Fetal Death in Tennessee, 2017-2021

2024 Report

Tennesee Department of Health | Family Health and Wellness

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Summary of Findings

From 2012-2021, the fetal mortality rate decreased 18% from 8.0 to 6.6 per 1,000 live births and fetal deaths, with an average of 567 fetal deaths annually.

Almost half (46%) of public health regions in Tennessee had a fetal mortality rate above the Healthy People 2030 Target of 5.7 fetal deaths per 1,000 live births and fetal deaths.

Nearly half of all fetal deaths were due to an unspecified cause. The top three identified causes were: placenta, cord, and membrane complications, maternal complications, and maternal conditions unrelated to pregnancy.

Fetal mortality rates for pregnant women without any prenatal care were 5.3 times the rate for those with any prenatal care.

Pregnant women with pre-pregnancy diabetes or hypertension, obesity, maternal infections, previous pregnancy loss, or preterm birth experienced higher rates of fetal death.

Fetal mortality rates were higher among those who smoke during pregnancy (7.9 vs. 6.1).

The fetal mortality rate for Non-Hispanic Black mothers was 2.1 times higher than the Healthy People 2030 Target. Other races/ethnicities met and exceeded the 2030 target.

Social drivers of health are critical for assessing health outcomes but data were not reliably collected on fetal death certificates.

Introduction

"Fetal death refers to the spontaneous intrauterine death of a fetus at any time during pregnancy" (CDC).[1] In Tennessee, fetal deaths of at least 20 weeks gestational age and/or 350 grams are mandated by law to be reported to the Tennessee Department of Health Office of Vital Records (TCA § 68-3-504). This report will focus on describing the characteristics and trends of reportable fetal deaths in Tennessee. Although fetal deaths at or after 20 weeks gestation are often referred to as stillbirths, this report will use the term fetal deaths.

Fetal death can be devastating for families, but has been largely overlooked in the United States.[2] While **previous work estimates that 25% of fetal deaths are preventable**, prevention is impossible without first understanding the data. This report is the first fetal death data report for Tennessee and is an important first step in supporting Tennessee families.

Fetal death is devastating and requires focused funding, research, and prevention efforts.

The Impact of Fetal Death

Fetal death can be extremely challenging for families, as they navigate complicated grief, confusion, and systems. There is also significant stigma associated with fetal death, further isolating grieving families.

Families who experience fetal death have higher rates of **anxiety, depression, and other mental health challenges.**[3] Fetal death can also impact family dynamics. While some studies show that partners report a stronger relationship after supporting each other through a fetal death, other research has shown that married or cohabitating couples are **40% more likely to break up** following a fetal death.[4]

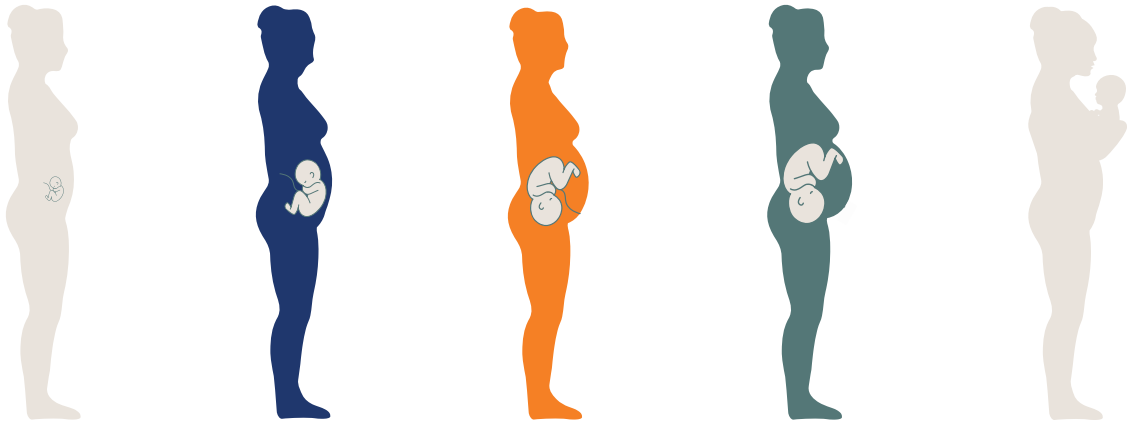
In addition to having high emotional costs, fetal death is also financially expensive. A previous study found that the **average hospital cost** for families who experienced fetal death was **$750 higher** than those with a live birth even if the length of stay in the hospital was the same.[5]

Data Collection

Healthcare providers complete fetal death certificates at the time of delivery and report them to The Office of Vital Records. Fetal deaths are reported for all deliveries in Tennessee and all out of state deliveries to Tennessee residents. The certificate includes various sections to collect data about the parents, pregnancy, and potential contributors to fetal death. **Data presented in this report are from 2017-2021, unless otherwise specified.**

Definitions

Fetal Death is the death of a fetus in utero that has reached a minimum of 20 weeks gestation and/or weighs a minimum of 350g.



Miscarriage

Death before 20 weeks with weight <350g

Intermediate Fetal Death

Death at 20-27 weeks

Late Fetal Death

Death at 28-36 weeks

Term Fetal Death

Death at 37+ weeks

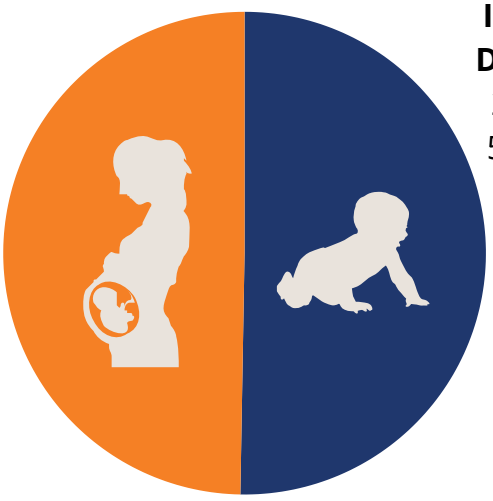
Infant Death

Death of an infant within 1 year of life

The Fetal Mortality Rate is the number of fetal deaths per 1,000 live births and fetal deaths.

Infant and Fetal Deaths

Infant deaths are the death of an infant within one year of life. **From 2017-2021, 49.7% of all fetal and infant deaths were fetal deaths.**[6]



