State of Africa's Stillbirths

AfricaCDC
Centres for Disease Control and Prevention

international stillbirth alliance

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Global Surgery

World Health Organization

Foreword: Director General, Africa Centres for Disease Control and Prevention

Every 30 seconds, a baby is stillborn somewhere in Africa. Behind each loss is a mother, a family, and a community whose grief is too often unseen, and whose tragedy is, in most cases, preventable. With nearly one million stillbirths each year, Africa bears more than half of the global burden. Yet stillbirths remain among the most invisible outcomes in our health systems, frequently undercounted, underreported, and overlooked in policy, planning, and financing decisions.

This invisibility is not only a moral failure; it is a health security risk. Stillbirths are among the most sensitive indicators of health system quality, equity, and resilience. They expose gaps in primary health care, weaknesses in emergency referral and preparedness, and failures in surveillance and data systems that are essential for learning, accountability, and rapid response. A health system that cannot prevent or count stillbirths lacks the foundational capacities needed to protect women, newborns, or communities, particularly during health emergencies. The *State of Africa's Stillbirths* report represents a critical step toward ending this silence. Anchored in African leadership and developed through a broad continental partnership (governments, UN agencies, civil society, communities, etc.), it is the first Africa-wide stocktake dedicated exclusively to stillbirths. It brings together evidence, country experiences, and the voices of affected parents to illuminate both the scale of the problem and the opportunities for action. The report shows that most stillbirths are preventable through evidence-based investments in strong primary health care, high-quality antenatal and intrapartum services, functional emergency obstetric and newborn care, and robust data systems. These investments not only reduce stillbirths and maternal and newborn mortality but also strengthen health system resilience, advance universal health coverage, and improve preparedness for future pandemics and emergencies.

Africa CDC's mandate under the Africa Health Security and Sovereignty Agenda, to build African-led resilience and reduce dependence on external systems, makes ending the invisibility of stillbirths not a peripheral concern but a core institutional priority. As the continent's premier public health institution, Africa CDC brings together the convening authority, technical expertise, and cross-border partnerships necessary to translate evidence into coordinated continental action. No other body is better placed to work with governments, harmonise data systems across borders, and ensure that the lessons of this report are embedded in national health plans and continental frameworks. As Africa advances its vision under Agenda 2063, preventing stillbirths is both a moral imperative and a strategic investment in Africa's health security, sovereignty, and collective future. I call on governments, partners, health leaders, and communities across the continent to use this report as a catalyst — to count every stillbirth, to invest in the systems that prevent them, and to ensure that no family's grief goes unseen or unaddressed."

H.E. Jean Kaseya
Director-General
Africa Centres for Disease Control and Prevention

Foreword: UNICEF, World Health Organization

Ending preventable maternal and newborn deaths and stillbirths is integral to achieving the global goals related to health, equality, and human rights. Through the Every Woman Every Newborn Everywhere (EWENE) Initiative, countries and partners have reaffirmed their shared commitment to ensure that every woman, every newborn, and every family receive quality, respectful care before, during, and after birth, without leaving anyone behind. This includes the EWENE 90–90–80–80 coverage targets, which set clear expectations for antenatal care, skilled attendance at birth, early postnatal care, and district-level readiness to provide emergency obstetric and small and sick newborn care.

Yet stillbirths remain insufficiently addressed within maternal and newborn health efforts. Despite the adoption of a global stillbirth target under the EWENE Initiative, progress has been uneven, and stillbirths continue to be inadequately reflected in policy priorities, data systems, and accountability frameworks. Strengthening data systems to guide evidence-based policies and programming is critical to closing this gap. This gap undermines the effectiveness of stillbirth prevention programmes and has adverse implications for the health, well-being, and rights of women and their families. Preventing stillbirths contributes directly to improving newborn survival and maternal health outcomes. This *State of Africa's Stillbirths* report contributes to a clearer understanding of why progress on stillbirth prevention has lagged and how it can be accelerated.

rather than advancing a single solution, it emphasises the importance of context-specific strategies that respond to countries' differing epidemiological profiles, health system capacities, and stages of development. Using the maternal, stillbirth, and newborn transition framework, the report illustrates how priorities must evolve from expanding access and basic quality of care to strengthening intrapartum services, surveillance, and accountability, and ultimately to addressing inequities and the experience of care.

This approach reinforces that preventing stillbirths is inseparable from improving the quality of care across the continuum of pregnancy and childbirth and from upholding the dignity and rights of women and families. Counting stillbirths, learning systematically from every loss, and providing compassionate bereavement care are essential elements of accountable health systems. UNICEF and WHO are committed to supporting governments in translating this evidence into action, ensuring that stillbirth prevention is fully integrated into national strategies, targets, and financing mechanisms. As the global community moves beyond the Sustainable Development Goals, progress for women and newborns will remain incomplete unless stillbirths are fully addressed. This report calls for renewed commitment to tailored, evidence-informed action—so that every pregnancy is valued and every loss is recognised.

Professor Mohamed Yakub Janabi
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Regional Office for Africa

Ms Etleva Kadilli
Regional Director, UNICEF Eastern and Southern Africa

Dr Hanan H. Balkhy
Regional Director, World Health Organization
Regional Office for the Eastern Mediterranean

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Regional Director, UNICEF West and Central Africa

Foreword: Parents

Across Africa, pregnancy begins as it does everywhere: with anticipation, preparation, and hope of welcoming a healthy baby. Families prepare their homes and hearts, and health workers prepare to support a safe delivery. Yet in many settings, stillbirth shatters that expectation. It leaves behind not only grief, but the realization that survival depends on whether families seek care in time, providers are supported to fulfill their roles, and health systems are responsive when complications arise.

As bereaved parents, members of the International Stillbirth Alliance (ISA) and Stillbirth Advocacy Working Group (SAWG) Africa, and part of the team that documented parents and health workers' experiences in this report, we recognize both the personal and public health dimensions of stillbirth. Its impact goes beyond the clinical management of labour and delivery. It extends to the silence and unanswered questions that follow parents and families home, and the realization that some of these losses were preventable. Parents and health workers from across the continent, though they never met, told the same story. Their experiences revealed gaps in care: missed warning signs, delayed referrals, inaccessible care, and limited bereavement care after loss.

Stillbirth prevention is a shared responsibility. Parents have an essential role in seeking antenatal care early, attending regular visits, promptly reporting any concerning changes to their provider, and planning for delivery with skilled birth attendants.

As parents do this, their trust in the health system must be met with care that is available, accessible, respectful, and effective. Health workers should be supported with the capacity, appropriate tools, continuous training, and enabling environments necessary to identify risks early, respond without delay, and prevent avoidable deaths. Respectful maternity care must also extend to comprehensive bereavement care, ensuring families experiencing stillbirth are treated with dignity, receive clear communication, and are effectively supported in their grief journey.

This first comprehensive report on the status of stillbirths across Africa presents information that can strengthen systems if acknowledged and acted upon. Every stillbirth represents a baby who was expected, and a family forever changed. We write this foreword in honour of those babies, parents, and health workers who shared their experiences, and in commitment to those yet to be born whose lives can be saved. We call on policymakers, health leaders, and partners to use this report in decision-making to take actions to reduce preventable stillbirths while better supporting families when loss occurs. The time to act, at scale and with urgency, is now.

Vivian Gaiko

Grace Mwashigadi

Nonkululeko Shibula

Linda Vanotoo

Affected parents
International Stillbirth Alliance (ISA)
Stillbirth Advocacy Working Group (SAWG) Africa

Acronyms

AI	Artificial Intelligence
ANC	Antenatal Care
CARMMA Plus	Campaign on Accelerated Reduction of Maternal Mortality in Africa Plus
CRVS	Civil Registration and Vital Statistics
DHIS2	District Health Information Systems 2
EmOC / EmONC	Emergency Obstetric (and Newborn) Care
ENAP	Every Newborn Action Plan
EWENE	Every Woman, Every Newborn, Everywhere
FP2030	Family Planning 2030
HMIS	Health Management Information System
IDSR	Integrated Disease Surveillance and Response
ISA	International Stillbirth Alliance
LMICs	Low- and Middle-Income Countries
MMR	Maternal Mortality Ratio
MPDSR	Maternal and Perinatal Death Surveillance and Response
NMR	Neonatal Mortality Rate
PHC	Primary Health Care
PNC	Postnatal Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBR	Stillbirth Rate
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN IGME	United Nations Inter-agency Group for Child Mortality Estimation

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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

An entity of the African Union

Safeguarding Africa's Health

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Executive Summary

Summary

Stillbirth is Africa's silent epidemic and one of the clearest indicators of health system failure.

Every 30 seconds, a baby is stillborn on the continent. In 2023 alone, nearly one million third-trimester stillbirths occurred across Africa - most are preventable. Countries cannot claim progress toward health security or universal health coverage while rates remain high and unexplained. Without accelerated action, five million stillbirths will occur between 2026 and 2030.

The State of Africa's Stillbirths Report **calls for urgent action to transform these losses into a catalyst for strengthening health systems and advancing Africa's health security and resilience.**

Why this report

Stillbirths are among the most sensitive indicators of health system performance. Africa's Health Security and Sovereignty Agenda aims to strengthen Africa's capacity to prevent, detect, and respond to health threats through resilient, self-reliant health systems. Stillbirths expose weaknesses in quality of care, surveillance, and emergency readiness, which are the same system capacities required to protect populations during outbreaks, crises, and routine care. Yet, stillbirth remains largely invisible in policy, financing, and accountability frameworks. This landmark Africa-led report provides the first continent-wide stocktake dedicated exclusively to stillbirths with a call to action, which was developed by more than 80 African experts from over 20 countries.

The Burden

Africa accounts for roughly half of the global burden of stillbirths, with nearly one million losses each year [1]. Half occur during labour, often within health facilities, signalling preventable failures in the quality of care at a period when risk is highest. Africa's intrapartum stillbirth rate is more than 40 times higher than that of Europe. While some countries have reduced stillbirth rates, progress has been slow. Africa experiences nearly the same number of stillbirths today as in 2000.

The Drivers

Stillbirths persist because women and families face avoidable medical conditions driven by cultural, social, systemic, and structural barriers to timely, high-quality care. Shortages of skilled health workers, limited emergency obstetric services, weak supply chains, and delayed referrals continue to compromise care. Policy, data, and implementation gaps are a challenge with only 44% of African countries reporting a national stillbirth target.

The Impact

Stillbirth causes cascading harm beyond the loss of a baby. It increases risks in subsequent pregnancies, contributes to long-term physical and mental health consequences for women and families, fuels burnout and attrition among health workers, and signals fragile health systems. Stillbirth incurs significant economic costs through lost productivity, increased healthcare needs, and reduced human capital, undermining broader social and economic development.

The Solutions

Preventing stillbirth protects Africa's human capital at the very start of life and strengthens resilient systems capable of responding to both routine health needs and emergencies. Up to 70% of stillbirths are preventable with existing interventions. Investments in quality care at birth — including skilled workforce, emergency obstetric and newborn care, intrapartum monitoring, and referral systems — simultaneously reduce maternal mortality, neonatal mortality, and stillbirth and improve developmental outcomes. Prevention strategies must be tailored to the country context and mortality level.

Pathways to progress

Ending preventable stillbirths is both a strategic investment in Africa's health, equity, and resilience and a moral imperative. The report calls for a continental shift from silence to accountability through five priority actions: commit, lead, and invest; strengthen health systems to deliver quality care; count, review, and learn from every stillbirth; centre families and communities; and tailor action to country context.

