Primary prevention includes the elimination of known risk factors, which include Rhesus disease, hyperbilirubinaemia and maternal iodine or thyroid hormone deficiency. Secondary prevention involves strategies that reduce premature birth and include medications that delay labour. Administration of magnesium sulfate and antenatal steroids reduce the rate and severity of cerebral palsy in premature infants, as does body cooling in high-risk full-term infants.

Cerebral palsy has a prevalence of approximately 1 in 500 neonates, with an estimated 17 million people affected worldwide. Premature birth and difficult labour associated with neonatal asphyxia are the most important risk factors for cerebral palsy. The risk of cerebral palsy development is 50-times higher in infants born <28 weeks of gestation than in full-term infants, but a modest increase in risk is already observed as early as 38 weeks of gestation. Although premature birth is a very important risk factor, full-term infants with signs of birth depression account for the majority of cases.

No definitive cure for cerebral palsy exists. Clinical management is directed at improving function and minimizing the effects of the factors that can make the condition worse, such as epilepsy, feeding challenges, hip dislocation and scoliosis. These management strategies include enhancing neurological function during early development; managing medical co-morbidities, weakness and hypertonia; using rehabilitation technologies to enhance motor function; and preventing secondary musculoskeletal problems.