Bringing stillbirth out of the shadows for all women having a baby in Australia

Can Australia rise to the challenge of reducing the rate of avoidable stillbirths?

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doi: 10.5694/mja12.11139

The large, well conducted study by Drysdale and colleagues published in this issue of the Journal shows a 2.4-fold increase in the odds of late-gestation stillbirth for women giving birth in Australia who were born in South Asia, compared with women born in Australia.¹ The relative risk was most pronounced at 41 weeks' gestation, when there was a concerning fivefold increase. These findings concur with international studies and require careful consideration.

Stillbirth is a tragedy for women, their partners and their families and is an important, yet largely ignored, public health problem at a global level. High-income countries need to reduce avoidable stillbirth and inequity among women.^{2,3} The increased risk of stillbirth in some populations in Australia, specifically Aboriginal and Torres Strait Islander women, is well known. In 2009, perinatal mortality and stillbirth rates for Indigenous women were 18.6 and 12.9 per 1000, respectively, compared with rates for non-Indigenous women of 9.4 and 7.5 per 1000.⁴ This excess mortality can be largely explained by measurable factors associated with disadvantage, such as maternal medical conditions and smoking.⁵ However, without known risk factors coming into play and without data on the causes, the reasons for the increased risk in women born in South Asia identified by Drysdale et al are unclear. What factors could be driving this disparity?

Drivers of disparity lie deep within the roots of disadvantage, through lack of access to the essential commodities of education, adequate nutrition and appropriate health care. Antepartum stillbirth is a marker of disadvantage linked to the general health of women and quality of antenatal care. Women living in disadvantage in India have some of the highest stillbirth rates globally,⁶ and this disparity persists even after migration to Australia, raising the possibility of inequity in access to essential services.

Antenatal care is likely to be a key factor. Drysdale et al report that women born in South Asia have a higher proportion of small-for-gestational-age infants.¹ Small size for gestational age is a substantial contributor to stillbirth,⁵ and antenatal surveillance with appropriate timing of birth is the mainstay of management. Unfortunately, optimal approaches for detecting small size for gestational age remain challenging, and further research is needed. We agree with the authors that the lack of evidence for benefit of customised birthweight models,⁷ which aim to differentiate the "small sick baby" from the "small normal baby", currently precludes their routine use in antenatal care.^{2,8} A

key assumption of customised birthweight models is that ethnicity exerts a solely physiological effect on the size of the baby. However, as ethnicity is strongly associated with socioeconomic status (which is associated with adverse pregnancy outcomes), the use of customised birthweight models could result in more harm than good for some, by normalising the size of the small infant at increased risk.⁹

The 2009 report of the Maternity Services Review made 18 recommendations to improve maternity care, including improving services for vulnerable populations, developing practice guidelines and improving data collection.¹⁰ Drysdale and colleagues' findings support these recommendations. While a National Maternity Services Plan has been developed,¹¹ progress with implementation by federal and state governments is slow.

To reduce stillbirth, we need good data on potentially important factors, including ethnicity and other social determinants of health, such as access to appropriate health care. At the most basic level, we need accurate data on numbers and causes of stillbirths. However, data deficiencies are evident. For example, the Australian Bureau of Statistics (ABS) reports rates of stillbirth¹² almost two per 1000 lower than the rate reported in national perinatal statistics.⁴ Further, ABS data on causes of stillbirth (based on presumed cause at the time of death) give an overall proportion of unexplained stillbirth of around 40%, but this figure is more likely to be around 20%¹³ after thorough investigation and classification.¹⁴ Despite the availability of nationally endorsed guidelines, a lack of appropriate evaluation of the causes of stillbirth still plagues prevention efforts. In particular, autopsy, the gold standard for investigating stillbirth, is often not performed.¹³ Actual or perceived cultural differences in acceptance of postmortem examination will affect the ability to mount effective prevention strategies.

Recent initiatives from the Australian and New Zealand Stillbirth Alliance and the Perinatal Society of Australia and New Zealand to improve clinician education and data collection,¹⁵ as well as efforts of the National Perinatal Epidemiology and Statistics Unit to standardise perinatal mortality reporting, offer hope of improved data quality to better inform stillbirth prevention strategies. Such data are paramount in driving improvements in health outcomes for Australia's most vulnerable women, including Aboriginal and Torres Strait Islander women and those born in South Asia, and their babies.

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Competing interests: Vicki Flenady is a member of the Board of the Australian and New Zealand Stillbirth Alliance (ANZSA) and President of the Perinatal Society of Australia and New Zealand. David Ellwood is a member of the Board of the ANZSA and the current President (Chair) of the International Stillbirth Alliance.

Provenance: Commissioned; externally peer reviewed.

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