Call to action to 2030

Every Woman Every Newborn Everywhere Mortality Targets

Maternal mortality ratio
global average
<70 / 100 000 live births

Stillbirth rate
≤12 / 1 000 total births

Newborn mortality rate
≤12/1 000 live births

Every Woman Every Newborn Everywhere Coverage Targets

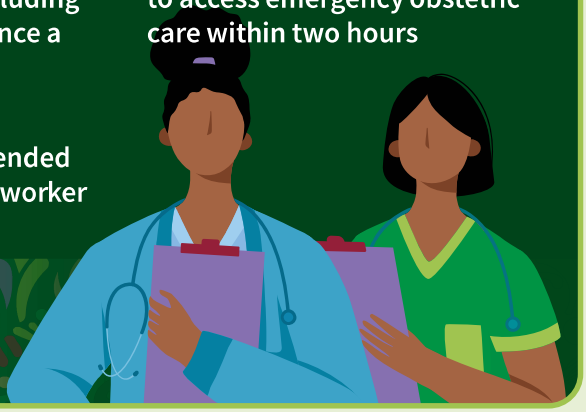
90% of women receive at least four or more antenatal care contacts

80% of women receive postnatal care, including those who experience a stillbirth

80% of the population is able to access emergency obstetric care within two hours

Universal access to family planning

90% of births attended by a skilled health worker



Priority Actions (2026–2030)

Commit, lead, & invest in integrating stillbirth prevention into national policies, budgets, and accountability mechanisms.

Capacitate the health system to deliver quality care in pregnancy and at birth with a skilled, supported workforce and functional referral systems.

Count, use & learn by turning one million losses into action through registration, review, and the systematic use of data.

Centre families and community by empowering parents, raising awareness, and ensuring respectful, culturally appropriate bereavement care.

Contextualise action by tailoring strategies to mortality phase to maximise impact and equity.

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Introduction

During pregnancy, there is hope and expectation for a new life, a new future, and healthy outcomes for mother and baby. Yet nearly one million families in Africa experience a stillbirth each year, a loss often hidden, uncounted, and unsupported [1, 2]. Behind every stillbirth is a mother who carried her pregnancy expecting life, a family left without answers, a community carrying grief that rarely finds a place in public discourse, and health workers forever impacted. These losses are not inevitable but rather signal urgent warnings about where health systems are struggling and where women and newborns are not receiving the care they need and deserve.

Africa's health security and sovereignty depend on the strength of national health systems to protect the most vulnerable, including women and newborns. Stillbirths expose critical weaknesses in service delivery, referral pathways, data systems, and emergency readiness, signalling gaps in system performance and preparedness. Reducing stillbirths is therefore central to Africa's health security and sovereignty agenda [3, 4], as it reflects countries' capacity to deliver quality care, generate and use their own data, and safeguard lives during both routine care and public health emergencies. Africa has a strong foundation of continental policy frameworks to support stillbirth prevention and improve maternal and newborn health through reproductive, maternal, newborn, child, and adolescent health (RMNCAH), universal health coverage (UHC) and primary health care (PHC) (Box 1) [5]. Anchored in Agenda 2063 and the Africa Health Strategy 2016–2030 and reinforced by global commitments, such as Every Women Every Newborn Everywhere (Box 2) [6, 7], there is political commitment to end stillbirth in Africa. The imperative now is to translate this commitment into coordinated, sustained action to improve access to and quality of care before and during pregnancy and at birth.

Box 2: Global stillbirth rate target

In 2014, 194 Member States at the World Health Assembly endorsed a target of reducing national stillbirth rates to ≤ 12 per 1,000 total births by 2030 and continuing to close equity gaps through the Every Newborn Action Plan (ENAP) [8]. This target is now included in the Global Strategy for Women's, Children's, and Adolescents' Health and supported by the Every Woman Every Newborn Everywhere (EWENE) movement. Learn more at ewene.org

Box 1: Key regional policy frameworks related to stillbirths in Africa

African Union Agenda 2063

Africa Health Strategy (2016–2030)

Abuja Declaration (2001)

Africa CDC agenda for Africa Health Security and Sovereignty (2025)

Continental Health Workforce Strategy

Maputo Plan of Action (2007, revised 2016)

CARMMA (2009) → CARMMA Plus (2021–2030)

AU Continental Sexual Reproductive Health and Rights Framework (2022–2030)

* Web Appendix *has a detailed mapping of continental policies with relevance to stillbirth*

Purpose and scope of this report

This report synthesises the burden, drivers, and consequences of stillbirth across the continent and identifies solutions based on evidence and priority actions to accelerate progress. It features specific country spotlights and lived experiences to exemplify and inform action by African governments and partners. The evidence draws primarily on published literature from Africa, identified through a desk review and expert consultation. The report aims to elevate awareness about stillbirths as a continental emergency and initiate consensus building on priority actions to address it. The report has five main sections to address key questions:

- The Burden: How big is the problem? What are the trends and variations?
- The Drivers: Why stillbirths happen?
- The Impact: Why stillbirths matter?
- The Solutions: What works to prevent stillbirths?
- The Pathways: How can countries accelerate progress?

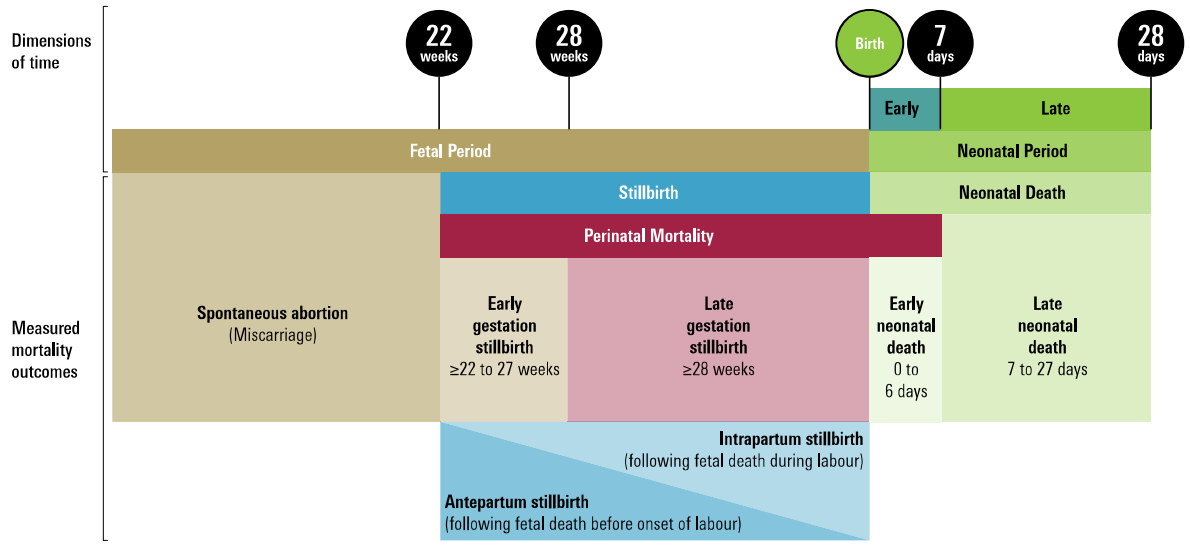
Box 3: Definition of stillbirth

All data presented in this report are restricted to late gestation stillbirths (≥28 weeks). This aligns with current UN reporting standards for international comparison, which is limited to late gestation stillbirths due to gaps in early gestation stillbirth data. Consequently, these numbers represent a significant undercount, masking the full scale of the stillbirth crisis across the continent.

According to the World Health Organization's ICD 11th revision, a stillbirth is a baby born following fetal death* at 22 or more completed weeks of gestation [9]. Stillbirths are further categorised as:

- Early gestation stillbirth (at 22 to 27 completed weeks of gestation)
- Late gestation stillbirth (at 28 or more completed weeks of gestation) (Figure 1).

Figure 1. ICD-11 definitions for miscarriage, stillbirth and neonatal death



Note: Fetal death may be diagnosed in utero by the absence of fetal heart sounds, confirmed by imaging techniques where available, or by the absence of signs of life after delivery or birth. Source: Blencowe et al. 2025. doi: 10.1002/ijgo.15794 [9]

Methodology

This report brings together available evidence and shares lived experience from across Africa to describe the burden of stillbirths, assess readiness for action, and identify priority solutions for prevention and care. It draws on multiple sources of evidence, including:

- **Review of existing evidence:** Published and grey literature on stillbirth burden, prevention, and measurement in Africa.
- **Analysis of stillbirth estimates:** National and regional stillbirth estimates were analysed to describe patterns and trends across countries [1].
- **Country data and policy review:** Surveys of stillbirth data systems and policy frameworks [2, 10].
- **Stakeholder consultations:** Consultations with 57 technical experts, policymakers, and parent advocates took place (September 2025 to February 2026) to contextualise findings and identify feasible policy and programmatic priorities.
- **Lived experience and country spotlights:** Testimonials from parents and health workers affected by stillbirth, and selected country examples identified through the literature and consultations, to illustrate challenges and opportunities for action.

This advocacy report focuses on key messages and policy implications. Detailed data, methods, and extended analyses as well as additional country spotlights and full testimonials are provided in the accompanying Web Appendix, accessible via hyperlinks throughout the report.

1. The Burden: How big is the problem

Every 30 seconds, a baby is born still in Africa.

Africa accounts for half of the world's burden, with nearly 1 million late-gestation stillbirths in 2023.

Progress has stalled as slow reductions in stillbirth rates have been offset by population growth, leaving the total number of stillbirths in Africa virtually unchanged.

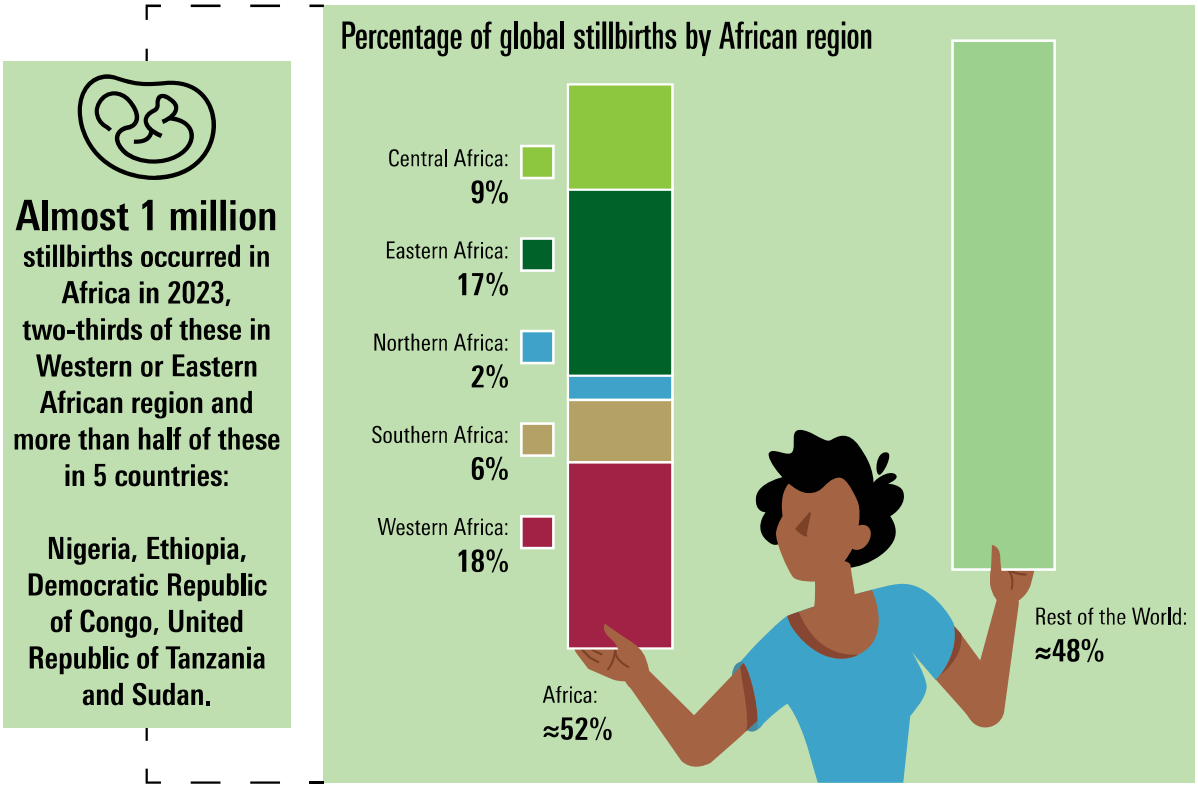
Numbers and rates of stillbirth

Globally, there were an estimated 1.9 million late gestation stillbirths (≥28 weeks) in 2023. Around half (990,000; 52%) of these stillbirths occurred in African countries. (Figure 2) Africa's rate of intrapartum stillbirth is 43 times higher than that of Europe [1]. Without accelerated action, an estimated five million stillbirths will occur between 2026 and 2030 (see Web Appendix for details). Global, regional, and country estimates are generated and published by the United Nations every two years (Box 4). Only 2 African countries have achieved the EWENE stillbirth rate target [11].

