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ORIGINAL ARTICLE

Somaliland women's perception of stillbirth- a descriptive survey study

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ABSTRACT

Background: Somali women, not only those living in Somaliland but also those living abroad as asylum seekers and refugees, are highly vulnerable in terms of perinatal health outcomes. Respectful and supportive care is critical for all women when stillbirth occurs and improving bereavement care and reducing the stigma that surrounds stillbirth are global priorities. Culturally- and context-specific approaches that build on an understanding of the needs of women giving birth to a stillborn baby, no matter where or why, are required.

Objectives: This study aims to investigate and analyze Somali women's experiences of stillbirth, including their perceived reasons for losing their unborn baby, the premonitions they had before giving birth and their experiences of psychosocial support from healthcare professionals and relatives.

Methods: A descriptive retrospective study was conducted at the Borama regional hospital in Somaliland. A study-specific questionnaire was developed that gathered personal information and data on topics related to women's experiences of stillbirth. Women who had either experienced a stillbirth at the hospital or had been referred there after a stillbirth 2015 were approached and 75 women agreed to participate in the study.

Results: Most of the women were multiparas and had experienced a previous stillbirth. Before having it confirmed that their baby was no longer alive most of the woman reported that they had felt no fetal movements and had a premonition that something was wrong. The most common perceived cause of stillbirth that the women reported was prolonged labour followed by a 'big baby'. Thirty-three women (44%) felt it was important to know the cause of the stillbirth and eight reported feeling angry or disappointed (11 %) with the health care providers who assisted them during labour, birth, or post-partum, although 41 women (55%) were satisfied with their treatment. A third of the women blamed themselves for their stillbirth and a majority spoke to others about it.

Conclusions: Our results show that women in Somaliland share similar perceptions of stillbirth as women in high income countries. This raises important implications for antenatal care and preventive interventions and stressed the need to respond to women's concerns regardless of background, context or setting. A maternal healthcare approach that is equal in its global application must be established to enable health care providers to give relevant information and care both in the cultural setting of Somaliland and elsewhere in the world where Somali-born women live and give birth.

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Background

Good health and wellbeing and gender equality, two of the United Nations' sustainable development goals, imply the global need to reduce the number of women and children who die unnecessarily, particularly as a result of childbirth [1]. In Somalia, the rate of stillbirths continues to be high, with an estimated 35.5 stillbirths per 1,000 births in 2015, a figure that is much higher than the target set by the World Health Organization's Every Newborn

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Action Plan (ENAP) of 12 or fewer stillbirths per 1,000 births in every country by 2030 [2]. Even so, the Somali figures are probably an underestimate of the actual stillbirth rates, because many such child deaths are still not registered or audited. There are many ways a national stillbirth rate can be reduced, increased access to obstetric services with skilled birth attendants, the provision of antenatal care to all women, intrapartum care, a functioning referral system, foetal monitoring, and access to and provision of caesarean sections [3-6], although context-specific barriers to some of these interventions might prevent their easy introduction. For instance, a study conducted in Somaliland, showed the refusal of consent from the extended family to perform emergency caesarean sections in good time, as a leading factor of maternal deaths and stillbirths [7]. Likewise, in another Somaliland study, a cross-sectional investigation into the reasons for maternal deaths and stillbirths identified the routine delay in the admission of late term pregnant women [8].

When stillbirth occurs, it is critical that all women, regardless of nationality, receive respectful and supportive treatment. Improving bereavement care [9] and reducing the stigma that continues to surround stillbirth are therefore, global priorities [10-12]. Culturally- and context-specific approaches are, accordingly, intended to develop a global consensus on bereavement care after stillbirth that also acknowledges the needs of women, families and their care providers. Research into care after stillbirth has focused predominantly on high income countries (HICs) despite the vast majority of stillbirths occurring in low and middle income countries (LMICs) [4, 9, 13]. Of 34 studies reviewed in a meta-summary of parents' and healthcare providers' experiences of care after stillbirth in LMICs [9], only five were from low income countries (LICs). All of these were from Africa, including one from Somalia. These studies showed that blame and stigma were the key themes associated with post-stillbirth care and were likely to be exacerbated by the absence of any audit of established medical causes. Support from parents and healthcare providers were found to be important but were often not available or limited because of health system constraints and the lack of training among healthcare providers. In order to expand the research that has been done into experiences of stillbirth in low-income countries, this study aims to investigate the reasons which Somali women offer for losing their baby, the premonitions they had prior to their loss and their experiences of the care and support they received from healthcare providers and relatives after it occurred. This research should enable professionals, both those based in Somaliland and those dealing with the considerable number of Somali women including those who are asylum seekers and refugees, to provide more relevant information and improved quality of care to a group particularly vulnerable to negative perinatal health outcomes [14, 15].

