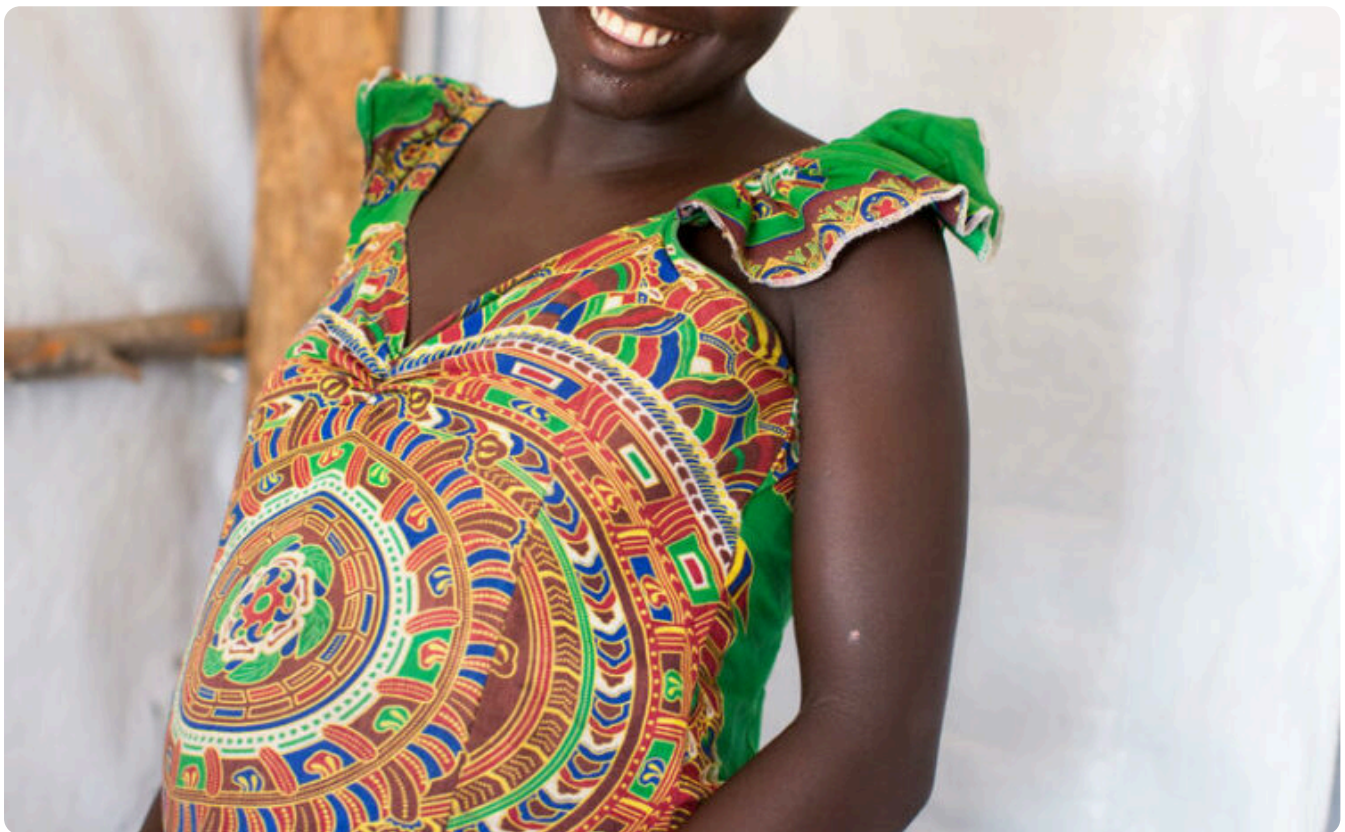


Aug 13, 2019

Stillbirths

Preconception Health: Stillbirth



17 years old Eva is seen by the EHU (Emergency Health Unit) midwife. This is her first baby. She fled South Sudan with her husband and arrived in Bidi Bidi Camp only three days before. Bidi Bidi camp holds 272,000 refugees out of a total of 780,000 South Sudanese refugees in Uganda. Nearly 60% of South Sudanese refugees are children. The Emergency Health Unit is treating children for some of the biggest child killers in the world like malaria, respiratory infection and acute watery diarrhea. It is also making sure children have their vaccines for diseases like polio and measles.

The placenta is a vital organ that develops during pregnancy to support the growth of the developing baby. Sometimes the placenta doesn't work as well as it should. The placenta may struggle to deliver all the oxygen and nutrients necessary to support the growing fetus. When its measurements are compared to other developing fetuses of the same age, a baby growing inside a mother with reduced placental function is smaller than its peers (called a fetal growth restriction or intrauterine growth restriction IUGR.) These babies are more likely to be **stillborn**, be born **preterm**, and face health complications after birth. (Gardosi, 2013).

A woman's health – before she becomes pregnant – can impact how her placenta functions during pregnancy. Mothers who are clinically obese when they enter pregnancy have higher rates of placental dysfunction than mothers who are not clinically obese when they conceive (Howell and Powell, 2017; Myatt and Maloyan, 2016). Mothers who conceive at age 35 or greater are also more likely to experience placental dysfunction (Lean et al., 2017). It is not surprising then, to learn that the top three modifiable risk factors for stillbirth in high income countries are maternal overweight/obese, maternal age greater than 35 and maternal smoking (Flenady, 2011). Globally, the top modifiable risk factors for stillbirth include maternal age, maternal infection, non-communicable disease like hypertension or diabetes and nutritional factors such as obesity or under-nutrition. (Lawn, JE, et al., 2016).

When the evidence is laid out like this, one can begin to appreciate that the most opportune time to prevent stillbirth is before a woman ever becomes pregnant. Very little can be done to change one's weight status or age after conception. However, when empowered to do so, a woman can plan or prepare for pregnancy. Equipped with knowledge, a woman can begin to take care of her health in preparation for a possible future pregnancy. Or, she may choose to plan for pregnancy for a time in her life when she is best able to support a healthy pregnancy.

Taking care of one's health in preparation for a future pregnancy is called preconception health. It is one of our most powerful tools for preventing adverse pregnancy outcomes, including stillbirth. Yet, most women are not equipped with the knowledge and power to make these decisions (Mitchell et al., 2010; Frey and Files, 2006). Most women prefer to receive this information from their healthcare provider, but fewer than half of health care providers discuss preconception health during routine appointments (Frey and Files, 2006; Goossens et al., 2016; Mitchell et al., 2013). We must do more to empower women to make informed decisions to support healthy pregnancy.

This post from a member of the Stillbirth Advocacy Working Group (SAWG) reflects the perspective of the author alone; it does not represent the views of the SAWG.

The Stillbirth Advocacy Working Group was founded by the Partnership for Maternal, Newborn and Child Health, and is co-chaired by the International Stillbirth Alliance and the London School of Hygiene & Tropical Medicine. Email co-chairs Hannah Blencowe or Susannah Leisher at hannah-jayne.blencowe@lshtm.ac.uk or shleisher@aol.com to learn more, or **[sign up to join the group here!](#)**

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