



****Embargoed to 23.30 UK time (GMT) / 18.30 US Eastern time on Monday 18 January 2016****

Slow progress on stillbirth prevention leaves parents of 2.6 million babies suffering in silence each year

Maternal and child deaths have halved while stillbirth remains a neglected global epidemic

More than 2.6 million stillbirths continue to occur globally every year with very slow progress made to tackle this 'silent problem', according to new research published in *The Lancet*. Despite significant reductions in the number of maternal and child deaths, there has been little change in the number of stillbirths (in the third trimester of pregnancy) ^[1] even though the majority are preventable.

Half of all stillbirths occur during labour and birth, usually after a full nine month pregnancy, and the research highlights that most of these 1.3 million deaths could be prevented with improved quality of care. Globally, 98% of all stillbirths occur in low- and middle-income countries. At the current rate of progress, it will be more than 160 years before a pregnant woman in Africa has the same chance of her baby being born alive as a woman in a high-income country today. However, the problem also remains significant in high-income countries where the number of stillbirths is now often higher than infant deaths.

The Ending Preventable Stillbirth research series states the annual rate of reduction for stillbirths is 2.0%, much slower than progress made for maternal (3.0%) and child deaths (4.5%).^[2] It also reveals the hidden consequences of stillbirth, with more than 4.2 million women living with symptoms of depression, often for years, in addition to economic loss for families and nations.

Series co-lead, Professor Joy Lawn from the London School of Hygiene & Tropical Medicine, said: "We must give a voice to the mothers of 7,200 babies stillborn around the world every day. There is a common misperception that many of the deaths are inevitable, but our research shows most stillbirths are preventable. Half of the 2.6 million annual deaths could be prevented with improved care for women and babies during labour and childbirth, and additionally, many more lives could be saved with effective care during pregnancy. We already know which existing interventions save lives. These babies should not be born in silence, their parents should not be grieving in silence, and the international community must break the silence as they have done for maternal and child deaths. The message is loud and clear - shockingly slow progress on stillbirths is unacceptable."

New estimates of stillbirth rates for 195 countries^[3] developed by the London School of Hygiene & Tropical Medicine with the World Health Organization and UNICEF reveal huge inequalities around the world. Ten countries account for two-thirds of stillbirths^[4] with India having the highest number, estimated at 592,100 in 2015. The highest rates are in Pakistan (43.1 per 1,000 total births) and in Nigeria (42.9). The lowest rates are in Iceland (1.3), Denmark (1.7), Finland (1.7) and the Netherlands (1.8). Netherlands is also making the fastest progress, reducing stillbirths by 6.8% per year. The United States is one of the slowest progressing countries with a reduction of 0.4% per year.

In every region around the world there are countries that are outperforming their neighbours, for example Rwanda is the fastest progressing country in Africa (annual rate of reduction of 2.9%) demonstrating that most stillbirths are preventable and progress is achievable.^[5]

UN Secretary-General, Ban Ki-moon, said: "Childbirth is one of the most risky moments of life for both mothers and babies. We must make a global push to eliminate the tragedy of the millions of mostly preventable stillbirth deaths that occur every year. That is why a focus on a continuum of care, from family planning through pregnancy to birth and beyond into childhood and adolescence, is a key element of the Every Woman Every Child movement and the Global Strategy for Women's, Children's and Adolescents' Health."

The new research includes the first global analysis of risk factors associated with stillbirth,^[6] underlining that many deaths can be prevented by:

- Treating infections during pregnancy – 8.0% of all stillbirths are attributable to malaria, increasing to 20.0% in sub-Saharan Africa, and 7.7% of all stillbirths are associated with syphilis, increasing to 11.2% in sub-Saharan Africa.
- Tackling the global epidemics of obesity and non-communicable diseases, notably diabetes and hypertension – at least 10% of all stillbirths are linked to each of these conditions.
- Strengthening access to and quality of family planning services – especially for older and very young women, who are at higher risk of stillbirth.
- Addressing inequalities – in high-income countries, women in the most disadvantaged communities face at least double the risk of stillbirth.

The research also highlights the underappreciated psychological, social and economic impacts of stillbirth on parents, families, caregivers, and countries. New estimates suggest at least 4.2 million women around the world are living with symptoms of depression due to stillbirth, suffering psychological distress, stigma and social isolation, as well as increased risk of family breakdown, and even abuse and violence.

