Insight

Bereavement care after stillbirth: need for a global framework

Stillbirth is a profound and often silenced global tragedy. The emotional, psychological, and social consequences for affected families are immense and long-lasting, yet structured bereavement care remains uneven, fragmented, and, in many countries, non-existent. Despite advances in perinatal health, a critical gap remains in how health systems support families in the aftermath of stillbirth. WHO has repeatedly highlighted the need for compassionate structured bereavement care, yet few countries have implemented comprehensive frameworks.

WHO defines stillbirth as the death of a fetus either at or after 22 weeks of gestation or with a birthweight of 500 g or heavier. More than 2 million stillbirths occur globally every year, predominantly in low-income and middle-income countries (LMICs). Yet, even in high-resource settings, parents report that their experiences of care are often marked by isolation, stigma, and disjointed support services.

Bereavement care for parents after stillbirth is not a luxury; it is a necessity and a form of therapeutic intervention with well documented benefits for maternal mental health, family cohesion, and patient trust in healthcare systems. However, unlike clinical management guidelines for stillbirth, bereavement support remains unstandardised and often inaccessible.

The RESPECT study aimed to develop a globalised consensus of evidence-based principles for bereavement care after stillbirth, and this study is, to our knowledge, the only one of its kind available in published literature. The principles were agreed on after consultation with expert stakeholders (including obstetricians, psychiatrists, specialist midwives, etc) from 26 countries. The consensus process entailed five sequential survey rounds and used a modified policy Delphi methodology, and the results showed that provision of high-quality bereavement care following stillbirth is guided by core principles that address the emotional, physical, and practical needs of affected families. These principles include fostering community awareness to reduce stigma and ensuring all care is delivered with compassion and respect. Women and their families should be supported in making informed shared decisions about birth options and be provided with clear comprehensible explanations regarding the cause of death following a thorough investigation. Recognising the diverse expressions of grief, care should be tailored and delivered sensitively, with access to ongoing emotional support. Comprehensive postnatal care must address physical recovery, psychological wellbeing, and offer a reliable point of contact after discharge. At an appropriate time, clinicians should offer guidance on future pregnancies and reproductive health. Finally, to ensure consistent and high-quality care, health-care providers must be equipped with ongoing training and professional support in bereavement care practices.

Although WHO has published recommendations about the prevention and management of stillbirths, currently no global bereavement standards or guidelines exist. A comparative analysis of six bereavement care guidelines from seven countries (Australia and New Zealand, Canada, England, India, Ireland, and the USA), and a synthesis of published literature on post-stillbirth bereavement practices (appendix), identified recurring themes in effective care, stark inequities in access and implementation, and a pressing need for a globally harmonised yet locally adaptable framework, which could form the foundation of high-quality bereavement care (panel 1). Bereavement care guidelines from Australia and New Zealand, Canada, England and Ireland demonstrate strong alignment with the best practice principles referenced in the RESPECT study. Importantly, all seven countries recommend, in the context of care after stillbirth, a multidisciplinary team approach, provision of culturally and linguistically appropriate and available resources, respectful and sensitive language, and the creation of a thorough individualised care plan incorporating and respecting all the family's wishes, expectations, values and preferences. All available guidelines recommend

***Panel 1:* Five key elements of bereavement care**

Memory creation
Offers parents the opportunity to see, hold, and commemorate their baby in a manner that is meaningful to them.

Effective communication
Families must receive honest, compassionate, and clear information about their baby's death, the results of any investigations, and what to expect in the days and weeks ahead.

Shared decision-making
Families should be involved in choices regarding labour, post-mortem examinations, and cultural or personal commemorative practices.

Emotional and psychosocial support
Support must be tailored to the family's needs, recognising the diverse individual and cultural expressions of grief.

Continuity of care
Structured follow-up and strong integration between hospital and community services is needed to ensure families are supported beyond the point of discharge.

See **Online** for appendix

For **neonatal and perinatal mortality data** see https://iris.who.int/handle/10665/43444

For more on **parents' experiences of care** see *Semin Fetal Neonatal Med* 2013; **18:** 76–82

For more on the **RESPECT study** see *Int J Gynaecol Obstet* 2020; **149:** 137–47

For **recommendations on prevention of stillbirths** see https://www.unfpa.org/sites/default/files/pub-pdf/PreventingStillbirthGuide-May2023.pdf

For the **Australian guidelines** see https://learn.stillbirthcre.org.au/wp-content/uploads/2024/01/CASaND-Guideline-2024-1.pdf

For the **Canadian guidelines** see https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-7.html

For the **English guidelines** see https://www.nbcpathway.org.uk/wp-content/uploads/2024/03/NBCP-Stillbirth-short-guidance-July-2022.pdf

For the **Irish guidelines** see https://www.hse.ie/eng/services/list/3/maternity/bereavement-care/

