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**Cochrane Special Collections****Stillbirth prevention and respectful bereavement care**

8 September 2021

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Stillbirth is a major public health problem with an enormous global mortality burden and psychosocial impact on women, families, communities, and health systems.[1,2] Using the World Health Organization (WHO) definition of 28+ weeks, one stillbirth occurs every 16 seconds around the world. However, the current global estimate of 2 million stillbirths a year is likely a significant underestimate of the actual burden, underpinned by a scarcity of data. Due to poorer quality of, and access to, antenatal care and care during birth in low-

and middle-income countries (LMICs), stillbirths below 28 weeks' gestation are not included in global estimates, though most high-income countries (HICs) count stillbirths from 20 weeks.

When stillbirths are tracked at lower gestational ages, up to 50% are found to occur at 20 to 27 weeks. Additionally, many stillbirths are not counted in mortality data even in high-income settings, so even HIC numbers are an underestimate of actual rates. Underreporting and invisibility of stillbirth globally highlights the lack of support for parents of stillborn babies.

Stillbirth is one of the most profoundly distressing events any parent could experience and often has lasting psychological, social, and financial consequences. Women experiencing the loss of a baby to stillbirth report feeling marginalized or may perceive themselves as being a failure as a mother or spouse, and in some communities these women are considered impure or taboo. Many women live in communities that expect women to forget their loss and "move on" to have another baby. To avoid stigmatization and shame, women may hide their babies' deaths completely, further contributing to underreporting and stymying efforts at prevention. The care of health workers and community is vital to parents' recovery after stillbirth.[3]

Despite the scale of the problem and potential for prevention, stillbirth has been largely neglected in global public health. The lack of attention to and acknowledgment of stillbirth as a profound, and largely avoidable, loss for families is both a result and a driver of fatalism and stigma which obstruct progress to end these preventable deaths. Compounding the tragedy of stillbirth is the fact that the majority of these deaths are preventable. Globally, approximately 84% of stillbirths occur in LMICs, where most could be prevented with adequate pregnancy and emergency obstetric care.[4] Even in HICs, where rates are comparatively low, further reductions are possible with an estimated 30% of stillbirths occurring due to factors of substandard care,[3] and persistent wide disparities in stillbirth rates between advantaged and disadvantaged populations.

Initiatives over the past decade are slowly bringing about change. The 2011 and 2016 [Lancet stillbirth series](#) highlighted the urgency of action required to prevent stillbirths, and in 2014, the World Health Assembly set the first-ever global stillbirth rate target with the endorsement of the [Every Newborn Action Plan](#), which has been adopted in many high-burden countries. A major step forward has been the inclusion of stillbirths in regular global reporting of child mortality estimates for the first time, with the October 2020 launch of the WHO/UNICEF/UN-IGME (United Nations Inter-agency Group for Child Mortality Estimation) report [A Neglected Tragedy: The Global Burden of Stillbirths](#). [4] Improving data on stillbirths through accurate counting, perinatal mortality audit and standardized classification are further vital steps required for the development and monitoring of effective strategies for prevention as well as for the provision of respectful supportive care for all parents after stillbirth and in subsequent pregnancies. In all this work, bereaved parents should be regarded as key allies and experts.

While there has been some improvement in the global stillbirth rate over the past 20 years, much more needs to be done. The recent COVID-19 pandemic has disrupted maternity care and highlighted existing inequities both within and between countries, with adverse effects on access to and quality of care likely increasing stillbirth rates, as well as compounding grief for families whose baby is stillborn, due to factors such as COVID-19-related social isolation and reduced availability of providers who might otherwise have provided bereavement care. Efforts to ensure optimal care throughout the pandemic are critical, particularly for disadvantaged populations.

This Special Collection has been created to highlight evidence-based interventions to reduce stillbirth and improve care for families after stillbirth and in a subsequent pregnancy, identify women at increased risk of stillbirth, and improve knowledge of causes of and contributors to stillbirth.

Evidently Cochrane has also produced an accompanying blog - ['Preventing stillbirth: What's the latest evidence?'](#)

Updated 8 September 2021: added Cochrane Clinical Answers to the review ['Induction of labour at or beyond 37 weeks'](#) and to the overview ['Antenatal interventions for preventing stillbirth: an overview of Cochrane systematic reviews'](#)

Preventing stillbirth

Induction of labour at or beyond 37 weeks' gestation

Free access

There is a tension between inducing to prevent stillbirths (particularly as pregnancies progress towards 41 weeks) and the desire not to induce so that babies maximize brain development and growth before birth. Risks of stillbirth or neonatal death increase as gestation continues beyond term (around 40 weeks' gestation). It is unclear whether a policy of labour induction can reduce these risks prior to 40 weeks. This review assesses the effects of a policy of labour induction at or beyond 37 weeks' gestation compared with a policy of awaiting spontaneous labour indefinitely (or until a later gestational age, or until a maternal or fetal indication for induction of labour arises) on pregnancy outcomes for the infant and the mother. *Associated Cochrane Clinical Answer: For women at or beyond term, how does induction of labor compare with expectant management for infant outcomes?*

