***The Lancet*: Ending preventable stillbirths: Stillbirth rates have fallen from 2000 to 2015 but there are still 2.6 million annual deaths, and progress lags behind that for child and maternal mortality**

**\*\*Embargo: 23:30 [UK time] Monday 18 January, 2016\*\***

**\*NOTE-a link under this press release provides country by country data and ranking lists\***

Approximately 2.6 million babies were stillborn in 2015, or around 7200 every day globally. Falls in stillbirth rates since the year 2000 are failing to keep pace with falls in childhood and maternal mortality rates, say the authors of ***The Lancet****’s* new Ending preventable stillbirths Series.

Of the 2.6 million stillbirths (which happen during the final trimester of pregnancy, or after 28 weeks gestation), half occur intrapartum (during the birthing process). While 98% of stillbirths occur in low-income and middle-income countries, they also remain a problem for high-income countries.

Series co-lead Professor Joy Lawn from the London School of Hygiene & Tropical Medicine, UK, and colleagues found that from 2000 to 2015 [paper 2], the global average stillbirth rate fell from 24·7 per 1000 total births to 18·4 - equivalent to an annual rate of reduction (ARR) of 2·0% for stillbirths. They say: “Thus, although some progress has been made, this reduction has been slower than for maternal (ARR 3·0%), neonatal (3·1%), and postneonatal mortality of children younger than 5 years (4·5%) over the same period.”

The authors also highlight that, for every country to reach the Every Newborn Action Plan[[1]](" \l "one) stillbirth target of 12 or fewer stillbirths per 1000 total births by 2030, this global ARR will need to more than double to 4.2%. A total of 94 mainly high-income countries and upper middle-income countries have already met this target, yet most of these still have wide equity gaps between the poorest and richest families which need to be addressed. Notably 56 countries, mainly in Africa, will need to at least double their progress to meet the target.

The Series also provides new findings on the preventability of stillbirths. Data from 18 countries suggests that congenital abnormalities account for a median of only 7·4% of stillbirths, dispelling the myth that all stillbirths are inevitable and are due to congenital conditions. Many disorders associated with stillbirths are modifiable and often coexist, such as maternal infections (malaria and syphilis account for 8.0% and 7·7% of stillbirths respectively), non-communicable diseases, nutrition and lifestyle factors (each about 10%), and maternal age older than 35 years (6·7%). Pre-eclampsia and eclampsia together contribute to 4·7% of stillbirths, while prolonged pregnancies contribute to 14·0% of stillbirths.

The authors highlight a number of countries that have made impressive progress. Among high income countries (HIC), the Netherlands had the highest annual rate of reduction from 2000 to 2015 (6·8%), attributed to improvements in antenatal care and care at birth, a wide-scale perinatal audit, coupled with a focus on women’s health before and during pregnancy.

Among low and middle-income countries (LMIC), Cambodia (ARR 3·6%), Bangladesh (3·4%) and Rwanda (2·9%) have made faster progress in stillbirth prevention than their neighbours. Rwanda for example has doubled the number of births in health facilities and improved the quality of this care as well as that of antenatal care.

Professor Joy Lawn and colleagues say: “Sub-Saharan Africa has the highest stillbirth rates and the slowest rates of progress worldwide, especially in countries with conflicts and emergencies. Thus at the present rates of progress, over 160 years will pass before the average pregnant woman in sub-Saharan Africa has the same chance of her baby being born alive as does a woman nowadays in a high-income country.”

Stillbirths remain a problem in high income countries (HIC) where variations in stillbirth rates across countries and large equity gaps persist. Estimates [paper 4] show an average stillbirth rate (after 28 weeks gestation) in 49 HICs of 3·5 per 1000 total births. Country-specific rates varied widely from 1·3 (Iceland) to 8·8 (Ukraine). The annual rate of reduction (ARR) from 2000 to 2015 varied with eight countries showing ARRs of less than 1%, and five countries with ARRs of more than 4%.

