

## 5. PROGRAMME IMPLEMENTATION ALONG THE CONTINUUM OF CARE



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Awa Sonta sits on a bed at the regional hospital in Djenne District, Mopti Region (Mali). She is recovering from delivery complications that resulted in the stillbirth of her baby. She had experienced three days of painful labour before being taken to a rural health centre in the village of Mougna, 15 kilometres from her home, on a cart pulled by two bulls – the only transportation available. An ambulance then transported her from the health centre to the regional hospital. By the time she arrived, her uterus had ruptured, and the baby had died.

Ending preventable stillbirths and providing respectful and supportive care after stillbirth – including bereavement care and care in subsequent pregnancies – requires implementation of programmes across the continuum of care. This chapter outlines and describes strategies for, and essential elements of, such programme implementation. The chapter is structured around four action areas:

- ACCESS TO CARE
- LEADERSHIP
- INFRASTRUCTURE, EQUIPMENT AND SUPPLIES
- HEALTH WORKFORCE

Additional guidance for bereavement care, which was introduced in [Chapter 3](#), is highlighted throughout this chapter in orange boxes, as shown below. This structure has been adopted to convey the important message that bereavement care is not an optional or additional element, but a crucial component of the continuum of care for families whose baby is stillborn.

Throughout this chapter, look out for more guidance specific to bereavement care as signified by these orange boxes.

### Access to care

To prevent stillbirth, every woman must have access to health care from preconception through to the postnatal period. This requires the removal of physical, socioeconomic and cultural barriers to services. Ensuring access to care will help to achieve a “more than triple return on investment” [\(52\)](#): fewer newborn and maternal deaths, fewer stillbirths and improved child development and lifelong health.

## Six strategies along the full continuum of care

### STRATEGY 1: Strengthen community-based health systems and interventions

Community-based health systems bring services geographically close to women and help to remove other barriers to service.

#### WHAT YOU CAN DO:

- Engage formal and informal community-based providers as key allies in increasing demand for and supply of health services. Include Indigenous midwives, doulas, community health workers, traditional birth attendants, village health volunteers, community-based birth attendants and companions. These providers can help reduce inequities in access to care (55-57).
  - **Local level:** Facilitate communication between health facility staff and community-based health workers.
  - **Policy level:** Where appropriate, explore how to integrate traditional birth attendants into health systems, so they are better equipped to link women with formal health facilities and provide support. [This BMC article \(58\)](#) may help.
- Foster an enabling policy environment to strengthen integration of community-based providers into the health system.
  - **Mid-level:** Meet with community-based providers to learn what blockages stand in the way of their integration into the health system.
  - **Policy level:** Include community-based provider representatives in regular progress reviews and development of new, more inclusive policies. Systematically check in with community-based providers to assess the effectiveness of the improved policies.
- Invest in mobile clinics and outreach services. These services provide crucial links between the community and the health system, particularly in remote areas. See [Sharing what works](#).
- Engage community and religious leaders to foster demand for health care and stillbirth support groups, deliver key health messages and help reduce stigma and misconceptions about stillbirth.
  - **Local level:** Invite leaders to talk about stillbirth on public radio.
  - **Mid-level:** Identify influential leaders and include them in stillbirth prevention campaigns.
- Partner with parents and communities, learning how to collaborate with them, giving them a place at the table and ensuring the necessary power balance to co-produce meaningful, accessible programmes of work and services.

#### LEARN MORE

- Read about [community-based models to improve maternal health outcomes and promote health equity \(59\)](#) in the USA.
- Read about [community-based care to improve maternal, newborn and child health in low-income settings \(60\)](#).
- Review the [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings \(61\)](#).
- Read [about a study \(62\)](#) demonstrating an example of mobile outreach services for mothers and children in conflict-affected Afghanistan.
- Access the [WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes \(63\)](#).



## Sharing what works

In Kenya, community health volunteers work directly with households in their villages. They identify and refer cases as needed and educate women on services available, including Kenya's [Linda Mama \(Protect a Mother\) programme](#). This programme provides free basic maternity services and has improved health-seeking behaviour during pregnancy and birth.

→ [Read more about Linda Mama](#)

In addition, integrated mobile outreach services serve hard-to-reach communities through public–private and community partnerships, overcoming access barriers including inability to pay for transport and long queues at facilities. These services allow ministries of health and non-governmental organizations to collaborate to expand the reach of both types of partners to meet maternal health targets. Partnerships facilitate a holistic approach by filling service gaps or providing technical assistance where services are limited. Joint work planning is encouraged to ensure well-coordinated outreach. → [Read more about Kenya's mobile outreach services.](#)

### STRATEGY 2: Establish clear referral and escalation pathways

Pathways for referral and escalation (for when there is concern about an acute pregnancy complication) are crucial to minimize delays in connecting women with the services they need as quickly as possible. This includes linkages with specialist services that may be outside the scope of midwives' work, as well as transportation to enable implementation of these pathways.

#### WHAT YOU CAN DO:

→ Find out: Does your MOH have a quality of care package? Ensure that it includes a policy for referral and escalation. If not, help to develop one and support its inclusion in the package.

