Perinatal outcomes among births to women with infection during pregnancy

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ABSTRACT

Objective This study is part of the Global Maternal Sepsis Study (GLOSS). It aimed to estimate neonatal near-miss (NNM) and perinatal death frequency and maternal risk factors among births to women with infection during pregnancy in low-income and middle-income countries (LMIC).

Design We conducted a 1-week inception hospital-based cohort study.

Setting The study was carried out in 408 hospitals in 43 LMIC of all the WHO regions in 2017.

Patients We included women with suspected or confirmed infection during pregnancy with at least 28 weeks of gestational age up to day-7 after birth. All babies born to those women were followed from birth until the seventh day after childbirth. Perinatal outcomes were considered at the end of the follow-up.

Main outcome measures Perinatal outcomes were (i) babies alive without severe complication, (ii) NNM and (iii) perinatal death (stillbirth and early neonatal death).

Results 1219 births were analysed. Among them, 25.9% (n=316) and 10.1% (n=123) were NNM and perinatal deaths, respectively. After adjustment, maternal pre-existing medical condition (aOR=1.5; 95% CI 1.1 to 2.0) and maternal infection suspected or diagnosed during labour (aOR=1.9; 95% CI 1.2 to 3.2) were the independent risk factors of NNM. Maternal pre-existing medical condition (aOR=1.7; 95% CI 1.0 to 2.8), infection-related severe maternal outcome (aOR=3.8; 95% CI 2.0 to 7.1), mother’s infection suspected or diagnosed within 24 hours after childbirth (aOR=2.2; 95% CI 1.0 to 4.7) and vaginal birth (aOR=1.8; 95% CI 1.1 to 2.9) were independently associated with increased odds of perinatal death.

Conclusions Overall, one-third of births were adverse perinatal outcomes. Pre-existing maternal medical conditions and severe infection-related maternal outcomes were the main risk factors of adverse perinatal outcomes.

BACKGROUND

Direct maternal infections account for 10.7% of all maternal deaths globally.1 Low-income and middle-income countries (LMIC) represent 98% of neonatal mortality, with 79% occurring in South Asia and sub-Saharan Africa.2 More than one-third of neonatal deaths occur during the first day of life and around two-thirds within the first week.3 4

Among those deaths, at least one-third is related to infection, and neonatal sepsis is a major cause of infant morbidity and mortality.4 Hibberd et al estimated the incidence of possible bacterial severe neonatal infection in 2016 to be 12.9% (95% CI 12.8% to 13.0%) with a case-fatality risk of 14% in sub-Saharan Africa, South Asia and Latin America.5 Although neonatal mortality declined worldwide between 1990 and 2019 by 20 deaths per 1000 live births,6 the global burden of infection-related neonatal mortality did not significantly drop,7 and the identification and management of maternal and neonatal infection are still challenging in developing countries.
Infection in pregnant women has mostly been examined as exposure in a disease-specific analysis. Consequently, previous studies showed that infants born to mothers with infection during pregnancy have an increased risk of adverse perinatal outcomes (APO), including stillbirths and neonatal deaths, compared with those who did not experience a maternal infection. However, in the specific population of women with infection during pregnancy, little is known about why some have ‘healthy babies’, while others’ pregnancies end with APO. Most of the available data are from high-income countries and often, limited samples of perinatal outcomes were examined. The WHO Global Maternal Sepsis Study (GLOSS), carried out in 52 countries, is an opportunity to provide data on the burden and risk factors of APO in this population in LMIC. Therefore, we aimed to determine the frequency and maternal risk factors of APO among births from women with suspected or confirmed infection during pregnancy in LMIC.

**METHODS**

**Study design and participants**

We included data from 43 LMICs participating in GLOSS, based on the World Bank classification, representing all of the six WHO regions. GLOSS was a hospital-based, prospective, 1-week inception cohort study. Figure 1 shows the map of the countries involved in the study. Detailed information on the study participants and procedures can be found elsewhere. Briefly, GLOSS included all women admitted or already hospitalised for at least 12 hours during the study identification week (28 November to 4 December 2017), with suspected or confirmed infection at any stage of pregnancy, up to the 42nd day after abortion or childbirth in participating health facilities, in purposefully selected geographical areas. Information on perinatal outcomes was collected for all births up to the seventh day after childbirth, discharge or death, whichever occurred first.