Infant Deaths
2,720
50.3%

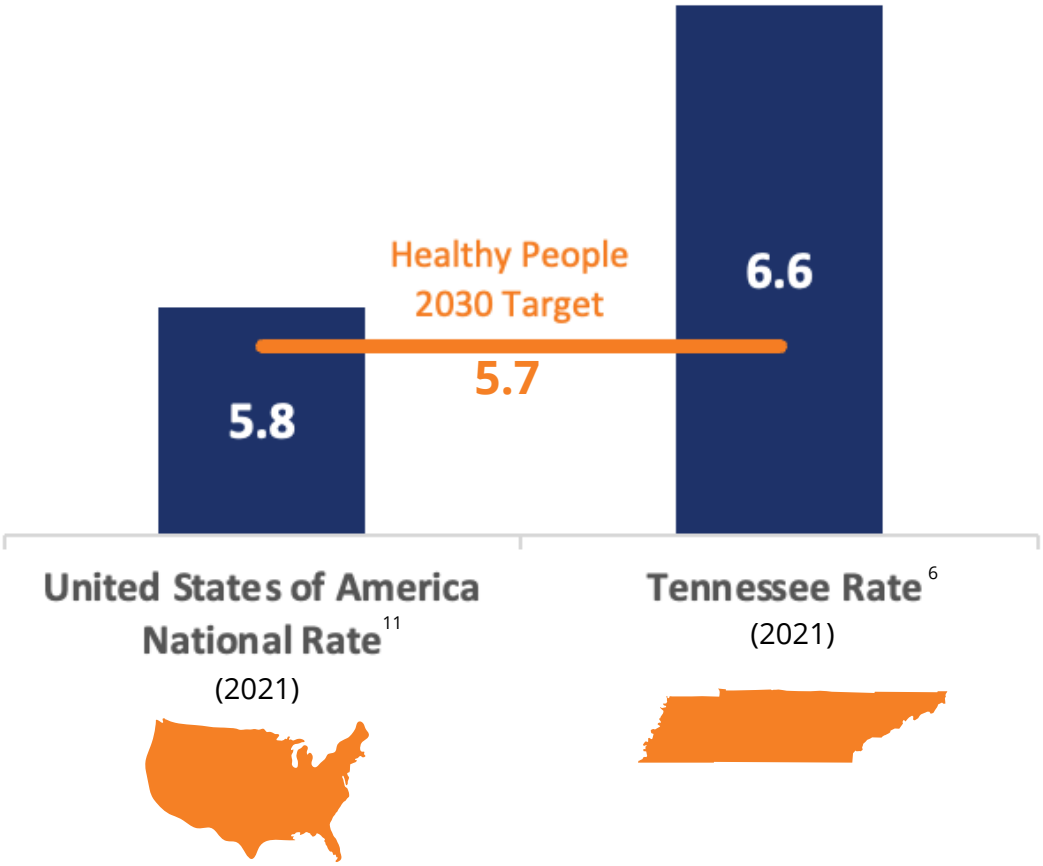
Fetal Deaths
2,690
49.7%

Healthy People 2030

The Tennessee fetal mortality rate is higher than the national rate and the Healthy People 2030 Target.

Developed by the Department of Health and Human Services (HHS), the Healthy People program has set national objectives for public health every decade since 1980. The goal of these objectives is to improve health outcomes for people living in the United States. One of these objectives is reducing fetal death.[7] The last three iterations of the Healthy People goals have increased the target fetal mortality rate, acknowledging the challenges with lowering this rate. Healthy People 2010 had a target of 4.1 fetal deaths per 1,000 live births and fetal deaths and by the time 2020 targets were set, this rate was raised to 5.6. This rate increased again for Healthy People 2030 to 5.7 fetal deaths per 1,000 live births and fetal deaths.[8,9,10]

Fetal Mortality Rates



Trends in Fetal Death in Tennessee

From 2012-2021 the fetal mortality rate in Tennessee decreased by 18%, or 1.4 fetal deaths per 1,000 live births and fetal deaths. In 2012, there were 650 reportable fetal deaths in Tennessee. By 2021, there were 541. Over this 10 year span there was an average of 567 fetal deaths annually.

The Tennessee fetal mortality rate has decreased from 2012-2021.

Tennessee Fetal Mortality Rates, 2012-2021[6]

From 2012 to 2021, There has been a statistically significant decrease in the statewide fetal mortality rate; however, this has not been a consistent decline. Most notable is the slight increase in fetal deaths observed since the pandemic. TDH continues to closely monitor these trends.

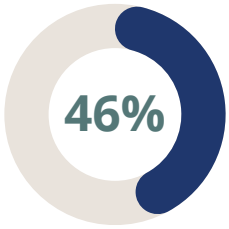
From 2012-2021 there were a total of 812,154 fetal deaths and live births in Tennessee.

In those 10 years,

Approximately 1 in 140 deliveries was a fetal death

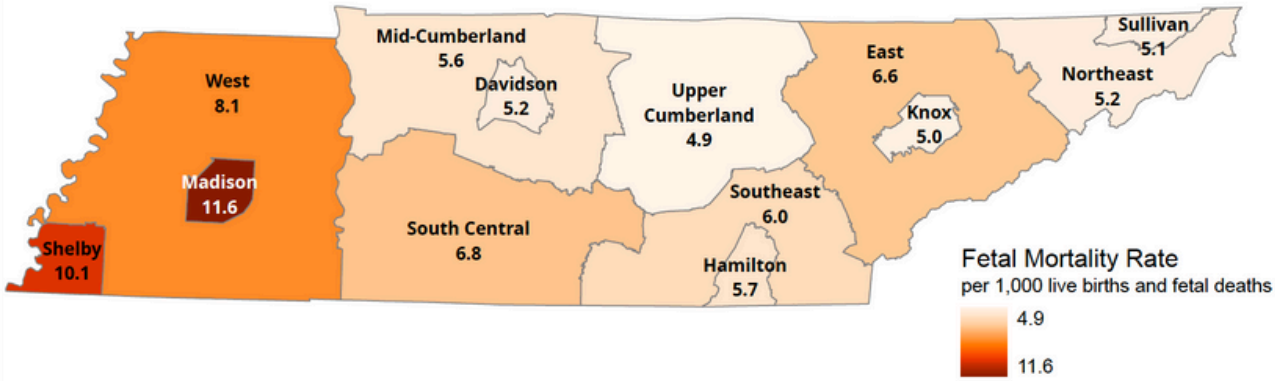
Geographic Distribution of Fetal Death

In Tennessee, there are 95 counties organized into 13 public health regions and metros. There are notable geographic disparities in fetal mortality rates across the state. West Tennessee has the highest fetal mortality rates.



of Tennessee public health regions have a Fetal Mortality Rate higher than the Healthy People 2030 Target

Fetal Mortality Rates for Tennessee Public Health Regions 2017-2021[6]



West Tennessee has the highest fetal mortality rates in the state.

Top 10 Counties with the Highest Statistically Reliable Fetal Mortality Rate, 2017-2021[6]

The fetal mortality rate in Lauderdale is over triple the Healthy People 2030 Target.

Lauderdale	17.2
Haywood	12.4
Madison	11.6
Union	11.5
Anderson	11.4
Dyer	11.1
Shelby	10.1
Hickman	9.7
Cocke	9.3
Marion	9.0

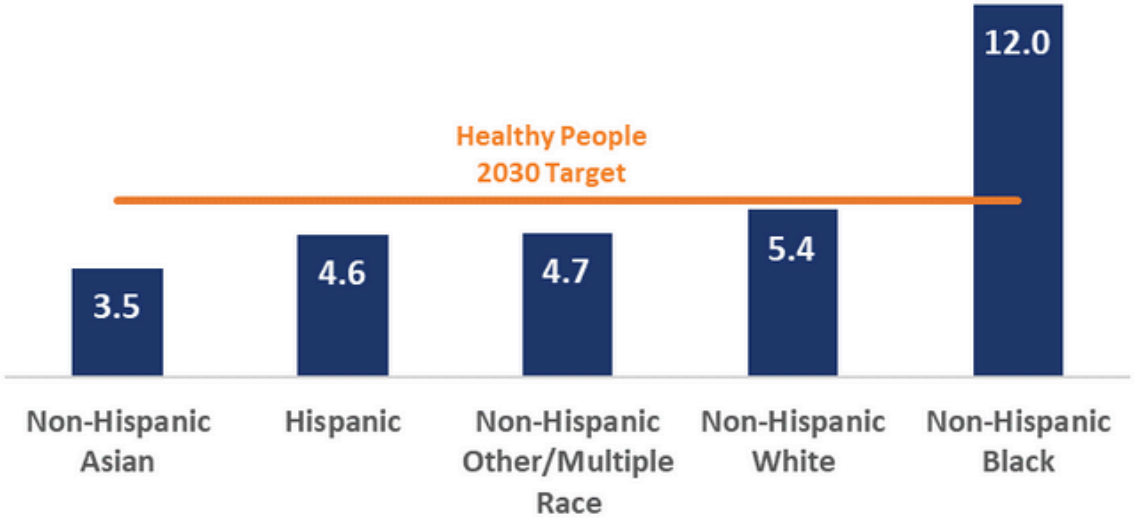
The fetal mortality rate is at least double the Healthy People 2030 Target for the 5 counties with the highest fetal mortality rates.