→ Strengthen referral linkages:

- **Local level:** Post, discuss and implement referral guidelines. If you cannot implement them, identify and report bottlenecks.
- **Policy level:** Ensure referral linkages are part of your quality of care policy.

→ Strengthen community-based transportation strategies and systems. Particularly when coupled with mobile-based interventions, these strategies and systems can reduce delays in care-seeking and increase facility-based care (see [Sharing what works](#)).

Asma Begum, a pregnant woman who goes to the hospital for health services–Bangladesh. Source: White Ribbon Alliance.



## Sharing what works

In Kenya, escalation policies are clearly integrated with health services. To reduce delays, most counties are strengthening public–private partnerships and reverse referrals (when the doctor moves to the referring facility for timely management of the complication). Some counties also have inter-facility (public to private) referrals (when the doctor moves with the patient to the new facility if the original facility lacks the necessary supplies or a functional operating theatre).

→ Watch [this short clip](#) and read [this newsletter article](#) for more information.

### STRATEGY 3: Develop a minimum package of health-care messaging for women

Ensuring that women know the services to which they have a right is key to increasing demand, improving quality of care and, ultimately, reducing stillbirths.

#### WHAT YOU CAN DO:

- Identify and integrate key messages into health education and health promotion packages delivered as part of bundles of care or through mHealth (see [Strategy 4](#)).
- Promote a self-care approach by ensuring women know what actions they can take to manage and support their own health (see [Learn more](#)).
- Be sure to integrate stillbirth-specific messages into health messaging. See [“Establish a narrative” in Chapter 4](#).

#### LEARN MORE

- When used appropriately, self-care interventions can increase access to care and improve health outcomes. The [WHO Guideline on Self-Care Interventions for Health and Well-Being, 2022 Revision \(64\)](#) includes self-care in the antenatal, intrapartum and postnatal periods and for family planning.
- The [Safer Baby Bundle](#) is a national initiative to reduce stillbirth rates in Australia. Read about how the Safer Baby Bundle was implemented in a regional Australian hospital in [Sharing what works](#).



## Sharing what works

The [Safer Baby Bundle](#) is a nationwide initiative in Australia incorporating five evidence-based elements to reduce late-gestation stillbirth rates. In Townsville, Australia, one of the greatest challenges the Safer Baby Bundle project team anticipated was relaying the important Safer Baby Bundle health messaging to the wider community. The Townsville Hospital and Health Service covers a very broad geographical area, including regional and remote communities. To ensure that the messaging was clear and consistent throughout the region, the team began with a local launch, including a parent with a lived experience of stillbirth, hospital public affairs and the State health minister. The launch was successful in reaching the wider Townsville community and promoting the Safer Baby Bundle. To aid implementation, the team sourced a TV for the antenatal clinic waiting room, which displayed educational content provided by the [Australian Centre of Research Excellence in Stillbirth](#). Other promotional materials were sourced, including banners, posters and magnets outlining the Safer Baby Bundle care elements. Promotional material was distributed to antenatal clinics and to women and their families. The launch and ongoing promotion of the Safer Baby Bundle created conversations around stillbirth, reducing the stigma of stillbirth and educating women and their extended families on how to reduce their risk.

→ [Read more about the Townsville Safer Baby Bundle launch](#)

### STRATEGY 4: Adopt innovative mHealth strategies to facilitate access to care

Innovative service delivery models including mHealth and other technologies can help to overcome key barriers to accessing care at the community level.



*mHealth is the use of mobile devices to improve population health, for example through delivering health messages, collecting health data, monitoring biomarkers or even delivering health care itself.*

### DATA HIGHLIGHTS

Stillbirth rates are highest among the poorest and most marginalized groups and in the most rural and remote regions (31). Even in HICs, **women from disadvantaged groups face at least double the risk of stillbirth when compared with more advantaged groups (65).**

### WHAT YOU CAN DO:

- Figure out how to integrate mHealth into the care provided in your setting (see [Sharing what works](#)).
- Adapt mHealth to provide information for and reminders to marginalized groups. Partner with leaders to ensure appropriate adaptation for these groups.

## Sharing what works

The Kenya MOH is progressively adopting a digital health platform that connects women with life-saving advice and referrals to care. Women receive reminders via bulk messaging about clinic days, pregnancy danger signs and actions required. These SMS prompts have driven key behaviour changes such as improved antenatal care attendance and uptake of breastfeeding, family planning and infant vaccination. Improved referral and triage of urgent cases has also occurred, connecting women and their babies who face life-threatening illness to the closest well-equipped facility.

### STRATEGY 5: Ask women what they want

Underpinning these first four strategies must be open dialogue with women about their experiences, needs and expectations in accessing care.

#### Bereavement care

Asking women and families what they want is crucial for respectful, supportive bereavement care (see [Sharing what works](#) for a case study related to seeing and holding the stillborn baby).

#### WHAT YOU CAN DO:

- Ensure women are treated as experts in identifying bottlenecks to accessing care as well as possible solutions. One way is to include women in reviews of draft policies.
- Use the White Ribbon Alliance [What Women Want](#) demands to guide priorities for service provision (see [Learn more](#)).
- Include women who have had a stillborn baby or newborn death in identifying ways to ensure access to care. Their voices and experiences can inform improvements to care, including ensuring care is respectful, both during and following death.
- [Contact ISA](#) to connect with women who have experienced stillbirth in your region.