Materials and methods

Design and setting

This is a descriptive retrospective survey conducted at the regional hospital in Borama, the capital city of the Awdal region in north-west Somaliland. Borama has approximately 320,000 inhabitants. In 2017, the birth rate in Somalia was estimated at 39.6/1000 persons and the infant mortality rate was 94.8/1000, the second highest infant mortality rate in the world [16].

Data collection tool

The questionnaire used in this study was based on a questionnaire developed to investigate stillbirth in the Nordic countries, particularly Sweden [17] and used with the permission of the original authors. Alongside personal information, the questions focus on women's experience of their stillbirth, particularly the support they received and their memories of their stillborn baby [17]. These questions were modified to fit the Somaliland context by an expert team of local physicians, midwives and nurses. The stillbirth data in this study, therefore, derives from women's own experiences, perceptions and premonitions of losing a baby at birth and not from any official medical records. The mother's perceived cause of the stillbirth (Table 3) may be both mothers' perception and a clinical diagnosis the mothers' have been informed about based on information to the mothers from the medical staff at the health facility. Minor modifications were made to the questionnaire after it was pilot tested by a small group of Somali women with experience of stillbirth three years before the questionnaire was distributed to the women.

Inclusion criteria

This study included all women being discharged from maternity care at the Borama regional hospital during a three month period between January 2015 and March 2015 with the experience of giving birth to a stillborn baby either at (a) Borama regional hospital itself, the regional referral hospital, (b) one of the other two hospitals in the district but then referred for treatment to the Borama hospital or (c) a private residence but where the birth was assisted by a traditional birth attendant associated with the Borama regional hospital who referred the woman for postpartum care at the hospital.

Data collection procedure

This study included all women being discharged from maternity care at the Borama hospital during a three-month period between January and March 2015 with the experience of giving birth to a stillborn baby. Physicians and nurses working at the Borama regional hospital were recruited as data collectors. They were responsible for providing information about the study and were trained to deliver the questionnaire by local research assistants who were university tutors and lecturers in their daily profession. When women were at the point of discharge, the attending physician or nurse provided them with written and oral information about the study. The research

assistants then arranged a face-to-face meeting in the participant's home and the questionnaire was completed in the presence of the principal investigators, as some of the participants had difficulties in reading and writing. Although the women were supported in their completion of the questionnaire, not all of them answered every question.

Data management and analysis

Due to the small sample size, we have opted for a purely descriptive approach, tabulating responses presenting the numbers and percentages. No across group comparisons were made, due to a number of small group sizes, which can pose a privacy concern for the respondents, while not providing generalisable evidence due to the small sample sizes. Responses were first recorded in Excel, and there after converted to SPSS for further data cleaning, analysis and tabulation.

Ethical considerations

Data collection was carried out in accordance with generally accepted ethical principles [18]. Approval for the study was obtained from the University of Hargeisa Research Ethics Committee (December 2014) and the Borama regional hospital management team gave their consent for the study to be conducted at their facility. Before beginning the questionnaire, the women were informed about the study, that their participation was voluntary and that they had the option to withdraw at any time without any further explanation. It was made clear that whether participating or not, there would be no effect on either the women's or their living children's health care. After signing or affixing their thumbprint to the informed consent form, the questionnaire was administered. After the completion of the questionnaire, the women were invited to speak in private with a caregiver if feelings relating to their experience of the stillbirth arose during their participation in the study. Contact information was kept in a sealed box at the Borama maternity ward in order not to threaten confidentiality until the relevant data was entered into an IBM SPSS file on a computer with a password requirement only accessible to the principal investigators.