Box 4: Stillbirth country profiles

Did you know that you can access your stillbirth country profile? UNICEF produces stillbirth country and regional profiles for 200 countries, using the estimates published by the United Nations Interagency Group for Child Mortality Estimation (UN IGME). Country profiles provide easy-to-use snapshots and interactive visualizations of levels, trends, and progress toward EWENE stillbirth targets, along with projections of future reductions and key related indicators such as neonatal and maternal mortality. Access the profiles at: childmortality.org/profiles

Figure 2. Africa's contribution to global burden of stillbirth



Source: United Nations Inter-agency Group for Child Mortality Estimation (2025).

Trends–Stalled progress

Progress in reducing stillbirths is now stalling across Africa. Over the past two decades, modest reductions in stillbirth rates have been achieved, yet the rate remains high at 21 per 1,000 total births in 2023. The total number of stillbirths has not decreased because progress has slowed down, and declines have not kept pace with population increase. As a result, Africa experiences nearly the same number of stillbirths today as in 2000, around one million pregnancies affected each year (Figure 3). Africa must go 8 times faster in order to achieve the global stillbirth target, based on the annual rate of reduction between 2015 and 2023 [5].

Progress also varies across African regions. While some have achieved gradual declines, stalling and slow reductions in many regions mean the continent is not on track to meet global or regional targets. Without accelerated action, the burden will remain persistently high. Supporting data and extended analyses are available in the Web Appendix.

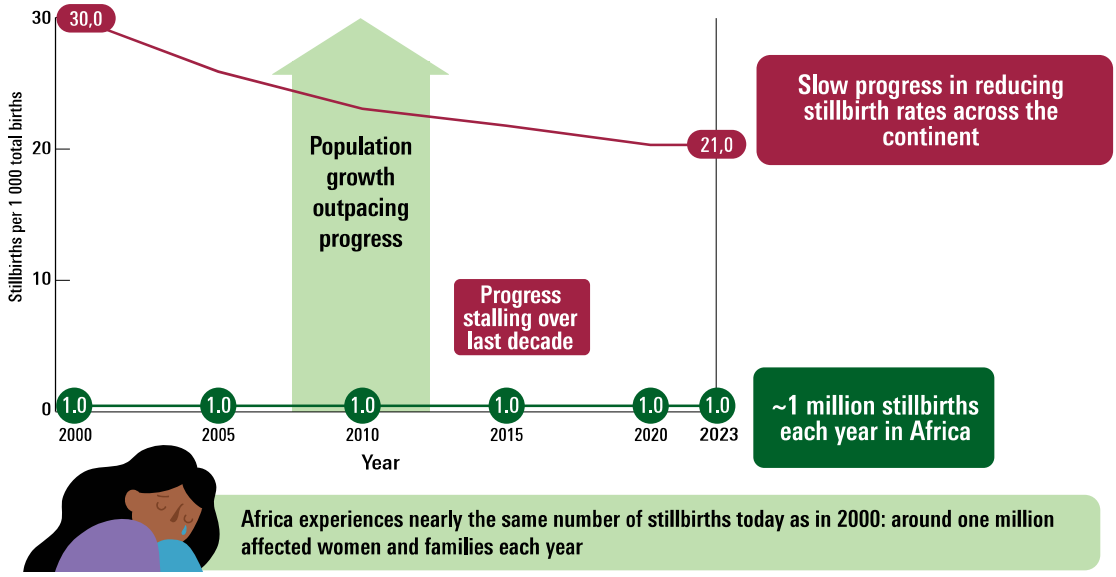
After 21 years as a midwife and hypnotherapist, stillbirth is the loss that never becomes routine.

Testimonial from Hanane Azouggagh, Morocco.
Access full testimonial.

Variation within Africa

Within Africa, stillbirth rates and trends vary widely across regions, countries, and within countries. The Central, Eastern, and Western African regions account for the greatest numbers (Figure 2). In terms of stillbirth rates, there is variation across the continent from 7.0 to 34.9 stillbirths per 1,000 total births, with lower rates typically seen in Northern Africa and the highest rates in Central and Western African regions (see Web Appendix for details). The World Health Organization (WHO) considers maternal mortality ratio (MMR), neonatal mortality rate (NMR), and stillbirth rate (SBR) together, given that their causes are closely linked [12]. **The Maternal, Newborn and Stillbirth Programmatic Transition Framework** classifies countries into five phases based on their combined mortality as a way to show the full burden and to identify priorities within each phase [12]. African countries are at different stages of the mortality transition (Figure 4), with most in Phases II and III, where mortality remains high to moderate. These settings need stronger, more integrated care around childbirth and better data systems to guide improvement. In contrast, North African countries such as Egypt, Algeria and Tunisia are in Phase IV, with much lower mortality and approaching international targets. No African country currently falls in Phase I (very high mortality) or Phase V (very low mortality). This variation underscores the wide disparities in mortality patterns across the continent and highlights the importance of understanding each country's context when interpreting progress. Within countries, subnational variations reveal major equity gaps.

Figure 3. Stillbirth rate and numbers in Africa, 2000-2023



Source: United Nations Inter-agency Group for Child Mortality Estimation (2025).

Figure 4. Maternal newborn stillbirth transition framework application to African countries

This figure shows the current phase of mortality transition for African countries. The transition framework uses cut-offs for maternal and newborn mortality and stillbirth to categorize a geographical unit (country or subnational region) into one of five phases. To move from one phase of transition to the next, thresholds for maternal mortality and newborn mortality and stillbirth need to be met.

Source: Special analysis conducted for this report using data from UN-IGME 2025 childmortality.org and WHO Maternal Mortality estimates 2025 and aligns with WHO transition categories [12]. Note: Maternal Mortality Ratio (MMR) per 100,000 live births; Stillbirth rate (SBR) per 1000 births; Neonatal mortality rate (NBR) per 1000 live births.

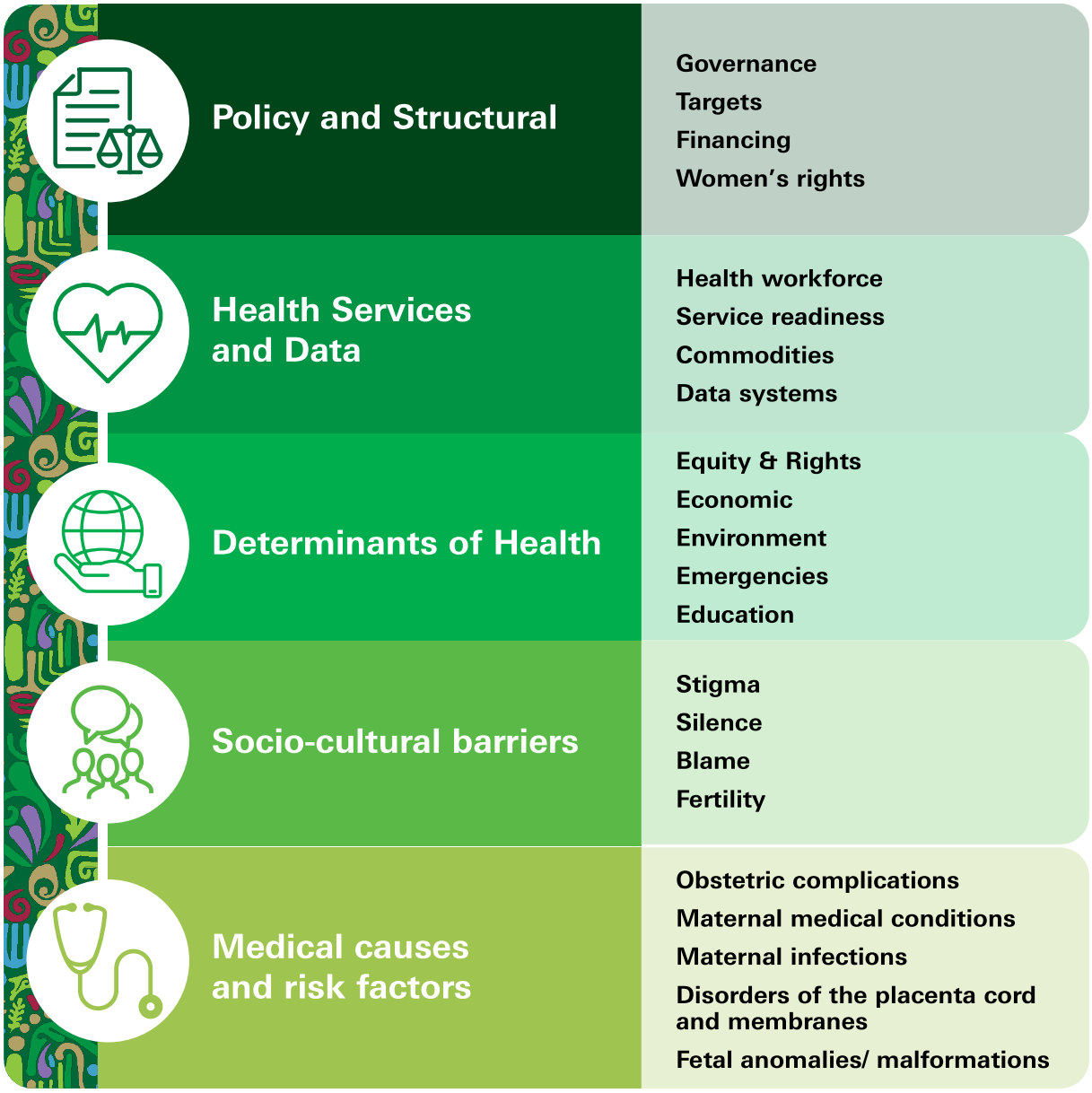
2. The Drivers: Why stillbirths happen

Stillbirths are not inevitable.

Stillbirths persist because women and families face avoidable medical conditions driven by cultural, social, financial, and structural barriers to timely, high-quality care. Nearly half of stillbirths occur during labour reflecting critical health systems failure.

Stillbirths in Africa result from interconnected, largely preventable factors operating across multiple levels—from medical complications during pregnancy and childbirth to social, health system, and policy determinants. Using a socio-ecological framework (Figure 5), this section explains how these layers interact to drive stillbirth risk.

Figure 5. Why stillbirths occur in Africa



Medical causes and risk factors

At the individual level, direct medical causes include:

Obstetric complications: e.g., prolonged/ obstructed labour, malpresentation

Maternal medical conditions: e.g., hypertensive disorders of pregnancy, gestational diabetes, anaemia, sickle cell disease

Maternal infections: e.g., HIV, TB, syphilis, malaria, Group B streptococcus

Disorders of the placenta cord and membranes: e.g., fetal growth restriction, antepartum haemorrhage/ placenta praevia, abruption, cord prolapse

Fetal anomalies/ malformations: e.g., anencephaly

Women of advanced maternal age, grand multiparity (≥5 births), long birth intervals (>3 years), with twin or high order pregnancies, malnutrition, obesity or a history of stillbirth or perinatal death are at increased risk [13, 14]. Stillbirths lack global cause-of-death data due to inconsistent classification systems, diagnostic variation, and omission from key reporting tools. Although, Africa is at the forefront in addressing these gaps (Box 4), this data gap directly hinders effective prevention strategies. Nearly half (48%) of Africa's stillbirths occur during labour (intrapartum stillbirths), signalling failures in timely management of complications. Though the proportion has declined since 2000, rates remain over 50% in Central and Western Africa (Web Appendix).

Box 5: Understanding Causes of Stillbirths in Africa: Evidence from the Child Health and Mortality Prevention Surveillance (CHAMPS), 2016-2023

The Child Health and Mortality Prevention Surveillance (CHAMPS) network uses standardised, post-mortem minimally invasive tissue sampling combined with clinical history, placental pathology, and fetal examination to investigate causes of child death and stillbirth across high-mortality settings. CHAMPS has ascertained causes of 2,087 stillbirths from sites in Ethiopia, Kenya, Mali, Mozambique, Sierra Leone, and South Africa [15].