We excluded all pregnancies that ended before 28 weeks of gestational age and women for whom the infection was suspected or confirmed after the seventh day postpartum.

**Outcome variable**

The outcome variable was perinatal outcome evaluated at the end of follow-up, with three categories, which were (1) alive without severe complication, (2) neonatal near-miss (NNM) and (3) perinatal death. Perinatal death included early neonatal death (within 7 days after childbirth) and stillbirth (fresh or macerated).

We applied the WHO definition of stillbirths and used the definition of NNM suggested by Santos et al and Pileggi-Castro et al (table 1). Babies alive without severe complications were born alive and did not experience any severe neonatal complications and were still alive at the end of follow-up.

**Independent variables**

Covariates included selected women’s demographic, obstetric and clinical characteristics. Demographic characteristics were mother’s age (in years), living with partner or spouse (yes/no) and schooling (in years). Obstetric factors were the number of previous births (none, one or more), other obstetric complications (none, any additional complication) and the final mode of birth (spontaneous/instrumental vaginal or caesarean section). Clinical characteristics included pre-existing maternal medical condition (none or any condition), the severity of the infection-related maternal outcome (less severe infection, infection-related complications and infection-related severe maternal outcome, which included maternal death and near-miss) as defined by the WHO Global Maternal Sepsis Study (GLOSS) Research Group’s pregnancy status at the time of suspicion or confirmation of the infection (during pregnancy, during labour, within 24 hours, between 24 and 72 hours and after 72 hours after childbirth), location at the time of suspicion or confirmation of the infection (arrived from home, referred by another facility, already hospitalised at the start of the study) and the source of infection (chorioamnionitis, endometritis, urinary tract infection, skin, wound, catheter infection and other infections).

Potential contextual factors were considered for adjustment. These included the country level of income (upper middle-income, lower middle-income and low-income) as defined by the World Bank in 2019, the WHO region (for Asia which we

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**Table 1** Criteria for the definition of neonatal near-miss cases (10,21)

<table>
<thead>
<tr>
<th>n#</th>
<th>Pragmatic criteria</th>
<th>n#</th>
<th>Management criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Birthweight &lt;1750 grams</td>
<td>1</td>
<td>Use of parenteral antibiotics</td>
</tr>
<tr>
<td>2</td>
<td>Gestational age at birth between 28 and 33 weeks</td>
<td>2</td>
<td>Ventilation (use of nasal continuous positive airway pressure or invasive support)</td>
</tr>
<tr>
<td>3</td>
<td>5 min APGAR score &lt;7</td>
<td>3</td>
<td>Intubation at birth</td>
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<td>4</td>
<td></td>
<td>4</td>
<td>Use of phototherapy within the first 24 hours after birth</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
<td>Use of any vasoactive drug</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>7</td>
<td>Use of anticonvulsants</td>
</tr>
<tr>
<td>8</td>
<td>Administration of surfactant</td>
<td>8</td>
<td>Administration of surfactant</td>
</tr>
<tr>
<td>9</td>
<td>Administration of blood product</td>
<td>9</td>
<td>Administration of blood product</td>
</tr>
<tr>
<td>10</td>
<td>Use of steroids to treat refractory hypoglycaemia</td>
<td>10</td>
<td>Use of steroids to treat refractory hypoglycaemia</td>
</tr>
<tr>
<td>11</td>
<td>Any surgery</td>
<td>11</td>
<td>Any surgery</td>
</tr>
</tbody>
</table>
combined two regions (South Eastern Asia and Western Pacific),
the level of care (tertiary, secondary or primary), the type of
health facility administration (public or private) and the number
of births in 2016.

Data source and collection
GLOSS data were collected at the facility and individual women
level with standardised tools. Each participating hospital
completed the facility form, which provided information on
hospitals’ characteristics. Individual women form collected data
on demographic, obstetric, clinical characteristics and informa-
tion on the infections and the management during their stay
in the health facility and information used to define perinatal
outcomes. Infections could be confirmed using clinical exam-
ination alone or complemented by a radiological, laboratory or
microbiological finding. Suspicion or confirmation of infection
was undertaken as part of standard routine care in health facil-
ities. A comprehensive description of the study procedures and
measurements is available in the protocol and the previous paper
of GLOSS.15 17

