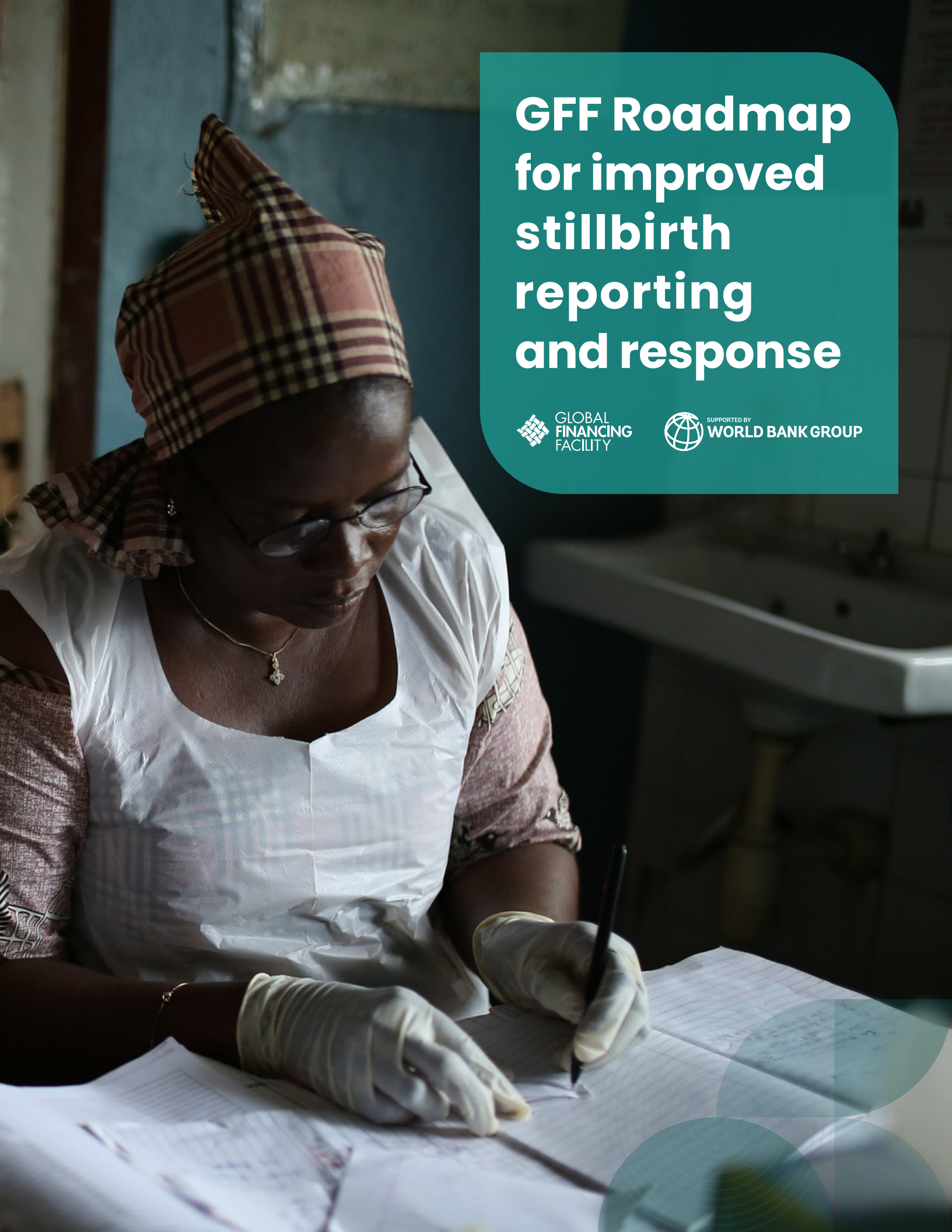


A woman wearing a white clinical gown, a patterned headwrap, and glasses is seated at a desk, wearing white gloves and writing on a form with a pen. The background is slightly blurred, showing a clinical setting.