Dr Vicki Flenady, Mater Research Institute, University of Queensland, Australia and colleagues conclude that if all high income countries (HICs) achieved stillbirth rates equal to the best performing countries (stillbirth rate 2·0 or less per 1000 births), an estimated 19400 late gestation (28 weeks or more) stillbirths could have been avoided in 2015. National mortality audit data suggest substandard care contributes to 20–30% of all stillbirths in HIC.

In high-income countries, a woman living under adverse socioeconomic circumstances has around twice the risk of having a stillborn child when compared to her more advantaged counterparts. Stillbirth rates for women of south Asian and African origin giving birth in Europe or Australia are two to three times higher than white women. Stillbirth in disadvantaged women can be addressed through education and alleviation of poverty, as well as improved access to health care, especially timely, culturally appropriate antenatal care.

Flenady and colleagues also call for national perinatal mortality audit programmes to be implemented in all high-income countries, including a systematic approach to classifying the causes of stillbirth and research focusing on stillbirth prediction, understanding placental pathways to stillbirth and causal pathways to unexplained stillbirth. They add that interventions to increase the number of women beginning pregnancy with a normal bodyweight are crucially important to improve pregnancy outcomes and longer-term health.

They also show that stigma and fatalism persists in high income countries. The International Stillbirth Alliance Survey conducted for the Series showed that around half of parents felt their community believed that “parents should not talk about their stillborn baby because it makes people feel uncomfortable*”*. One parent said “…many women told me that my son’s death was likely ‘nature taking care of my mistakes’”.

Flenady and colleagues conclude that “Stillbirths are a major public health issue in HICs and reductions in rates have not matched those for neonatal mortality. Variation and socioeconomic disparities in stillbirth rates, suboptimum uptake of interventions, low proportions of stillbirths attributed to congenital abnormality and high proportions classified as unexplained, and the contribution of substandard care factors suggest stillbirths are not inevitable, and that further reduction in HICs is possible.”

Dr Frederik Frøen, Norwegian Institute of Public Health, Oslo, Norway, and colleagues review progress made since the previous ***Lancet***Stillbirths Series[[2]](" \l "two) published in 2011. They say that worldwide attention to babies who die in stillbirth is rapidly increasing, from integration within the new UN Secretary General’s Global Strategy for Women’s, Children’s and Adolescent’s Health[[3]](#three), to country policies inspired by the Every Newborn Action Plan.  Many countries specifically requested inclusion of a stillbirth targetthat, if achieved, would prevent over half of stillbirths worldwide. However of 67 LMIC countries with accessible plans only 15 even mention stillbirths. Authors note that “Still, in most countries, implementation of the recommended community actions and health interventions for antenatal and intrarpartum care is generally low. Hardly any development funding for implementation has been disbursed.”

Frøen and colleagues discuss how both the plans above have helped increase the recognition and prioritisation of stillbirths. However they note that some points have still not been made strongly enough, such as the recognition that stillbirths are not just abstract numbers but are babies that die; and that prenatal health is the biological foundation of life-long health for every newborn to enable him or her to attain the maximum level of health and potential during their lifetime, and reduce the later risk of non-communicable diseases.

Dr Alexander Heazell, Maternal and Fetal Health Research Centre, St Mary’s Hospital, Manchester and colleagues highlight the often underappreciated implications of stillbirths on parents, families, health-care providers and societies worldwide [paper 3].  They estimate that 60–70% of grieving mothers in high income countries (HIC) reported grief-related depressive symptoms that they regarded as clinically significant 1 year after their baby’s death. In about half of cases, these symptoms endured for at least 4 years after the loss. If these figures are extrapolated to the 2·6 million women who had a stillbirth globally each year, an estimated 4·2 million women are living with depressive symptoms after stillbirth.

Stigma was also particularly evident in low and middle income countries (LMIC), in cultures where talking about death is taboo, and where the dead baby was not yet deemed to be a person. In these contexts, mothers’ accounts suggested that they suppressed grief in public*,* instead choosing to deal with the emotions privately and alone.