Disparities in Fetal Death in Tennessee

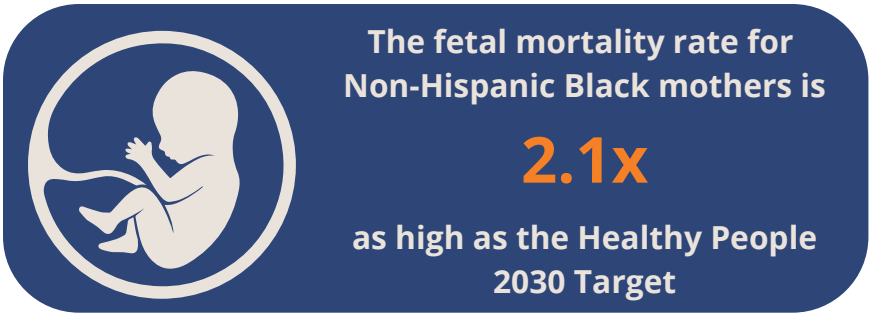
Health disparities persist in many fields, including several health outcomes. Certain racial and ethnic groups disproportionately experience some negative health outcomes, including fetal death. It is critical to acknowledge these disparities and carefully consider them when planning research and prevention efforts. Activities aimed at improving fetal mortality rates should prioritize the needs of the communities most impacted.

Despite accounting for just 19% of all deliveries, Non-Hispanic Black pregnant women experienced 35% of all fetal deaths.

Fetal Mortality Rate by Maternal Race/Ethnicity 2017-2021 [6]



Efforts to reach the Healthy People 2030 Target would need to carefully consider the causes for these disparities and the needs of these specific communities to improve health equity and decrease fetal mortality rates.



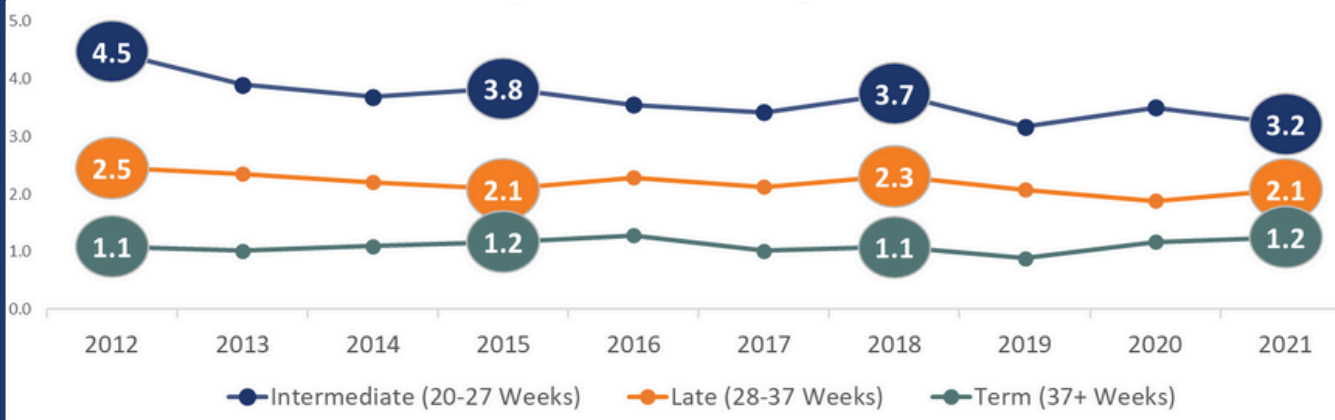
Gestational Age

Half of fetal deaths occurred from **20-27 weeks.**

1/6 of fetal deaths occurred at **term.**

There was a statistically significant 28.8% decrease in the fetal mortality rate from 2012-2021 for the *intermediate* gestational period. Within that same timeframe, fetal mortality rates for the *late* and *term* gestational periods decreased and slightly increased, respectively; however, those changes were not statistically significant. Overall, the rates were lower in later gestational periods.

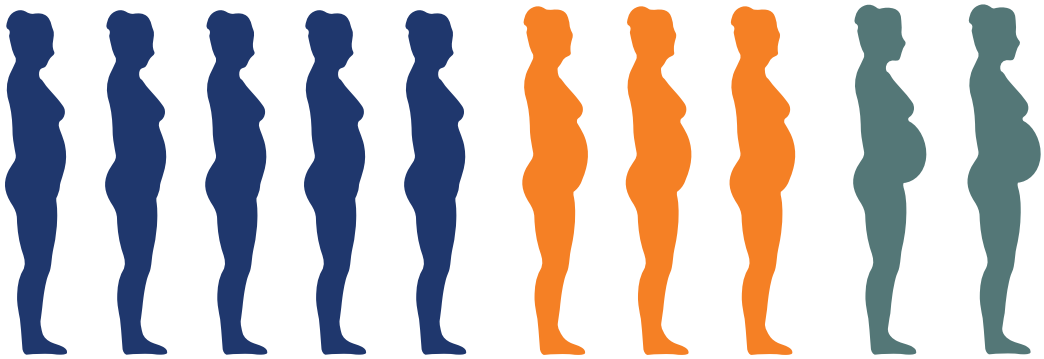
Tennessee Fetal Mortality Rates by Gestational Period, 2012-2021[6]



Fetal Deaths Reported from 2017-2021[6]

From 2017-2021, the majority of fetal deaths were in the intermediate period, followed by late and term. A total of 5 out of 6 fetal deaths during this time occurred before 37 weeks.

Of Fetal Deaths:



52%
occurred in the Intermediate Period

32%
occurred in the Late Period

16%
occurred at Term

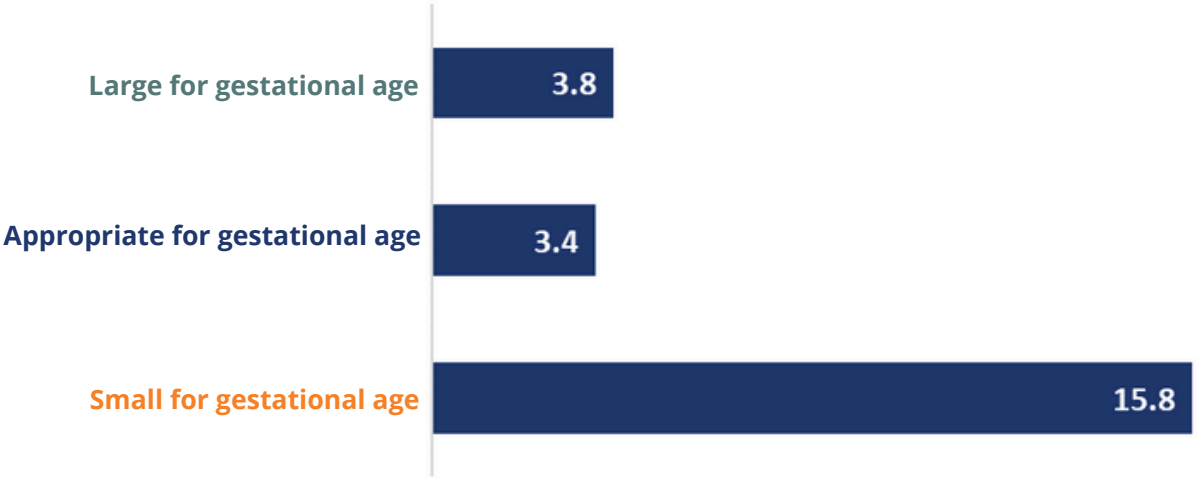
A closer examination of the data in 3 week intervals is consistent with a decrease in fetal mortality rates as gestational age increases. At 20-23 weeks, 58% of all fetal deaths and live births (at 20-23 weeks gestational age) were fetal deaths. This decreased to 18% at 24-27 weeks and 8% at 28-31 weeks.