Christina Sapulaye from Malawi, who experienced a stillbirth last year, said: "It was a very painful situation to me and I never knew what to do... I am being stigmatised by my own people and was divorced due to the stillbirth, and now I am by myself with my little kids."^[7]

Fathers also commonly report suppressing their grief, and almost half of 3,503 parents surveyed in high-income countries felt society wanted them to forget their stillborn baby and try to have another child.^[8]

The economic impact of stillbirth for families ranges from funeral costs for their baby to loss of earnings due to time off work, with data suggesting 10% of bereaved parents remain off work for six months. The direct financial cost of stillbirth care is 10-70% greater than for a live birth, with additional costs to governments due to reduced productivity of grieving parents and increased welfare costs.

Dr Alexander Heazell, Series co-author from the Tommy's Stillbirth Research Centre at St Mary's Hospital, University of Manchester, said: "The consequences of stillbirth have been hugely underestimated. Our research suggests that grief and symptoms of depression after stillbirth often endure for many years. It is vital we, as carers, see the loss through the eyes of those parents affected to provide sensitive and respectful bereavement care. We know that something as simple as supporting parents to see and hold their baby and providing bereavement support can reduce the long-term negative impact of stillbirth. Dealing with stillbirth can also have a psychological impact on health workers; consequently, better training and provision of support for those looking after affected families should also be a priority."

While there is currently significant investment in care and research for babies after they are born, the research calls for more focus on the baby before birth, with increased funding that reflects the scale of 2.6 million deaths a year. They argue that high-quality care during pregnancy and labour would result in a quadruple return on investment by saving lives of mothers and newborns, preventing stillbirths, and also improving child development.

Series co-lead, Vicki Flenady, Associate Professor from the Mater Research Institute - University of Queensland, said: "There is a huge variation in progress on stillbirths, even in high-income countries, from rates of 1.3 to 8.8 stillbirths per 1,000 total births, with stigma, taboo and fatalism still a reality. All countries should implement and respond to high quality national audits of these deaths, which will lead to improvements in quality of care. This has been the case in the Netherlands, which has had the steepest reduction in stillbirth rates. If every high-income country achieved stillbirth rates of 2 or less, like the best performing countries, then nearly 20,000 stillbirths could have been prevented in 2015."

The Ending Preventable Stillbirth Series was developed by 216 experts from more than 100 organisations in 43 countries and comprises five papers. The research provides compelling evidence of the preventability of most stillbirths, forming the basis for action from parents, health care professionals, and politicians. It follows the research group's 2011 series on stillbirths also published in *The Lancet*.^[9]

ENDS

For more information, to arrange interviews with key spokespeople, and for case studies, please contact the London School of Hygiene & Tropical Medicine press office on press@lshtm.ac.uk or +44(0)2079272802.

- Excel sheet of data on stillbirth for 186 countries with rankings
- Summaries of the Series papers
- Executive summary of the Series
- B-roll of expert and case study interviews plus UK and African hospital footage

All available at this link: <http://bit.ly/1ZtFglx>

- Embargoed copies of the Series papers and linked comments:
 - For full Series paper 1, 'Stillbirths: progress and unfinished business,' see: <http://press.thelancet.com/Stillbirths1.pdf>
 - For full Series paper 2, 'Stillbirths: rates, risk factors, and acceleration towards 2030,' see: <http://press.thelancet.com/Stillbirths2.pdf>
 - For full Series paper 3, 'Stillbirths: economic and psychosocial consequences,' see: <http://press.thelancet.com/Stillbirths3.pdf>
 - For full Series paper 4, 'Stillbirths: recall to action in high-income countries,' see: <http://press.thelancet.com/Stillbirths4.pdf>
 - For full Series paper 5, 'Stillbirths: ending preventable deaths by 2030,' see: <http://press.thelancet.com/Stillbirths5.pdf>
 - For Series Comments see: <http://press.thelancet.com/StillbirthsComments.pdf>

NOTE: THE ABOVE LINKS TO PAPERS ARE FOR JOURNALISTS ONLY; IF YOU WISH TO PROVIDE LINKS FOR YOUR READERS, PLEASE USE THE FOLLOWING, WHICH WILL GO LIVE AT THE TIME THE EMBARGO LIFTS: <http://www.thelancet.com/series/ending-preventable-stillbirths>