For the **Raising Parent Voices advocacy toolkit** see https://www.stillbirthalliance.org/wp-content/uploads/2023/04/PVI-INDIA-TOOLKIT_EDIT_-09_09_2022.pdf

For more on **ACOG stillbirth management** see *Obstet Gynecol* 2009; **113:** 748

For more on the **CLASS checklist** see *medRxiv* 2023.06.07.23291084

For more on **assessing the effectiveness of stillbirth care** see *BMC Pregnancy Childbirth* 2016; **16:** 16

For more on **continuity of care** see *BJOG* 2018; **125:** 160–70

acknowledging the individual experiences of grief, the importance of memory-making, and implementing follow-up appointments conducted by experienced clinicians with the appropriate utilisation and referral to mental health support services as needed. All, except the Indian guidelines, reference the importance of adequate training, and support for clinicians involved in stillbirth care should be emphasised. India's Raising Parent Voices advocacy toolkit represents a critical step forward in LMIC settings by promoting advocacy and awareness, although formal clinical guidelines remain limited. The introduction of bereavement support officers has been shown to improve the management of perinatal loss and is recommended in the guidelines from Australia and New Zealand, Canada, England, and Ireland. The USA's guidance from the American College of Obstetricians and Gynaecologists focuses on clinical protocols, such as stillbirth evaluation and management of subsequent pregnancy, rather than detailed, holistic bereavement support. Only the guidance from Australia and New Zealand and England recommends the implementation of a system to alert all health-care professionals that a parent has experienced bereavement, and future guidelines from other countries should consider this aspect.

The CLASS checklist—created by the Italian Charity CiaoLap Foundation—is designed to assess adherence to best-practice bereavement care principles, as part of the OPALE (Observatory on PerinatAL hEalth) project in Italy. The OPALE cross-sectional study included 261 women who experienced stillbirth over 10 years. Before the CLASS checklist, diverse and variable standards of bereavement care existed throughout Italy due to a lack of national standardised guidelines. The OPALE study sought to review and evaluate such different practices of stillbirth care in comparison with recommendations from leading guidelines (that made up the CLASS checklist). Its use was associated with significantly lower grief scores in mothers, underscoring the effectiveness of guideline-aligned care. Adopting frameworks like the CLASS checklist could enhance care in settings lacking formal guidelines. Moreover, they may support audit, evaluation, and training, which are often the weakest components of bereavement systems.

Stillbirth bereavement care must be re-envisioned as an essential public health intervention. Building on the success of frameworks such as the WHO's stillbirth guidelines, we advocate for the development of a globally informed bereavement care model grounded in key clinical and cultural principles. It must be evidence-based, drawing on established best practices such as the RESPECT study principles and the CLASS checklist, which provide structured frameworks for compassionate communication and care. The model should also be scalable, acknowledging that different settings, particularly those with limited resources, may require tiered or incremental implementation strategies. Cultural adaptability is essential, enabling care to be responsive to the unique practices of each community. To ensure quality and accountability, the model must be measurable, with evaluation tools such as validated grief scales, family satisfaction surveys, and clinical audits used to assess its effectiveness. Lastly, the model should incorporate professional support mechanisms, including the presence of bereavement-trained staff, accessible mental health services, and clear pathways to ensure continuity of care across hospital and community settings. We believe there are three strategic priorities for bereavement care: education and training, policy development and implementation, and research and evaluation (panel 2).

Stillbirth remains one of the most devastating experiences a family can face; yet, bereavement care remains an under-prioritised and under-resourced aspect of maternal health. While countries like Australia, England, and Ireland have advanced comprehensive guidelines, the global absence of standardised, culturally sensitive bereavement care frameworks contributes to preventable psychological harm and health system distrust. There is now an urgent opportunity and moral imperative to integrate bereavement care into routine maternity services, guided by global principles and tailored to local realities. An integrated, respectful, and evidence-informed approach to stillbirth bereavement care that prioritises compassion and continuity is crucial.

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Panel 2: Three strategic priorities for bereavement care

Education and training
All health professionals involved in perinatal care should receive mandatory training in bereavement support, trauma-informed communication, and cultural sensitivity. Integration of bereavement education into medical and midwifery curricula is essential.*

Policy development and implementation
Ministries of health and professional societies must prioritise the creation of national bereavement care guidelines. This includes funding for bereavement officers, system alerts to notify providers of family loss, and establishing designated bereavement care spaces.

Research and evaluation
Despite the emotional and social significance of stillbirth, there is a surprising lack of clinical trials on bereavement interventions.† Research is needed to evaluate the effectiveness of debriefing sessions, peer support, memory-making, and long-term psychosocial outcomes.‡

JBI Evid Synth* 2024; **22: 2003–89. †*Cochrane Database Syst Rev* 2013; **2013:** CD000452. ‡*Women's Health (Lond)* 2024; **20:** 17455057231224180.