Statistical analysis
We computed the proportion of NNM and perinatal deaths and
their rate per 1000 live births with a 95% CI. We then fitted a
mixed effects multinomial logistic regression model to examine
the relationship between maternal characteristics and APO. In
all the analyses, the category of babies born alive without severe
neonatal complications was the outcome variable reference
category. We first assessed the effects of the characteristics with
crude ORs taking into account the country level clustering of
the data in simple multinomial logistic regression models. We
then fitted a two-level hierarchical multiple multinomial logistic
regression model to estimate the adjusted odds ratios (aOR) with
their 95%CI.22 The first level of this hierarchical model referred
to maternal characteristics of each birth and the second level was
the hospital and country-level variables. We used the intraclass
correlation coefficient to assess the relevance of the multilevel
analysis. The final model was selected using a stepwise approach
based on the assessment of the Bayesian Information Criteria
(BIC) and Akaike Information Criteria (AIC). In the null model,
the AIC and BIC were 2055.5 and 2076.0, respectively. They
dropped to 1763.7 and 1893.6, respectively, in the first model,
which only included level of care as the hospital-level adjust-
ment factor and 1747.8 and 1927.6, respectively, in the final
model that controlled for country income level and the number
of births. Based on the AIC, we considered that the final model
fits the best. Furthermore, we performed a subanalysis using
the final model with confirmed cases only (n=933). However,
that analysis identified the same factors and did not significantly
change the ORs; hence we did not present those results.

All statistical analyses were performed using Stata V.15.1
(Stata 2017: Release 15. College Station, Texas, USA).

Ethical considerations
Women were screened and included by the hospital teams. Data
were extracted from medical records and no interaction was
required with the women. The participants’ identification data
were kept confidential. Depending on the country’s regulations

Figure 2  Flowchart of the study. LMIC, low-income and middle-income countries.
and local Institutional Review Boards (IRB), the need for informed consent was waived or sought and obtained from the participants or their caregivers if the former was unconscious. Each site also submitted the protocol to its national or institutional ethics committee for approval before data collection.

RESULTS

We included 408 hospitals, including 317 (77.7%) located in an urban area. Tertiary and secondary level hospitals represented 38.7% (n=158) and 44.1% (n=180) of the sample, respectively (online supplemental appendix 1). These facilities were from 43 LMIC: 13 in Africa, 9 in Asia (South-East Asia and Western Pacific), 6 in Eastern Mediterranean, 5 in Europe and 10 in the Americas. The list of the countries involved is presented in online supplemental appendix 2. A total of 1219 births were analysed.

Figure 2 shows the flowchart of the study. Overall, 276 babies born alive were suspected of having an early neonatal infection, including 199 NNM and 20 perinatal deaths.

Neonatal near-miss

Among all NNM cases, 42.7% (n=135) met the pragmatic criteria, including 29.7% (n=84) who had a gestational age between 28 and 33 weeks, and 82.6% (n=261) met the management criteria. 61.1% (n=193) of the near-miss cases were treated with parenteral antibiotics, and 20.3% (n=64) had phototherapy within 24 hours after birth (online supplemental appendix 3). The overall percentage of NNM was 25.9% (n=316; 95% CI 23.5 to 28.5) of all births, and the intrahospital rate was 278.7 (224.9 to 332.4) cases per 1000 live births (table 2).

Table 2 Percentage and rate of perinatal outcomes per 1000 live births from women with infection during pregnancy, by the country level of income