GFF Roadmap for improved stillbirth reporting and response



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*Teuk Thla Health Center in
Phnom Penh, Cambodia.
Photo: © Dominic Chavez
The Global Financing Facility*

The Global Financing Facility (GFF) has been partnering with countries since 2015 to accelerate progress in the health outcomes for women children, and adolescents. Central to the GFF's country-led approach is the development of a costed prioritized investment case to provide a roadmap for achieving universal coverage of a package of reproductive, maternal, child, adolescent health, and nutrition (RMNCAH-N) services. The 2021-2025 GFF Strategy affirms this approach with a renewed focus on country leadership, equity, high-quality health services, sustainable health financing, and improved use of data for decision-making. Improved monitoring of stillbirth is an important part of this Strategy, as it is both a sensitive indicator of poor quality care during pregnancy and childbirth and a critical component of data for decision making. The following report addresses what has until now been a gap in GFF's RMNCAH-N agenda.

Why is counting stillbirths important for Global Financing Facility (GFF)-supported countries?

Each year, globally, nearly 2 million pregnancies result in stillbirths. The COVID-19 pandemic has led to a significant increase in stillbirths (1).

The Every Newborn Action Plan (ENAP), led by the World Health Organization (WHO) and UNICEF and endorsed by 194 WHO member states, calls for each country to achieve a rate of 12 stillbirths or fewer per 1,000 total births by 203 (2). Almost all 37 GFF-supported countries¹ are off track to reach their stillbirth targets of 12 stillbirths or fewer per 1,000 total births, translating into about half a million lives lost (Table 1).

Most stillbirths are preventable, and high stillbirth rates are a marker of low access and coverage of quality antenatal and intrapartum care. Notably, 42% of stillbirths occur between the onset of labor and birth (1). This percentage is even higher in sub-Saharan Africa and Central and Southern Asia, where about half of all stillbirths occur during the intrapartum period (1). Intrapartum stillbirth is a tragedy since timely interventions could have prevented a majority of these deaths. For too long, stillbirths have not been included when assessing the impact of poor quality antenatal and intrapartum care. Stillbirths have received less attention as a public health issue than neonatal, under-five mortality, and maternal mortality: During the past two decades, the annual rates of reduction of stillbirths have been much smaller than reductions in neonatal deaths, deaths among children ages 1-59 months, and maternal deaths (1). Consequently, the benefit of investing in improved

antenatal and intrapartum care has been underestimated, with missed opportunities for scaling up more specific interventions to end preventable stillbirths.

The first step for countries to prevent stillbirths is to accurately identify and report them. Although the availability of stillbirth data is improving, it is still very limited in low and middle-income countries (LMIC), where 84% of stillbirths occur. Nearly one-third of the 195 countries studied by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) had no stillbirth data (24 countries) or lacked high-quality data (38 countries). Currently, these national data systems do not record stillbirths, or the stillbirth data is unusable due to non-standard definitions, inaccurate classification, or underreporting (1).

Not counting the stillbirths occurring annually in the GFF-supported countries is a missed opportunity for measuring impact and return on investments. The UN IGME estimated that 22.1 million pregnancies will result in a stillbirth between now and 2030 if the stillbirth rate for each country stays at the 2019 level (1). Across the 37 GFF-supported countries, if the ENAP stillbirth target of 12/1000 total births was reached, over 500,000 stillbirths would be averted each year based on 2019 estimates (Table 1).

¹This includes 36 GFF partner countries + Honduras (a GFF eligible country that received emergency COVID-19 EHS grant co-financing on an exceptional basis).

Table 1. **GFF-supported countries: Stillbirth rates, numbers of stillbirths, and stillbirths that could be averted if ENAP target were met**

	IGME stillbirth rate estimates (stillbirths per 1000 total births) (1) ^{2,3}		Estimated number of stillbirths in 2019 (IGME)	Stillbirths averted if ENAP target of 12 stillbirths/1000 total births were met ⁴
COUNTRY	2010	2019		
Afghanistan	32.6	28.4	35,384	20,433
Bangladesh	29.7	24.3	72,508	36,702
Burkina Faso	23.7	19.5	15,141	5,823
Cambodia	16.5	12.5	4,573	183
Cameroon	21.7	19.4	17,872	6,817
Central African Republic	32.5	29.8	5,147	3,074
Chad	30.1	27.5	18,802	10,597
Cote d'Ivoire	26.8	23.2	21,735	10,493
DRC	30.1	27.2	98,871	55,251
Ethiopia	31.1	24.6	90,323	46,263
Ghana	25.1	21.7	19,529	8,730
Guatemala	15.9	12.7	5,498	303
Guinea	26.8	25.2	11,895	6,231
Haiti	22.6	19.9	5,470	2,172
Honduras	10.1	8.5	1,787	-
Indonesia	11.9	9.5	45,857	-
Kenya	20.6	19.7	30,030	11,738
Liberia	25.4	24.2	4,008	2,021
Madagascar	17.5	16.5	14,671	4,001
Malawi	20.0	16.3	10,440	2,754