Size by Gestational Age

Most fetal deaths occurred at a very low birthweight. However, as weight and gestational age are closely linked, size-for gestational-age (SGA) is a better measure of fetal growth.

Babies classified as small for gestational age had the highest fetal mortality rate.

Fetal Mortality Rate by Birthweight for Gestational Age, 2017-2021[6]



Small for gestational age: weight below 10th percentile for that gestational age

Appropriate for gestational age: weight between 10th and 90th percentile for that gestational age

Large for gestational age: weight above 90th percentile for that gestational age

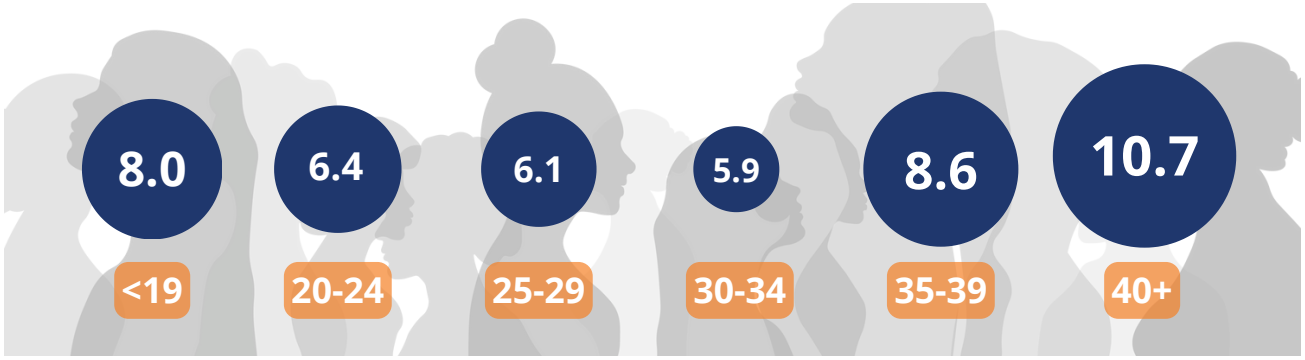
While 57% of fetal deaths were appropriate weight for gestational age, this group had the lowest fetal mortality rate. Those with a weight that was small for gestational age only accounted for 35% of fetal deaths but had the highest fetal mortality rate at 15.8 fetal deaths per 1,000 live births and fetal deaths. **The fetal mortality rate for those small for gestational age was 4.6 times higher than those that were appropriate for gestational age.**

Maternal Age and Plurality

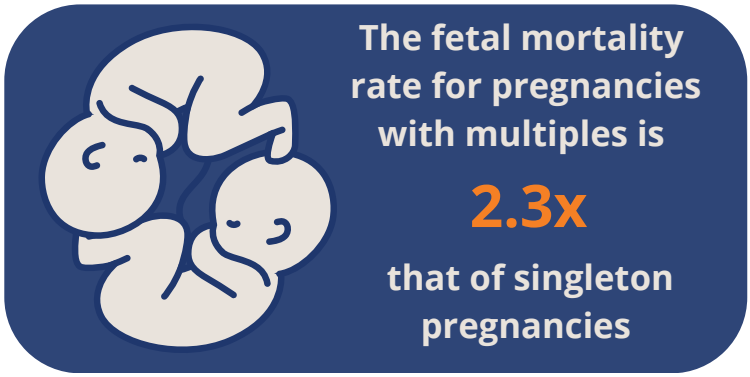
Fetal mortality rates differ by maternal age at time of delivery. The rates are higher than the Healthy People 2030 Target for all maternal age groups. **Fetal mortality rates were lowest for pregnant women aged 25-34.** There is a trend in decreasing fetal mortality rate through maternal age 34. At 35, the fetal mortality rate steadily increases through maternal age older than 40.

Fetal mortality rates are highest in pregnant women younger than 19 and older than 35.

Fetal Deaths per 1,000 Live Births & Fetal Deaths by Maternal Age, 2017-2021[6]



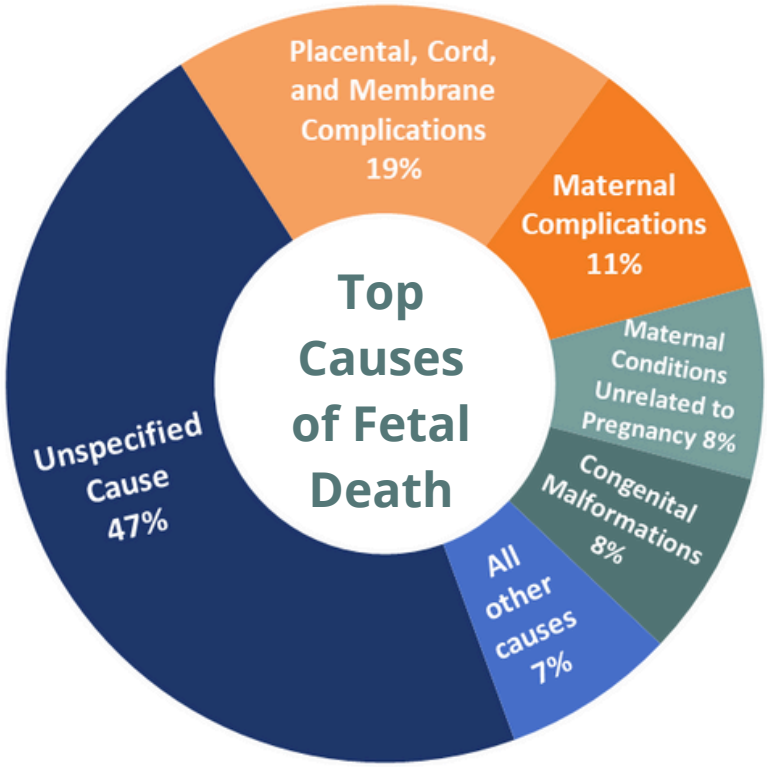
Fetal mortality rates also differ depending on plurality. Singleton pregnancies have a fetal mortality rate of 6.3 while pregnancies with multiples have a fetal mortality rate of 14.3.



Other factors, such as the sex of the child, do not contribute to statistically significant differences in fetal mortality rates.

Causes of Fetal Death in Tennessee[6]

Nearly half of all fetal deaths have an unspecified cause.