#### LEARN MORE

- The White Ribbon Alliance [What Women Want](#) campaign asked 1.3 million women from over 115 countries to state their demands in relation to quality reproductive and maternal care. Their top five requests were:

1. **Respectful and dignified care**
2. Availability of water, sanitation and hygiene
3. Availability of medicines and equipment
4. Availability of midwives and nurses, and better support for them
5. Close, fully functioning health facilities



## STRATEGY 6: Address unconscious bias in interactions between health-care providers and women

A final key strategy for increasing access to care is addressing implicit bias among health-care providers.

Implicit bias occurs when unconsciously held beliefs and assumptions about race, social status, ethnicity, religion, age, sexuality or other individual characteristics influence one person's judgment of and interactions with another person. These potentially harmful beliefs and assumptions contribute to inequalities in health care that lead to worse health outcomes among specific populations (66). Such biases are not only held by individuals; they are also entrenched within institutions, manifested as institutional policies and practices that can result in lower quality and inadequate uptake of health services (67).

### WHAT YOU CAN DO:

→ Integrate learning about unconscious bias into institutional policies.

- **Local level:** Roleplay with health providers to learn how bias might affect treatment. Discuss your observations. [Introduce training.](#)
- **Mid-level:** Review relevant policies with representatives of marginalized populations to see how policies may inadvertently enable implicit bias. Brainstorm revisions.

### LEARN MORE

- Read about the [law in California](#) that addresses implicit bias in maternity care.



## Sharing what works

In LMICs, seeing or holding a stillborn baby is culturally inappropriate – is this true? An obstetrician's perspective in India.



A mother holds her stillborn baby in PGIMER Chandigarh, India. Her eyes have been concealed on request. Image shared by Bharti Sharma, Consultant WHO SEARO Project, Department of Obstetrics and Gynecology, with permission.

As an obstetrician working in a busy labour room, I never thought seeing or holding a stillborn baby would help a mother in coping. Memory-making in this situation seemed to be inappropriate – something that could exacerbate trauma. But increasing evidence has shown that seeing and holding a stillborn baby can be beneficial for bereaved parents. Due to limited evidence and huge burden in our setting, a stillborn baby is usually wrapped and handed to the family members. Decisions about the stillborn baby and mother are primarily left to the family; mothers are not usually involved. I recently cared for a woman who had a stillborn baby. When we asked the mother and her family directly whether they wanted to see or hold the baby, the family agreed. So, in place of wrapping the stillborn baby with a cloth, the baby was cleaned and dressed properly, as we do for a live born baby. After holding the baby, both parents were content and expressed their gratitude to health-care providers.

Since then, other women have agreed to see and hold, and spend quality time with, their stillborn baby. These mothers have taught me that the grief of a mother following a stillbirth is not country-specific: it is the same worldwide. Contact and quality time with a stillborn baby is powerful, and every parent – no matter where they live – deserves this opportunity. As health-care providers, it is our moral responsibility to provide such opportunities, and to respect the preferences of bereaved parents.



## Leadership

Good leadership fosters and catalyses efforts towards a common goal.



*Leadership brings people and resources together, inspiring and supporting and enabling people to achieve a common goal as a united team. Leadership is about empowering and serving others to a point where people develop an “ownership mindset” (68).*

### What does leadership for stillbirth prevention and support look like?

#### At the community level

Women who experience stillbirth are members of a family and of a community. Leadership at community level is therefore crucial for stillbirth prevention and care.

Community leaders can play an important role in disseminating health messages to community members and community health workers. Doing so empowers communities to demand access to health services and to quality and respectful care.

#### RESOURCE

- The White Ribbon Alliance [Power On: A Toolkit for Community Organizing \(69\)](#) can help guide community level action around health and health rights and respectful maternity care.



#### WHAT YOU CAN DO:

- Identify community leaders to [advocate](#) at various levels of care to ensure that no woman or family are left behind.
- Provide community leaders with health information as it relates to stillbirth prevention and care. See these [Australian Centre of Research Excellence in Stillbirth examples of stillbirth prevention information resources in various languages](#).



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Esther Achieng, the Village Health Team member (VHT) and mobilizer arriving at a homestead in Olibai village and using her megaphone to mobilize mothers and caregivers in the community to gather for the monthly immunization outreach.

- With community leaders, encourage women to attend antenatal care for the health and well-being of themselves and their babies.
- Consider establishing outreach clinics where they are not available (read more in [Access to care](#)).

#### LEARN MORE

- Leadership efforts must reflect an understanding of the structural determinants of health. Read about how [systems thinking helps solve challenges in global health \(70\)](#), including stillbirth.

## At the clinical care level

Mid-level leaders need to ensure appropriate deployment of midwives who are not only competent but also interested in providing quality and respectful midwifery care. Clear and consistent leadership and accountability can contribute to the reduction of stillbirths.

#### WHAT YOU CAN DO:

- Ensure that those caring for women along the continuum are educated, qualified and licensed to provide midwifery care. This requires training, supporting and enabling more midwives.
- Ensure that more experienced staff are always available to support less experienced staff.