Antenatal interventions for preventing stillbirth, fetal loss and perinatal death: an overview of Cochrane systematic reviews

Stillbirth is generally defined as a death prior to birth at or after 22 weeks' gestation. It remains a major public health concern globally. Antenatal interventions may reduce stillbirths and improve maternal and neonatal outcomes in settings with high rates of stillbirth. There are several key antenatal strategies that aim to prevent stillbirth including improved nutrition, and prevention and management of infections. This overview aims to summarize the evidence from 43 Cochrane systematic reviews on the effects of antenatal interventions for preventing stillbirth for low risk or unselected populations of women. *Associated Cochrane Clinical Answers: For pregnant women, what are the effects of smoking cessation interventions?; For pregnant women, what are the effects of vitamin supplements for prevention of stillbirth, fetal loss, and perinatal death?; For pregnant women, what are the effects of midwife-led and trained traditional birth attendant-led care? And For pregnant women, what are the effects of antenatal screening on fetal growth and well-being?*

Interventions relating to fetal movements for improving pregnancy outcomes

Free access

Maternal perception of decreased fetal movements (DFM) or altered fetal movements may help to identify a baby at risk. Concern has been raised that increasing awareness and monitoring may be associated with harms associated with iatrogenic birth. This is a protocol for a review aiming to assess the effect of interventions to improve awareness and detection of fetal movements and interventions to address the clinical management of decreased fetal movements on maternal, perinatal and childhood outcomes.

Novel approaches for identifying women at increased risk of stillbirth

Biochemical tests of placental function versus ultrasound assessment of fetal size for stillbirth and small-for-gestational-age infants

Free access

Being small-for-gestational (SGA) or growth-restricted is the single largest risk factor for stillbirth. While correct and early identification of a small baby is associated with a reduction in perinatal mortality, antenatal detection remains a challenge. Every year many SGA babies are missed while others are falsely identified as SGA, resulting in potential harms related to preterm delivery. This review assesses the diagnostic accuracy of ultrasound assessment alone, placental biomarkers alone, and combinations of both to identify pregnancies that end in stillbirth or the birth of a small for gestational age baby.

Use of biochemical tests of placental function for improving pregnancy outcome

Free access

The function of the placenta is critical to maintaining the health of the baby. Markers of placental function can be easily assessed in maternal blood or urine. This review seeks to determine whether placental function tests and or clinician awareness of placental function test results reduces perinatal mortality.

Improving care after stillbirth and in subsequent pregnancies ▲

Stillbirths: economic and psychosocial consequences

Negative effects, particularly on parental mental health, appear to be moderated by empathic attitudes of care providers and tailored interventions. While data are sparse, stillbirth carries substantial additional costs to that of a livebirth, both in the perinatal period and in additional surveillance during subsequent pregnancies. Stillbirth prevention efforts are influenced by the value placed on the life of the baby in the community.

Care prior to and during subsequent pregnancies following stillbirth for improving outcomes

Free access

Stillbirth affects at least 2 million families worldwide every year and has enduring consequences for parents and health services. Parents in a subsequent pregnancy following stillbirth face a risk of stillbirth recurrence, alongside increased risks of other adverse pregnancy outcomes and psychosocial challenges and may benefit from more specialized care. This review assesses the effects of different interventions or models of care prior to and during subsequent pregnancies following stillbirth on maternal, fetal, neonatal, and family health outcomes, and health service utilization.

Improving knowledge of causes of and contributors to stillbirth ▲

Interventions for investigating and identifying the causes of stillbirth

Free access

There is no global, standard approach to investigating the causes of stillbirth. Furthermore, in poorly resourced settings the ability to undertake investigations may be limited. This review aims to identify which approaches are most helpful to finding causes of stillbirth and how cost-effective the different approaches are. The review also considers the effect of different approaches on parents' wellbeing, including psychosocial outcomes.

Death audits and reviews for reducing maternal, perinatal and child mortality

Open access

Facility-based death audits and reviews may help to improve the quality of care and prevent adverse outcomes for mothers and children, although data are limited and the effect on reducing stillbirths is unknown. The [WHO audit and review of stillbirths and neonatal deaths recommends](#) that maternal and perinatal death reviews should be conducted in all hospitals globally. The review suggests that maternal and perinatal death audit and review may need to be implemented as part of a support package including training of doctors and midwives and outreach visits to provide supervision and mentorship.

About this Special Collection

References

<https://www.stillbirthalliance.org/>

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