Risk and burden of adverse intrapartum-related outcomes associated with non-cephalic and multiple birth in rural Nepal: a prospective cohort study

Naoko Kozuki,1 Joanne Katz,1 Subarna K Khatry,2 James M Tielsch,3 Steven C LeClerq,1,2 Luke C Mullany1

ABSTRACT

Objectives: Intrapartum-related complications are the second leading cause of neonatal death worldwide. We estimate the community-level risk and burden of intrapartum-related fetal/neonatal mortality and morbidity associated with non-cephalic and multiple birth in rural Sarlahi District, Nepal.

Design: Community-based prospective cohort study.

Setting: Rural Sarlahi District, Nepal.

Participants: Pregnant women residing in the study area.

Methods: We collected data on maternal background characteristics, conditions during labour and delivery, fetal presentation and multiple birth during home visits. We ran log-binomial regression models to estimate the associations between non-cephalic/multiple births and fresh stillbirth, early neonatal mortality and signs of neonatal encephalopathy, respectively, and calculated the per cent attributable fraction. To better understand the context under which these adverse birth outcomes are occurring, we also collected data on maternal awareness of non-cephalic presentation and multiple gestation prior to delivery.

Primary outcome measures: Risk of experiencing fresh stillbirth, early neonatal encephalopathy and early neonatal mortality associated with non-cephalic and multiple birth, respectively.

Results: Non-cephalic presentation had a particularly high risk of fresh stillbirth (aRR 12.52 (95% CI 7.86 to 19.95), reference: cephalic presentation), 20.2% of all fresh stillbirths were associated with non-cephalic presentation. For multiple births, there was a fourfold increase in early neonatal mortality (aRR: 4.57 (95% CI 1.44 to 14.50), reference: singleton births). 3.4% of early neonatal mortality was associated with multiple gestation.

Conclusions: Globally and in Nepal, a large percentage of stillbirths and neonatal mortality is associated with intrapartum-related complications. Despite the low incidence of non-cephalic and multiple birth, a notable proportion of adverse intrapartum-related outcomes is associated with these conditions. As the proportion of neonatal deaths attributable to intrapartum-related complications continues to rise, there is a need to investigate how best to advance diagnostic capacity and management of these conditions.

Trial registration number: NCT01177111; pre-results.

BACKGROUND

It is estimated that 662 000 neonatal deaths and 1.3 million stillbirths occur annually due to intrapartum-related complications, or complications during labour and delivery. Of the 303 000 maternal deaths that occur each year, 20.6% occur from intrapartum and postpartum haemorrhage, 2.8% from complications during labour and delivery, and another 2.8% due to obstructed labour. Deaths and morbidities combined, intrapartum-related
complications account for the loss of 74.6 million disability-adjusted life years (excludes stillbirths) according to 2012 estimates. Early identification and management of childbirth complications, such as obstructed labour or malpresentation, and access to a skilled birth attendant are effective in reducing intrapartum-related mortality. An estimated 60 million women still deliver at home globally, of whom over 85% deliver without a skilled birth attendant present.

Intrapartum-related complications can occur without warning among the healthiest mothers, but several risk factors are identifiable antenatally. Non-cephalic presentation and multiple gestation are two such conditions. These conditions can lead to adverse birth outcomes by causing prolonged labour and limiting fetal oxygenation, or by causing fetal entrapment. While the association between these conditions and adverse birth outcomes in low and middle income countries (LMICs) has been reported previously in tertiary facility-based settings, the study population is unlikely to be representative. Very few studies have reported on the community-level risks in a context where home delivery rates are still high.

We conducted a prospective cohort study in rural Nepal to examine non-cephalic presentation and multiple gestation as potential risk factors for adverse intrapartum-related fetal and neonatal outcomes. Understanding the burden of mortality and morbidity associated with these conditions and the current standard of care could provide more generalisable evidence to justify improved diagnostic capacity, better quality of care at birthing facilities and increased access to quality, comprehensive emergency obstetric care in low-resource settings.

METHODS

The study was conducted from March 2014 to March 2015 in rural Sarlahi District, Nepal. Sarlahi District is located in the southern terai plains of the country, bordering the Indian state of Bihar on the south. The data were collected as a part of the Nepal Oil Massage Study, a community-based cluster-randomised controlled trial examining the impact of sunflower seed oil massage on neonatal mortality and morbidity, compared with traditional mustard seed oil massage (Clinicaltrials.gov NCT01177111). The intervention of the trial occurred after the birth of the infant; thus, we do not expect any impact on the results of this study, which looks at outcomes proximate to the time of delivery. While the main study began enrolment in November 2010, data on fetal presentation were collected only starting March 2014.