#### LEARN MORE

- Increased leadership and accountability can save lives. [Read about the hospital in Zimbabwe \(71\)](#) that showed a reduction in intrapartum stillbirths following deployment of competent midwives and timely caesarean sections.

Effective leadership at the clinical level can facilitate stillbirth surveillance and response, as is done for maternal deaths. This means identification of stillbirth causes, contributing factors and practice changes.

#### WHAT YOU CAN DO:

- Promote collaboration among health-care professionals in maternity units and with women using the services.
- Promote openness among staff in relation to the concerns of parents and families. Give parents the option to be included in review at the health facility level of their baby's death (perinatal mortality review).
- Collaborate with educational institutions for pre-service skills development and continuing or in-service education, where deemed necessary based on surveillance.
- Monitor and evaluate quality of care. Use findings to inform practice change.

#### LEARN MORE

- Leadership should provide continuous and consistent support as well as positive, motivating feedback to health-care workers. [Read more about how investing in midwives and midwifery \(72\)](#) offers a cost-effective approach to reducing stillbirths and improving other maternal and newborn health outcomes.

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A social awareness meeting about maternal death, infant mortality, stillbirth and other health issues is conducted by the Ministry of Health and Family Welfare in Pirganj, Thakurgaon (Bangladesh) on 8 September 2014.



## At the policy level

To have an impact at the policy level, it is valuable to have a designated individual to provide overall leadership in stillbirth prevention and care.

### WHAT YOU CAN DO:

- Use your networks to identify an individual who is knowledgeable on maternal, newborn and child health issues, as well as government and non-governmental politics. This individual should be someone who has the capacity to forge collaborative relationships with local and international organizations, to pull financial and human resources together for greater impact.
- Educate them on your country's or region's stillbirth prevention needs. Brainstorm a list of policy asks for which to advocate.
- Again, ensure parents have a platform to share their stories; these stories can be very powerful in driving action at the policy level. Make sure to engage interested parents beyond storytelling, to help inform policy and practice through their expertise.

Finally, efforts to prevent or reduce the incidence of stillbirths will require advocacy. The designated leader's role is partly to ensure that the voices of advocates are heard. This includes the voices of relevant professional organizations, which represent the health workforce.

### RESOURCE

- This [Advocacy Toolkit for Midwives \(73\)](#), developed by the International Confederation of Midwives (ICM), includes information and guidance on advocating for increased resources for midwives, raising awareness about health issues, increased rights and protections for midwives and more.



### TIP

- A women's health ambassador can sit at the table of policymakers and push for strategies for stillbirth prevention and care.
- Read about the role and impact of the Kyrgyzstan chief midwife in [Sharing what works](#).



### REFLECTION

*Do you know of someone in your region or setting who has pushed for change in women's and children's health? What do you think it would take for them to also push for stillbirth prevention and care?*

### WHAT YOU CAN DO:

- Revisit [Chapter 4](#) for guidance on making an impact at different levels, including at the policy level.
- Use the resources and tips provided in the upcoming section on [Health workforce](#) to guide and support leadership efforts.
- Work to develop clinical care standards for your setting to show key areas for quality improvement. The [Australian Stillbirth Clinical Care Standard \(74\)](#) is one example, which describes 10 quality statements and seven indicators to reduce stillbirth and improve care following stillbirth, including in subsequent pregnancies.

## Sharing what works

In 2016, ICM worked with the Kyrgyz Alliance of Midwives (KAM), the Kyrgyzstan MOH and other stakeholders to introduce the [Midwifery Services Framework](#). Work plans were developed to strengthen midwifery education, regulation and KAM, including the appointment of a chief midwife by the MOH. Asel Orozalieva became the second chief midwife in 2022. The chief midwife promotes and supports midwives and midwifery in Kyrgyzstan by advocating for the profession politically at the level of the MOH of the Kyrgyz Republic. She is visible by her participation in conferences, workshops and seminars held by the MOH and other development partners. As a midwifery leader, the chief midwife has had a positive impact on relationships with development partners and stakeholders. She actively promotes midwives by nominating them for MOH awards. Since the role was introduced, there has been improvement of the regulatory and legal framework of midwives in the Republic. In 2018, the MOH approved competencies for midwives adapted from [ICM Essential Competencies of Midwifery Practice](#). The autonomous practice of midwives has improved in the regions where they independently provide services for the management of pregnancy, as well as childbirth and the postnatal period.

→ Read more about the Midwifery Services Framework in the [Health workforce](#) section at [Models of care](#).

## Bereavement care

Organizational support within a health facility helps to ensure quality of bereavement care by creating the necessary structures, processes and conditions across the health service that facilitate supportive and respectful care. Here is what health facility directors can do:

- Seek out relevant evidence-based policies, protocols and guidelines and make them accessible to all staff.
- Identify local champions to lead on the development and implementation of bereavement support initiatives.
- Advocate for all staff – including students and new graduates – to receive training to deliver best practice perinatal bereavement care.
- Informal and formal support mechanisms such as debriefing should also be available (see [Health workforce](#)). Promote clinical mentoring and supervision to build staff capacity and sustainability for high-quality care.
- Make available dedicated spaces for provision of bereavement care (see [Infrastructure](#)).
- Establish data-collection processes for monitoring quality of bereavement care.
- Establish local partnerships and referral mechanisms in the community (such as parent support groups).
- Identify and work with community leaders such as traditional leaders, women's cooperatives, parent organizations and religious groups.