A cause of death was identified for 94% of cases. Intrauterine hypoxia (69%) was the primary fetal condition, commonly associated with maternal hypertension (17%) or placental abnormalities (18%). Placental complications were present in around a third or more of stillbirths except in Ethiopia. Maternal medical conditions (40%) and congenital infections (28%), notably Group B Streptococcus and E. coli, were major causes in South Africa. In contrast, congenital anomalies were most prevalent in Ethiopia (24%), dominated by neural tube defects.

Expert panels determined that 72% of these stillbirths were preventable, primarily through improved antenatal and obstetric care. The CHAMPS approach provides a replicable framework for generating essential evidence to inform targeted interventions to reduce stillbirths across Africa.

48%

Nearly half of stillbirths occur during labour in Africa

Most of these are highly preventable

Socio-cultural barriers

Across Africa, cultural and societal perceptions profoundly shape how stillbirth is understood, experienced, and reported [16]. In many communities, stillbirth remains shrouded in silence, stigma, and spiritual significance. Cultural beliefs and practices, including associations with witchcraft, restricted burial rituals, and gendered taboos, shape responses to stillbirth, as reported by studies in Uganda, Kenya, and South Africa [17-19]. Stillbirth stigma remains pervasive and is often linked to gendered blame and secrecy [20, 21].

Health workers, too, are deeply impacted by stillbirth. Their psychological trauma, including burnout, shame, and fear, can compromise the quality of care they provide, increasing the risk of poor clinical decision-making, reduced responsiveness, and adverse outcomes for women and newborns [22, 23]. The growing body of African-led research on socio-cultural barriers related to stillbirth marks an important shift toward culturally sensitive bereavement and prevention strategies [22, 24].

"There is no heartbeat."

"Returning home without a baby was devastating. I was supported by family, friends, and community. Rather than withdrawing, I chose connection and allowed my grief to be witnessed and shared instead of carrying it alone.

Later, a second pregnancy ended in stillbirth and reopened wounds. Cultural blame and narratives questioned my choices and future, but we chose resilience and faith. Now I support others experiencing similar pain. Loss changes you forever, but it can also teach you how strong you are and how deeply connection and compassion matter when everything else falls away."

Testimonial from Melita Matenchi, parent, South Africa

Access more testimonials online

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COUNTRY SPOTLIGHT

Kenya: Strengthening bereavement care for parents after stillbirth

Kenya is strengthening bereavement care as part of respectful maternity and newborn services, with counties leading practical innovations to support families after stillbirth or neonatal loss. Structured bereavement care trainings build health workers' confidence and communication skills. Facilities designate bereavement champions who mentor colleagues and embed compassionate practices. Peer-support models are expanding, with civil society organisations like the TEARS Foundation Kenya broadening counselling networks. Kenya is seeing stronger collaboration between parent groups, professional associations, and government actors using Raising Parents' Voices tools.

Learn more: https://pmnch.who.int/resources/tools-and-toolkits/stillbirths-toolkit/kenya

Note: Stillbirth rate (SBR) per 1000 births; Neonatal mortality rate (NBR) per 1000 live births.

Determinants of health

Intersecting inequalities of gender, poverty, place, race, and power shape women's vulnerability and increase the risk of stillbirth [25]. Five intersecting domains together influence adverse birth outcomes, including stillbirth: **Equity & Rights, Economic, Environment, Emergencies, and Education** (the '5 Es') [26].

Equity & Rights: In many African contexts, women's social identity is defined through motherhood; when pregnancy ends in stillbirth, women may be blamed, silenced, stripped of motherhood status, and deemed "incomplete," deepening psychological distress and marital strain [17, 27, 28]. Ethnic and racial inequalities further limit access to respectful care and recognition, particularly for marginalised groups.

Economic: Poverty and gender inequality heighten stillbirth risk by limiting access to timely, quality care [29].

Environment: Climate change and pollution are rising but under-recognised contributors to increased stillbirth risk [30, 31].

Emergencies: Conflict, displacement, and epidemics disrupt maternity care and heighten stillbirth risk. Unfortunately, humanitarian responses seldom include stillbirth prevention or bereavement support, despite evidence of compounded trauma and stigma [32].

Education: Limited education compounds risks by disempowering women, enabling early marriage, and reducing access to care [33].

COUNTRY SPOTLIGHT

Zimbabwe and South Africa: Addressing Climate-Related Risks to Stillbirth Prevention

Rising temperatures are an emerging threat to maternal and newborn health, including stillbirth. Extreme heat during pregnancy increases risks of stillbirth, preterm birth, and hypertensive disorders through dehydration, inflammation, and reduced placental blood flow. Through the HIGH Horizons Project, Zimbabwe and South Africa are generating evidence on the effects of heat on pregnant women, newborns, and health workers. HIGH Horizons is testing heat-adaptation strategies, including low-cost facility cooling and MotherHeatAlert, a mobile app providing climate-health information. The complementary HAPI Project examines heat-adaptation interventions, positioning both countries as leaders in climate-related stillbirth prevention. Learn more: www.high-horizons.eu/

Health service and data gaps

Health service

Preventable stillbirths persist across Africa due to systemic weaknesses in health workforce capacity, service readiness, access to essential medicines and technologies, and fragmented data systems.

Health workers are central to stillbirth prevention and response, yet major gaps undermine their effectiveness. Many countries in Africa must at least double their midwifery workforce by 2030 and address the inequitable distribution of health workers across their populations [34]. Inconsistencies in competence and uneven application of the "skilled birth attendant" definition remain challenges [35]. Studies from Benin, Malawi, Tanzania, and Uganda have identified gaps in pre-service training, skills, and professional behaviours among midwifery care providers [36, 37]. Few health workers have training in bereavement care after a stillbirth.

Access to essential commodities remains inadequate in Africa, with only 22–40% of priority maternal medicines and 28–57% of child health commodities available across facilities, as reported in eight African countries [38]. Shortages of oxytocin, magnesium sulfate, antibiotics, medical oxygen supplies, and resuscitation equipment remain a major challenge [39].

Only half of the African countries have functional emergency transport systems and adequate facilities that provide basic or comprehensive emergency obstetric and newborn services [10]. A systematic review of studies from sub-Saharan Africa identified poor antenatal care quality, failure to use partographs, ill-equipped facilities, and delayed referral as direct contributors to stillbirth [13]. Expanding access to skilled birth attendance and midwifery-led care, reliable transport, and emergency obstetric care are essential to close this survival gap.

"I witness stillbirth as a daily reality—and one that is largely preventable."

At Muhimbili National Hospital in Tanzania, I witness stillbirth as a daily reality—and one that is largely preventable. Many women arrive in critical condition after receiving limited antenatal care and inadequate monitoring at lower-level facilities. One of the most challenging responsibilities is informing families of a stillbirth. Providing privacy, compassion, and time to grieve is essential, yet emotionally demanding. Unfortunately, structured emotional or professional support for staff is limited. There are no formal bereavement care protocols or routine debriefing sessions. Reducing stillbirths requires stronger referral systems, consistent resources, and standardised bereavement care training to support both families and health workers.

Testimonial from Jafari B. Lutavi, Midwife, Tanzania

Access more testimonials online

Data gaps

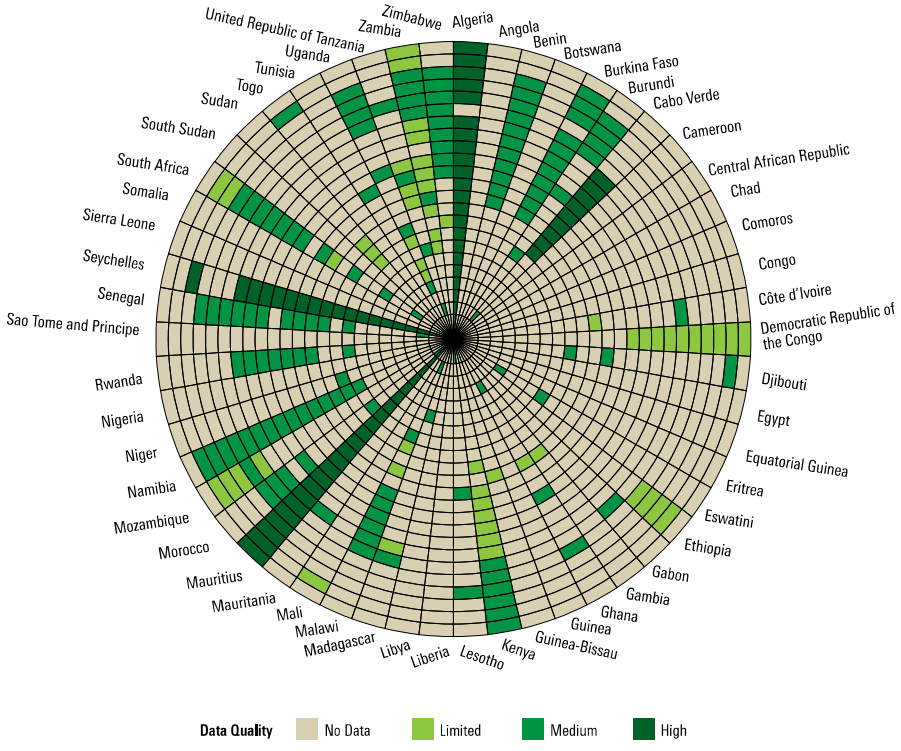
Reliable, timely, and disaggregated data are the foundation for action, yet stillbirths remain among the least recorded health outcomes in Africa. Most African countries do not currently contribute quality data to global databases, leaving major data gaps in understanding the true scale of the problem (Figure 6). Fragmentation across Health Management Information Systems (HMIS), Civil Registration and Vital Statistics (CRVS), and Maternal and Perinatal Death Surveillance and Response (MPDSR), alongside inconsistent definitions poor digitization of pregnancy and delivery outcomes, and limited nationally representative disaggregated data, prevents accurate counting and cause-of-death identification [1]. See the Web Appendix mapping of related data systems. A 2024 stillbirth policy survey of 33 African countries found although 82% (27/33) mandate the recording of stillbirths through laws or policies, only 17 include them in civil registration, 22 report conducting formal reviews, and 16 countries use a standard cause-of-death classification system [2]. Data use and feedback remain weak. While most African countries (81%, 39/48) record stillbirths in HMIS, only 26 have integrated stillbirth into MPDSR [10]. See the Web Appendix for a mapping of stillbirth-related data systems.

COUNTRY SPOTLIGHT

Nigeria: Strengthening Stillbirths Data Visibility and Use for Decision-making

To tackle the challenge of stillbirth data visibility, Nigeria has a national Stillbirths Dashboard developed by the Federal Ministry of Health and Social Welfare in collaboration with the IHVN-IRCE SPEED Project. The dashboard consolidates DHIS2 data across all 36+1 states, providing real-time insights for programme planning, budgeting, and rapid response. By making state-level trends publicly accessible, Nigeria has enabled health leaders to act on timely evidence. Dashboard analysis identified Zamfara State as having Nigeria's highest stillbirth rate (53 per 1,000 live births), prompting expansion of Helping Babies Breathe (HBB) neonatal resuscitation training to the state. Learn more: www.ihvnigeria.org/project-improves-nigerias-still-birth-data-access-use/

Figure 6. Available quality data for African countries in the UN Inter-agency group for child mortality estimations database



Note: The circle represents data availability by country for a certain year, beginning with 2000 (innermost circle) and ending with 2023 (outermost circle). Country-years are classified as having high data quality if registration data are available. Country-years are classified as having medium data quality if data are only available from sources requiring bias adjustments (i.e., surveys or HMIS). Availability of survey data is considered for the period over which the survey was conducted. Country-years are classified as having limited data quality if only population study data are available. Source: Special analysis conducted for this report using data from UN IGME 2025 childmortality.org [1]

Policy and structural

While 98% of African countries report including stillbirth prevention in national health strategies, a significant policy-implementation gap persists (Figure 7). Less than half of countries has set measurable targets and two-thirds have implementation plans for emergency obstetric care. Bereavement care is largely absent from national policy frameworks. Inadequate financing and systems readiness further undermine these policies. Additional policy and system readiness indicators related to stillbirth for Africa are available in the Web Appendix [98]. Furthermore, stillbirths are rarely mentioned and almost never tracked as outcomes in national RMNCAH investment cases and Global Financing Facility-linked World Bank projects for women, children, and adolescent health [41], and only 0.003% of global aid for women, children, and adolescents specifically referenced stillbirths between 2002 and 2019 [42]. Without greater visibility and targeted financing, political commitments on stillbirths will not translate into action or accountability.