Results

Demographic background

At the time of the stillbirth, the women in this study were between the ages of 18 and 38 years. (Mean 29.8, SD±5.3). A majority of them (n=45, or 60%) had given birth to their stillborn baby at the Borama regional hospital with the remainder (n=30, or 40%) having given birth to their stillborn baby at home (Table 1). Most of the stillbirths (n=47, or 63 %) occurred in full term pregnancies (Table 1), with 23% (n=17) occurring preterm in gestational week 29-37 and 15% (n=11) occurring earlier than gestational week 29. None of the women were post term. A majority of the women (89%) indicated that the stillbirth was not their first birth; only eight women (11%) were primipara. Out of the 67 multipara women, 23 (31%) had at least one previous stillbirth (Table 1).

Table 1. Socio-demographic data, obstetric history and medical conditions during pregnancy.

Characteristics (total n=75)	*n*	*%*
Mother's age (years)		
18-20	6	8.0
21-25	9	12.0
26-30	25	33.3
31-35	23	30.7
36-38	12	16.0
Location of birth		
Hospital	45	60.0
Home	30	40.0
Gestational age at birth (weeks)		
≤28	11	14.7
29-37	17	22.7
38-42	47	62.7
≥43	0	0
First pregnancy		
Yes	8	10.7
No	67	89.3
Number of previous live births		
0	9	12.0
1	11	14.7
2	14	18.7
3	15	20.0
4	7	9.3
≥5	19	25.3
Number of previous still births		
0	52	69.3
1	2	2.7
2	13	17.3
3	3	4.0
4	4	5.3
≥5	1	1.3
Medical conditions during pregnancy		
Hypertension	6	8.0
Diabetes Mellitus	1	1.3
Vaginal bleeding	13	17.3
Other	25	33.3
None	30	40.0

Women's perceptions and premonitions pre partum

Before having medical healthcare providers (HCP) confirm that their baby was no longer alive, 34 (45%) of the women reported that they had felt 'no fetal movements', 11 (15%) reported feeling that they had lost contact with their unborn baby and a further 16 women (21%) reported that they 'felt something was wrong'. Only 6 women (8%) reported they had felt no sign of anything being wrong. A large majority of women, (n= 61, or 81%) reported knowing at least 24 hours before the birth that the outcome of the pregnancy would be a stillbirth; 14 women (19%) realised this during or after labour. Ten women (13%) reported that they did not understand that their baby was dead even after the stillbirth (Table 2).

Table 2. Mother's premonitions before the stillbirth

Characteristics (total n=75)	*n*	*%*
Knew there was intrauterine foetal death during pregnancy		
Yes	30	40.0
No	45	60.0
Missing	0	
Knew there was intrauterine foetal death during labour		
Yes	46	61.3
No	29	38.7
Missing	0	
Time period she knew about foetal death before labour		
1 day	31	41.3
>24 hrs	30	40.0
During labour and/or after delivery	14	18.7
Missing	0	
Before knowing the baby was dead, I felt...:		
No contact with my baby	11	14.7
No foetal movements	34	45.3
Worried	8	10.7
Felt something	16	21.3
Did not know	6	8.0
Missing	0	
After the delivery of a still birth I...:		
Did not understand that the baby was dead	10	13.3
Wanted someone to confirm whether the baby was dead or alive	17	22.7
Felt that the baby was dead	48	64.0
Missing	0	

Women's perceived causes of the stillbirth

Prolonged labour was the most common perceived cause of stillbirth and was indicated by 11 women (15%). The second largest perceived cause, indicated by 8 women (11%), was that their baby was 'big'. Other causes that were indicated were 'ablation of the placenta' (8%) and Group B Streptococcus (GBS) infection (9%). Four women (5%) stated that the cause of the stillbirth was the delay of the caesarean section. The delay was caused by the lack of the mandatory signed informed consent form from both maternal and paternal family members prior to a caesarean section. Even so, none of these four women reported being sad or angry towards their HCP for their actions pertaining to the stillbirth. Only three women (4%) mentioned 'negligence by healthcare staff' and 'lack of care during labour and delivery' as a cause of their stillbirth in the Borama hospital and none of them reported being angry or sad with the HCP (Table 3).