Field workers initially surveyed our study area to identify all married women of reproductive age (15–40 years of age). Subsequently, these women were visited at home every 5 weeks to identify any new pregnancies. A pregnancy test was provided if the women reported no menstrual period since the prior visit. Positive tests led to recruitment and consent to study participation, followed by the collection of the woman’s reproductive and pregnancy history, anthropometric measurements and socioeconomic status. Households were instructed to notify the study staff of delivery as soon as possible. On the first home visit following delivery, data on labour and delivery conditions and neonatal vital status and anthropometry were collected. Neonatal and maternal vital status and morbidity were ascertained on home visits on days 1, 3, 7, 14, 21 and 28.

The main exposures of interest were non-cephalic presentation and multiple birth. We categorised maternal report of fetal presentation as cephalic (head presenting first), non-cephalic (feet, umbilical cord, arm or buttocks presenting first) or caesarean section (C-section). For those presenting in cephalic presentation, we did not seek further clarification regarding face or brow presentation. Those who underwent C-section were excluded from the analysis on fetal presentation, as we did not collect information on the indications for C-section. For fetal presentation, a sensitivity analysis was conducted excluding and including multiple births in the analysis. Any pregnancy with more than one fetus was categorised as multiple birth (whether live or stillborn), and those missing data on fetal presentation (including C-sections) were included in the multiple birth analysis.

We examined outcomes that are most proximate to the time of labour and delivery: fresh stillbirth, defined as a stillbirth with maternal self-report of the fetal skin not being pulpy (assumed to have occurred within 12 hours prior to delivery), first-day neonatal mortality and early neonatal mortality (within the first 7 days of life). We also examined neonatal encephalopathy as an adverse outcome. Neonatal encephalopathy is identified and staged by severity using clinical and EEG criteria. However, owing to lack of medical equipment access and the use of non-clinicians for data collection, we applied a basic clinical sign-based definition: report of convulsions/seizure or two of the following: lethargy, poor suck or respiratory rate <10 breaths/min. The signs were based on maternal report except respiratory rate, which was measured by a trained staff member. Only those who had morbidity data collected at least once in the early neonatal period were categorised for neonatal encephalopathy, including those who later experienced early neonatal death. We also created an aggregate ‘any adverse outcome’ variable of having any of the aforementioned outcomes. Maternal deaths as an outcome were also examined, but were excluded due to data limitations and small sample size. Ten maternal deaths occurred during the data collection period, with corresponding fetal / neonatal outcomes of three miscarriages, three fresh stillbirths and four live births. Fetal presentation data were not collected for maternal death cases. The findings on stillbirths and live births in relation to fetal presentation were based on data from singleton pregnancies. Data on single or multiple gestation were not collected for miscarriages.
On the first data collection visit following delivery, we also asked women who gave non-cephalic or multiple birth whether they were aware of the condition prior to delivery, how they found out and whether any birth preparations were made in the light of their knowledge.

**Analysis**

We summarised the rates of fresh stillbirth, first-day mortality, early neonatal mortality, neonatal encephalopathy and any of the above outcomes, comparing cephalic versus non-cephalic births, and singleton versus multiple births, respectively. Using those outcomes as dependent variables, we estimated unadjusted and adjusted risk ratios (RR) using log-binomial regression for fetal presentation and log-binomial regression with generalised estimating equations\(^1\) to account for clustering within twin pairs for multiple birth. For the outcome of ‘any of the above’, the Poisson regression model with robust variance was used for both risk factors due to convergence issues.\(^1\) We included the following prespecified potential confounders in the models: preterm (defined as gestational age <37 completed weeks), facility birth (reference: home birth), maternal height <145 cm, maternal weight <2500 g (excluded for fresh stillbirth and the aggregate of non-cephalic presentation was statistically significantly higher among preterm (<37 weeks) than term births (3.1% vs 1.8%, p<0.001).

The adverse outcome rates were as follows for singleton non-cephalic infants: a fresh stillbirth rate of 168/1000 births compared with 13/1000 births among cephalic infants, an early neonatal mortality rate of 67/1000 live births compared with 13/1000 live births and a neonatal encephalopathy rate of 20.9% compared with 4.7%. Among the 111 non-cephalic singleton births with data on stillbirth and mortality and morbidities through the first week of life, 39.6% experienced an adverse outcome; among the 5720 cephalic singleton births, 7.0% experienced an adverse outcome (table 2).