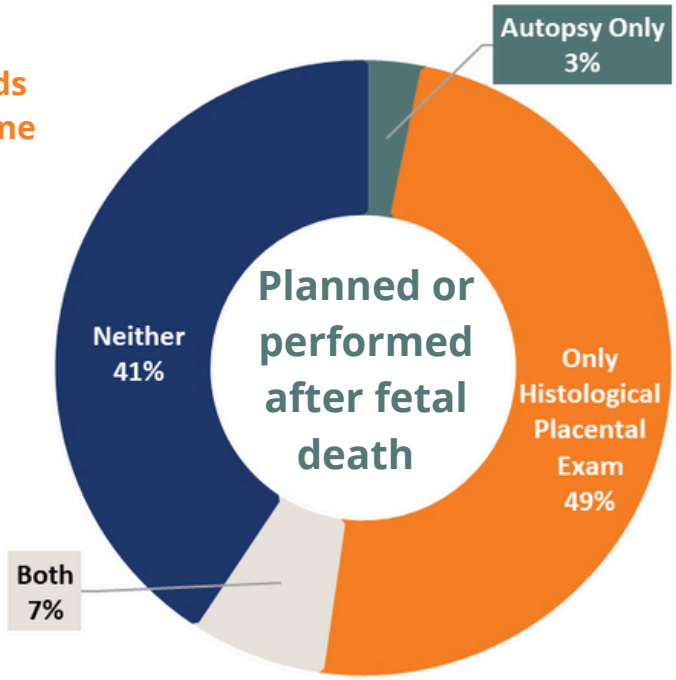


While the top 5 causes of fetal death are mostly consistent across gestational age periods, there is some variation for those that occur at term (37+ weeks). At term, maternal complications is replaced as the third top cause by congenital anomalies; and diabetes mellitus is the fifth top cause of fetal death, with 3% of fetal deaths past 37 weeks having this cause reported.

While there is variability across Tennessee, nearly half (47%) of all fetal deaths reported by hospitals from 2017-2021 listed an unspecified cause. Some higher volume hospitals in the state have less than 30% of fetal deaths with an unspecified cause.

The American College of Obstetrics and Gynecology (ACOG) recommends autopsy, placenta, cord, & membrane histological exams, and genetic evaluations in the event of fetal death to determine cause.[12]

In Tennessee, data is only collected on autopsy and histological placental exam. Autopsy or histological placental exam was performed in 59% of fetal death cases.



Risk Factors - Pregnancy History

Pregnancy history can impact future pregnancy outcomes. These are separate from characteristics of the current pregnancy. While previous live births and previous cesareans (among families with previous pregnancies) were not significantly associated with changes in fetal mortality rate, other pregnancy-related histories were found to be associated with increased fetal mortality rates.

Certain previous pregnancy outcomes show increased fetal mortality rates.

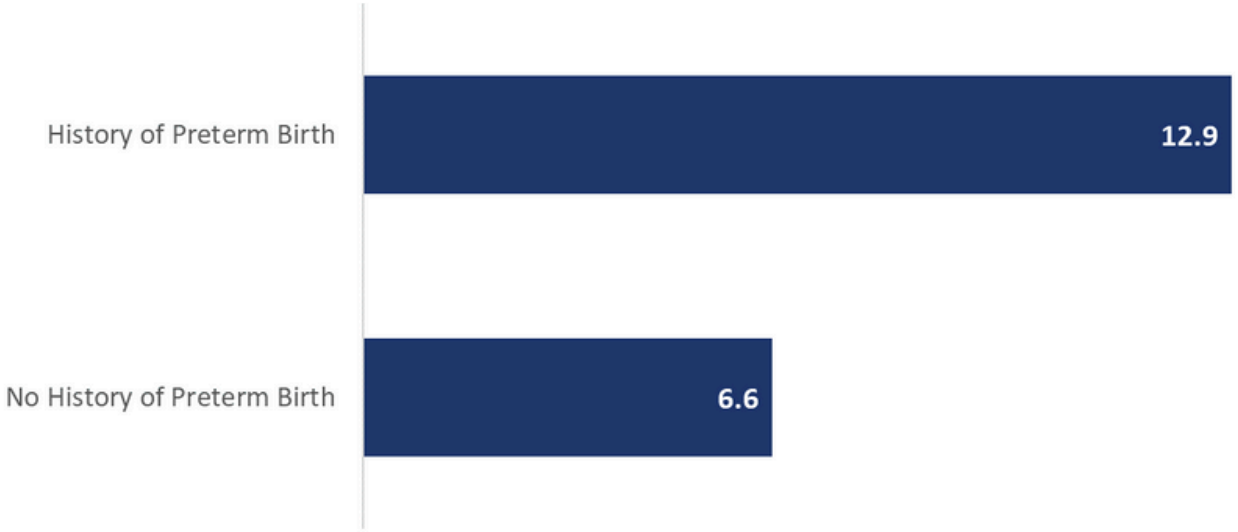
Families who previously suffered the loss of a fetus had a 40% increase in fetal mortality rate

The fetal mortality rate was 6.0 fetal deaths per 1,000 live births and fetal deaths for those who hadn't experienced a previous fetal loss. It was 8.4 for those who had previously experienced a pregnancy loss at any point during pregnancy.

History of preterm birth had the largest increase in fetal mortality rates. Among those with a previous pregnancy, **the fetal mortality rate for those with a history of preterm birth was nearly double that of those without.**

Fetal Mortality Rates by History of Preterm Birth*, 2017-2021[6]

*Among those with previous pregnancies



Risk Factors - Pre-Pregnancy

Optimal pre-pregnancy health supports the health of both the pregnant woman and the developing baby. Pre-pregnancy diagnosis with chronic conditions such as diabetes and hypertension, can lead to adverse outcomes.

Good pre-pregnancy health shows lower fetal mortality rates.

The Fetal Mortality Rate for those with Pre-pregnancy Hypertension is

That is 2.4x higher than the fetal mortality rate for those without at 6.3.

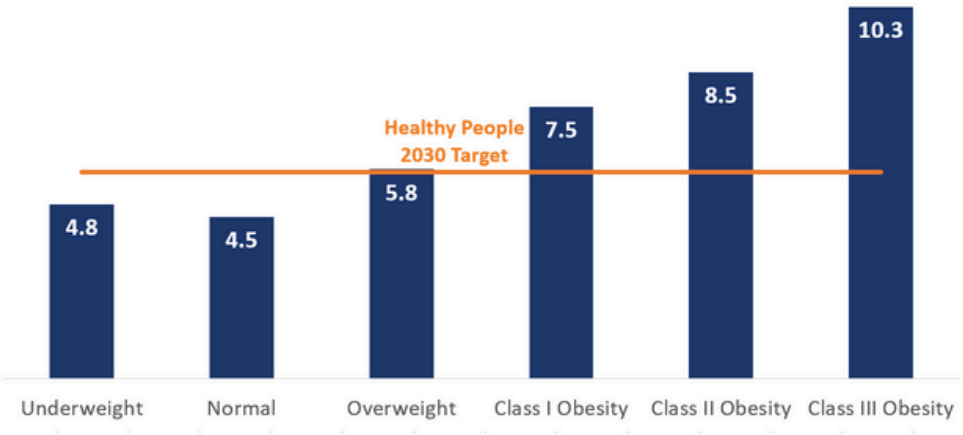
The Fetal Mortality Rate for those with Pre-pregnancy Diabetes is

That is 3.1x higher than the fetal mortality rate for those without at 6.4.

The impact of gestational diagnoses of diabetes and hypertension after 28 weeks was not significant on fetal mortality.[6]

Further, higher or lower than "normal" pre-pregnancy body mass index (BMI) is connected to adverse outcomes for both the pregnant woman and the baby. BMI is calculated using a person's height and weight. Tennessee fetal death data shows that with increasing pre-pregnancy BMI past "normal" the fetal mortality rate increases.