	IGME stillbirth rate estimates (stillbirths per 1000 total births)(1) ^{2,3}		Estimated number of stillbirths in 2019 (IGME)	Stillbirths averted if ENAP target of 12 stillbirths/1000 total births were met ⁴
COUNTRY	2010	2019		
Mali	23.0	19.7	16,251	6,352
Mauritania	25.4	22.0	3,385	1,539
Mozambique	25.5	21.7	25,096	11,218
Myanmar	16.3	14.1	13,493	2,010
Niger	21.9	19.6	21,283	8,253
Nigeria	23.7	22.2	171,428	78,764
Pakistan	36.5	30.6	190,483	115,784
Rwanda	18.9	16.9	6,798	1,971
Senegal	22.6	19.7	11,157	4,361
Sierra Leone	27.7	23.7	6,249	3,085
Somalia	29.1	26.8	17,738	9,796
Tajikistan	10.9	9.0	2,542	-
Tanzania	21.8	18.8	40,480	14,642
Uganda	20.8	17.8	29,928	9,752
Vietnam	9.6	7.8	12,479	-
Zambia	17.3	14.8	9,597	1,816
Zimbabwe	23.7	16.0	7,113	1,778
TOTAL				504,704

² UN IGME stillbirth estimates are developed in consultation with countries and are based on available country-level data sources including registration systems (e.g., CRVS, birth or death registries, or HMIS), household surveys (e.g., DHS), or from population-based studies (1).

³ Current DHS questionnaires significantly underestimate stillbirths (14,23).

⁴ Assuming countries already below 12 SBR stay at or below current level.

What are the challenges to reporting stillbirths?

Many data systems in LMIC — including Health Management Information Systems (HMIS), Civil Registration and Vital Statistics (CRVS) systems, perinatal death⁵ audits linked to maternal and perinatal death surveillance and response (MPDSR), and population-based household surveys such as Demographic Health Surveys (DHS) or Multiple Indicator Cluster Surveys (MICS) — do not sufficiently report stillbirths.

There are several reasons for this at the different health systems levels (see Table 2 for more information):

1

National and sub-national levels – Limited awareness of the burden of stillbirths; disparate country-level standards and guidance on the definition of stillbirths and standards of measurement⁶; lack of legal frameworks requiring perinatal death notification and notification/registration of stillbirths; limited government financing to monitor stillbirths; and challenges with recording stillbirths and data systems for routine reporting; surrounding stillbirths and reporting of stillbirths.

2

Health facility and community levels – Non-standardized health facility registers; low levels of community-based reporting; misclassification of stillbirths and inaccurate reporting due to inadequacy of health workers' skills, lack of time, and/or stigma and fear of blame associated with stillbirths/lack of legal frameworks to protect health care workers in these deaths.

3

Individual-level – Social and religious norms and stigma surrounding stillbirths and reporting of stillbirths.

⁵The perinatal deaths are those occurring in the perinatal period [from 22 completed weeks of gestation and ending 7 completed days after birth (i.e., includes days 0-6 after birth)]. Therefore, perinatal deaths include both early and late stillbirths and early neonatal deaths.

⁶Many countries use different definitions for stillbirths, however, for international comparisons, the World Health Organization (WHO) through the 10th revision of the International Classification of Diseases (ICD-10) recommends the following definition "a fetal death occurring at ≥ 1000 grams, or if birthweight is not available at ≥ 28 weeks of gestation, or ≥ 35 cm crown-heel length." However, for the most recent UN estimates and from ICD-11 onwards the ≥ 28 weeks gestational age definition is used for international comparison, with the ≥ 1000 gram threshold only if gestational age is not available (1).

What recent changes are helping the reporting of stillbirths?