<table>
<thead>
<tr>
<th>Perinatal outcomes</th>
<th>Total (n=1219)</th>
<th>Rate per 1000 live births</th>
<th>Low income (n=245)</th>
<th>Rate per 1000 live births</th>
<th>Lower middle income (n=593)</th>
<th>Rate per 1000 live births</th>
<th>Upper middle income (n=381)</th>
<th>Rate per 1000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alive without severe complication</td>
<td>780</td>
<td>64.0</td>
<td>153</td>
<td>62.4</td>
<td>351</td>
<td>59.2</td>
<td>276</td>
<td>72.4</td>
</tr>
<tr>
<td>Neonatal near-miss*</td>
<td>316</td>
<td>25.9</td>
<td>278.7 (224.9–332.4)</td>
<td>52</td>
<td>21.2</td>
<td>172</td>
<td>29.0</td>
<td>317.9 (245.7–390.2)</td>
</tr>
<tr>
<td>Perinatal death</td>
<td>123</td>
<td>10.1</td>
<td>180.5 (80.8–286.2)</td>
<td>70</td>
<td>11.8</td>
<td>129.4</td>
<td>13</td>
<td>34.7 (11.2–58.2)</td>
</tr>
<tr>
<td>Early neonatal death</td>
<td>38</td>
<td>3.1</td>
<td>33.5 (20.2–44.8)</td>
<td>13</td>
<td>5.3</td>
<td>18</td>
<td>1.5</td>
<td>33.3 (18.4–48.2)</td>
</tr>
<tr>
<td>Stillbirth</td>
<td>85</td>
<td>7.0</td>
<td>75.0 (41.0–108.9)</td>
<td>27</td>
<td>11.0</td>
<td>123.9</td>
<td>52</td>
<td>4.3 (57.2–139.6)</td>
</tr>
<tr>
<td>Fresh stillbirth</td>
<td>34</td>
<td>2.8</td>
<td>30.0 (14.7–45.2)</td>
<td>12</td>
<td>4.9</td>
<td>55.0 (23.0–87.1)</td>
<td>20</td>
<td>1.6 (37.6–150.2)</td>
</tr>
<tr>
<td>Macerated stillbirth</td>
<td>51</td>
<td>4.2</td>
<td>45.0 (21.4–68.5)</td>
<td>15</td>
<td>6.1</td>
<td>68.8 (3.2–140.8)</td>
<td>32</td>
<td>2.6 (59.1–88.6)</td>
</tr>
</tbody>
</table>

*Based on criteria presented in table 1.

Table 3 Perinatal outcomes of births from women with infection during pregnancy by maternal demographic and obstetric characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Alive without severe complication (n=780)</th>
<th>OR</th>
<th>95% CI</th>
<th>p value</th>
<th>Neutonal near-miss (n=316)</th>
<th>OR</th>
<th>95% CI</th>
<th>p value</th>
<th>Perinatal death (n=123)</th>
<th>OR</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
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<tr>
<td>&lt;20</td>
<td>101 (60.5)</td>
<td>1.0</td>
<td>0.8 to 1.3</td>
<td>0.385</td>
<td>10 (5.5)</td>
<td>0.9</td>
<td>0.6 to 2.1</td>
<td>0.438</td>
<td></td>
<td></td>
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<tr>
<td>20–35</td>
<td>553 (64.6)</td>
<td>222 (25.9)</td>
<td>1.2</td>
<td>0.8 to 1.7</td>
<td>0.385</td>
<td>81 (9.5)</td>
<td>1.2</td>
<td>0.7 to 2.2</td>
<td>0.522</td>
<td></td>
<td></td>
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<tr>
<td>35 and more</td>
<td>122 (65.6)</td>
<td>42 (22.6)</td>
<td>0.9</td>
<td>0.6 to 1.3</td>
<td>0.430</td>
<td>22 (11.8)</td>
<td>1.2</td>
<td>0.7 to 2.1</td>
<td>0.438</td>
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<tr>
<td>Living with partner/spouse</td>
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<tr>
<td>No</td>
<td>78 (67.2)</td>
<td>26 (22.4)</td>
<td>ref</td>
<td></td>
<td></td>
<td>12 (10.3)</td>
<td>ref</td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>672 (64.5)</td>
<td>266 (25.5)</td>
<td>1.2</td>
<td>0.8 to 1.8</td>
<td>0.393</td>
<td>104 (10.0)</td>
<td>1.0</td>
<td>0.5 to 2.1</td>
<td>0.987</td>
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<tr>
<td>Schooling (years)</td>
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<tr>
<td>Less than 5</td>
<td>103 (54.8)</td>
<td>47 (25.0)</td>
<td>ref</td>
<td></td>
<td></td>
<td>38 (20.2)</td>
<td>ref</td>
<td></td>
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</tr>
<tr>
<td>5–11 years</td>
<td>329 (64.9)</td>
<td>138 (27.2)</td>
<td>1.2</td>
<td>0.5 to 2.8</td>
<td>0.747</td>
<td>40 (7.9)</td>
<td>0.4</td>
<td>0.2 to 0.8</td>
<td>0.003*</td>
<td></td>
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</tr>
<tr>
<td>12 or more</td>
<td>108 (68.8)</td>
<td>40 (25.5)</td>
<td>1.1</td>
<td>0.5 to 2.7</td>
<td>0.789</td>
<td>9 (5.7)</td>
<td>0.2</td>
<td>0.1 to 0.5</td>
<td>0.001*</td>
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<tr>
<td>Number of previous births</td>
<td></td>
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<tr>
<td>0</td>
<td>237 (64.1)</td>
<td>87 (23.5)</td>
<td>ref</td>
<td></td>
<td></td>
<td>46 (12.4)</td>
<td>ref</td>
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<tr>
<td>1 or more</td>
<td>534 (63.8)</td>
<td>226 (27.0)</td>
<td>0.9</td>
<td>0.6 to 1.2</td>
<td>0.401</td>
<td>77 (9.2)</td>
<td>1.4</td>
<td>0.9 to 2.1</td>
<td>0.206</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other obstetric complications†</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Any additional complication</td>
<td>279 (56.5)</td>
<td>141 (28.5)</td>
<td>1.4</td>
<td>1.0 to 2.0</td>
<td>0.026*</td>
<td>74 (15.0)</td>
<td>2.7</td>
<td>1.6 to 4.5</td>
<td>0.000*</td>
<td></td>
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<tr>
<td>None</td>
<td>501 (69.1)</td>
<td>175 (24.1)</td>
<td>ref</td>
<td></td>
<td></td>
<td>49 (6.9)</td>
<td>ref</td>
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<tr>
<td>The final mode of birth</td>
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<tr>
<td>Vaginal (spontaneous/instrumental)‡</td>
<td>327 (63.3)</td>
<td>127 (24.6)</td>
<td>0.9</td>
<td>0.6 to 1.4</td>
<td>0.716</td>
<td>63 (12.2)</td>
<td>1.6</td>
<td>1.0 to 2.5</td>
<td>0.069</td>
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<td></td>
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<tr>
<td>Caesarean-section</td>
<td>444 (64.7)</td>
<td>187 (27.3)</td>
<td>ref</td>
<td></td>
<td></td>
<td>55 (8.0)</td>
<td>ref</td>
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</tr>
</tbody>
</table>