Fetal Mortality Rate by Maternal Pre-Pregnancy BMI, 2017-2021[6]



BMI is a function of weight and height.

<18.5kg/m²: underweight; 18.5kg/m²- <25kg/m²: normal; 25kg/m²- <30kg/m²: overweight; 30kg/m²- <35kg/m²: class I obesity; 35kg/m²- <40kg/m²: class II obesity; >40kg/m²: class III obesity

of fetal deaths happened to pregnant women with a pre-pregnancy BMI in the obese category

Risk Factors - Substance Use

Substance use during pregnancy has been related to many adverse pregnancy outcomes such as premature birth, low birthweight, developmental delays, and mortality.[13]

Smoking is a very common type of substance use, even among pregnant women. More than 1 in 10 pregnant women in Tennessee from 2017-2021 reported any smoking during pregnancy. It is even more common among those that experience fetal death.

Any smoking during pregnancy leads to higher rates of fetal death.

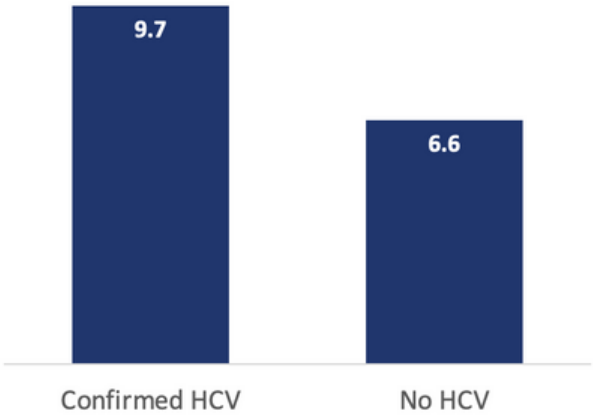
14.1% of fetal death certificates reported maternal smoking as a risk factor during pregnancy

There was a **1.3x higher rate of fetal death among pregnant women who smoked** any amount during pregnancy compared to those who didn't. The fetal mortality rate was 6.1 for those who **did not** smoke and 7.9 for those who **did** smoke.[6]

Information related to other substance use is not reported on the fetal death certificate. Hepatitis C virus (HCV) transmission is most common among persons who use drugs (PWUD); thus, HCV is often used as a proxy for injection drug use.

Data on persons with HCV in pregnancy are collected by the Tennessee Department of Health (TDH) Viral Hepatitis Program. Confirmed cases have at least one positive HCV Nucleic Acid Amplified Test (NAAT) during pregnancy or, in the absence of a prenatal laboratory report, at least one HCV NAAT conducted within 12 months prior to pregnancy and the last HCV NAAT prior to pregnancy is positive. The fetal mortality rate was higher in those with HCV.

Fetal Mortality Rate by Maternal Hepatitis C Infection, 2017-2021[6]



HCV is connected to higher rates of fetal death even when not used as a proxy for injection drug use. When not adjusting for substance use, there are higher odds of fetal death in Tennessee when the b has HCV.

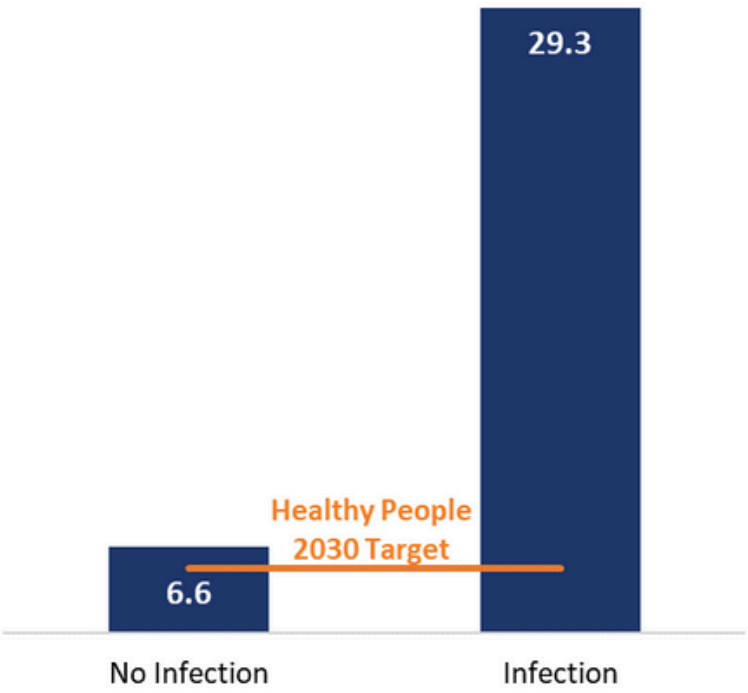
Risk Factors - Infections

In addition to HCV, other maternal infections during pregnancy can negatively impact the health of both pregnant woman and baby. Chlamydia, gonorrhea, and syphilis are the only sexually transmitted infections collected on the fetal death certificate in Tennessee.

Data show that syphilis infection during pregnancy is a major risk factor for fetal death.

Nearly 3% of all women with a syphilis infection during pregnancy experienced a fetal death.

Fetal Mortaltiy Rates by Maternal Syphilis Infection, 2017-2021[6]



The fetal mortality rate for those with a syphilis infection was over 4x higher than those without.

And 5x higher than the Healthy People 2030 Target.

The US has seen a substantial rise in syphilis. Syphilis cases increased by 73.9% (101,590 to 176,713 cases) from 2017 to 2021.[14]

Congenital syphilis cases increased even more. Data shows drastically higher rates of fetal death and adverse outcomes for babies born with congenital syphilis.[15]

The Tennessee Department of Health STI Program conducts congenital syphilis surveillance and aims to improve outcomes for parents and their babies.

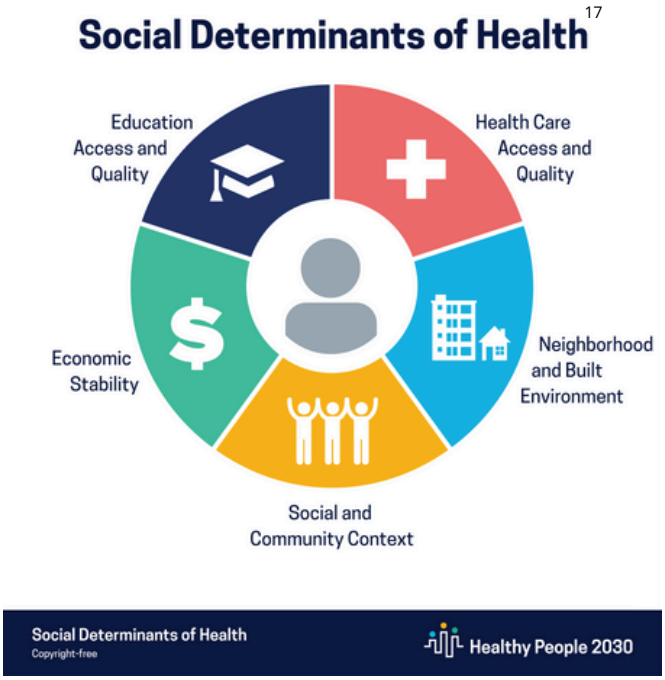
Nationwide Congenital Syphilis Cases[15]

Risk Factors - Social Drivers of Health

Social Drivers of Health are not reliably measured.