Series papers

- Paper 1: Frøen JF, Friberg IK, Lawn JE, et al, for The Lancet Ending Preventable Stillbirths Series study group. Stillbirths: progress and unfinished business. Lancet 2016; 10.1016/S0140-6736(15)00818-1
- Paper 2: Lawn JE, Blencowe H, Waiswa P, et al, for The Lancet Ending Preventable Stillbirths Series study group with The Lancet Stillbirth Epidemiology investigator group. Stillbirths: rates, risk factors, and acceleration towards 2030. Lancet 2016; 10.1016/S0140-6736(15)00837-5.
- Paper 3: Heazell AE, Siassakos D, Blencowe H, et al, for The Lancet Ending Preventable Stillbirths Series study group, with The Lancet Ending Preventable Stillbirths investigator group. Stillbirths: economic and psychosocial consequences. Lancet 2016; 10.1016/S0140-6736(15)00836-3
- Paper 4: Flenady V, Wojcieszek AM, Middleton P, et al, for The Lancet Ending Preventable Stillbirths study group and The Lancet Stillbirths in High-Income Countries Investigator Group. Stillbirths: recall to action in high-income countries. Lancet 2016; 10.1016/S0140-6736(15)01020-X.
- Paper 5: de Bernis L, Kinney MV, Stones W, et al, for The Lancet Ending Preventable Stillbirths Series study group with The Lancet Ending Preventable Stillbirths Series Advisory Group. Stillbirths: ending preventable deaths by 2030. Lancet 2016; 10.1016/S0140-6736(15)00954-X

[1] In the Series, stillbirth refers to all pregnancy losses after 22 weeks of pregnancy. For the comparable national estimates of stillbirth in the series, the researchers used the World Health Organization's definition of stillbirth, which is a foetal death after 28 weeks of pregnancy. Some countries, especially high income, have their own definition of stillbirth, which in all cases is a lower gestational age eg 20 or 22 weeks and so using these definitions the numbers of stillbirths would be higher. The excel data sheet also shows some of these differing definitions. The 2011 Lancet Stillbirth Series used either the definition of a birthweight of at least 1000 g or a gestational age of at least 28 weeks.

[2] Average annual rate of reduction 2000-2015 for stillbirth is 2%, maternal mortality is 3% and post-neonatal mortality of children under-five years is 4.5%.

[3] Globally there were 18.4 stillbirths per 1,000 total births in 2015, compared with 24.7 stillbirths in 2000. Therefore the Every Newborn Action Plan (<http://www.everynewborn.org/every-newborn-action-plan/>) target of 12 or fewer stillbirths per 1,000 in every country will not be met by 2030 unless at least 56 countries double their rate of progress.

[4] India, Nigeria, Pakistan, China, Ethiopia, Democratic Republic of Congo, Bangladesh, Indonesia, Tanzania, Niger.

[5] Progress in Rwanda is attributed to increased coverage of care and more midwives.

[6] Risk factors are not mutually exclusive and might coincide in same woman, so sum exceeds 100%.

[7] Christina's interview is available in b-roll and in a short video at: <http://bit.ly/1ZtFglx>

[8] A survey of 3,503 bereaved parents in high-income countries found that 43% felt their community believed they should try to forget their stillborn baby and have another child.

[9] *The Lancet* Stillbirth Series 2011: <http://www.thelancet.com/series/stillbirth>

The Lancet Ending Preventable Stillbirths Series study group: Mater Research Institute, University of Queensland (Brisbane, Australia), Norwegian Institute of Public Health (Oslo, Norway), Save the Children (Edgemead, South Africa), UNFPA, the United Nations Population Fund, London School of Hygiene & Tropical Medicine (UK), University of Manchester (UK), International Stillbirth Alliance (NJ, USA).

The Lancet Ending Preventable Stillbirths Series Advisory Group: Era en Abril (Buenos Aires, Argentina), Institute for Clinical Effectiveness and Health Policy (Buenos Aires, Argentina), Griffith University (Gold Coast, QLD, Australia), The Hospital for Sick Children (Toronto, Canada), University of British Columbia (Vancouver, Canada), Grand Challenges Canada (Toronto, Canada), Paris Descartes University (France), Postgraduate Institute of Medical Education & Research (Chandigarh, India), International Confederation of Midwives (The Hague, Netherlands), University of Groningen (Groningen, Netherlands), Wellbeing Foundation (Lagos, Nigeria), University of Pretoria (South Africa), Partnership for Maternal, Newborn & Child Health (Geneva, Switzerland), Department of Reproductive Health and Research, WHO (Geneva, Switzerland), Well Being Foundation Africa (London, UK), Department for International Development (London, UK), Children's Investment Fund Foundation (London, UK), University of Central Lancashire (Preston, UK), Family Care International (New York, USA), Department of Pediatrics, Stanford University (USA), UNICEF Headquarters (New York, USA), Columbia University (New York, USA), Every Woman Every Child (New York, USA), Maternal Health Task Force, Harvard University (Boston, USA), White Ribbon Alliance (Washington, DC, USA), Bill & Melinda Gates Foundation (Seattle, USA), Global Alliance to Prevent Prematurity and Stillbirth (Seattle, USA), University of Utah Health Sciences Center (Salt Lake City, USA), University of St Andrews (UK), US Agency for International Development (Washington, DC, USA), Save the Children and Saving Newborn Lives (Washington, DC, USA), St Raphael of St Francis Hospital, Nsambya (Kampala, Uganda).