Table 3. Mother's perceived cause* of the stillbirth

Characteristics (total n=75)	*n*	*%*
Maternal causes		
Prolonged labour	11	14.7
Refused assisted delivery	0	0
GBS infection	6	8.0
Preeclampsia	3	4.0
Eclampsia	3	4.0
Foetal causes		
Big baby	8	10.7
Trauma during the pregnancy	2	2.7
Placenta ablatio	7	9.3
Placenta insufficiency	1	1.3
Umbilical cord presentation/ prolapse/cord around neck	5	6.7
Malformation of the baby	1	1.3
Healthcare interventions		
Caesarean section	0	0
Negligence	3	4.0
Lack of midwife	0	0
Traditional birth attendant	1	1.3
Informed consent not signed	4	5.3
Assisted delivery	1	1.3
Other causes		
Lack of finances and transportation	0	0
Other / Unknown	19	25.3

* The table is based on statements by the mother on her own perception of the cause of stillbirth as well as on clinical diagnoses which she had been informed about by medical staff at the health facility.

Women's perceptions of care and support post-partum

While 56 women reported that HCP, (Doctors, Skilled Birth Attendants (SBA), Traditional Birth Attendants (TBA), did explain to them what the cause of their stillbirth might have been, 42 of the women (56%) claimed that it was not important for them to know. However, 33 (44%) women did feel it was important to know the cause, and of these 9 (27%) reported that they had not been given a possible reason by either their physician or other healthcare professionals. Eight women (11%) reported feeling angry or disappointed with the performance of healthcare professionals during their labour, birth or post-partum recovery, whereas 41 women (55%) where satisfied with the support they received (Table 4). A third of the women (n=23, or 31%) reported that they felt blamed for the stillbirth. Still, only 14 women (19%) reported feeling depressed after their stillbirth or experiencing anxiety in relation to it; 48 women (64%) in fact reported feeling psychologically well. Whether or not the women felt blamed, two-thirds of them (n=66, or 88%) spoke to others about their loss. More than half of the women (56%) reported speaking to their living children about their stillborn sibling (Table 4).

Table 4. Mother's experienced support from healthcare providers and relatives.

Characteristics (total n=75)	*n*	*%*
It's important to get a reason of foetal death from the care giver		
Yes	33	44.0
No	42	56.0
Missing	0	
Doctor explained the cause of death		
Yes	29	38.7
No	46	61.3
Missing	0	
SBA/TBA explained the cause of death		
Yes	29	38.7
No	46	61.3
Missing	0	
Relative accompanied mother during labour and birth		94.7
Yes	71	94.7
No	4	5.3
Missing	0	
Happy with staff support during labour, birth or postnatal		
Yes	41	54.6
No	18	24.0
Missing	16	
Angry/sad with staff intervention during labour, birth or postnatal		
Yes	8	10.7
No	50	66.7
Missing	17	
Felt blamed for loss of the baby by family		
Yes	23	30.7
No	51	68.0
Missing	1	
Spoke to others about the loss of the baby		
Yes	66	88.0
No	9	12.0
Missing	0	
Told her children about the deceased		
Yes	42	56.0
No	33	44.0
Missing	0	
Felt psychologically well		
Yes	48	64.0
No	27	36.0
Missing	0	
Had anxiety about the loss		
Yes	11	14.7
No	64	85.3
Missing	0	
Had depression about the loss		
Yes	5	6.7
No	68	90.7
Missing	2	

Discussion

Before having it medically confirmed that their unborn baby was no longer alive, most of the women reported that they felt no fetal movements and sensed that something was wrong. Our results show that some women felt blamed. The women felt their families blamed them for the stillbirth. A previous study of women's experiences of stillbirth in Somaliland [19] also identified similar feelings of blame and regret. The women in that study blamed themselves for not holding the stillborn baby even though they wished to do so and felt that they had been prevented from doing so because their family and the HCPs did not believe they should hold a dead body[19]. While seeing or holding a stillborn baby is often linked to deep-seated cultural norms which discourage these practices, research has shown that both actions can greatly assist women to cope with feelings of loss and blame. HCPs who encourage women to see their baby and hold it, and reassure them that they need not be afraid of their feelings, can greatly improve the birth experience and help women to cope with their grief [9, 13]. In a study of the experience of stillbirth in Sweden, parents who, within 30 minutes of its birth, both saw and held their stillborn baby describe this as the time they valued most in enabling them to cope with their loss. To emphasise touching and holding the stillborn baby has been shown to be of benefit in studies from high-income settings, and may also be of benefit to parents in low-income country settings. As evidence-based practice has shown, this experience can be beneficial to parents' future well-being, regardless of whether the cause of the stillbirth is known or not [20], and ought to be encouraged in all settings.