The twinning rate was 8.2 out of 1000 pregnancies. No triplets were reported. The adverse outcome rates were as follows for multiple births: a fresh stillbirth rate of 28/1000 births compared with 18/1000 births among singleton infants, an early neonatal mortality rate of 152/1000 live births compared with 14/1000 live births among singleton infants and a neonatal encephalopathy rate of 11.1% compared with 4.9% among singleton infants. For the 83 twins with data on stillbirth and...
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>By fetal presentation (singleton, vaginal births only)</th>
<th>By gestation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cephalic birth n</td>
<td>% or mean (SD)</td>
<td>Non-cephalic birth n</td>
</tr>
<tr>
<td>Maternal age at delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18 years old</td>
<td>529</td>
<td>8.5</td>
<td>14</td>
</tr>
<tr>
<td>18−&lt;35 years old</td>
<td>5555</td>
<td>88.8</td>
<td>113</td>
</tr>
<tr>
<td>≥35 years old</td>
<td>170</td>
<td>2.7</td>
<td>4</td>
</tr>
<tr>
<td>Maternal gravidity (excluding this pregnancy)</td>
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</tr>
<tr>
<td>0</td>
<td>1773</td>
<td>28.4</td>
<td>48</td>
</tr>
<tr>
<td>1–2</td>
<td>2892</td>
<td>46.2</td>
<td>62</td>
</tr>
<tr>
<td>3–4</td>
<td>1210</td>
<td>19.3</td>
<td>14</td>
</tr>
<tr>
<td>≥5</td>
<td>380</td>
<td>6.1</td>
<td>7</td>
</tr>
<tr>
<td>Facility delivery rate</td>
<td>6253</td>
<td>43.4</td>
<td>131</td>
</tr>
<tr>
<td>Location of delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>2461</td>
<td>39.4</td>
<td>35</td>
</tr>
<tr>
<td>At her maternal home</td>
<td>938</td>
<td>15.0</td>
<td>17</td>
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<tr>
<td>At a health post/clinic</td>
<td>1941</td>
<td>31.0</td>
<td>37</td>
</tr>
<tr>
<td>At a hospital</td>
<td>774</td>
<td>12.4</td>
<td>33</td>
</tr>
<tr>
<td>On the way to a facility</td>
<td>132</td>
<td>2.1</td>
<td>9</td>
</tr>
<tr>
<td>Outdoors</td>
<td>7</td>
<td>0.1</td>
<td>0</td>
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<tr>
<td>Maternal education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No years</td>
<td>4292</td>
<td>68.6</td>
<td>96</td>
</tr>
<tr>
<td>1–9 years</td>
<td>1265</td>
<td>20.2</td>
<td>26</td>
</tr>
<tr>
<td>≥10 years</td>
<td>697</td>
<td>11.1</td>
<td>9</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
<td>Madheshi</td>
<td>6016</td>
<td>96.5</td>
<td>129</td>
</tr>
<tr>
<td>Pahadi</td>
<td>218</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>Maternal height</td>
<td>150.7 (5.6)</td>
<td>150.5 (6.1)</td>
<td>150.5</td>
</tr>
<tr>
<td>150–&lt;155 cm</td>
<td>1857</td>
<td>29.7</td>
<td>36</td>
</tr>
<tr>
<td>150–155 cm</td>
<td>2151</td>
<td>34.4</td>
<td>42</td>
</tr>
<tr>
<td>≥155 cm</td>
<td>1358</td>
<td>21.7</td>
<td>31</td>
</tr>
<tr>
<td>Birth outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth weight‡: low birth weight (&lt;2500 g)</td>
<td>5349</td>
<td>2706 (413): 29.7</td>
<td>77</td>
</tr>
<tr>
<td>Gestational age§: preterm birth (&lt;37 weeks)</td>
<td>6159</td>
<td>39.2 (2.7): 25.4</td>
<td>126</td>
</tr>
<tr>
<td>Small-for-gestational-age¶</td>
<td>4925</td>
<td>41.6</td>
<td>71</td>
</tr>
<tr>
<td>Non-cephalic presentation (excluding C-sections and unknowns)</td>
<td>6386</td>
<td>2.1</td>
<td>82</td>
</tr>
</tbody>
</table>

*Unit=mother.
†Unit=child.
‡Limited to weights taken within 72 hours of birth.
§Limited to feasible GA, between 24 and 46 weeks.
¶Intergrowth standard, cut-offs available for 24–43 weeks GA.
mortality and morbidities through the first week of life; 28.9% experienced an adverse outcome; among the 5906 singleton births, 7.9% experienced an adverse outcome (table 2).