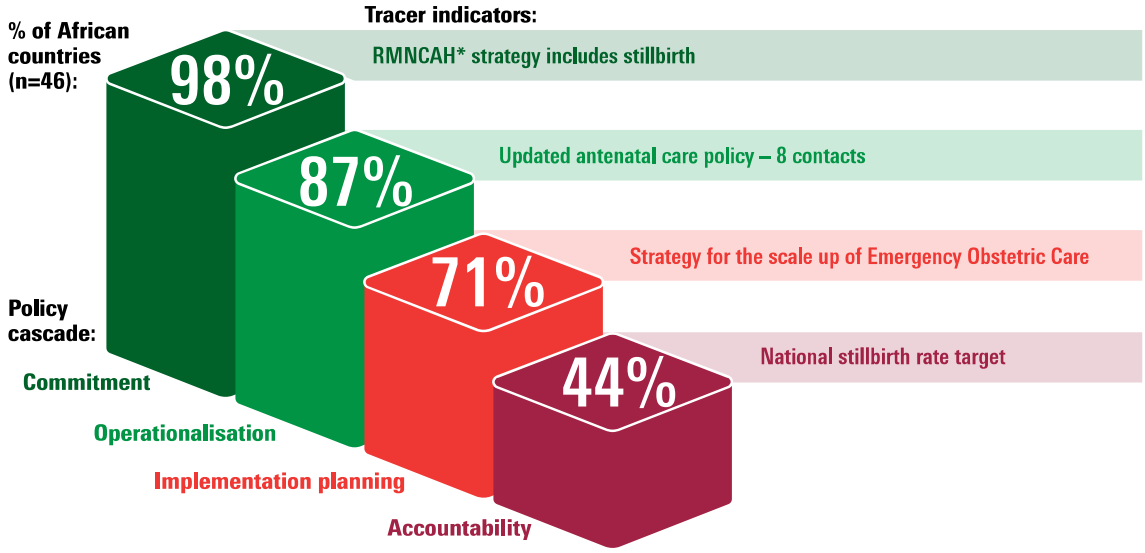
COUNTRY SPOTLIGHT

Namibia: Strengthening Governance Through Legislative Mandate

Namibia's Public and Environmental Health Act (2015) mandates the reporting of maternal, neonatal, and stillbirth deaths within 7 days, with confidential enquiries conducted by a National Committee. Death reviews began in 2010 and now cover all regions. The latest triennial report (2021-2024) shows that stillbirths far outnumber neonatal deaths, mainly occurring before labour onset despite antenatal care attendance. Namibia also has the e-birth notification system, which digitizes all delivery outcomes and has improved reporting and accountability.

Challenges include limited review capacity; only 30% of submitted stillbirth files are reviewed nationally, and there were misclassifications between miscarriages and stillbirths. Priorities include aligning data practices with international guidelines and strengthening private sector engagement in reviews.

Figure 7. The stillbirth policy accountability gap in Africa



This figure shows the stillbirth policy-to-implementation cascade across 46 African countries using four tracer indicators. While most countries include stillbirth prevention in national RMNCAH strategies, progressively fewer report updated clinical guidance, scale-up strategies, and measurable national targets, highlighting a critical gap between policy commitment and accountable implementation. Note: RMNCAH – Reproductive, maternal, newborn, child, and adolescents health

Source: Special analysis using EWENE-CSA data tracking from 46 countries in Africa, year 2025-26. Additional policy indicators for Africa can be found in the Web Appendix

No family should survive loss and be abandoned by the system meant to care for them.

In 2016, I lost my daughter Tyrah to a cord prolapse. No doctor was available. The emergency was poorly managed. I bled so severely I needed a transfusion. Afterward, I was placed in a ward full of mothers with live babies; no counselling, no explanation, no compassion.

In 2017, my daughter Tiffany was born prematurely at 35 weeks in a hospital without enough facilities to save her. She lived 37 hours. Again, I was surrounded by newborn cries that deepened the trauma and later discharged without support. There was no follow-up. Cultural stigma added to the pain, "it's a curse," people said. My husband grieved too, but his pain was invisible. He was told to "be strong" and had no space to mourn. In 2024, our son Oliver was born alive and healthy, a new chapter of healing and hope. Today, through the Empower Mama Foundation, we advocate for trauma-informed care, respectful maternity services, and support for fathers' mental health. No family should survive loss and then be abandoned by the system meant to care for them.

Hannah Mwangi and Leonard Nango'le, Kenya
Access more testimonials online.

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3. The Impact: Why stillbirths matter

Stillbirths are a hidden burden and impose profound emotional, economic, and health costs on families, health workers, and communities that remain largely uncounted and unaddressed.

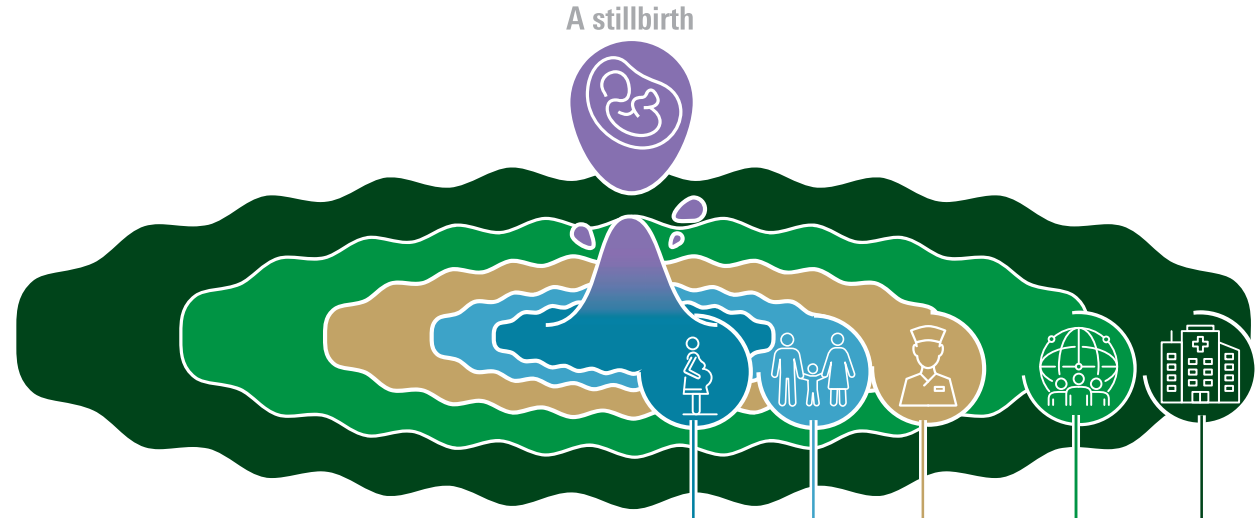
Persistently high stillbirth rates signal weak health systems and limited capacity to withstand shocks, emergencies, and pandemics.

Stillbirths carry significant economic costs through lost productivity, increased healthcare needs and reduced human capital, undermining broader social and economic development.

A continent-wide burden

Nearly one million stillbirths occur in Africa each year, generating profound social, emotional, and economic costs that extend far beyond the loss of a baby. These losses affect women, families, health workers, and entire communities—and quietly undermine trust in health systems. [43]. Stillbirths generate cascading costs that extend far beyond individual loss, undermining health system performance, workforce stability, public trust, and national preparedness for health shocks.

Figure 8. The ripple effects of stillbirth



Mother
Psychological and emotional distress, physical complications, including risk in future pregnancies, isolation, stigma, and financial hardship

Father and Family
Psychological and emotional distress, caregiving and economic burden, strained family dynamics

Health Workforce
Moral injury and burnout, increased workload and stress, staff attrition and retention challenges

Health System
Increased healthcare costs, unnecessary interventions, inefficient use of limited resources, exposed system quality gaps, reduced service readiness and response

Society
Lost productivity and human capital, eroded trust in health services, collective trauma

Women and families

For African women and families, stillbirth is a profound personal tragedy and a social crisis. Women frequently experience stigma, isolation, and abandonment, particularly in settings where social status is closely tied to motherhood [17, 44]. An estimated 60–70% of women experience depressive symptoms after stillbirth, and at least 30% develop intense grief reactions, increasing their vulnerability to chronic anxiety, depression, and post-traumatic stress disorder [45].

The social and emotional impacts are often compounded by physical comorbidities associated with traumatic birth, including increased risk of post-partum haemorrhage, infection, obstetric fistula, and uterine rupture [46]. Gender norms that equate a woman's value and social identity with childbearing mean that when pregnancy ends in stillbirth, that identity may be questioned. Women may be viewed as "incomplete", blamed for the loss, stripped of motherhood status, and silenced, which deepens psychological distress and marital strain and can worsen household economic security [17, 27]. Recognising bereaved women as mothers—through rituals, language, and respectful bereavement care—restores dignity and mental wellbeing [47].

Health workforce

Stillbirth in Africa is also associated with a severe, yet often invisible, toll on health workers. Clinicians experience profound psychological distress, including guilt, sadness, and burnout, which is exacerbated by a lack of training and systemic support [22, 48]. Operating within a culture of blame and fear of litigation, they are left traumatised and unsupported after a stillbirth. This occupational crisis threatens workforce retention and undermines the capacity to provide compassionate, quality bereavement care, making staff support a critical component of improving maternal health outcomes.

Breaking the news of a stillbirth never gets easier. Parents want answers we don't always have. There is little formal training in bereavement care. Most of what I learned came from experience and from colleagues.

Bereavement care should be included in medical and midwifery training.

Dr. Nafissa Osman, Mozambique

Access more testimonials online.

Wider society and health security

Persistently high stillbirth rates are incompatible with claims of health security. The same system failures that lead to stillbirth—poor monitoring, delayed referral, lack of blood, oxygen, and surgical capacity—undermine outbreak detection, emergency response, and pandemic preparedness.

Maternal and perinatal outcomes are among the most sensitive indicators of system strength; when stillbirth rates remain high, health system resilience is already compromised [49].

4. The Solutions: What works to prevent stillbirths

Preventing stillbirths strengthens the whole health system and yields multiple returns on investments: fewer maternal and newborn deaths, healthier child development, and stronger health system resilience, security, and pandemic preparedness.

The solution to stillbirths is quality care for all women—before and during pregnancy, and at birth—delivered by competent, capacitated teams within strong, accountable health systems.

Solutions to strengthen the whole health system

Preventing stillbirths is a powerful lever for strengthening health systems and accelerating progress across reproductive, maternal, newborn, and child health. It represents a high-return efficiency gain rather than a new cost—reducing avoidable emergency spending, protecting household productivity, and preserving future human capital. Investments in high-quality antenatal and intrapartum care shift health financing from expensive crisis response to lower-cost prevention, improving fiscal sustainability and economic resilience.

Returns on these investments are multiple and reinforcing: improved survival, prevention of stillbirths, reduced disability, healthier early child development, and stronger health system resilience, security, and pandemic preparedness (Figure 9) [49]. Critically, governments can unlock greater and more measurable gains from service delivery improvements by counting stillbirths as part of the national burden of disease, strengthening accountability and ensuring that quality-of-care investments are prioritised where they deliver the greatest impact.

Table 1 outlines the core health system levers governments can act on immediately to prevent stillbirths. These actions are feasible, affordable, evidenced-based, and align with existing national, continental, and global health commitments.