The good news is that many countries and global organizations are pushing to strengthen the counting of stillbirths. Despite there being no specific target for stillbirths in the Sustainable Development Goals (SDG), all the GFF-supported countries have endorsed the ENAP target to achieve 12 stillbirths or fewer per 1,000 total births by 2030.

ENAP also provides countries with a roadmap for ending preventable stillbirths and newborn deaths (2). The UN Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) includes stillbirths in its vision statement (3). Stillbirths are one of the "100 Core Health Indicators" of the WHO and Every Newborn core indicators (2,4). The UN IGME generates stillbirth estimates every two years.

In addition, there has been greater attention paid to the inclusion of stillbirths in HMIS and population-based surveys: Based on research evidence, the DHS core survey module (DHS-8) was recently

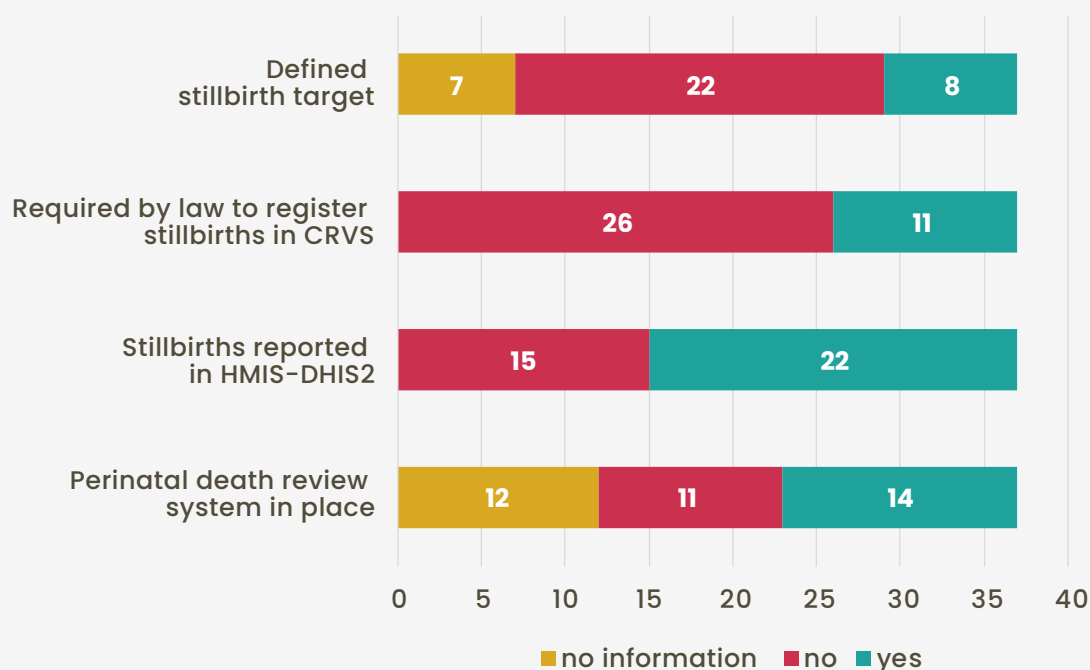
changed to collect a woman's full pregnancy history, rather than a full birth history as was done in the past, which improves the reporting of stillbirths (5). Global guidance has been developed on improving the registration of live births, stillbirths, and deaths (6). Various tools, digital collection forms, automated analyses, training, and reports are available to improve HMIS performance for stillbirth data collected at the health facility up to sub-national and national levels (7). Also, guidance for conducting perinatal death surveillance and response in clinical and policy settings is available from the WHO (8,9).

What is the current state of stillbirth reporting in GFF-supported countries?

Across the 37 GFF-supported countries, only a fifth have defined stillbirth targets in their national RMNCAH-N plans (2) and fewer than a third are required by law to register stillbirths in their CRVS systems (Figure 2). Around 40% do not currently

report stillbirths in their HMIS (10). Fewer than 40% have a perinatal death review system (2). Though this analysis (Figure 2) is only limited to those countries currently supported by the GFF, these shortfalls are likely to be typical of other LMIC as well.

Figure 2. Number of GFF-supported countries with defined stillbirth targets and stillbirth data collection systems



Note: The values are based on secondary data sources published since 2017.

How can countries improve the monitoring and reporting of stillbirths?

Table 2.