The non-cephalic presentation rate was 13.5% for first twins and 20.0% for second twins. Twins who were non-cephalic had an adverse outcome rate of 41.7% compared with twins who were cephalic with a rate of 22.6%.

Fetal presentation among singletons
We estimated a fivefold increased risk of adverse outcomes for non-cephalic singletons compared with cephalic singletons (aRR 4.85 (95% CI 3.72 to 6.32)). When including multiple births and their individual presentation at birth into the analysis, the association did not change significantly (aRR 4.74 (95% CI 3.69 to 6.08)). Non-cephalic presentation had the strongest association with fresh stillbirth, with a 13-fold increase in risk (aRR 12.52 (95% CI 7.86 to 19.95)) (table 3). About 20.2% of fresh stillbirths, 4.6% of neonatal encephalopathy and 7.8% of adverse outcomes were associated with non-cephalic presentation.

Multiple births
Multiple birth was not statistically significantly associated with fresh stillbirth, but had a close to fivefold increased risk of early neonatal mortality (aRR 4.57 (95% CI 1.44 to 14.50)). Multiple births had a marginally significant increased risk of experiencing signs of neonatal encephalopathy (aRR 2.26 (95% CI 0.97 to 5.26)). Multiple birth was associated with 3.4% of early neonatal mortality and 2.0% of adverse outcomes (table 4).

For the outcome of first-day mortality, adjusted RRs were not estimated for either risk factor due to the low rate of the outcome.

Awareness of condition prior to start of labour
Among the mothers who experienced a singleton non-cephalic delivery (n=131), only 25.4% were aware of their condition prior to the start of labour. Among these, a majority (67.6%) knew through an ultrasound examination, 17.6% through self-examination and the remaining through physical examination by a health worker (multiple responses were allowed). Among the 34 who knew, 23.5% did not make any particular birth preparation. When including the mothers who were not aware of fetal presentation prior to the start of labour, only 19.8% made birth preparations (see online supplementary table S1). The facility delivery rate was higher (70.6% vs 49.0%, p=0.029) and the rate of adverse outcomes was lower among those who knew the presentation prior to delivery compared with those who did not (21.4% vs 45.8%, p=0.029). The aRR of adverse outcomes for non-cephalic presentation was 2.74 (95% CI 1.40 to 5.36) among women who knew and 4.99 (95% CI 3.91 to 6.38) among those who did not, both compared with cephalic presentation.
### Table 2  Crude fetal and neonatal mortality/morbidity rates, by fetal presentation and singleton/multiple birth status

<table>
<thead>
<tr>
<th>Fetal presentation at delivery (singleton, vaginal births only)</th>
<th>Multiple births*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal presentation</td>
<td>Singleton</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Cephalic</td>
<td>80/6229 (13 per 1000 births)</td>
</tr>
<tr>
<td>Non-cephalic</td>
<td>42/6149 (7 per 1000 live births)</td>
</tr>
<tr>
<td>Fresh stillbirth</td>
<td>80/6149 (13 per 1000 live births)</td>
</tr>
<tr>
<td>First-day mortality</td>
<td>261/5609 (4.7% of live births)</td>
</tr>
<tr>
<td>Early neonatal mortality</td>
<td>402/5720 (7.0% of births)</td>
</tr>
</tbody>
</table>

*There were no triplets in our study.

†Must have had at least one assessment of clinical signs of neonatal encephalopathy prior to day 7. About 7.6% of cephalic births and 11.3% of non-cephalic births alive at day 7 had no assessment prior to day 7. About 9.8% of singletons and 19.1% of twins alive at day 7 had no assessment prior to day 7.

‡Includes births with data on stillbirth status and mortality/morbidity through day 7. About 91.8% of all cephalic births and 88.8% of all non-cephalic births contributed data. About 89.7% of all singleton births and 76.9% of all multiple births contributed data.

