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BJOG Editor's Choice

Stillbirth: understand, standardise, educate – time to end preventable harm

Executive Scientific Editor, Dr Dimitrios Siassakos, discusses his top articles from this issue in an audio podcast available at: https://soundcloud.com/bjog/stillbirth-issue.

Stillbirth is a global issue historically misunderstood and under-acknowledged. Awareness is improving, with desire for action and advocacy intensifying (Flenady et al. *Lancet* 2016;387:691–702; de Bernis et al. *Lancet* 2016;387: 703–16). Stillbirth has been selected as an indicator of progress towards the Sustainable Development Goals (Indi cator and monitoring framework for the Global Strategy for Women's, Children's and Adolescents' Health [2016–2030]). Key was the appreciation that efforts to improve prevention of stillbirth and care for bereaved parents are likely to improve maternity care and outcomes for every parent. In this special *BJOG* issue, academics, clinicians and women affected by stillbirth from across the globe endeavour to help us understand where the problems are and how to address them to improve care.

Global burden

The impact of stillbirth on society is significant and wide-ranging. Campbell and colleagues (pages 108–117) estimate the costs of stillbirth using published data, but acknowledge that their estimate of about £700 million per year in health costs, lost productivity, litigation and funerals is conservative. Their comprehensive economic modelling could not capture the full range of psychosocial effects, including effects on members of the wider family and healthcare providers (Burden et al. *BMC Pregnancy and Childbirth* 2016; 16:9). For example, siblings, including surviving twins, may suffer ill effects from a stillbirth and need long-term counselling and support.

As Goldenberg (pages 119–129) and McClure show (pages 131–138), conditions responsible for the burden of stillbirth in low and middle-income countries include mainly maternal and fetal infections, pre-eclampsia, and peripartum events leading to fetal asphyxia. Lavin and Pattinson (pages 140–147) postulate, having compared practices in South African provinces, that more comprehensive antenatal care could prevent some stillbirths. In a higher income setting (Australia), private care was also associated with a lower stillbirth rate (Adams et al. pages 149–158). Further research is needed to examine the benefits of improved antenatal care, and also prompt intervention (Maaløe et al. pages 235–245) to save term babies. However, efforts to identify babies at risk may be hampered by the poor predictive value of risk factors (Hirst et al. *BJOG* 2017; https://doi.org/10.1111/1471-0528.14463) and therefore a blanket policy of induction of labour at term might be a more feasible option. The ARRIVE trial (clinicaltrials.gov: NCT01990612) should shed light on the risks and benefits of elective induction at 39 weeks of gestation. Future studies should also examine the impact of interventions on parental experience.

Parental experience – to be analysed, not misapprehended

The INSIGHT study (Siassakos et al. pages 160–170) shows that care after stillbirth is not always sensitive or even sensible. Some parents felt abandoned, while others perceived excellent care and continuity. There was often good support during birth, but most parents never had a meaningful discussion of the options for mode and timing of birth. Worse, some requests, for example for caesarean birth, were misunderstood and not appropriately discussed. The worrying lack of training in post mortem consent, identified by Lewis and colleagues in their review of 21 studies (pages 172–181), combined with the refusal by parents in INSIGHT to have a post mortem because untrained staff 'made it up as they went' and told parents that the post mortem examination 'never shows anything anyway', mandates urgent improvements in care after stillbirth.

Optimisation of antenatal care should extend to future pregnancies. Subsequent pregnancies, as Malacova and colleagues (pages 183–192) show, have high risk for adverse outcomes relating to poor placental function. Not surprisingly, parents need more care and intervention (Wojcieszek et al. pages 193–201; Gravensteen et al. pages 202–210). Should every healthcare setting aspire to have a dedicated team, including mental health experts, looking after these subsequent pregnancies? That would ensure the families' emotional needs are supported alongside increased medical surveillance.

Time to understand, time to act

We have to act now. We must agree to a standard global definition for stillbirth that takes into account improvements of care at the limits of viability. We must improve the quality of data to identify the causes of stillbirth, and agree how to classify causation (Reinebrant et al. pages 212–224). We must record better data about late terminations of pregnancy, so that we can perform meaningful international comparisons (Blondel et al. pages 226–234).

Expert consensus alone will not be good enough. We must educate the public (Nuzum et al. pages 246–252), because better awareness can boost prevention programmes, as well as reduce the parents' shock when stillbirth occurs in an otherwise uneventful pregnancy. We must learn from the successes of the Sudden Unexpected Death in Infancy campaigns, and design new prevention campaigns (Heazell et al. pages 254–262) with care, evidence, and sensitivity (Flenady et al. page 253). We must improve perinatal mortality reviews (Smith pages 101–3), by involving parents who offer unexpected insights as to where our care goes wrong, and ways to improve it (PMRT Collaboration; The PARENTS study).

The time of ignorance has passed. Now is the time for informed collective action, together with parents. Now is the time to implement the very best practice with whatever resources are available. Now is the time to make a difference in the lives of women and their families across the globe. ■

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