Adeline Boatin[1]

[1]Massachusetts General Hospital

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Title: Insights on Stillbirths in Africa using the Robson Classification System: Mini Commentary

Adeline A. Boatin

Department of Obstetrics and Gynecology, Massachusetts General Hospital

Harvard Medical School, Boston, USA

Contact:

55 Fruit Street,

Dept OB/GYN

Massachusetts General Hospital

Boston, MA 02114

Email: adeline_boatin@mgh.harvard.edu

Tel: +1 617 726 1320

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Globally, stillbirths remain a largely neglected health crisis, with up to 2 million stillbirths annually and minimal progress in reduction.[1] Despite several global initiatives targeting perinatal mortality, such as the Every Newborn Action Plan (ENAP) launched in 2014, efforts to decrease stillbirth rates have seen only a modest 2.3% decline over the last 20 years.[1]This underscores the urgent need for novel approaches to understand and addresse this global challenge.[1,2]

Compounding this issue is a substantial lack of comprehensive data on the trends, timing and causes of stillbirths.[1] Many classification systems for categorizing stillbirths have been developed to address this data gap.[3] To be useful, classification systems should ideally use routinely collected data that does not require substantial input to collect, and that is already readily available. However, most stillbirth classification systems have failed to meet the criteria that allow widespread adoption, particularly in resource-constrained environments where stillbirth rates are the highest.[4]

In this issue of the journal, Hanson et al use the Robson 10-group Classification system to explore stillbirth trends in four countries – Benin, Malawi, Tanzania, and Uganda – using data on over 80,000 births and just over 3000 stillbirths collected from 16 hospitals. Their use of the Robson Classification System across these four countries and hospitals of varying levels of care demonstrates the benefits of the chosen classification system: wide applicability across various settings, objective and easily standardizable classifications, and easy comparability across time and place.[5] Although not used in this exploration, this classification system

also benefits from being versatile in that it can be applied to understand not only stillbirths, but also cesarean delivery or other intrapartum outcomes of interest, thus gaining an efficiency with data collection.

The findings from Hanson et al highlight leading contributors to stillbirth among the studied countries – group 10 (preterm births), group 3 (multipara in spontaneous labor) and births complicated by malpresentation and multiple gestations. While high rates of intrapartum stillbirths among preterm deliveries demand attention, they are not surprising. More surprising and warranting further investigation are the high rates of stillbirth seen in Group 3, which, under normal circumstances, should be at the lowest risk for mortality.

Importantly, as pointed out by the authors, analysis using the Robson classification system serves as a starting point to pinpoint areas for focused investigation and quality improvement, while also offering valuable insights for each hospital on performance, guidance on where to concentrate efforts, and potentially where to seek lessons from "good performers."

Globally, we have far to go to combat high rates of stillbirths. Using versatile and standardized approaches, as done by Hanson et al offers the opportunity to facilitate targeted investigations and to promote cross-country learning and continuous improvement for maternal and perinatal care.

References

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