CHALLENGES	RECOMMENDED ACTIONS
National- and sub-national	
Strategies, legal frameworks, and funding	
• The definition of stillbirth is not aligned with international standards and is not used consistently in all data reporting tools.	• Ensure that the definition of stillbirths is aligned with international standards. While countries can define stillbirths as they want depending on their context, at a minimum, all countries should report stillbirths at ≥ 28 weeks gestation for international comparison. Where feasible, also collect data for early gestation stillbirths (≥ 22 - < 28 completed weeks) and report these separately to those ≥ 28 weeks (9).
• Lack of legal frameworks requiring perinatal death notification and civil registration legislation to include the registration of stillbirths.	• Institute legal framework, safeguards, or protocol for perinatal death notification.
• Limited government financing to monitor stillbirths and improve data systems.	• Increase country investments in stillbirth monitoring and national and subnational data collection and system reforms, including financing to strengthen CRVS and MPDSR systems.
• Limited awareness of the importance of stillbirth data as a marker of equity and the quality of antenatal and intrapartum care.	• Increase awareness and political commitment to the importance of stillbirth reporting through advocacy, training, and targeted education (11).
• Lack of clear and consistent guidelines on the definition of stillbirths and standards for measurement.	• Support the development of a national strategy that includes the definition and goals for preventing stillbirths and how stillbirths should be reported.

CHALLENGES	RECOMMENDED ACTIONS
Actionable information systems	
HMIS	
Some countries do not record or report stillbirth via HMIS/DHIS2 even if there is a policy to do so.	- Record stillbirths in HMIS/DHIS2 using the standard WHO minimum perinatal data set (8,12). - Include tracking of early stillbirths (fetal deaths 22-27 weeks) and late gestation stillbirths (fetal deaths ≥ 28 weeks) in DHIS-2.
Many exclude home births and births in private health facilities.	- Extend the reach of HMIS systems to track live births and stillbirths occurring in private sector facilities and at home. - Improve interoperability between health facility and community information systems to capture stillbirths. - Link verbal autopsy from home births with MPDSR systems.
CRVS	
Recording stillbirth data is generally not included in CRVS legal frameworks or CRVS strengthening efforts.⁷	Where necessary, develop/amend a costed national CRVS strategy and implementation plan, including reporting stillbirths.
Low coverage of CRVS in LMICs, particularly for rural populations or some marginalized groups.	- Collect stillbirth data in CRVS and produce vital statistics. - Expand access to computerized CRVS systems. - Introduce innovations to improve birth registration in countries with low national and sub-national coverage through incentives to community-level staff.
Perinatal death reviews	
Perinatal death reviews are not as widely implemented as maternal death reviews.	- MPDSR should not be limited to maternal and neonatal deaths but should routinely include the review of stillbirths. - As recommended by the WHO, ensure national prioritization of prevention of maternal and perinatal deaths and conducting a "No Name, No Blame, and No Shame" MPDSR through a national MPDSR policy and guidelines, a legal framework for notifying deaths and involving communities and other sectors, availability of MPDSR tools, nurturing team relationships and a culture of quality improvement among those who participate in the audit, and regular audit meetings (9,13).
Failure to move to full-scale national and sub-national implementation of MPDSR.	- Define common/core measures for monitoring MPDSR at the health facility, district/regional, and national levels to better track implementation by all programs at all levels and to facilitate learning. - Establish MPDSR committees at provincial/district levels and align their roles in information sharing and communication - Coordinate maternal and perinatal death reviews and activities, including how to prioritize the review of perinatal deaths. - Integrate MPDSR into routine monitoring systems to standardize the process and accountability within both the public and private sectors.

⁷Stillbirths are not included in Civil Registration as they do not have a legal identity – but information on stillbirths can be collected in a 'fetal death' or 'stillbirth' register which can be used for the purposes of vital statistics.