Sónia Felizberto Camilo, 24 years old, is a mother of twins, Junito and Junior, who are 9 months old. The twins were born at the Ramiane Health Centre (RHC) after the construction of the new water and sanitation facilities. Their older children were born while these facilities did not yet exist and they were two very different experiences.



## Infrastructure, equipment and supplies

Infrastructure, equipment and supplies are required for stillbirth prevention and care. Fully resourcing health facilities to provide quality care along the continuum – including as part of stillbirth prevention and care – requires innovation, education, investment and political will.

### Infrastructure

Infrastructure needs for stillbirth prevention and care include (but are not limited to):

- Roads to facilitate access, referrals and supply delivery
- Electricity for functioning facilities and equipment
- Clean water supply for care provision
- Emergency medical services
- Established referral routes
- Pathology and diagnostic services

Ensuring that the required infrastructure is available requires a dedicated department(s) or organization(s) at the national level to be accountable for identification and prioritization of needs, as well as data collection and planning, implementation and maintenance of the infrastructure itself. The department must also have the authority to coordinate infrastructure needs with other government sectors and non-governmental organizations at national, district and local levels.

### REFLECTION

*Which government department is accountable for infrastructure needs related to stillbirth prevention in your setting? Is there more than one? How could you connect with someone at this department to plan for improvements?*

### WHAT YOU CAN DO:

- Collaborate with colleagues to identify local issues with infrastructure, equipment and supplies. [Try this problem-solving tool](#).
- Lobby (if you work at the **local** or **mid-level**) or secure funding (if you work at the **local** or **policy level**) to adopt new tools, technology and delivery strategies to extend the reach of the health service to overcome infrastructure shortcomings. The guidance under [Strategy 4: Adopt innovative mHealth strategies to facilitate access to care](#) in Chapter 4 may help.
- Promote collaboration between the different government ministries responsible for ensuring that stillbirth-related infrastructure needs are met:
  - **Local level:** Invite local authorities to a forum to discuss infrastructure successes and challenges.
  - **Mid-level:** Organize a round table of peers in other ministries to share feasible solutions to challenges in infrastructure provision.

### RESOURCE

- The [Ethiopia Health Sector Transformation Plan \(75\)](#) describes a five-year strategic plan to ensure the health system provides excellence in health service delivery, quality improvement and assurance, leadership and governance and health system capacity. Seek out and use existing documentation like this to inform infrastructure planning.

## Bereavement care

Key recommendations for the preparation of the physical environment for respectful and supportive bereavement care include identifying a dedicated space for delivering bad news and carrying out all discussions with parents. These spaces should be:

- Private and quiet
- Large enough for extended family/support people to gather
- Where appropriate, free of medical equipment or other materials that could be confronting or upsetting to bereaved parents (balancing emotional needs with any postnatal clinical needs)
- Conducive to unrushed and uninterrupted time for personalized care
- Separated from other families, either in separate rooms or, in low-resource settings, curtained-off areas

## Equipment and supplies

[Table 5.1](#) shows examples of critical equipment and supplies along the continuum of care. Whether it is cataloguing what is missing from this list and identifying bottlenecks or lobbying your peers to budget for availability of these essential supplies, you can take action no matter the level at which you work.

### RESOURCES

- Refer to the [Pregnancy, Childbirth, Postpartum and Newborn Care Guide for Essential Practice](#). Section L, “Equipment, supplies, drugs, and laboratory tests”, contains detailed lists of supplies for antenatal, intrapartum and postnatal care (76).
- The WHO guidelines on [intrapartum \(37\)](#) and [postnatal \(3\)](#) care may also be helpful. These guidelines contain main resource requirements tables with equipment and supply needs for specific interventions.



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Midwife Paulina Chepkumun of Kartita Health Centre III packing baby resuscitating equipment in the maternity ward. “UNICEF mentoring programme has meant a lot for me. I was trained, I now have the skill. I save lives of many babies. I used to try resuscitating a baby for 10 minutes then I would give up. Now I can do up to 40 minutes and the baby gets back to life” she said.

**TABLE 5.1:** CATALOGUING EXAMPLES OF EQUIPMENT AND SUPPLIES NEEDED ALONG THE CONTINUUM OF CARE

| WHAT'S NEEDED  | WHAT'S AVAILABLE | WHAT'S MISSING |
|--|------------------|----------------|
| <b>Preconception period</b>  |                  |                |
| Comprehensive family planning equipment and supplies   |                  |                |
| Supplies to facilitate diagnosis and treatment of non-communicable and sexually transmitted infections   |                  |                |
| <b>Antepartum period</b>   |                  |                |
| Supplies to enable dual testing for serious infections such as HIV and syphilis  |                  |                |
| Prophylactic medications such as iron and folic acid supplementation, calcium and aspirin  |                  |                |
| Blood pressure measuring equipment and urine dipstick to identify proteinuria  |                  |                |
| Other supplies depending on context and needs, such as mosquito netting, maternal vaccinations   |                  |                |
| <b>Intrapartum period</b>  |                  |                |
| Equipment for monitoring of maternal and fetal well-being  |                  |                |
| Birth kits with sterile cord clamps, bag and mask devices, partograph and neonatal suction tubing  |                  |                |
| Vital medications such as antibiotics, IV fluids, synthetic oxytocin and drugs to treat hypertension   |                  |                |
| Surgical equipment to facilitate caesarean sections  |                  |                |
| <b>Postpartum period</b>   |                  |                |
| Supplies and equipment for adequate postnatal physical assessment, including blood pressure cuffs, thermometers, infant weighing scales                      |                  |                |
| Medications and supplies for pain management, such as oral paracetamol and cooling packs, and life-saving medications such as antibiotics to treat infection |                  |                |
| Supplies for HIV and TB testing and iron supplementation   |                  |                |