Differences in post-stillbirth care were revealed by the International Stillbirth Alliance survey (LMIC n=117, HIC n=2020), which reported that parents in LMICs were less likely than those in HICs to be offered contact with their baby (35% in LMICs *vs* 94% in HICs), the opportunity to see and hold their baby (42% in LMICs *vs* 95% HICs), make memories (35% in LMICs *vs* 87% in HICs), and name their baby (39% in LMICs *vs* 83% in HICs) after a stillbirth.

The authors conclude: “On the basis of these data, the key element of what works to reduce the impact of stillbirth on bereaved parents and families can be summarised as seeing through the eyes of those affected. This includes staff who understand what different parents and families need and when they need it; communities that acknowledge grief and loss and do not stigmatise those who have had stillbirths; employers who provide effective leave arrangements; and governments that provide tangible support, such as funeral costs, and paid leave from work commitments. Stillbirth is associated with substantial direct, indirect, psychological, and social costs to women, and to their families, society, and government.”

In the final paper, Dr Luc de Bernis, UN Population Fund, Geneva, Switzerland, and colleagues [paper 5] say that the estimated 7200 stillbirths that occur every day are hidden in global public health and women’s rights initiative despite the evidence shown in 2011. Nearly half are intrapartum stillbirths and are highly preventable with high-quality care at birth and early identification of at-risk pregnancies.

Even though the promotion of women’s and children’s health inherently includes the prevention of stillbirths, intentional efforts are necessary to address stillbirth since progress has lagged behind. Thus the authors propose three ways to effectively and appropriately incorporate stillbirths in post-2015 initiatives for women’s and children’s health in order to meet the full potential of efforts. These criteria include: acknowledge the burden of stillbirths; address actions needed to prevent stillbirths with antenatal and intrapartum care; and monitor stillbirths with a target and/or outcome indicator.

The paper highlights the already agreed goals, targets and indicators including the Every Newborn Action Plan[[1]](" \l "one), calling on every country to achieve a rate of 12 stillbirths or fewer per 1000 total births by 2030. In addition, the authors highlight a number of important milestones related to family planning, antenatal care, care during labour and birth, post-mortem respectful and supportive care and reducing stigma as well as improved monitoring and research in this area.

The authors say: “As the use of the Millennium Development Goals came to an end in 2015, 2016 must be a turning point for ending preventable deaths—stillbirths, and maternal, newborn, and child deaths…One of the most important contributions to ending preventable stillbirths will be the intentional incorporation of stillbirths into global, regional, and national policy frameworks for women’s and children’s health.”

They conclude: “Every Woman Every Child[[4]](#four) has called for prioritization of stillbirths post-2015 but stillbirth prevention and response will need to be done differently to reach the full potential of 2030 with 126 million more mothers and children alive, including 21 million stillbirths prevented.”

In a linked Comment, ***The Lancet*** Editor-in-chief Richard Horton, and Senior Editor Udani Samarasekera, write: “The number of stillbirths remains alarmingly high: 2·6 million stillbirths annually, with little reduction this past decade. But the truly horrific figure is 1·3 million intrapartum stillbirths. The idea of a child being alive at the beginning of labour and dying for entirely preventable reasons during the next few hours should be a health scandal of international proportions. Yet it is not. Our Series aims to make it so.”

NOTES TO EDITORS:

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***.

[1] <http://www.everynewborn.org/>

[2] <http://www.thelancet.com/series/stillbirth>

[3] <http://www.who.int/life-course/partners/global-strategy/en/>

[4] Every Woman Every Child is a multi-stakeholder movement to implement the United Nations’ Global Strategy for Women’s, Children’s and Adolescents’ Health that was launched by the UN Secretary-General in September 2015 in support of the Sustainable Development Goals framework. See more at: <http://www.everywomaneverychild.org/commitments/what-is-a-commitment>

**To arrange interviews with key spokespeople and for case studies, please contact the London School of Hygiene & Tropical Medicine press office on E)** [**press@lshtm.ac.uk**](mailto:press@lshtm.ac.uk) **or T) +44 (0) 20 7927 2802**