CHALLENGES

RECOMMENDED ACTIONS

Population-based household surveys

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| <ul style="list-style-type: none"> • Few country large-scale retrospective household surveys (e.g., DHS, MICS) report on stillbirths and/or use a woman's full pregnancy history (FPH) method. | <ul style="list-style-type: none"> • Ensure the use of more reliable measures of stillbirths (i.e., for household surveys using a full pregnancy history instead of a full birth history) (11,14). • Add questions on gestational age and birthweight for all births, vital status at birth for all stillbirths and neonatal deaths, and sex of stillborn baby (11). |
| <ul style="list-style-type: none"> • Most marginalized/vulnerable groups may not be fully represented (e.g., in fragile settings). | <ul style="list-style-type: none"> • Include the most vulnerable in household surveys: women <15 years old, never married, and living in fragile settings (11). |
| <ul style="list-style-type: none"> • Data quality accuracy can be affected by length of interviewer training, socio-cultural beliefs, and/or women not knowing their stillborn baby's gestational age or birthweight. | <ul style="list-style-type: none"> • Ensure sufficient quality and length of interviewer training, including building rapport with respondents to earn a woman's trust and interviewer's understanding of and respect for local culture (15) • Address misreporting by raising awareness and public education about stillbirth to reduce the stigma experienced by women. Promote respectful maternity care agenda (16). |

Data use and interoperability

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| <ul style="list-style-type: none"> • Data reports are not always shared with health care workers or higher-level data systems. • Lack of bidirectional HMIS feedback. | <ul style="list-style-type: none"> • At the national level, use data collected in data systems detailed above to track progress toward the ENAP target of 12 stillbirths or fewer per 1,000 total births in every country by 2030. Report and review stillbirth data and neonatal deaths at the facility and district levels, monitoring for potential misclassification (1). Disaggregate reported stillbirth rates at all levels of care, equity groupings, and for public and private facilities. |
| <ul style="list-style-type: none"> • Different data systems are often not interlinked and interoperable. | <ul style="list-style-type: none"> • Look for opportunities to integrate stillbirth reporting in existing systems (e.g., CRVS system, MPDSR, HMIS, and at the community level) (if stillbirth reporting is not routine). Improve interoperability between different data platforms to streamline data systems and increase efficiency. |
| <ul style="list-style-type: none"> • Stillbirth data are not always used for action at both national and sub-national levels. | <ul style="list-style-type: none"> • Ensure that stillbirth data are accessible at all health systems levels through dashboards, monthly reports, and annual reports and that they are understood, valued, and acted upon (11). |
| <ul style="list-style-type: none"> • Widespread use of macerated and fresh stillbirth.⁸ | <ul style="list-style-type: none"> • Disaggregate by antepartum/ intrapartum and not fresh/macerated. |

CHALLENGES

RECOMMENDED ACTIONS

Health facilities/communities

Health and community registers

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| <ul style="list-style-type: none"> • Facility registers do not always record key perinatal outcome information. They can be very complex, not streamlined, too long, and/or provide vague instructions. | <ul style="list-style-type: none"> • Ensure standardized and streamlined registers for countries using either paper or electronic systems. Involve health care workers in designing the changes to existing registers to meet their needs for clinical decision making and data reporting. Move from classifying stillbirths from fresh and macerated to using the presence of a fetal heart rate on admission for delivery to classify stillbirths as antepartum or intrapartum. |
| <ul style="list-style-type: none"> • Registers do not always use the WHO standardized system for classifying stillbirths and neonatal deaths. • Summary forms/ tally sheets used to aggregate data not aligned with registers. | <ul style="list-style-type: none"> • Record stillbirths using the standard WHO minimum perinatal data set (8,12). • Standardize HMIS systems flow to include registers, forms, and electronic HMIS (e.g., DHIS-2). |
| <ul style="list-style-type: none"> • Community-based births are often not recorded, especially stillbirths. | <ul style="list-style-type: none"> • Improve community-based reporting through community sources. Explore integrating the reporting of stillbirths with other existing initiatives, such as community-based maternal death surveillance and response systems, integrated disease surveillance and response systems, or ongoing public health campaigns (e.g., vaccination). |
| <ul style="list-style-type: none"> • Misclassification between stillbirth and neonatal death is common through community informants. | <ul style="list-style-type: none"> • Train community informants on how to identify and report stillbirths (8). • Explore different modes of data collection for births occurring outside of the health system, including pregnancy registers and mhealth innovations (11). |