Social Drivers of Health (SDOH) describe the conditions in which people live and how they impact a variety of health outcomes. These are nonmedical factors such as housing, transportation, access to medical care, access to nutritious food, and more. Previous work suggests that up to **50% of poor heath outcomes can be attributed to social drivers of health.**[16]

Assessing SDOH is critical for understanding any health outcomes and to assess potential modifiable factors. **Unfortunately, they are not reliably collected on the fetal death certificates.**[6]



Insurance status is accepted as a great marker for other social drivers of health. Unfortunately, it is not collected.

Maternal Education

of fetal death certificates.

WIC Enrollment

of fetal death certfifcates.

Risk Factors - Social Drivers of Health

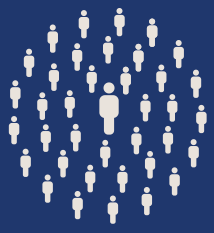
Rurality

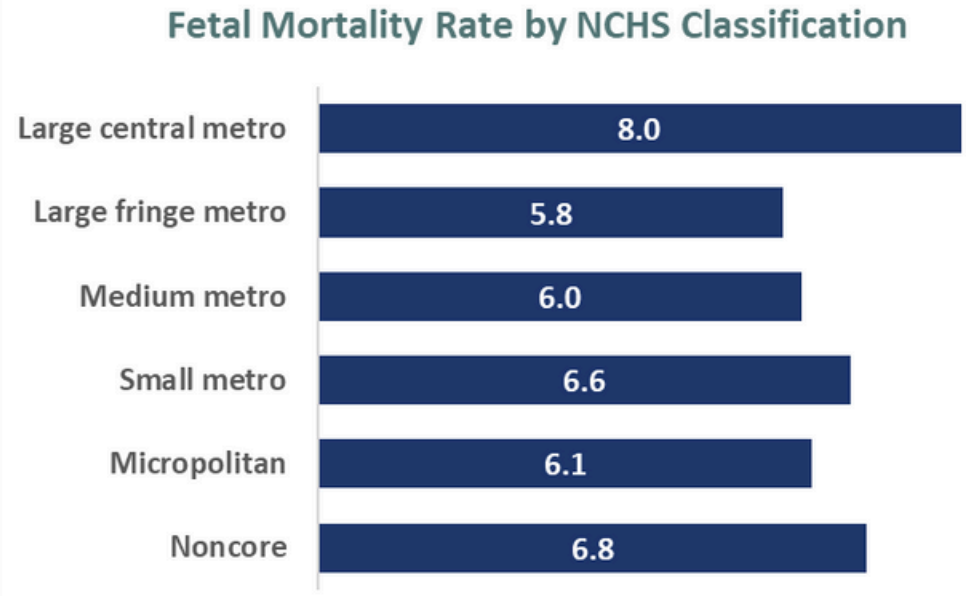
People living in rural areas often face higher rates of unemployment, lower levels of education, and lower access to health and social services when compared to residents of more populated areas. All of these factors are significant contributors to social drivers of health and can lead to disparities in healthcare outcomes.[18]

National Center for Health Statistics Population Classifications Definitions[19]

Large Central Metro	Large Fringe Metro	Medium Metro	Small Metro	Micropolitan	Noncore
at least 1 million that: 1. contains entire population of principle city or 2. completely contained within principle city or 3. contains at least 250,000 residents of principle city	at least 1 million that does not qualify as large central	250,000 to 999,999	249,999 to 50,000	49,999 to 10,000	less than 10,000

In Tennessee, more populated areas do not have lower fetal mortality rates.





There was significant variation in fetal mortality rates by the urban/rural classifications listed above. This association seems to be driven by large central metros and there is not a statistically significant trend in this association with increasing or decreasing rurality.

It is important to note that the racial and ethnic compositions of metro and non-metro regions differ. As racial and ethnic disparities in fetal mortality rates are prominent in Tennessee, this likely impacts the metro and non-metro fetal mortality rates.

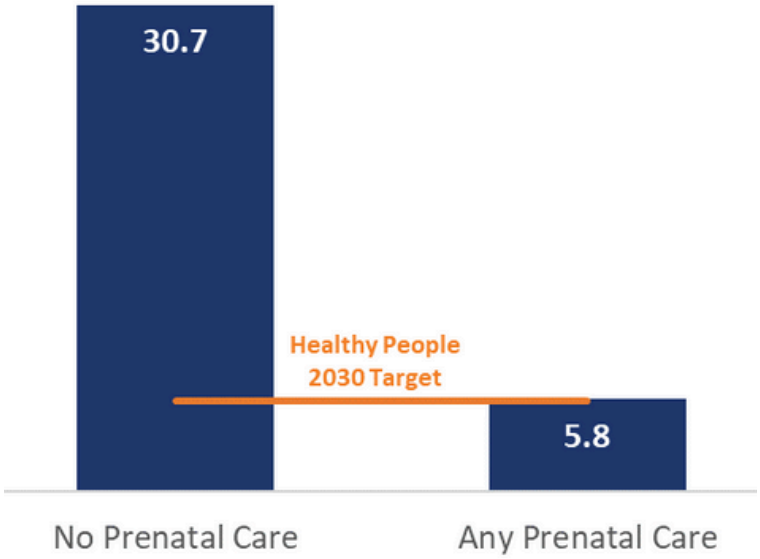
Prenatal Care

Prenatal care is critical for assessing the health of both mom and baby. Regular check-ups are important to prevent several adverse outcomes, including fetal death. The typical schedule for prenatal appointments is:[20]

11.8% of fetal deaths happened to women with **no prenatal care.**

While following a set schedule planned by a patient and their care provider is ideal, accessing any prenatal care during pregnancy is better than none.

Fetal Mortality Rate by Prenatal Care, 2017-2021[6]



The Fetal Mortality Rate is

higher than the Healthy People 2030 Target for women with no prenatal care during pregnancy.

It is important to note that as 52% of fetal deaths occur before 28 weeks, expectant women may not have had the opportunity to have many appointments prior to fetal death. This data still shows the importance of having any prenatal care to support the health of both the expecting mother and baby.

Another measure to assess prenatal care is the adequacy of prenatal care. Unfortunately, due to the inconsistent availability of the data point for first appointment (a critical component to assessing adequacy of prenatal care), that metric is not measurable at this time.

Several factors can impact access to adequate prenatal care, including limited obstetric providers in the area. Three in five Tennessee counties are considered maternity care deserts or have low access to maternity care.[21]

Support and Prevention Efforts

Fetal and Infant Mortality Review Teams

Fetal and Infant Mortality Review, or FIMR, Teams monitor and assess fetal and infant deaths in their regions and work diligently to provide support for families. They review cases of fetal and infant death, conduct family interviews, and establish targeted community programs. Each team is notified of all fetal deaths but does review on a selected cohort.

CRT

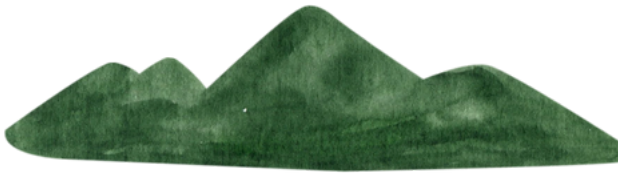
Case Review Team

Receives and reviews reports of fetal and infant death to collect all relevant information surrounding the death.

CAT

Community Action Team

Focuses on implementation. The CATs use information & recommendations from CRT to support the community.



Tennessee

Current funding and personnel constraints only allow the State to fund FIMR teams in Davidson, Hamilton, Knox and Shelby, the most densely populated counties in Tennessee.