HIV: human immunodeficiency virus; IV: intravenous, TB: tuberculosis

## Health workforce

High-quality care is founded on a competent, educated, motivated and well-supported health workforce. Health workforce strategies for stillbirth prevention and care along the continuum of care should cover staffing, training, models of care and support.

### Staffing

#### Along the full continuum of care

Availability of [skilled health personnel \(77\)](#) is key, including midwives, nurses, obstetricians, gynaecologists, paediatricians, anaesthetists, pathologists, allied health workers and others. Midwives are especially critical because they provide many services across the reproductive health and childbirth continuum.

#### RESOURCES

- Investments in nursing and midwifery are vital. [The State of the World's Midwifery 2021 \(78\)](#) highlights a global shortage of sexual, reproductive, maternal, newborn and adolescent health workers – mainly midwives. It outlines critical investments to ensure midwives can achieve their potential. Similarly, [The State of the World's Nursing 2020 \(79\)](#) highlights the case for investment in nursing education, jobs and leadership.
- Investing in midwifery means building an enabling environment. [Building the Enabling Environment for Midwives: A Call to Action for Policymakers \(80\)](#) sets out policies to ensure midwives can perform their full scope of practice with autonomy and accountability, while working in a safe, fair, well-functioning health-care system.

- Critical shortages of surgeons, obstetrician-gynaecologists and anaesthesiologists contribute to inadequate access to and quality of obstetric and surgical care in LMICs [\(81\)](#). The [WHO Global Health Observatory](#) tracks data on the numbers of licensed and qualified surgeons, obstetricians and anaesthetists actively working in countries.
- Bringing health-care workers to rural and remote areas can improve care in underserved settings. The [WHO Guideline on Health Workforce Development, Attraction, Recruitment and Retention in Rural and Remote Areas \(82\)](#) sets out key policies on education, regulation, incentives and support to build the rural and remote health workforce.
- Action in LMICs is a must. [Human Resource Strategies to Improve Newborn Care in Health Facilities in Low- and Middle-income Countries \(83\)](#) provides strategies to better equip health-care workers in LMICs to provide high-quality maternity care through national-level workforce policies.

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Dimple Ghetia is a Nurse practitioner Midwifery works with the midwife led labour room. She has also received supportive training by UNICEF. Location: PDU Civil Hospital, Rajkot, India.





## WHAT YOU CAN DO:

- Use the template in [Annex 8](#) to map relevant policies and recommendations against what is available in your own setting.

## Training

### Along the full continuum of care

All women and babies have the right to respectful and dignified health care, with no disrespect or abuse of women during pregnancy and childbirth. This requires training.



### RESOURCES

- The [RESPECT Toolkit \(84\)](#) includes practical guidance on how to run workshops to train health workers to provide respectful maternity care. These workshops can help health-care workers better understand what is meant by respectful maternity care (see [Box 5.1](#)) and how to respond to challenging practice situations.
- The March of Dimes training programme [Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare](#) offers specific education and training to better recognize and reflect on ingrained, harmful stereotypes and other implicit biases that reduce equitable care. Read more in Chapter 5 at [Strategy 6: Address unconscious bias in interactions between health-care providers and women](#).
- Provision of respectful care can be especially strained in fragile and humanitarian response settings. The Inter-Agency Working Group on Reproductive Health in Crises has developed the brief: [Approaching Implementation of Respectful Maternity Care in Humanitarian Settings \(85\)](#) with useful information and links.

### BOX 5.1: SEVEN RIGHTS OF CHILDBEARING WOMEN FROM THE [RESPECT TOOLKIT \(84\)](#)

1. Be free from harm and ill treatment
2. Information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care
3. Privacy and confidentiality
4. Be treated with dignity and respect
5. Equality, freedom from discrimination, equitable care
6. Health care and the highest attainable level of health
7. Liberty, autonomy, self-determination and freedom from coercion

## WHAT YOU CAN DO:

- Consider running a workshop on respectful maternity care in your setting.
- Incorporate implicit bias training and awareness into health provider training curricula.

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Mother, Uyalkan Abibila kyzy and father, Jamshidbek uulu Altynbek with their baby girl Tolgonay in the family yurta (tent), who survived a difficult birth thanks to the skilled intervention of an obstetrician and a midwife trained by UNICEF. Kyrgyzstan



## DATA HIGHLIGHTS

To be effective in stillbirth prevention, care providers must believe that it is possible to reduce stillbirth rates. [The Lancet Ending Preventable Stillbirths Series](#) showed that, even in HICs, **only around one third of care providers agreed with the statement “Many stillbirths are preventable” (65)**. Better education and training may combat providers’ fatalistic views about the inevitability of stillbirth. Success stories can also help reinforce the message that stillbirths can be reduced through improved care.