The shortage of medical resources in Somaliland results in a lack of routine audit and disclosure of the medical causes of stillbirth. Failure to disclose the established medical causes for stillbirth, however, risks perpetuating the culture of stigma and blame that many women feel, even though there may be a reluctance to express or disclose these causes in a society with a strong religious faith. Both Osman et al. (2017) [19] and Kiruja et al. (2017) [8] suggested such cultural reticence was at work in the studies they conducted into stillbirths among Somali women with life threatening conditions.

The limited access women in this study had to reliable information about the cause of their stillbirth is reflected in the fact that many of them gave reasons that were unlikely to be medically accurate or real. Of the women who indicated they knew the cause of their baby's stillbirth, many of them said it was because their baby was "big". Somali women's concerns about having babies that are too big to deliver were first reported by Essen et al. in 2000 [21] and Rush (2000) [22] when it was discovered that women of Somali origin living in Sweden were limiting their food intake in pregnancy adopting what they felt were lifesaving strategies that would ensure safe delivery of the baby [21]. Rush (2000) noted that this tendency among women to deliberately reduce their food intake in order to try to ensure a deliverable baby occurs in many different cultures [22]. Pregnant women implement a set of practices based on a logic referring to both their social register (their family and elderly members of their community) and their biomedical register (their antenatal consultants at a healthcare facility or the healthcare professionals who attend them during childbirth) [23]. HCPs should, therefore be aware of these different registers and encouraged to do more to mediate

and mitigate the impact of common cultural perceptions surrounding the causes of stillbirth.

Previous research in high income cultures has shown that, similar to the experiences of the Somali women in this study, it is not unusual for affluent and educated women to have a premonition that something is wrong with their baby before giving birth to a stillborn [24-25]. Research has shown, however, that premonitions can increase the risk that women will blame themselves for failing to act promptly in seeking medical assistance and thus directly contributing to the death of their baby. Asking women about premonitions and reassuring them that this is a common experience might help them to manage the feeling of guilt after a stillbirth [26]. On the other hand, within the antenatal care process research findings suggest that women should be encouraged to listen to their bodies and trust their instincts if they think their baby may be at risk due to reduced fetal movements [27]. As it is still uncertain how best to manage women with reduced fetal movements, trials in this area are ongoing [28].

Experiences of women who give birth to a stillborn baby in low income settings are understudied, even though most cases of stillbirth take place in these settings. This descriptive study makes an important contribution to our knowledge about stillbirth in Somaliland, which has been sparsely studied despite the high prevalence of stillbirth in the region [16]. We need to understand not only the medical causes of stillbirth, but also the perceptions of women themselves and the support they receive from the existing healthcare system, if the findings from recent research on decreased fetal movement are to be implemented and the number of stillbirths to be reduced. With this background, the data on premonitions, experiences and perceptions of the 75 women included in this study are highly valuable. However, the present study has important limitations. The small convenience sample collected cannot be the base of causal claims, or generalisable to the whole population of women experiencing stillbirth in low-income settings, or even Somaliland. This study only provides a descriptive cross-sectional picture of the experiences of a small number of Somali women. Furthermore, we cannot ensure that the principal investigators did not have an impact on the recruitment and the results especially in cases where the women needed help with reading, understanding and answering the questionnaire, which potentially impacts on its external validity. More research is needed to understand women's experiences of stillbirth in low-income settings, and whether factors such as age, parity and previous experiences of stillbirth plays a part in shaping these experiences.

Conclusions

Our results show that women in Somaliland report similar perceptions of stillbirth as women in high income countries. This raises important implications for antenatal care and preventive interventions, suggesting that an adequate response to stillbirth should be developed, regardless of women's nationality, context or setting. A maternal healthcare approach that is equal in its global application must be established to provide relevant information and care in the Somaliland cultural setting and elsewhere in the world where Somali-born women live and give birth.