Health worker competency, training, and supervision

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| <ul style="list-style-type: none"> • Difficulty in correctly classifying stillbirths, including those that are antepartum and intrapartum. • Lack of health worker training in HMIS competencies. • Inadequate technical skills and knowledge to complete MPDSR processes. | <ul style="list-style-type: none"> • Conduct and improve pre-service and in-service training on the importance of accurate recording and registering every birth and death, including stillbirths; timely newborn care, recognizing signs of life and neonatal resuscitation; recording fetal heart rate on admission; accurate gestational age assessment for both live and stillborn babies; build health worker skills to implement MPDSR processes; record stillbirths by antepartum/ intrapartum and not fresh/ macerated; socio-cultural norms regarding stillbirths, and communicating about the stillborn baby to bereaved women and families in a sensitive manner (11,17). |
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⁸The assumption is that a “macerated” stillbirth is when the fetus died more than 12 hours prior to childbirth and “fresh” less than 12 hours prior to childbirth. “Macerated” thus implies antepartum stillbirths and “fresh” intrapartum stillbirths. This classification does not match observed data and should be discontinued (24).

CHALLENGES

RECOMMENDED ACTIONS

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| <ul style="list-style-type: none"> • Misclassification resulting from stigma and fear of blame associated with stillbirths. | <ul style="list-style-type: none"> • Institute a health facility “No Name, No Blame, and No Shame” reporting process for stillbirths as outlined by WHO for MPDSR reporting (see MPDSR section above) (9,13). |
| <ul style="list-style-type: none"> • Length of time to fill out registers for busy health workers. | <ul style="list-style-type: none"> • Conduct health facility analyses of data recording roles and practices and data flows. Determine who should be responsible for data entry and allocate necessary resources. • Explore use of digital technology and mobile apps for recording and reporting stillbirths. |
| <ul style="list-style-type: none"> • Low motivation for HMIS tasks. | <ul style="list-style-type: none"> • Value health care workers’ routine data recording. |
| <ul style="list-style-type: none"> • Minimal supervision on how to fill out the registers and data quality. | <ul style="list-style-type: none"> • Provide supportive supervision to improve data quality. • Improve data quality through cycles of audit and feedback, comparing HMIS monthly reports to labor ward register data (18). |

Availability of resources

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| <ul style="list-style-type: none"> • Shortage of human and material resources at health facilities, including HMIS logistics. | <ul style="list-style-type: none"> • Ensure sufficient hardware for data entry, including paper registers, summary forms, computers, internet, servers, and power backup. Explore data collection systems that function in settings with intermittent or limited electricity (11). • Ensure functional and suitable digital weighing devices for every birth (19). • Explore innovations to improve the measurement of gestational age and birthweight (11). • Provide guidelines and job aids for weighing live and stillborn babies at birth. |
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Families/Individuals

- | | |
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| <ul style="list-style-type: none"> • Social and religious norms and stigma surrounding stillbirths and reporting of stillbirths. | <ul style="list-style-type: none"> • Provide improved communication between families and health care providers for improved care and reporting of stillbirths (20). • Provide bereavement support for families, communities, and caregivers affected by stillbirths⁽²⁰⁾. Conduct implementation research on this understudied topic in LMICs. • Address misreporting by raising awareness and public education about stillbirth to reduce the stigma experienced by women. Promote respectful maternity care agenda (16). |
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How can countries leverage the GFF partnership to improve stillbirth reporting and prevention?

Through a country-led process, there is an opportunity to improve the prevention and reporting of stillbirths in GFF partner countries. The list below captures areas where work is ongoing through the partnership and where future efforts could be focused.

RMNCAH-N investment cases

- Government and country platform stakeholders ensure that CRVS components for timely and accurate data on vital events, including stillbirths, are included in RMNCAH-N investment cases.
- MOH conducts assessments on stillbirth data sources.
- Government (or country platform) prioritizes activities to improve the availability, quality, and use of data on stillbirths in national reporting systems.

GFF Country Platform

- Stakeholders raise awareness of stillbirth reporting as a marker of poor maternal health and low access and coverage of quality antenatal and intrapartum care; the importance of stillbirth prevention; addressing stigma and blame associated with stillbirths.
- Government forms a group of champions in-country, including the private sector, who will advocate for stillbirth prevention and reporting at national and sub-national levels and reaching the ENAP stillbirth target of 12 stillbirths or fewer per 1,000 total births.
- Stakeholders develop an implementation plan that outlines the roles and responsibilities for implementation and accountability for results for the investment case.