## WHAT YOU CAN DO:

- Identify a success story from your own setting and share it with colleagues in your network.
- Reach out to your network for success stories from their settings and consider how a similar approach could be implemented where you work.

## During antenatal and intrapartum care

Training and education on effective communication and teamwork is vital to promote and support well-functioning multidisciplinary maternity teams.

## RESOURCES

- [Each Baby Counts + Learn & Support](#) (EBC L&S) aims to improve clinical escalation practices through promoting excellence in teamwork and better communication. Three interventions – Team of the Shift, Teach or Treat and Advice Inform Do (AID) – aim to create a supportive workplace culture, enhance psychological safety among staff and reduce hierarchical decision-making.
- [PROMPT](#) programmes aim to reduce preventable harm to mothers and babies through practical obstetric multi-profession training. Training focuses on enhancing teamwork through improving communication, team roles and leadership and situational awareness.



## Sharing what works

Essential Steps in Managing Obstetric Emergencies (ESMOE) is a skills and simulation drills training programme implemented nationwide in South Africa. It was developed to train obstetricians to combat the high rate of maternal and neonatal morbidity and mortality in prevalent South African conditions. ESMOE aims to improve the quality of care for women suffering from obstetric emergencies, encourage best practice, retain skills and knowledge by building the capacity and confidence of health-care workers and achieve better maternal and neonatal outcomes.

→ [Read more about ESMOE](#)

## WHAT YOU CAN DO:

- Work with colleagues, health administrators and other key decision makers to promote effective communication and teamwork through evidence-based training.
- For specific clinical obstetric skills, implement context-based training sessions and drills (see [Sharing what works](#)).

## During postnatal care

Training to provide supportive and respectful bereavement care following stillbirth remains crucial. Providing sensitive, individualized physiological care and advice, including for lactation management, pain management and wound care, is also imperative.

As part of comprehensive best practice care following stillbirth or neonatal death, the [IMproving Perinatal Mortality Review and Outcomes Via Education \(IMPROVE\) workshop](#) includes training on management of physiological symptoms in the context of post-stillbirth care. Read more about the IMPROVE workshops in [Sharing what works](#).

## Bereavement care

Bereavement care is typically provided by nurses and midwives, especially in inpatient settings. Depending on the particular setting, obstetricians, community health workers and others may also provide bereavement care.

A list of formal bereavement care training programmes is provided in [Resources](#). Such programmes are typically available in high-resourced countries, but it is possible to adapt them for other settings.

## RESOURCES

- [Learn more about IMPROVE eLearning and workshops](#)
- [Read about Resolve Through Sharing Bereavement Training](#)
- [Access the SANDS UK stillbirth and neonatal death support training](#)
- [Visit the UK National Bereavement Care Pathway website](#)



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Kadiatu Sama, who has had no prenatal care and whose child was stillborn, is comforted by a woman nurse in the maternity ward of the government hospital in the southern town of Bo (Sierra Leone).

## Sharing what works

IMproving Perinatal Mortality Review and Outcomes Via Education (IMPROVE) is an interactive workshop providing training in best practice care following stillbirth or neonatal death, developed and run by the [Perinatal Society of Australia and New Zealand](#) and the [Australian Centre of Research Excellence in Stillbirth](#). The workshop is available to all relevant medical, nursing, midwifery and allied health workers (including ultrasonographers, social workers and others). Following a short introductory lecture, small groups of participants rotate around six learning stations – each facilitated by an experienced educator – before completing a formal assessment. The IMPROVE learning stations cover: communicating with parents about perinatal autopsy; autopsy and placental examination; investigation of stillbirths; examination of babies who die in the perinatal period; institutional perinatal mortality audit and classification; and respectful and supportive bereavement care (including breaking bad news and care in subsequent pregnancies). The workshop is aligned with the [Australia and New Zealand Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death](#), but it can be adapted for international contexts with the assistance of ISA. IMPROVE workshops have been run in sites across Australia, as well as in Fiji, Ireland, the Netherlands, Spain, Vancouver and Vietnam.

- [Learn more about IMPROVE eLearning and workshops](#)
- Read the [formal evaluation of the IMPROVE workshop by Gardiner and colleagues \(86\)](#)
- [Contact ISA](#) to enquire about setting up an IMPROVE workshop in your region

Even if you work in a setting where there are no formal bereavement care programmes, components of bereavement care can be implemented with minimal additional resources. These components include sensitive, respectful communication with parents, as outlined in the [Raising Parent Voices Advocacy Toolkit – India Providers' Version](#) (see [Box 3.1](#) and [Sharing what works](#)).

### TIP

- Develop local guidelines for communication, ensuring privacy of parents, enabling space for family and chosen support people, and respectful handling of the baby's body.
- No matter what your setting, offer opportunities to see and hold the stillborn baby and support parents' preferences (revisit [Sharing what works](#)).