*Statistically significant (p<0.05).
†Includes haemorrhage, hypertensive and thromboembolic disorders, dystocia, trauma during childbirth, anaesthesia, and surgery-related complications.
‡Instrumental: 35 cases.
levels of income (online supplemental appendix 4) and the WHO regions.

The maternal factors that were significantly associated with NNM in the unadjusted analysis were other obstetric complications (OR=1.4; 95% CI 1.0 to 2.0) (table 3), infection-related severe maternal outcome (OR=1.9; 95% CI 1.1 to 3.1), maternal transfer from another facility (OR=2.5; 95% CI 1.4 to 4.5), the fact that the mother was already hospitalised at the start of the study (OR=1.5; 95% CI 1.0 to 2.1) and chorioamnionitis (OR=2.4; 95% CI 1.3 to 4.6) (table 4).

After adjustment, only pre-existing medical conditions (aOR=1.5; 95% CI 1.1 to 2.0) and infections suspected or diagnosed during labour (aOR=1.9; 95% CI 1.2 to 3.2) were independently associated with higher odds of NNM (table 5).

### Perinatal death

The overall proportion of perinatal deaths was 10.1% (n=123; 95% CI 8.3 to 11.9) (table 2). The intrahospital rate of perinatal death was 108.5 (64.9 to 152.0) deaths per 1000 live births, with a variation across countries levels of income: 183.5 (80.8 to 286.2), 129.4 (78.8 to 180.0) and 34.7 (11.2 to 58.2) deaths per 1000 in low-income, lower middle-income and upper middle-income countries, respectively. Among these deaths, 85 were stillbirths, including 34 (40.0%) of fresh stillbirths. After stratification by country income level, the percentages of perinatal deaths were 16.3%, 11.8% and 3.4% of all births in low-income, lower middle-income and upper middle-income countries, respectively (online supplemental appendix 4). The percentages in the WHO region are presented in online supplemental appendix 5.

Online supplemental appendix 6 shows the crude ORs of the relationship between pregnancy outcomes and country and hospital characteristics. Tables 3 and 4 show crude ORs of sociodemographic, obstetric and clinical factors.