### Table 3  Adjusted risk ratios (aRR) between non-cephalic presentation/potential confounding variables and adverse intrapartum-related fetal/neonatal outcomes among singletons

<table>
<thead>
<tr>
<th>Fresh stillbirth</th>
<th>Early neonatal mortality</th>
<th>Signs of neonatal encephalopathy</th>
<th>Any of the aforementioned conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>aRR (95% CI)</td>
<td>aRR (95% CI)</td>
<td>aRR (95% CI)</td>
<td>aRR (95% CI)</td>
</tr>
<tr>
<td>Non-cephalic presentation</td>
<td>12.52 (7.86 to 19.95)</td>
<td>1.42 (0.20 to 10.21)</td>
<td>3.20 (1.87 to 5.46)</td>
</tr>
<tr>
<td>Preterm</td>
<td>1.87 (1.22 to 2.87)</td>
<td>2.04 (0.96 to 4.33)</td>
<td>0.82 (0.57 to 1.18)</td>
</tr>
<tr>
<td>Facility delivery (reference: home delivery)</td>
<td>0.93 (0.62 to 1.41)</td>
<td>0.98 (0.46 to 2.08)</td>
<td>1.62 (1.25 to 2.10)</td>
</tr>
<tr>
<td>Maternal stature &lt;145 cm</td>
<td>1.25 (0.75 to 2.09)</td>
<td>1.95 (0.89 to 4.29)</td>
<td>1.52 (1.11 to 2.07)</td>
</tr>
<tr>
<td>Low birth weight (&lt;2500 g)*</td>
<td>—</td>
<td>5.11 (2.19 to 11.89)</td>
<td>1.02 (0.77 to 1.34)</td>
</tr>
<tr>
<td>Primiparous</td>
<td>1.27 (0.83 to 1.95)</td>
<td>1.06 (0.48 to 2.37)</td>
<td>1.43 (1.09 to 1.88)</td>
</tr>
<tr>
<td>Education (reference: no education)</td>
<td>1.28 (0.79 to 2.09)</td>
<td>0.58 (0.17 to 1.97)</td>
<td>0.80 (0.58 to 1.12)</td>
</tr>
<tr>
<td>1–9 years</td>
<td>0.69 (0.29 to 1.65)</td>
<td>1.47 (0.41 to 5.28)</td>
<td>0.70 (0.44 to 1.12)</td>
</tr>
<tr>
<td>≥10 years</td>
<td>1.11 (0.69 to 1.80)</td>
<td>2.57 (0.86 to 7.70)</td>
<td>1.01 (0.76 to 1.35)</td>
</tr>
</tbody>
</table>

*Newborn weight is not included for stillbirth-related outcomes.
Based settings. The results we present here are more these conditions have been conducted in tertiary facil-

...important targets for intervention. Around the globe,1 and if this trend continues, the con-

...intrapartum-related complications has been on the rise

...mortality is associated with multiple gestation. The pro-

...substantial proportion of adverse intrapartum-related

...abnormalities and placenta previa are associated with

...of low awareness of the aforementioned conditions that we were unable to capture in our data, such as frac-

...treatments and spinal cord injury for the fetus/neonate and genital tract lacerations for the mother.21 We had few reports of maternal deaths in our study; we expected low numbers in relation to our sample size, given the mater-

...women and her household members have timely aware-

...would be to improve diagnostic capacity and access so women and her household members have timely aware-

...at delivery among women who reported experiencing one or the other. These two conditions are

...and facility-based care.

...one important step to addressing these conditions would be to improve diagnostic capacity and access so
...of this capacity can be attributable to human resource and equipment cost. Several studies from developing countries have shown success with shifting sonographic diagnostic tasks to non-radiologist clinicians. A study conducted at the same study site showed that auxiliary nurse midwives, who are high school graduates with 18 months of midwifery training, can accurately diagnose non-cephalic presentation and multiple gestation using ultrasonography, with just 2 weeks of training. Groups are also exploring whether sonographic technology can be altered to meet the cost and staffing barriers in low-resource settings. Expanding ultrasonographic access will require appropriate regulation. Currently, many unregulated private clinics operate in South Asia, leading to concerns of inaccurate diagnoses and illegal fetal sex determination. Better incorporation of ultrasonography into the formal healthcare system may help with regulation, but there will still need to be political will at the national, district and community level to systematically address this issue and to allow appropriate clinical use of the technology.