After my baby was born dead, what I fear most is becoming pregnant again

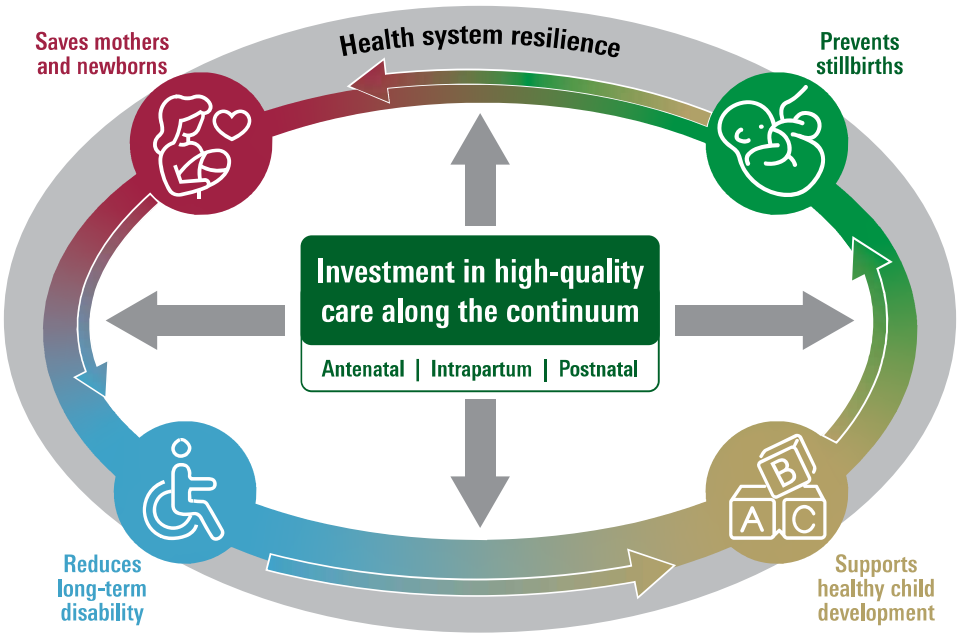
In 2024, I became pregnant again after my 10- and 8-year-old, and I was full of joy at the thought of welcoming another child into our family. I worked in Obo, a remote town in eastern CAR. My husband thought it would be safer for me to relocate to Bangui to give birth because of better medical care. I went into labour late at night. My sister rushed me to the nearest maternity facility, but the midwives said they could not manage my complications. Because of delays waiting for an ambulance, I only reached the main hospital the next day at noon. My baby was already gone. No one told me until evening. I cried until I had no strength left.

The loss followed me home. For three months, I bled constantly, struggled to walk, and often felt paralysed. My husband blamed me for the loss and left. I eventually found a new job and attended some counselling, but the sadness still weighs heavily on me. I never saw my baby alive. I keep a photo of his lifeless body on my phone, but I still cannot bring myself to look at it. What I fear most now is becoming pregnant again.

Testimonial from Bousseina Fotor, parent, Central African Republic

Access more testimonials online.

Figure 9. Preventing stillbirths strengthens the whole system



The diagram depicts how investing in and strengthening quality care across antenatal, intrapartum, and postnatal periods generates multiple reinforcing benefits, including fewer stillbirths, improved maternal and newborn survival, better child development outcomes, and stronger health system resilience.

Table 1. Strengthening health system levers for stillbirth prevention

System levers	What's needed for stillbirth prevention and bereavement care
1. Leadership and Governance	• Strengthen prioritization, planning and resource allocation for maternal and newborn health within national development plans [50] • Mobilise political, professional, and community champions to increase demand for skilled care and accountability [20, 50, 51] • Promote the societal value of the mother–baby dyad
2. Service Delivery	• Strengthen access and quality along the continuum of care, with particular emphasis on quality intrapartum care and timely decision-making • Invest in service delivery models that optimise access and quality within the respective healthcare system with reliable referral systems [52] • Ensure access to 24/7 delivery and emergency obstetric and newborn care [53-55] • Provide respectful and compassionate care after pregnancy loss [22, 24, 47]
3. Health Financing	• Remove or reduce user fees for maternity care [56, 57] • Allocate domestic funds for essential drugs, supplies, and referral transport [38, 50, 58] • Track domestic and external financing for maternal and newborn health, including stillbirths [41, 59] • Social protection measures, such as cash transfers, maternity entitlements, and bereavement benefits [56, 60]
4. Health Workforce	• Train, deploy, and retain midwives and nurses [14, 53] • Develop sustainable healthcare teams deploying the most appropriate mix of specialist care, task-shifting and task-sharing to make best use of resources [52, 57] • Strengthen midwifery-led models of care and community health worker networks to link families with care [51, 61] • Equip health workers in bereavement care, and embed supportive organisational cultures and processes, including debriefing mental health support [13]
5. Access to Essential Medicines, Vaccines, and Technologies	• Strengthen supply chains and maintenance of essential equipment [38] • Introduce context-appropriate technologies that improve early detection and response • Ensure consistent availability of life-saving commodities (e.g., uterotonics, antibiotics, blood, fetal monitoring devices)
6. Health Information Systems	• Count and register every stillbirth in routine health information systems [2] • Strengthening interoperability across multiple data systems such as CRVS, HMIS, IDSR, and MPDSR platforms • Use data for learning, quality improvement, and accountability at all levels • Conduct regular stillbirth reviews to identify modifiable factors

What stands out most to me is that many stillbirths we see are preventable.

The leading causes are conditions we understand well and are manageable, yet outcomes remain poor because of inadequate capacity to diagnose and intervene, especially at lower-level facilities. Delays in seeking care can determine whether a baby lives or dies.

Ultimately, what remains clear to me is that adherence to protocols dealing with the causes of stillbirths, strengthening client education about these causes, and the need to report early to hospitals will reduce preventable stillbirths.

Testimonial from Dr. Benedict Affare, Obstetrician Gynaecologist, Ghana

Access more testimonials online.

COUNTRY SPOTLIGHT

Morocco: Expanding Access Through Free Maternal Healthcare and Women's Empowerment

Morocco achieved dramatic improvements through policy reforms and expanded access to services.

The country removed user fees for delivery care, including caesarean sections, and upgraded public facilities. Antenatal care coverage surged from 9.4% to 60.9% receiving at least four visits, while institutional delivery tripled from 28.3% to 86.1% between 1992 and 2018. Removing financial barriers while strengthening services drove substantial maternal and perinatal mortality reductions, including stillbirths.

Learn more: www.exemplars.health/topics/neonatal-and-maternal-mortality/morocco/what-did-morocco-do

Solutions through existing platforms

Global, continental, and national initiatives already provide strong entry points for action. By explicitly integrating stillbirth, governments can accelerate progress, improve accountability, and maximise returns on existing investments. Three main platforms are listed here but there are many others. For example, strengthening existing platforms for HIV, syphilis, and other sexually transmitted infections will reduce stillbirths caused by maternal infections.

Family Planning 2030 (FP2030): Preventing high-risk and unintended pregnancies

FP2030 is a global partnership supporting universal access to voluntary, rights-based family planning by 2030. Its core targets are to expand modern contraceptive use, reduce unmet need, and improve quality and choice. Achieving these targets will lower the risk of stillbirth before pregnancy even begins. *Learn more: www.fp2030.org*

Every Woman, Every Newborn Everywhere (EWENE): Delivering high-impact care at scale

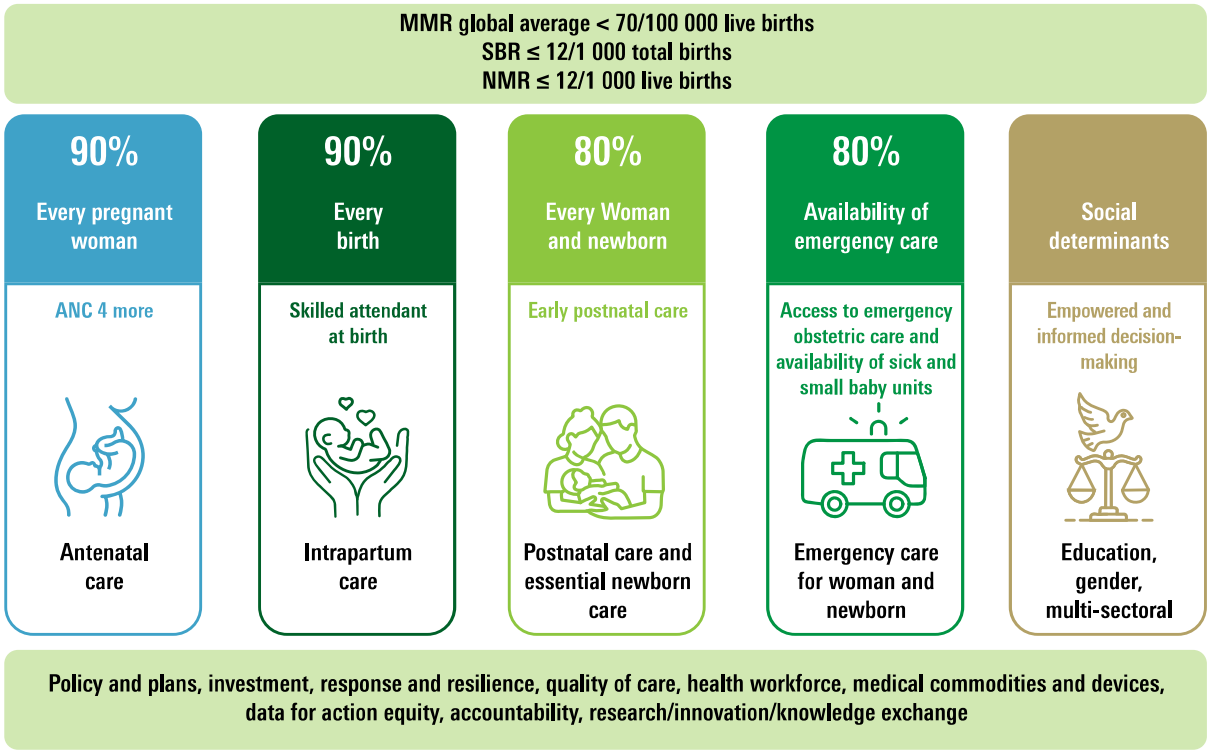
EWENE brings together governments, UN agencies, and partners around a shared agenda to expand access to quality maternal and newborn care. Its 90–90–80–80 population coverage targets for five high-impact packages of care align directly with interventions proven to reduce antepartum and intrapartum stillbirths (Figure 10) [62]. Achieving EWENE targets, especially in districts with the greatest disparities, would lead to measurable reductions in stillbirths while also accelerating progress on maternal and newborn survival and child development.

Learn more: www.ewene.org

CARMMA Plus: Elevating political leadership and accountability in Africa

The Campaign on Accelerated Reduction of Maternal Mortality in Africa Plus (CARMMA Plus 2021–2030) offers a continental political platform to accelerate progress on maternal and newborn health. Embedding explicit stillbirth targets, indicators, and accountability mechanisms within CARMMA Plus can convert political commitment into measurable reductions in stillbirths while strengthening health systems. *Learn more: https://carmma.au.int/en/documents/2022-11-22/re-strengthened-carmma-plus*

Figure 10. Every Women Every Newborn Everywhere targets and milestones



Progress in reducing stillbirths across Africa has been too slow and is now stalling. Over the past two decades, modest reductions in stillbirth rates have been achieved across all African regions, but rates remains high (figure A). Because stillbirth rates have stagnated and the number of births on the continent continues to rise, the total number of stillbirths has not decreased. As a result, Africa experiences nearly the same number of stillbirths today as in 2000—around one million pregnancies affected each year.

Source: Maternal, newborn and stillbirth programmatic transition framework: background paper. Geneva: World Health Organization; 2025. [12]

Solutions by programmatic priorities

A life-course and continuum-of-care approach is one of the most cost-effective strategies for improving maternal and newborn outcomes, including stillbirth prevention [63]. Figure 11 highlights key interventions for stillbirth prevention and bereavement care at each stage of the continuum, drawing on existing WHO guidelines and best practices [64].