After adjustment, we also observed that the factors independently associated with increased odds of perinatal death were lower maternal age (aOR=2.2; 95% CI 1.0 to 4.7), vaginal birth (aOR=1.8; 95% CI 1.0 to 2.9) and growing birthweight (aOR=3.8; 95% CI 2.0 to 7.1). The factors independently associated with increased odds of perinatal death were also the factors independently associated with higher odds of NNM.

### DISCUSSION

This study adds to previous efforts in estimating the burden of NNM and perinatal death using global data in the specific population of women with confirmed or suspected infection during pregnancy in LMIC. We showed that one-third of the births were APO (25%) were NNM and 10% were either stillbirth
The study population is at higher risk of adverse perinatal mortality.8 From women in the general population, but they show that our estimates on the specific population involved in the current research. Nevertheless, the NNM rates and percentages in our estimates on the specific population involved in the current research imply that the more complicated the mother's age nor her education level) were associated with NNM or perinatal death from women with infection during pregnancy.29 30

Few studies estimated the rate of NNM in LMIC with the definition adopted in this study.25 26 None of them provided estimates on the specific population involved in the current research. Nevertheless, the NNM rates and percentages in our study were much higher than the existing ones.25 26

Thirty-four stillbirths out of 85 (40.0%) were fresh. These estimates are consistent with the distribution of the global burden of stillbirth as reported by the United Nations (UN).27 In its latest report, the UN raised concerns regarding some perinatal deaths, particularly stillbirths, referring to them as ‘loss that could be avoided with improved monitoring and timely access to emergency obstetric care when required’. Indeed, some perinatal deaths, particularly intrapartum deaths (fresh stillbirth) and neonatal deaths within the first hours of life, can be prevented through improved intrapartum care for both the woman and the baby because they are linked to the access and quality of care during pregnancy and childbirth.27 28 In LMIC, hospitals often face a lack of skilled maternity staff who are well trained in emergency newborn care, essential drugs and the right equipment for managing neonatal conditions, including in intensive care. This significantly reduces their capacity to care for women with infection and their newborns, such as the ones from our study population.29 30

In this analysis, we estimated the likelihood of a particular birth falling into the group of NNM or perinatal death instead of the group of babies alive without severe complication based on the mother’s characteristics. The main maternal factors identified in this study imply that the more complicated the mother’s clinical condition, the worse her perinatal outcome. Any condition that severely affects the mother during pregnancy or immediately after childbirth can also threaten the baby’s life.31 Thus, preventing or diagnosing and treating infection during pregnancy, appropriately and timely, can potentially save both the mother’s and the baby’s lives.22

Surprisingly, in this study, the severe maternal outcome was associated with NNM in the unadjusted analysis, but it was no longer statistically significant after adjustment. In contrast, a recent cohort study reported that newborns whose mothers had life-threatening conditions had almost 13 times higher risk of experiencing NNM.28 But that study did not include only women with infection. Second, we analysed both NNM and perinatal death with infection. Second, we analysed both NNM and perinatal death with infection.
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Strengths and limitations
This study could be the first to provide evidence on perinatal outcomes in the specific population of women with infection during pregnancy using data from as many as 43 LMIC. In addition, GLOSS used a standardised screening checklist and inclusion criteria to ensure that all participants across the countries were included on the same basis and a validated definition of NNM cases. Further, the awareness campaign that accompanied the GLOSS could have improved maternal infection identification and added diagnostic reliability.34

Nevertheless, NNM and perinatal death frequency could be underestimated because we stopped the babies’ follow-up when the mothers were discharged. In addition, only a limited number of sociodemographic factors were assessed. Finally, we relied solely on routinely available procedures and could not confirm all cases of infections, and APO were identified based on criteria reported by healthcare providers.

CONCLUSION
Pregnancies complicated with infection can result in a high proportion of APO. Our study showed that a quarter of all births were NNM, and 1 out of 10 were perinatal deaths. In total, one-third of all births in our study population represented APO. In fetuses and infants born to women with infection during pregnancy, the severity of women’s clinical condition was the main factor associated with the fact that some have ‘healthy babies’, while others’ pregnancies end with APO. Healthcare providers and policymakers in LMIC should strengthen hospitals’ readiness and capacity to prevent and timely identify maternal infections and complications. To do so, facilities should address their needs for optimal skilled staff, equipment and drug availability for good quality emergency obstetric and newborn care.

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