Data for decision making

- Stillbirths are included in data reporting for the GFF data portal.
- GFF works with other development and financing partners in countries to adopt the same stillbirth indicators across all relevant health sector projects.
- GFF supports World Bank teams to include stillbirths prevented as an impact indicator in projects that support high-quality intrapartum care; stillbirth reporting in projects that support strengthened HMIS; and stillbirth inclusion in MPDSR where this is part of an M&E framework.
- GFF supports World Bank teams for the inclusion of stillbirths prevented as a disbursement linked indicator (DLI) or result (DLR) in Program for Results (PforR) operations, given that stillbirths are an indicator of poor quality of antenatal and intrapartum care and service delivery.

Health financing and health service quality

- Government and country stakeholders build on existing in-country health financing work to ensure adequate domestic financing to achieve the following:
 - a) Improve the utilization of facility-based health care services for antenatal and intrapartum care;

- b) Improve clinical practice and quality of services provided during antenatal care and labor and delivery; and
- c) Sustain the supply of quality RMNCAH-N products and technologies, including systems for demand forecasting and procurement for essential equipment (including infant weighing scales).
- In results-based financing (RBF) platforms, government and country stakeholders improve the quality of HMIS, including the reporting of stillbirths, through verification mechanisms and use disaggregated data (equity) for course correction every quarter.

Analytics, innovation, and implementation research

When requested by the Government, GFF and development partners can provide technical support to:

- Report and estimate stillbirth prevention potential.
- Ensure that guidelines and legal frameworks incorporate international stillbirth definitions and standards for measurement and reporting.
- Provide funding and technical assistance (TA) to identify and cost the scaled use of innovations (to address key constraints in identifying, recording, and reporting stillbirths at the community and health facility levels) (11, 21).
- Ensure that stillbirth indicators are integrated into existing reporting systems, including digital HMIS platforms; are interoperable; and are accessible at all health systems levels through dashboards with routine data review. Support, for example, can include:
 - Analyzing existing CRVS systems to identify gaps, including indicators (reporting of fetal deaths), birth and fetal death registration coverage, birth and death registration sites or reporting modalities, quality of birth and death registration data, submission mechanisms for vital registration records, and demand and utilization of CRVS data.
 - Assisting countries in strengthening existing CRVS systems to capture all life events, including fetal deaths; building electronic systems for sustainable and efficient delivery of CRVS services; and linking to other data-collection systems.
 - Providing TA for countries to change labor and delivery registers and HMIS-DHIS2 reporting systems to include recording gestational age, presence of fetal heart sound during labor, and birth outcome for each birth and death (2).
- Conduct in-country implementation research on interventions to standardize labor ward register design and improve register layout, column labeling, and cell coding to see whether it improves data quality (18).
- Conduct in-country implementation research to streamline HMIS data systems, including registers and case notes, to improve real-time decision-making (e.g., better classification of stillbirths) while reducing the documentation burden on health workers (3).
- Conduct assessment of the impact on quality of stillbirth reporting of a two-way data flow from the labor ward registers into the HMIS and with feedback returning to the health facility to strengthen health care workers' performance (18).
- While not the focus of this report, TA should not stop at improving the monitoring and classification of stillbirths but can also extend to responsiveness and stillbirth prevention. TA can include quality and respectful antenatal care and screening for infections; intermittent preventive treatment of malaria for pregnant women; and improved quality of care during birth, including the implementation of the 2020 WHO Labor Care Guide.



Conclusion

Many national data systems in LMIC do not record stillbirths, or the stillbirth data is unusable due to non-standard definitions, inaccurate classification, or underreporting. The 2020 Report of the UN IGME called stillbirths a “neglected tragedy” because they are unnecessary, unseen, unrecognized, underprioritized, and underfinanced (1,22). As a first step, stillbirths must be counted accurately. The GFF can support governments in improving stillbirth reporting and responsiveness through technical support for improved HMIS and explicitly addressing preventable stillbirths within co-funded projects.

Pregnant woman and a community health worker during a health checkup in Niger.
Photo: © Olivier Girard / The Global Financing Facility

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1818 H Street NW
Washington DC 20433
Telephone: 202-473-1000
Internet: www.worldbank.org

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