Metro Public Health Dept
Nashville/Davidson County

Davidson County FIMR

Davidson FIMR has a combined CAT with two MPHD home visiting programs, Healthy Beginnings and the Nashville Strong Babies Healthy Start Programs, which have multidisciplinary action teams focused on improving maternal child health and reducing inequities. As of this report, the CATs are focused on: quality & unbiased healthcare, affordable and stable physical environments (affordable housing and childcare), and maternal mental health. They are aiming to leverage qualitative data from family interviews to develop a thoughtful and holistic report to describe fetal death within the county.

Fetal and Infant Mortality Review Teams

Hamilton County FIMR

Hamilton FIMR CATs are focused on implementing “Count the Kicks”, smoking and drug use cessation programs, and addressing health disparities. They have also developed and shared a comprehensive prenatal packet. An educational element is included in the distribution of these packets to local OBGYN clinics, as distributors offer to explain various components. Lastly, they leverage creative methods to advertise programs, such as, movie theater pre-shows, bus ads, and bereavement cards and packets.

Knox County FIMR

Knox FIMR has one CAT focused on implementing programs to meet the needs in the community such as doula services, birth equity alliance, support for mental health providers, and teen pregnancy prevention. Barriers to implementation are often red tape and funding; however, the team is developing solutions, particularly to increase the number of birth workers, such as scholarships for doulas.

Shelby County FIMR

Shelby FIMR is, at the time of this report, in a development and growth phase. They are aiming to grow community baby showers and a community-based doula program. Their CATs are guided by data from needs assessments and CRT. They are eager to promote health equity, educate providers on Maternal and Child Health, and focus on the health of the whole family, including men's health.

Count the Kicks

Tracking fetal movement is a simple and effective way to combat fetal death. It is recommended to pay extra attention to the baby's movement from **the start of the third trimester.** This allows parents to more easily determine deviations from the normal trends and contact their providers in a timely manner.

The baby's movement can either be tracked manually or by using the Count the Kicks application. As of January 2021, "Count the Kicks" received designation of Best Practice by the Association of Maternal and Child Health Programs.[22]

Implementation Efforts in Tennessee

In July 2024, TDH will launch a new partnership with Healthy Birth Day, Inc. to implement Count the Kicks statewide. Through this partnership, providers and expectant families will have access to tools and co-branded educational resources that have the potential to reduce the total number of fetal deaths that occur during the third trimester across Tennessee.

More information can be found at countthekicks.org

Download the App

Or click here

Look at the Evidence

Or click here

Provider Education

Or click here

Recommendations

Statewide efforts to emphasize surveillance, research, and support programs are critical to prevent fetal death and meet the Healthy People 2030 Target.

Health Departments

Promote telehealth programs to reach Tennesseans who struggle to access maternity care.

Continue programs that support family planning, including leveraging telehealth.

Continue STI Prevention programs including screening, testing, and providing resources.

Leverage evidence-based state health department tobacco cessation programming (GIFTS).

Update variables on fetal death certificates to include critical social drivers of health such as insurance.

Prioritize prevention investments and resources to sub-populations with high fetal mortality rates.

Institute statewide prevention efforts that can help all Tennesseans.

Health Systems & Providers

Increase emphasis on sexual education and promotion of family planning services, leveraging tools like telehealth.

Encourage and support patients in family planning, optimizing pre-pregnancy & pregnancy health.

Test for STIs per guidelines and if positive, treat the patient and any partners to avoid reinfection.

Offer training opportunities to minimize provider implicit bias as well as improve shared decision making and patient trust in the healthcare system.

Improve determination and documentation for cause of fetal death by offering training support to staff and increasing investigative efforts.

Increase autopsy rates for determining cause of death.

Increase education to medical records staff on the importance of consistent collection of social drivers of health data

TDH Resources & Resource Navigation

Community Health Access and Navigation in Tennessee (CHANT)

The Community Health Access and Navigation in Tennessee (CHANT) Program is dedicated to supporting families in Tennessee by fostering patient-centered engagement, providing support for the navigation of a complex system of health and social services, and impacting pregnancy, child, and maternal outcomes. The team helps families connect with the necessary resources depending on individual needs and medical diagnoses and coordinate care that often involves several programs, providers, and personnel. A fully voluntary and free service, CHANT combined three previous public health programs, Help Us Grow Successfully (HUGS), Children's Special Services (CSS), and Tenncare Kids Community Outreach into one model of care coordination. Care coordinators in CHANT maintain updated resource guides to assist families in navigating the health and social services system.

CHANT Website

Or click here

CHANT Referral Form

Or click here

Growing Inside Free of Tobacco and Smoking (GIFTS)

Or click here

Telehealth Family Planning & Care

Or click here

TN HIV/STD Program

Or click here

Diabetes Program

Or click here

Hypertension

Or click here

Bereavement Resources

We acknowledge that fetal death is an unbelievably challenging loss. There are many wonderful resources available to support families facing fetal death. To simplify access to these resources please find some extensive resource links in the following pages.

Bereavement Resources

Statewide Bereavement Resources

Middle Tennessee State University (MTSU) Bereavement Resources

The Middle Tennessee State University Center for Health and Human Services Department and University College has partnered with the Tennessee Department of Health for 20 years to develop training resources for first responders to manage infant death scene investigations. Along with other training materials, a comprehensive statewide bereavement booklet was developed to be used by first responders when they encounter grieving families to assist them in locating resources. While this resource was developed specifically for first responders, it is available online and can be shared with families and providers. This booklet is updated annually through a lengthy process to ensure all resources listed are up to date and available for use by families.

To Access Resources Please Scan:

Or click here

The Bereavement Resources Booklet can be found under
"Other Training Resources"
"Infant Mortality"
"Sudden Unexplained Infant Death Resources - Bereavement Support Services"

Share

Share is a national organization that strives to support families navigating infant and fetal death.

Or click here

Bereavement Resources

FIMR Bereavement Resources

Davidson County FIMR

The Nashville/Davidson Metro Public Health Department Team is dedicated to supporting families facing the loss of an infant or pregnancy. They hold a quarterly Bereavement Stakeholders meeting with hospital bereavement staff to troubleshoot issues and share resources and practices. Additionally, the Davidson FIMR team has partnered with the Child Death Review team for a workgroup focused on improving communication about autopsies and increasing rates of completion. They have also developed several resources for grieving parents to access after experiencing the loss of a child that can be found on their website.

Davidson FIMR Resources

Or click here

Hamilton County FIMR

The Hamilton County Public Health Department FIMR Team strives to provide thoughtful support to families facing fetal and infant loss . When families experience a loss they receive a condolences card in the mail with further information about what and who FIMR is. They also receive small packets with forget me not seeds, a poem, and some relaxation tea. These efforts serve to not only show care to the families, but also improve family interview rates. Additionally, they have several resources for grieving families on their website.

FIMR Grief Resources

Or click here

Grief Hurts Helpful Hints

Or click here

FIMR Homepage

Or click here

Bereavement Resources

FIMR Bereavement Resources

Knox County FIMR

Most hospitals in Knox county make necessary referrals to families who face fetal loss. The University of Tennessee has an especially effective program, with a department dedicated to supporting these families. The Knox County Health Department FIMR team also maintains a referral list and partners with community groups such as Ready Nest Counseling and Project Gabriel. Project Gabriel was founded by a local woman who suffered a loss and offers counseling resources.

KNOX COUNTY TENNESSEE HEALTH DEPARTMENT

Resources to be Avaliable Online

Or click here

PDF Resource List

Or click here

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