austria and Ireland, a baby weighing less than 500g qualifies as a stillborn.

In less developed countries with poor quality of care, World Health Organisation's definition is often used: a birth weight of at least 1000 grams or a gestational age of at least 28 weeks.[11] Similarly, in Pakistan, healthcare providers classify all pregnancy losses after 28 weeks of pregnancy as stillbirths. As a consequence, not only the health professionals mis-classify and under-report stillbirths, but also the parents and families are unclear about the difference between miscarriage, stillbirth and early neonatal deaths (the death within one week after birth).[11] In the absence of a uniform definition and practical difficulties in gauging the stillbirths, precise estimation of mortality statistics is hindered. And more importantly, if used as a slippery term, it raises questions on the value of human life and when life becomes worth saving.[12] Furthermore, intra-partum foetal death and early neonatal death are good indicators of quality of care during childbirth.

What are the underlying causes of stillbirths?

The underlying factors of stillbirths are multiple and diverse in nature and vary from place to place. These are related to individual behaviours, knowledge, attitudes and practices, societal and cultural values, healthcare providers' knowledge, attitudes and practices and quality of healthcare.[13] They can be divided into two broad groups: community-related and healthcare delivery system related. These two groups come into play whenever an interaction takes place between community members and healthcare providers. An understanding of how women/community and healthcare providers interact will provide critical insights into the ways stillbirths occur and are managed. This understanding to generate recommendations concerning the corrective measures at policy, and practice, levels can reduce the risks and rates of stillbirth across the country.[11]

The direct medical causes of stillbirths are well documented, such as: congenital abnormalities, ante-partum haemorrhage, infection, prematurity, maternal accident, prolonged labour, cord-prolapse and mal-presentation. Some of these direct medical causes are indicative of poor quality of care of services, clinical error and medical negligence.[14] At the community level, nearly two-third of deliveries continue to take place at home with more than 62% of all deliveries assisted by untrained birth attendants.[6] Hence, in a substantial number of cases the exact cause of stillbirth remains unconfirmed with the communities explaining stillbirths according to socio-cultural and religious beliefs. The notion that stillbirths may be caused by cosmological forces, such as 'black magic' or the will of God, may underpin patients' decision-making and shape their access to and use of services during maternal health emergencies.

What is the importance of understanding social meanings of stillbirths?

Social and religious beliefs further determine the degree to which parents are allowed to grieve publicly, or whether stillborn infants are named, referred to, or their bodies viewed and held by family. Among Pakistan's Muslim communities, religious rituals like wrapping the body in white sheets (kaffan) and funeral prayers are offered only if the signs of life are found after birth. For babies born without signs of life, the body is also wrapped in the kaffan, but buried without funeral prayers.

Sometimes, healthcare providers refer to the dead baby as foetus and by doing so they reduce the existence of the baby.[11] Similarly, once the baby is born dead, its value is diminished further by society, implicitly diminishing dignity of the grieved mother. In comparison, mothers view stillborns as unborn children instead of foetuses. It is likely that the support provided by the healthcare providers is dependent upon the meaning they attach to the loss.[15] Should healthcare providers not view stillbirth as a loss worthy of grief and social recognition, they may have less empathy for patients and therefore provide insufficient or inadequate support and counselling.

Conclusion

In Pakistan, many interventions known to improve maternal and child health are in place, but stillbirths remain a neglected priority. Undoubtedly, there exists a gap in the understanding of social meanings related to stillbirths. It is imperative to analyse how stillbirths are perceived by the community (demand side) and the healthcare providers (supply side) and how they are defined in the Pakistani context and recognised as a problem warranting intervention. Stillbirths are higher in poor and marginalised women. These health disparities are rooted in maternal behaviours and the physical and social environments in which they live as well as the healthcare delivery system. Investments in health system interventions which reach out to such women from

deprived segments of society and facilitate their access to quality maternal health services should be the focus of future government policies and viewed as targets for change.

Acknowledgement

We are grateful to Prof. Dr. Vincent De Brouwere of the Institute of Tropical Medicine, Antwerp (ITM-A), Belgium, and, Director of Research based at IRD-INAS, Rabat, Morocco, for reviewing the manuscript and comments that helped us to finalise this writeup.

References

1. Lawn JE, Blencowe H, Pattinson R, Cousens S, Kumar R, Ibiebele I, et al. Stillbirths: Where? When? Why? How to make the data count? Lancet 2011; 377: 1448-63.
2. Bhutta ZA, Yakoob MY, Lawn JE, Rizvi A, Friberg IK, Weissman E, et al. Stillbirths: what difference can we make and at what cost? Lancet 2011; 377: 1523-38.
3. McClure EM, Pasha O, Goudar SS, Chomba E, Garces A, Tshefu A, et al. Epidemiology of stillbirth in low-middle income countries: a Global Network Study. Acta obstetricia et gynecologica Scandinavica 2011; 90: 1379-85.
4. UNFPA. State of world population 2013 - Motherhood in Childhood: Facing the challenge of adolescent pregnancy. United Nation's Population Fund, 2013.
5. Ministry of Health. Procedures Manual For District Health Information System (DHIS). Islamabad: National Health Information Resource Center (NHIRC), Ministry of Health, Pakistan; 2009.
6. National Institute of Population Studies. Pakistan Demographic and Health Survey 2006-07. Ministry of Population Welfare, Government of Pakistan, 2007.
7. The Partnership for Maternal Newborn & Child Health. Analysing Commitments to Advance the Global Strategy for Women's and Children's Health: The PMNCH 2011 Report. Geneva: 2011.
8. Rowe RE, Garcia J, Macfarlane AJ, Davidson LL. Improving communication between health professionals and women in maternity care: a structured review. Health Expectations 2002; 5: 63-83.
9. Guildea ZE, Fone DL, Dunstan FD, Sibert JR, Cartlidge PH. Social deprivation and the causes of stillbirth and infant mortality. Arch Dis Child 2001; 84: 307-10.
10. Khan S, Wilson A-K, Hooper E. Gender Inequality, Social Exclusion and Maternal and Newborn Health. In: Briefing Paper prepared for RAF, editor. Islamabad: Research and Advocacy Fund; 2010.
11. Frøen JF, Cacciatore J, McClure EM, Kuti O, Jokhio AH, Islam M, et al. Stillbirths: why they matter. Lancet 2011; 377: 1353-66.
12. Cecil R. The Anthropology of Pregnancy Loss. Comparative studies in miscarriage, stillbirth and neonatal death. Oxford: Berg Publishers; 1996.
13. Thomas SB, Fine MJ, Ibrahim SA. Health disparities: the importance of culture and health communication. Am J Public Health 2004; 94: 2050.
14. Oyebode F. Clinical errors and medical negligence. Advances Psychiatr Treatment 2006; 12: 221-7.
15. Plagge J, Antick JR. Perceptions of Perinatal Loss: Miscarriage versus Stillbirth. Annual Meeting of the Western Psychological Association; May, 2007; Vancouver, BC, 2007.