Despite wide-ranging improvements in obstetric care, the ability to give birth to a live baby has been largely absent from the maternal health agenda: stillbirth is a tragedy that afflicts mothers, after months of expectation and anticipation, with a sweeping and startling sadness. Plaguing both the developed and developing nations, stillbirth is a pervasive but surprisingly overlooked problem. Its causes vary between developing and developed nations, however, and so do the interventions it requires.

The trouble in addressing stillbirth lies largely in its definition. Even within the United States, the classification of stillbirth varies in each state, making it extremely difficult to understand the scope of the problem. In an interview with the HCGHR, Catherine Spong, the author of “Stillbirth” and Branch Chief at the National Institute of Child Health & Human Development at NIH stated, “In some states the pregnancy has to last twenty weeks; in others, it has to be five hundred grams; other states it’s twenty-four weeks and even five months in some, whatever that means.” This lack of standardization caused by the wide array of classification systems makes it extremely hard to locate the root causes of stillbirth.

The global context magnifies these issues. In countries without readily available medical facilities, fetuses may not be delivered immediately after death, and maturation in the womb hinders the ability to discern their exact weight. Furthermore, without regular medical visits the mother may not know the exact stage of her pregnancy. The constructive classification systems for high-income countries, although not yet fully developed, rely on technology and a level of care that is unavailable in many places. In an interview with the HCGHR, Dr. Ana Langer, the leader of The Women and Health Initiative and Professor of the Practice of Public Health at the Harvard School of Public Health, remarked, “very often, the mother just stops feeling the fetus’s movement and then goes to a health clinic where they discover that is a stillbirth.” This is a distressing and disturbing experience for many women but basic research on prevention is obstructed by a lack of a common vocabulary. Langer noted, “this is an issue that could be potentially solved if people came together to agree on basic definitions, but that hasn’t happened yet in this field.”

Building on the complexity of standardization, the circumstances of stillbirth are quite different between developed and developing countries. Data collected by the WHO suggest that the highest rates of stillbirth occur in South Asia and Sub-Saharan Africa.

“The trouble in addressing stillbirth lies largely in its definition.”
In developing countries, most stillbirth cases are associated with obstetric complications, issues for which solutions have been found with the advancement of care in developed countries. In addition to complications arising from a lack of obstetric care, a large proportion of stillbirths occurs during delivery, “a clear indication of a very poor quality of childbirth care or a lack of a skilled attendant,” according to Langer. “It’s a network of factors,” she says: “in those countries the health systems are very weak, and therefore there aren’t enough trained providers, facilities, supplies, or all of the above. And at the same time women have poor access to whatever services do exist.”

The disparity in stillbirth rates between developing and developed nations indicates a clear difference in the causes of these tragedies. Still, further research in obstetrics is needed: in the United States, a large portion of stillbirths occur as a result of unknown causes.

Inequities in stillbirth rates do not just exist between developed and developing nations: they exist within the United States as well. The current stillbirth rate in the United States is approximately two to six per thousand deliveries at twenty weeks’ gestation or greater. However, the stillbirth rate among black women in the United States is between one and eleven per thousand deliveries, revealing a huge racial disparity. Because of the complexity of classification that surrounds the reporting of stillbirth, the causes of this difference are largely unknown. However, Spong remarks, “If you look across preterm births, stillbirths, and infant mortality, there is a disparity across all three where there are higher rates among African American women than non-African American women.”

This imbalance affects all obstetrical conditions and many medical conditions as well.

Stillbirth is an issue riddled with disparities and varied definitions, making it difficult for maternal health organizations and researchers to effect change.

“Further research in obstetrics is needed: in the United States, a large portion of stillbirths occur as a result of unknown causes.”

However, much can and should be done to reduce stillbirth rates, taking into account the context in which they occur. Countries without a functional health care system require basic infrastructure development in order to establish a setting in which mothers can access treatment and evidence-based interventions. However, according to a series published by the *Lancet* highlighting the global rates and causes of stillbirth, the mission of stillbirth prevention alone cannot garner enough support to implement these critical programs, so the issue must be integrated with broader programs that attempt to reduce maternal, fetal, and neonatal mortality.

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