For risk screening to improve health outcomes, access to and quality of facility-based care needs to be improved as well. Major barriers to accessing facility-based intrapartum care remain in low-income countries, such as cost, transport and cultural acceptability. Reduction or elimination of user fees is one type of intervention that has been tested in LMICs and has succeeded in increasing facility delivery rates. In Nepal, in addition to the elimination of user fees for antenatal and intrapartum care, a conditional cash transfer system awards cash to women who attend four antenatal care visits and also to women who have a facility delivery. A study conducted in a nearby district has shown, however, that these programmes have inequitably benefited the wealthier strata of society. The costs incurred prior to receiving the cash, such as that of the woman or household members getting to and staying near a facility, remain prohibitive for many.

We expect these barriers to be more pronounced when trying to reach higher-level facilities that can handle complications and have C-section capacity. Detection and management of breech births using C-section has previously been identified as an intervention that could reduce neonatal mortality rates in LMICs. Of those in our study who had a facility delivery, a large majority delivered in a health post or a health clinic. Health posts and clinics should have skilled birth attendants, but do not have the capacity to handle complicated deliveries. The nearest referral facility with C-section capacity from our study area is located 3–4 hours away by car. This level of access fails to meet the recommended ratio of one comprehensive emergency obstetric care (CEmOC) facility per 500,000 population.

Even after reaching the facility, quality of care is a major concern, posing the very critical question of whether a referral in actuality gives the woman and her child better chances of survival. A review indicated that among women admitted into a facility for complications in LMICs, the mean wait time was ~24 hours, with major causes of delays being shortage of treatment materials, surgery facilities and qualified staff. In addition to the clinical quality of care, disrespectful care serves as a major deterrent. A landscape review conducted on respectful care highlighted seven types of disrespect and abuse women and their family members incur at facilities during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities. In a separate qualitative study conducted in our study area, many female focus group participants reported hearing of physically abusive intrapartum care (Under review). These quality issues put into question the ethics of referral, taking into account the great burden posed on families to complete such referrals. For referrals to successfully improve health outcomes, the complexity of household-side and facility-side barriers needs to be acknowledged and addressed.

There are several limitations to our study. Some of our variables are based on maternal recall. For the outcome of neonatal encephalopathy, we most likely overestimate the incidence with the use of non-specific clinical signs, as we could not use neuroimaging equipment for diagnosis in this context. Furthermore, not all children had a morbidity assessment conducted within the first 7 days of life and clinical signs such as poor suck and lethargy may be subject to reporting bias and are also subjective. Given the poor record keeping in facilities and the fact that about half of the women had a facility delivery, we were unable to validate any of the self-reported variables against clinical records. For self-report of fetal presentation, we believe there is minimal misclassification. Family members who were present at the time of delivery were able to provide insight during the data collection interview, and a separate study on health indicator validity from Mozambique reported high validity of maternal recall of fetal presentation. We did not collect data on the indications for C-section. Several women may have undergone the C-section because of non-cephalic or multiple birth. By excluding those cases, we may be overestimating the risk of non-cephalic birth or multiple birth and underestimating the incidence of these conditions, although it is unlikely to be of a large magnitude, given that only 3% of deliveries were by C-section. We used the date of the last menstrual period to calculate gestational age. We expect the error to be small due to the five-weekly home visits that were made to identify missed menstrual periods, but we still expect some misclassification of preterm births. We were unable to confirm gestational age using any other clinical or ultrasonographic methods in this setting.

CONCLUSIONS

Non-cephalic and multiple births have significantly increased the risk of adverse intrapartum-related pregnancy
outcomes. Despite the low incidence, the per cent of adverse pregnancy outcomes attributable to these two factors is considerable. These findings may justify investments in screening programmes to identify these women prior to the time of delivery and to appropriate improvements in quality of care and access to tertiary care. Subsequent studies must explore if and how early diagnosis impacts institutional delivery rates and subsequent health outcomes.

Author affiliations
1. Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA
2. Nepal Nutrition Intervention Project—Sarlahi (NNIPS), Lalitpur, Nepal
3. Department of Global Health, George Washington University Milken Institute School of Public Health, Washington, District of Columbia, USA

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Contributors
NK made primary contributions to the design, conduct, analysis and interpretation of the research. JK and LCM contributed to the design, data analysis plan and interpretation of the results. SKK, JMT and SCL contributed to the conduct of the research and interpretation of the results.

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Data sharing statement
The data belong to an ongoing trial and are not available at this time.

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Risk and burden of adverse intrapartum-related outcomes associated with non-cephalic and multiple birth in rural Nepal: a prospective cohort study

Naoko Kozuki, Joanne Katz, Subarna K Khatry, James M Tielsch, Steven C LeClerq and Luke C Mullany

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