

Despite clear dangers, stillbirths remain a forgotten epidemic

It is estimated that 2.6 million stillbirths – the death of a baby after 28 weeks of pregnancy but before or during childbirth – occur globally each year, with 98% of them taking place in low and middle-income countries (LMICs). In 2015, 41% of the global stillbirth rate [occurred](#) in African LMICs, with a third of that happening in East Africa. The extent of the neglect cuts across the board from national to the global agenda of the United Nations, particularly when one considers that stillbirths weren't included in the Millennium Development Goals despite MDGs 4 and 5 aiming to address the reduction in child and maternal mortality, respectively. Neither were stillbirths included in Sustainable Development Goals fifteen years later, despite once again the inclusion of SGD 3 and goal 13 on “Good Health and Well-being.” Something is clearly off.

The SDG neglect of stillbirths happened despite the publication in 2014 of “Every Newborn Action Plan” (ENAP) by the World Health Organisation, which set itself the goal of reducing stillbirths to 12 or less per 1,000 births by 2030. Moreover, a year later, the WHO published *Ending preventable stillbirths by 2030* in which it recognized stillbirths as a preventable epidemic requiring global attention.

Causes of stillbirths in Africa

There are two types of stillbirths: fresh stillbirth and macerated stillbirth. In the former, the baby dies during labor or delivery and, in the latter, the baby dies 12 to 24 hours before delivery. Along these types are three main causes of stillbirths: maternal, fetal, and institutional.

A 2019 [study](#) conducted in Malawi, Zimbabwe, Kenya, and Sierra Leone in 2019 identified four causes of stillbirth in Africa are: maternal stillbirth include maternal age (<15 and >35); the presence of pregnancy-related hypertensive disorders; chronic diseases (such as diabetes, HIV, anaemia, haemorrhage); and infection and alcohol/tobacco consumption. Moreover, half of these stillbirths occurred during the childbirth process.

In the same year, another [prospective, hospital-based, observational study](#) conducted in Soweto, South Africa, attributed stillbirths to fetal, genetic, or structural abnormalities of the fetus. Among these causes, “fresh stillbirths were associated with breech delivery compared to cephalic delivery,” and these findings were corroborated by [another study](#) thereafter. Breech delivery, as the studies noted, occurs when the baby’s feet present first instead of the head, therefore necessitating urgent cesarean procedures that, when delayed, increase the chances that the baby will die during delivery.

At least five institutional factors have been identified to cause stillbirths in Africa: lack of partograph use (a tool used for adequate labour monitoring); absence of prenatal care; lack of timely emergency obstetric management skills; delay in access to health facilities, and lack of trained healthcare providers, amongst others.

Reducing stillbirth in Africa

Early detection of the risks can significantly reduce stillbirths in Africa. Although since the 1990s there has been great progress in reducing maternal and child mortality in Africa – maternal deaths cut by 41% and under-five mortality by 33%, according to the [UNFPA](#) – stillbirths have largely been forgotten. As a result, between 2000 and 2019 mortality rates in Sub-Saharan Africa [increased](#) from 0.77 million in 2000 to 0.82.

So, what can be done? First is the sensitization of Africans on the importance of medical check-ups before, during, and after pregnancy. Indeed, preconception, prenatal and postnatal consultations uptake for every woman of reproductive age are the main weapons that need to be deployed in order to win the battle against stillbirths. Also related to this is that sexual education in adolescent health is a factor that African governments should use in view of the information age we are living in.

Secondly, investing in healthcare infrastructure in order to ease access to health facilities is vital, considering the fact that nearly 60% of the global stillbirths [occur](#) in rural families where there is no or limited access to family planning services, healthcare facilities, midwifery care services and emergency obstetric care.

Third, the appropriate and continuous training of healthcare providers in managing obstetric emergency conditions and following them up remains essential. This challenge is linked to the [six building blocks](#) of an efficient healthcare system developed by WHO, which African countries are currently implementing.

Further, there is a need to focus on updating national research agendas on reproductive health matters to address the most common neglected and preventable health issues. Indeed, healthcare policies should be underpinned entirely by research. Local research findings are more generally specific and give birth to national health policies tailored to local needs. African countries should aim to rely mostly on their own research rather than foreign ones.

But none of the above will help if African countries don't invest in creating appropriate national research programmes and infrastructure to identify specific causes of stillbirths. This has been linked to the inability to establish tailored reproductive health policies in different African countries.

Indeed, to sustainably address the problem of stillbirths, this challenge must be regarded not only as an institutional factor but as a structural issue with grave implications. But for this to happen, African governments must recognise the social, economic and psychological factors affecting health outcomes, which is the only way to craft long-term solutions to the challenges we face, including that of preventable stillbirths.