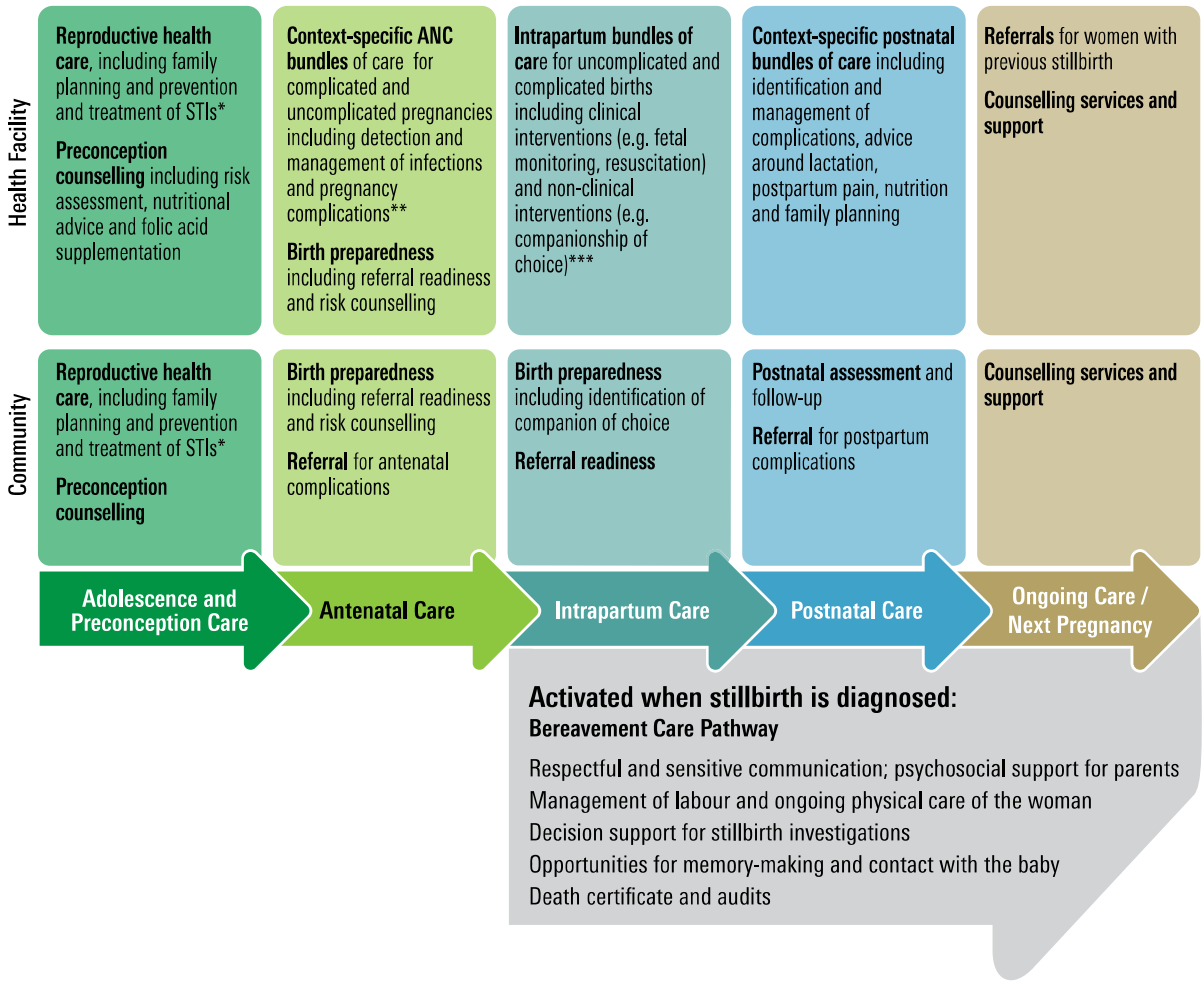
High-impact entry points:

- **Pre-pregnancy and adolescence:** Strengthen women's and adolescent health, nutrition, and access to family planning to reduce unplanned and high-risk pregnancies.
- **Pregnancy (antenatal care):** Ensure early, high-quality antenatal care for risk detection and management, including hypertension, anaemia, infections, and other complications.
- **Birth (intrapartum care):** Improve birth preparedness and referral systems, provide continuous labour support and regular fetal monitoring, and ensure timely access to functioning emergency obstetric and neonatal care, including safe and appropriate use of caesarean section.
- **Immediate newborn and postnatal care:** Ensure effective newborn resuscitation, maternal follow-up, and early postnatal support to prevent avoidable deaths.

I lost one of my twins at 31 weeks inside a hospital with modern medicine. The question that changed my life was 'if this could happen to me, how about women in facilities that are not fully equipped?'

Dr. Frances Wurie, Sierra Leone.
Access full testimonial.

Figure 11. Interventions along the continuum of care for stillbirth prevention and bereavement care



ANC: antenatal care; EmOC: emergency obstetric care; STI: sexually transmitted infection

* Plus other public health measures to improve the general health and well-being of all women of reproductive age.

** May include interventions such as umbilical artery Doppler ultrasound screening, maternal smoking cessation and awareness of fetal movements, maternal vaccinations, environmental precautions (such as mosquito net use to prevent malaria) and timing of birth, group B streptococcus testing and others.

*** Includes monitoring of labour progress and maternal status.

See Web Appendix for full list of WHO-related guidelines.

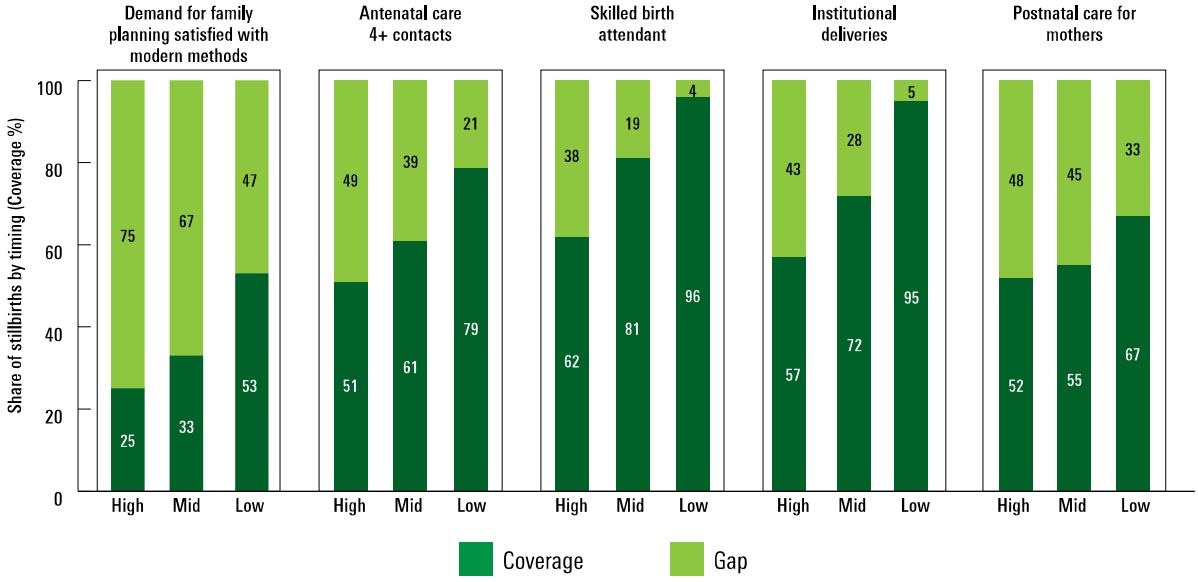
Solutions to increase access

Coverage of essential maternal and newborn health services varies widely across Africa and across the continuum of care. Gaps in care represent missed opportunities to prevent stillbirths and avoidable maternal and newborn deaths. Figure 12 shows both current coverage and the remaining opportunity gap for key maternal and newborn services across countries within the different phases of the mortality transition framework. Across all contexts, coverage is highest around the time of birth, while major gaps remain before pregnancy and after delivery. In high-mortality settings, the largest gaps are in family planning and antenatal care four contacts. Even in lower-mortality settings, access gaps persist. Closing these gaps is one of the fastest and most equitable ways to reduce stillbirths and strengthen health systems.

Strategies that work

- **Prioritise equity**: Target women and families who are poorest, most remote, and most marginalised to address the highest stillbirth risk. Recognise bereaved women as mothers, through rituals, language, and respectful bereavement care, and restore dignity and mental well-being [47].
- **Reduce access barriers**: Expand mobile outreach services, maternity waiting homes, transport vouchers, and strengthened referral systems to reduce geographic and financial barriers to timely care [13, 51, 56, 60, 65].
- **Prevent high-risk pregnancies:** Expand access to voluntary family planning and postpartum contraception to reduce unplanned and high-risk pregnancies associated with stillbirth [13, 57, 66].
- **Strengthen community delivery platforms:** Use community outreach, youth-friendly services, and routine integration of fertility counselling into antenatal and postnatal care to increase uptake and continuity of care [51, 57, 65-67].

Figure 12. Coverage of care along the continuum for Africa by mortality context



Note: This figure presents current coverage (dark green) and the remaining opportunity gap (light green) for key maternal and newborn health services across countries grouped by mortality transition phase: High mortality level = Phase 2; mid mortality level = Phase 3; low mortality level = Phase 4. The gap represents the proportion of the population not yet reached by these services.

Source: Coverage estimates by mortality transition phase were calculated as population-weighted averages using 2024 World Population Prospects live birth and female population data. Country-level coverage values were drawn from the UNICEF The State of African Children 2025 Statistical Compendium. This analysis was conducted specifically for this report.

The pain remains like an open wound.

April 15, 2024 is the day I gave birth by caesarean section to my stillborn baby. Throughout my pregnancy I was exhausted, vomiting, and short of breath, yet I was repeatedly told not to worry. In the ninth month, I had no signs of labour. At the hospital, two healthcare workers supported me. For that, I am grateful. But in the post-partum unit, the cries of other babies made my pain even worse. My family, especially my mother and sisters, became my main support. Apart from them, there was no other support. I wish I could meet a specialist. I carry deep loneliness. The pain remains like an open wound. I tell other pregnant women that early care may save a baby's life.

Testimonial from Latifa Bellili, Tunisia

Access more testimonials online.

Solutions to improve quality

Expanding coverage alone will not reduce stillbirths if care quality remains poor [68]. Although most births in Africa now occur in facilities with skilled providers, intrapartum stillbirths remain unacceptably high due to gaps in the quality of care [69, 70]. Common indicators, such as "skilled birth attendance" and "institutional delivery", mask these gaps, as they do not capture whether essential actions occurred—such as effective fetal monitoring, timely recognition of complications, or prompt life-saving decisions. Late referral and delayed life-saving interventions results in adverse perinatal outcomes, including stillbirth [13], as demonstrated recently in Uganda [71].

Strengthening intrapartum care requires effective teams, referral systems, strong data systems, and routine review of adverse outcomes. Health worker competency and preparedness in preventing stillbirth, as well as bereavement care, needs to be part of pre-service and in-service training [72] Midwifery-led models of care are central for improving quality care in pregnancy and at birth [73, 74]. Every US $1 invested in health workers yields a nine-fold return through improved health and productivity [75].

Solutions that respond to context

Tailoring strategies to countries' mortality contexts will enable governments to focus resources where returns will be greatest [76-78]. The Maternal, Newborn, and Stillbirth Programmatic Transition Framework describes how countries progress through different phases as deaths among women, newborns, and stillborn babies decline, and why priorities must shift accordingly (Figure 13). In high-mortality settings, the focus is on expanding basic access and strengthening core primary health-care and referral systems. In moderate-mortality settings, priorities shift toward improving quality, equity, and respectful care. In lower-mortality settings, sustaining high-quality care and avoiding unnecessary or harmful interventions becomes critical. Across all phases, stillbirth prevention is most effective when embedded within strong primary health care and broader societal responses, supported by the application of WHO guidance and tools to operationalise the transition framework [12]. Contextual shocks, such as climate change and humanitarian emergencies, must be addressed through climate-resilient, gender-responsive health systems and emergency preparedness that ensure continuity of essential maternal and newborn services, including stillbirth prevention, respectful care, and bereavement support [79, 80].

COUNTRY SPOTLIGHT

Senegal: Access Through Community Health Workers to Prevent Stillbirths

Senegal has built one of Africa's largest community health systems through Cases de Santé (health huts), employing over 16,000 community health workers across five major types to serve rural areas. Results have been transformative: prenatal visits increased from 14% to 57%, skilled birth attendance nearly doubled from 29% to 56%, and exclusive breastfeeding rose from 5% to 42% between 1993 and 2017, demonstrating community health workers' vital role in improving outcomes, including early detection of high-risk pregnancies that can lead to stillbirth. Learn more: www.exemplars.health/topics/stunting/senegal/how-did-senegal-implement

COUNTRY SPOTLIGHT

South Sudan: Training midwives to reduce maternal and perinatal deaths

Strengthening and investing in midwives is one of the most effective ways to prevent stillbirths and avoidable maternal and newborn deaths. South Sudan, a country affected by long-term instability and with high stillbirth rates, has been working to increase the number of midwives in the country. The Catholic Health Training Institute established in 2010, provides a rigorous three-year programme combining classroom learning, clinical practice, and hospital internships. More than a decade of midwife training has produced more than 350 graduates, 85% of which are employed and working in South Sudan. Learn more: https://borgenproject.org/maternal-mortality-in-south-sudan-2/

Determine your country's strategic priorities by applying the tool. Access the manual.