## Sharing what works

In Uganda, a 30-year-old woman and her husband came for a 20-week check-up. This couple had suffered a miscarriage before and were notably anxious. They felt that things were not right. After bereavement care training, the nurse knew to listen carefully to what this couple was saying and to acknowledge their fears. She made eye contact with the couple and told them that we would do a thorough exam to see how the baby was progressing. Upon auscultation, no heartbeat was found. The parents began to cry. While she empathized with their pain, the nurse wanted to be truthful, and she told them that the baby had died. The couple continued to cry and she gave them some time alone. The nurse then discussed options about how to birth the baby, as well as other decisions to make. The nurse's training helped her to realize that being actively present, listening to and acknowledging concerns and communicating clearly and respectfully helped both the family and the nurse cope with this most difficult situation. Letting the family grieve, taking time and supporting the couple through decision-making empowered them to be active in caring for their baby. The nurse felt better able to cope knowing that she gave them the best possible care while supporting them as a family.

## Models of care

### During antenatal, intrapartum and postnatal care

Midwife-led continuity of care models – where a primary/named midwife is assigned to every woman from the start of the pregnancy,

coordinating collaboration with other health professionals when necessary (87) – are recommended by WHO from antenatal through to postnatal care in settings with well-functioning midwifery programmes (3, 30, 37). Evidence has shown specifically that women who are cared for under midwife-led continuity models of care are less likely to experience stillbirth and neonatal death (88).

## Sharing what works

In New Zealand, midwife-led continuity of care is the national standard of care with [93.5% of pregnant women booking with a midwife lead maternity carer](#). Midwifery care is publicly funded, largely provided in the community and supported by a nationally agreed referral guideline that ensures access to secondary and tertiary level hospital services when required. Because midwives are embedded in the community, they develop relationships with – and become known and trusted by – not just women, but often their extended families as well.

→ [Read more about continuity of midwifery care in Aotearoa, New Zealand](#)

## DATA HIGHLIGHTS

**Stillbirth rates among Indigenous women in Canada, the USA and Australia are 1.5–2 times higher than their non-Indigenous counterparts (89-91).** But in New Zealand – where midwifery continuity of care is the standard – **rates of stillbirth at 20 weeks' gestation or more among Māori women are similar to their New Zealand European counterparts (5.50 versus 5.15 per 1,000 births) (92).** These data are not readily explained by variations in social determinants of health, which raises the possibility that midwife-led continuity of care could be mitigating some of the adverse effects of disparity for Indigenous mothers in New Zealand. Read more in [Sharing what works](#).

## WHAT YOU CAN DO:

- If midwife-led continuity of care is feasible in your setting, start by increasing the number and quality of practising midwives in your region. Use the [Midwifery Services Framework](#) to help.
- If midwife-led continuity of care is not feasible in your setting, increase continuity through other care providers to improve quality of care.

## RESOURCES

- The [Midwifery Services Framework](#) serves as a tool to guide countries through the process of developing and strengthening their midwifery services.
- For a quick summary, watch [this video](#) describing the Midwifery Services Framework journey.

## Care in pregnancies subsequent to stillbirth

Specialist services, including multidisciplinary clinics, can offer an individualized approach to care in pregnancies subsequent to stillbirth, with medical and psychosocial care tailored to the unique needs of women and families (93).

## WHAT YOU CAN DO:

- If feasible in your setting, build a case for a dedicated service providing care in pregnancies subsequent to stillbirth. See examples of such services in [Learn more](#).
- If a dedicated service is not available or feasible, invest in training for individual health-care providers for pregnancy-after-loss care. The IMPROVE workshop is one example (revisit [Sharing what works](#) in the [Training](#) section).

## LEARN MORE

- Read about the [Rainbow Clinic](#) at St Mary's Hospital in Manchester, UK.
- Read about the [Stillbirth and Reproductive Loss \(STAR\)](#) and [Integrated Support After Infant Loss \(iSAIL\)](#) clinics in Melbourne and Sydney, Australia.
- Read about the [Subsequent Pregnancy Program](#) at Sunnybrook Health Sciences Centre in Toronto, Canada.



## Supporting the health workforce

### Along the full continuum of care

Supporting the health workforce requires global recognition of the importance of reproductive, maternal, newborn and child health and its role in shaping society at large.

#### WHAT YOU CAN DO:

- **Advocate** for appropriately respected and remunerated health service roles, with opportunities for continuing development and career progression.
- Carry out public awareness and education initiatives to communicate the importance of reproductive, maternal, newborn and child health and highlight career pathways.

### During antenatal, intrapartum and postnatal care

As described in [Chapter 1](#), the adverse psychological effects of stillbirth are felt by health-care workers as well as women and families (94). Failure to support health-care workers, particularly midwives as those providing social and emotional support to families (24), will exacerbate existing workforce shortages. Specific attention to individuals' well-being is also crucial.

#### WHAT YOU CAN DO:

- Promote a workplace culture that enables and supports self-care through modelling, education and training.

Remember, whatever level you work at and whatever the initiative, you can take action.

Examples include:

- **Local level:** Garner support from colleagues, work with community leaders and engage in formal [advocacy](#).
- **Mid-level:** Contribute to case-making and planning and advocate upward.
- **Policy level:** Lead in funding and policy development and lobby other ministers.