**For Executive Summary, see:** [**http://press.thelancet.com/StillbirthsExecSumm.pdf**](http://press.thelancet.com/StillbirthsExecSumm.pdf)

**For a country by country ranking list, and other key data from the Series see:** [**https://www.dropbox.com/s/6xtms9fjjql1zim/Lancet%20Stillbirth%20Series%20embargo%20data\_FINAL%2014thjan.xlsx?dl=0**](https://www.dropbox.com/s/6xtms9fjjql1zim/Lancet%20Stillbirth%20Series%20embargo%20data_FINAL%2014thjan.xlsx?dl=0)

**For full Series paper 1, ‘Stillbirths: progress and unfinished business,’ see:** [**http://press.thelancet.com/Stillbirths1.pdf**](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**](http://press.thelancet.com/Stillbirths2.pdf)

**For full Series paper 3, ‘Stillbirths: economic and psychosocial consequences,’ see:** [**http://press.thelancet.com/Stillbirths3.pdf**](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**](http://press.thelancet.com/Stillbirths4.pdf)

**For full Series paper 5, ‘Stillbirths: ending preventable deaths by 2030,’ see:** [**http://press.thelancet.com/Stillbirths5.pdf**](http://press.thelancet.com/Stillbirths5.pdf)

**For Series Comments see:** [**http://press.thelancet.com/StillbirthsComments.pdf**](http://press.thelancet.com/StillbirthsComments.pdf)

**For Comment Appendix see:** [**http://press.thelancet.com/StillbirthsAppx.pdf**](http://press.thelancet.com/StillbirthsAppx.pdf)

**For paper 1 Appendix see:** [**http://press.thelancet.com/StillbirthsAppx1.pdf**](http://press.thelancet.com/StillbirthsAppx1.pdf)

**For paper 2 Appendix see:** [**http://press.thelancet.com/StillbirthsAppx2.pdf**](http://press.thelancet.com/StillbirthsAppx2.pdf)

**For paper 3 Appendix see:** [**http://press.thelancet.com/StillbirthsAppx3.pdf**](http://press.thelancet.com/StillbirthsAppx3.pdf)

**For paper 4 Appendix see:** [**http://press.thelancet.com/StillbirthsAppx4.pdf**](http://press.thelancet.com/StillbirthsAppx4.pdf)

**For paper 5 Appendix see:** [**http://press.thelancet.com/StillbirthsAppx5.pdf**](http://press.thelancet.com/StillbirthsAppx5.pdf)

**For full *The Lancet Global Health*** **Article and Comment see:** [**http://press.thelancet.com/TLGHStillbirths.pdf**](http://press.thelancet.com/TLGHStillbirths.pdf)

**For *The Lancet Global Health*** **Appendix see:** [**http://press.thelancet.com/TLGHStillbirthsAppx.pdf**](http://press.thelancet.com/TLGHStillbirthsAppx.pdf)

**For a press release from London School of Hygiene and Tropical Medicine see:** [**https://www.dropbox.com/s/i0gltbrubuhhvim/Lancet%20stillbirth%20series%20press%20release%20final%20EMBARGOED%2023.30%20GMT%2018.01.16.pdf?dl=0**](https://www.dropbox.com/s/i0gltbrubuhhvim/Lancet%20stillbirth%20series%20press%20release%20final%20EMBARGOED%2023.30%20GMT%2018.01.16.pdf?dl=0)

**NOTE: THE ABOVE LINKS ARE FOR JOURNALISTS ONLY; IF YOU WISH TO A PROVIDE LINK TO THIS PAPER 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**](http://www.thelancet.com/series/ending-preventable-stillbirths)

**Caroline Brogan**

**Media Relations**

*The Lancet* journals

125 London Wall

London

EC2Y 5AS

Phone: +44 (0) 20 7424 4249

Mobile: +44 (0) 7500 761363

Email: [c.brogan@lancet.com](mailto:c.brogan@lancet.com)