Summary in Somali

CINWAAN

Aragtida haweenka Soomaaliland ee umula ilmo mayd ah: Daraasad Baaris Sifeynaysa Xaaladda

SOOKOOBID

Hordhac: Haweenka Soomaaliyeed dhammaantood, oon ahayn keliya kuwa ku nool Somaliland, iyo xataa kuwa ku nool qurbaha, waxay la kulmi karaan natiijooyin caafimaad ee halis ah marka ay dhalaan. Daryeelka ku dhisan ixtiraam iyo taakuleyn ayaa muhiim u ah dumarka dhala ilmo mayd ah. Khaasatan in la daryeelo murugada lasoo gudboonaata iyo in la yareeyo dhaleeceynta ku xeeran markii ay hooyadu dhasho ilmo mayd ah, taasoo ah mid adduunweynuhu mudnaan siiyey. In la helo daryeel ku dhisan qaab dhaqameedka iyo deegaanka waa muhiim si loo fahmo baahida haweenka dhalay ilmo mayd ah, iyada oon loo eegin meesheey joogaan iyo sababta.

Ujeeddo: Daraasaddan ayaa looga gol leeyahay in lagu baaro khibradda haweenka Soomaaliyeed ee dhala ilmo mayd ah, iyo in la fahmo sababaha ay u maleynayaan in ay ku waayeen ilmahooda uurka ku jira, astaamaha ay lahaayeen ka hor inta aysan dhalin iyo khibradaha iyo taageeridda nafsiyadeed ay kala kulmeen daryeelka caafimaadka iyo qaraabadoodaba.

Hababka: Daraasad dib-u-eegis ah oo sharraxaad leh ayaa lagu sameeyay cusbitaalka gobolka Boorama ee Somaliland. Su'aalo daraasaddan u gaar ah ayaa lasoo saaray, taasoo ku saleysan macluumaad shakhsiyadeed iyo xog ku saabsan mowduucyada la xiriira khibradaha haweenka dhala ilmo mayd ah. Sanadkii 2015 ayaa laga soo uruuriyay haweenka ku dhalay cusbitaalka ilmo mayd ah ama loo gudbiyay cusbitaalka markey dhaleen kaddib. 75 haween ah ayaa ogolaaday inay ka qayb qaataan daraasadda.

Natiijooyinka: Haweenka intooda badani waxay ahaayeen kuwo caruuro badan dhalay oo lasoo kulmay in ay dhalaan ilmo mayd ah. Inta aan la xaqiijin in uu ilmahoodu caloosha ku dhintay, badi haweenku waxay soo sheegeen inaysan dareemin wax dhaqdhaqaaq ah ilmaha uurka ku jira , oo aaney dareemin inay wax khaldan yihiin. Sababta ugu badan ee ay haweenku u arkeen, in ilmihii oo mayd ahi dhasho waxay ahayd foosha oo dheeraatay, midda kalena waxay ahayd 'ilmo weyn'. Soddon iyo seddex haweenka ka mid ah ayaa sheegay inay muhiim tahay in ay ogaadaan sababta keentay ilmaha caloosha ku dhintay, qaar ka mid ahna waxay sheegeen inay ka caroodeen ama ay ka niyad jabeen xirfadlayaasha daryeelka caafimaadka kuwaas oo ka caawiyey markii ay foolanayeen, dhalayeen, ama dhalmada kadib. Inta badan haweenku way ku qanacsanaayeen daaweyntooda. Seddex meelood meel ka mid ah haweenku waxay isku eedeeyeen in ay dhaleen ilmo meyd ah, badankoodna dadka kale ayay

kala hadleen arrintaas.

Gunaanad: Natiijooyinkayagu waxay muujinayaan in haweenka ku nool Somaliland wadaagaan aragtiyo la mid ah kuwa haweenka kasoo jeeda wadamada horumaray xagga dhalidda ilmo mayd ah. Tani waxay kor u qaadeysaa saameyn muhiim ah oo ku saabsan daryeelka caafimaadka markey hooyadu uurka leedahay, iyo wax ka qabadka ama ka hortagga.

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Author contributions
All authors have made substantial contributions to all parts in the research process.

Disclosure statement
No conflict of interest.

Ethics and consent
Approval for the study was obtained from the University of Hargeisa Research Ethics Committee.

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Paper context
This paper contributes to an understanding of the needs of women giving birth to a stillborn baby, no matter where or why. Data is presented from a descriptive, retrospective study conducted with 75 women after experiencing stillbirth. Before having it confirmed that their baby was no longer alive most of the woman reported that they had felt no fetal movements and had a premonition that something was wrong. The women felt it was important to know the cause of the stillbirth. A maternal healthcare approach that is equal in its global application must be established to provide relevant information and care.

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