Figure 13. Strategic choices for the mortality transition by phase

	Phase 1 MMR ≥ 700 SBR + NMR ≥ 80	Phase 2 MMR 300-700 SBR + NMR 56-80	Phase 3 MMR 100-300 SBR + NMR 31-55	Phase 4 MMR 20-100 SBR + NMR 11-30	Phase 5 MMR <20 SBR + NMR <10
Challenges	Weak health systems, low accessibility, availability, equity, quality and demand	Improving service utilization and coverage & building health systems capacity for universal coverage	Scaling up secondary & tertiary care and ensuring quality, equity, availability and access	Working towards UHC while maintaining quality and equity of access to care for all including for specialised care	Universal access to primary/secondary/tertiary levels of care to manage difficult mortality/morbidity
Strategic choices	Increasing demand building community services, district health systems & community & multi-sector partnerships	Improving service coverage, facility utilisation, and health system capabilities	Building system and institutional capacity for phase I-III intervention package for main causes of mortality	Expanding system capacity for package of interventions for obstetric and neonatal specialties	Sustaining and improving system capabilities and sector collaborations for mortality reduction

Note: Maternal mortality ratio (MMR) per 100,000 live births, stillbirth plus neonatal mortality (SBR + NMR) per 1,000 total births

Source: Maternal, newborn and stillbirth programmatic transition framework: background paper. Geneva: World Health Organization; 2025 [12].

Research priorities for stillbirth in Africa

Research on stillbirth prevention and bereavement care in Africa remains limited, highlighting the need for a structured, inclusive process to define regional research priorities. Clinical research priorities may include improving prevention and early detection of antepartum risks (e.g. hypertension and fetal growth restriction), strengthening intrapartum fetal monitoring and decision-making, assessing the role of new technologies and AI, and defining minimum postnatal assessments to reduce risk in subsequent pregnancies. Health systems research priorities may include community-based approaches to address social and environmental risks, scaling AI-assisted ultrasound and continuity of midwifery care, defining tiered intrapartum service delivery models, and developing comprehensive care packages for families after stillbirth. A continent-wide priority-setting process is essential to refine, align, and sequence these research questions for maximum impact.

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5. The Pathways: How can countries accelerate progress

Accelerating progress requires coordinated action across health systems, communities, and governments.

The continental call to action will build resilient health systems and advance Africa's Health Security and Sovereignty Agenda. The pathway requires countries to commit, lead, and invest, deliver quality care at birth, count and learn from stillbirth, centre families and communities, and tailor action to context.

Addressing preventable stillbirths supports Africa's vision of stronger, self-reliant health systems under Africa's Health Security and Sovereignty Agenda. Stillbirth prevention is a test of whether health systems deliver safe, quality care at birth. The continental call to action aligns with EWENE targets and outlines five priority actions for African governments and partners to accelerate progress towards ending preventable stillbirths by 2030.

1. Commit, lead, and invest

Stillbirth prevention must be elevated as a national priority and embedded within health policies, plans, and financing mechanisms with clear leadership and accountability. Governments should set explicit national stillbirth reduction targets and integrate stillbirth indicators into national health strategies and accountability health sector performance frameworks. Investments should align with burden and address key system gaps, including the health workforce, referral and emergency care, and data systems.

Resource for Action

The International Stillbirth Alliance's "Preventing and addressing stillbirths along the continuum of care: A Global advocacy and implementation guide" provides practical tools, policy messaging, and implementation strategies to help governments and partners elevate stillbirth prevention within national maternal and newborn health agendas. It is a ready-to-use resource to help move from commitment to action. See online.

2. Capacitate health systems to deliver quality care in pregnancy and at birth

Strengthen health system readiness to deliver high-impact, evidence-based interventions across the continuum of care will prevent stillbirth. This includes strengthening emergency obstetric and newborn care, ensuring timely referral, maintaining essential medicines and equipment, and providing respectful bereavement care. Frontline health workers require clear guidance, supervision, and safe working environments.

A competent, supported workforce, especially midwives and nurses, is the foundation of quality care and health system surge capacity during crises and pandemics. Innovation, including midwifery-led point-of-care ultrasound, digital fetal monitoring, remote training, and community reporting tools, leveraging AI-tools where applicable, should be piloted and scaled where evidence shows benefit, supported by implementation research.

COUNTRY SPOTLIGHT:

Uganda: Turning Data into Action

Uganda has emerged as a leading example of strengthening Maternal and Perinatal Death Surveillance and Response (MPDSR), moving from fragmented reviews to coordinated, learning-focused national programming. Progress accelerated when leaders at all levels consistently engaged with routine DHIS2 data to guide decisions. A critical catalyst for change in Uganda was when teams acknowledged that high stillbirth and maternal death rates signified health systems failure. This consensus built the urgent, shared ownership necessary to drive improvement. The country's distinctive strength lies in translating reviews into action through deliberate follow-through on recommendations. Uganda also adopted Tanzania's "deep-dive" review practice, demonstrating how South-South learning can rapidly strengthen systems.

3. Count, use and learn

Strong surveillance and data systems are essential for accountability and improvement. Counting every stillbirth and learning from every loss must become a public health priority. Integrating stillbirths into national surveillance systems, strengthening civil registration, and using data to drive improvement are essential to reveal the true scale of the problem and guide effective solutions. Governments should ensure every stillbirth is counted, reviewed, and used for action.

This includes publishing annual stillbirth data through reports or dashboards, adopting standard cause-of-death classification, and strengthening perinatal death surveillance and response. Integration across CRVS, HMIS, and MPDSR systems ensures stillbirths are visible in routine performance monitoring and quality improvement. Reliable data are also critical for early warning, emergency preparedness, and evidence-informed decision-making.

4. Centre families and communities

Preventing stillbirths requires trust, dignity, and community engagement. Governments and partners must amplify the voices of bereaved parents, embed respectful and culturally sensitive bereavement care, and create safe spaces for grief and learning. People-centred approaches reduce stigma, improve reporting, strengthen service use, and reinforce accountability. Community engagement is also a core component of resilient, responsive health systems. They should also support community awareness and engagement with cultural and religious leaders to address stigma, promote understanding of stillbirth, and ensure that families experiencing loss are treated with dignity and compassion. Strengthening trust and reporting at community level also improves surveillance systems, supporting earlier detection of risks and stronger health system preparedness.

5. Contextualise action

Governments and partners should apply the mortality transition model to tailor priorities to their setting. High-mortality contexts require rapid expansion of basic access and system strengthening; moderate-mortality settings require a focus on quality, equity, and respectful care; and lower-mortality settings require sustaining quality while avoiding over-medicalisation. Context-appropriate strategies ensure resources are directed where system weaknesses are greatest, accelerating stillbirth reduction while strengthening broader health system resilience and health security.

COUNTRY SPOTLIGHT:

Republic of the Congo: Strengthening Stillbirth Surveillance Through National Death Observatory

The Republic of Congo integrates stillbirth prevention within its RMNCAH Strategy 2022–2026, prioritising emergency obstetric and newborn care (EmONC), improved referral systems, and quality intrapartum care. The country operates a National Maternal, Neonatal and Infant Death Observatory that actively tracks stillbirths using standardised tools and mandatory annual reports. Stillbirths are notified and investigated through the Maternal, Perinatal, Neonatal, and Child Deaths Surveillance and Response platform. Surveillance findings directly inform programmatic responses, including strengthening EmONC capacity and addressing referral delays.

COUNTRY SPOTLIGHT:

Burkina Faso: Pioneering Weekly Stillbirth Surveillance in Sub-Saharan Africa

Burkina Faso has made stillbirth reduction a national priority through its 2025–2030 RMNCAH Strategic Plan. In 2022, the country became the first in West Africa to include stillbirths in weekly national surveillance via the Compulsory Weekly Telegram Letter, enabling rapid identification of high-incidence areas. Key interventions include EmONC training, extended perinatal audits to include stillbirths, and improved equipment availability. Innovations such as neonatal thermal bracelets, digitised community surveillance, and solar-powered delivery rooms address challenges in fragile contexts. These efforts reflect growing political commitment to preventing perinatal deaths.

Conclusion

Stillbirths represent a preventable continental emergency. Africa's persistently high stillbirth numbers and rates expose deep weaknesses in health systems, but they also reveal one of the greatest opportunities to accelerate progress on health and development goals. By ensuring that every stillbirth is counted, reviewed, and prevented wherever possible, countries can transform loss into learning, silence into accountability, and commitment into change. The State of Africa's Stillbirths Report calls for stronger accountability for every loss and highlights the importance of improving care during pregnancy and at birth to advance Africa's health security and sovereignty. Ending preventable stillbirths is both a strategic investment in Africa's Health Security and Sovereignty Agenda and a moral imperative. Strengthening intrapartum care, surveillance systems, and emergency obstetric readiness will simultaneously reduce maternal deaths, save newborns, and build resilient health systems capable of protecting women, newborns, and communities. With leadership, sustained investment, and accountability, Africa can turn one million invisible losses into action, ensuring every loss is acknowledged, every system learns, and every family receives dignity and care.

I woke up from anaesthesia expecting to hold my baby. Instead, there was silence

I am a midwife. I have stood beside countless women as life entered the world. But nothing fully prepared me to be on the other side of the bed. I have experienced four pregnancy losses before, and when I finally carried to term, we named our son Elikem meaning "I am established." His name was our declaration of hope. In October, after an emergency Caesarean section, that hope collapsed. I woke up from anaesthesia expecting to hold my baby. Instead, there was silence. No cries. No cuddles. Just silence. When I was finally allowed to see Elikem, he was physically perfect. Tall. Whole. But gone. Placed in a postnatal ward among celebrating mothers, I watched joy unfold around me while colleagues asked, "Where is your baby?" No one had told them. I wished someone had told me how isolating this would be. At home, our loss was met with avoidance and cultural discomfort. Silence replaced condolence. My husband and I grieved alone and in silence. I now advocate for compassionate bereavement care. Stillbirth is not just a medical event. It is a life-altering loss. Still babies should be prepared in a presentable way for family viewing and time together.

Testimonial from Irene Torshie Attachie, Ghana

Access more testimonials online

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Call to Action

Vision

We envision a world in which preventable stillbirths no longer occur, and care for families and health workers after stillbirth is compassionate, high-quality, and culturally appropriate.

Mortality targets by 2030:

National:
12 stillbirths or fewer **per 1 000** total births in every country

Aligned to EWENE mortality targets for maternal and neonatal mortality

Subnational level:
All countries set and meet targets to close equity gaps and **use data to track** and **prevent** stillbirths

Coverage targets by 2030:

Family planning:
Universal access

Antenatal care:
≥90% of pregnant women
attend at least four antenatal care visits
in every country

Care during labour and birth:
≥90% of women give birth
with a skilled health worker present

Postnatal care:
≥80% of women and their babies
receive postnatal care within two days,
this includes women who have experienced a stillbirth

Emergency obstetric care:
≥80% of countries with > 50% of the population
able to physically access the closest EmOC health facility within 2h of travel time

Priority actions:

Commit, lead & invest in integrating stillbirth into national policies, budgets, and accountability mechanisms.

Capacitate the health system to deliver quality care in pregnancy and at birth with a skilled, supported workforce and functional referral systems.

Count, use & learn by turning one million losses into action through registration, review, and the systematic use of data.

Centre families and community by empowering parents, raising awareness, and ensuring respectful, culturally appropriate bereavement care.

Contextualize action by tailoring strategies to the mortality phase to maximise impact and equity.

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Access more information about the partnership, supporting data, testimonials, and country spotlights at https://africacdc.org/download/state-of-africas-stillbirths/.

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