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Impact of IUFD on Mothers in Developing Countries: A Rapid Review

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ABSTRACT

Background: Losing a baby to IUFD has a profound emotional impact on mothers. This not only affects their mental health and quality of life but also emphasizes the importance of psychological support in the recovery process.
Objectives: This review aims to explore recent evidence on the biological, psychological, and social impact of intrauterine fetal death (IUFD) on mothers in developing countries.
Methods: This review involved searching databases from 2015 to 2023 through sources such as PubMed, ScienceDirect, and Wiley, as well as search engines such as Google Scholar and Research Rabbit. Articles were selected with the help of Mendeley and evaluated using the JBI Critical Appraisal Guidelines for Qualitative Research. Of the 314 articles found, 5 articles met the inclusion criteria.
Results: This review identified three main themes: biological impact (disturbing physical changes and danger warning signs), psychological impact (mothers' emotional responses), and social impact (moral support, negative stigma, health workers' misbehavior, and the need for better social protection).
Conclusions: To provide adequate emotional support as well as clear and comprehensive information about the causes and next steps after fetal death, health workers need to be equipped with skills and knowledge. In situations that require difficult information delivery, midwives also need to have the sensitivity and skills to help parents manage and respond appropriately to their emotions.

Keywords: *Postpartum Women; Pregnant Women; IUFD; Stillbirth; Developing Countries*

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INTRODUCTION

Infants who die after reaching 28 weeks of gestation but before or during birth are classified as stillborns (World Health Organization, 2022). The United States Center for Health Statistics explains that fetal death occurs when a baby is born without signs of life, such as no breathing, no heartbeat, no cord pulses, or no definite muscle movement. It is independent of gestational age. The term IUFD (intrauterine fetal death) is often used to describe fetal death after reaching a certain gestational age or weight, which has varied over the years. Currently, the most commonly accepted definition is fetal death that occurs after the pregnancy reaches 20 weeks or when the fetal weight reaches or exceeds 350 grams (Pantha et al., 2020).

Nearly 2 million babies are born dead every year, which equates to one every 16 seconds. More than 40% of these events occur during labor. Many of these cases could be prevented with better and adequate care during labor, including regular monitoring and quick access to emergency obstetric services when needed (Chowdhury et al., 2022). Fetal death at birth is one of the most common pregnancy outcomes, with an incidence rate of approximately 1 in every 160 births in the United States. In developed countries, there are various risk factors that are often associated with fetal death, including non-Hispanic black race, never having given birth before (nulliparity), older maternal age, obesity, pre-existing diabetes, chronic high blood pressure, smoking, alcohol consumption, assisted reproductive technology pregnancy, multiple pregnancy, male fetus, marital status, and previous obstetric history. Some factors, such as smoking, can be changed, but many others cannot (Berry et al., 2020). Many of the risks associated with IUFD can be prevented through better prenatal care and accurate early detection, thereby reducing the frequency of IUFD events (Ara et al., 2019).

Fetal death is a traumatic event that is difficult for most mothers and health professionals to accept. It can have a negative impact on the lives of the mother, partner, family, and community. Research shows that informing mothers about fetal death is very difficult and often leads to dissatisfaction with the support received, so mothers who have lost a baby need psychological support to help cope with grief, community stigma, and recovery after childbirth and loss (Antoine et al., 2022).

Losing a baby during the perinatal period can cause grief, as the mother had bonded with the fetus before it was born. This period and grieving process should not be underestimated by health professionals providing care. However, in some African countries, little psychological support is provided to mothers who experience perinatal death. Perinatal bereavement needs to be analyzed in all its complexity (Dormian-Sinaga et al., 2020). Experienced stillbirth during pregnancy or childbirth is a tragedy that often receives little attention in health programs and policies. In fact, the impact can be in the form of considerable material and immaterial losses, including depression, financial burden, economic impact, and lingering stigma and taboos (WHO, 2022).

In 2014, WHO adopted the Every Newborn Action Plan (ENAP), which aims to achieve the global target of 12 or fewer stillbirths per 1,000 births in the third (final) trimester in every country by 2030. As of 2021, 139 countries have reached this target, but 56 countries are not expected to reach it by 2030 without specially designed programs (Berry et al., 2020). The aim of this review is to explore the current research evidence on the impact of IUFD on mothers in developing countries, including biological, psychological, and social aspects.

REVIEW METHOD

This review discusses the impact of IUFD on the mother. This review used rapid reviews, which are a form of knowledge synthesis that apply a systematic approach to describe the evidence related to a topic and rapidly identify key concepts, theories, sources, and knowledge gaps. Although rapid reviews have been widely conducted, there is still a need to improve the quality of methodology and reporting of results. This study used the PRISMA-ScR guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) (Tricco et al., 2018). This review method adopts the approach developed by Arksey & O'Malley (2005) The steps taken in this rapid review include: (1) identifying research questions; (2) identifying relevant studies; (3) selecting relevant studies; (4) extracting and compiling data from the selected studies; and (5) systematically compiling, summarizing, and reporting the results.

(1) Identifying Research Questions

Rapid literature review question based on PCC framework table 1: "What is the impact of IUFD on mothers in developing countries?" Specific keywords are listed in table 2.

Table 1. PCC Framework

P ***(Population)***	***C*** ***(Concept)***	***C*** ***(Context)***
Women, pregnant women, postpartum women,developing countries	IUFD	Impact on mother's life

Literature selection was carried out using PubMed, ScienceDirect, and Wiley databases. As well as using search engines such as Google Scholar and Research Rabbit. The article search used keywords restricted to Postpartum OR postnatal OR pregnan* OR antenatal AND wom?n AND Intra Uterine Fetal Death OR Stillbirth AND impact OR effect AND Developing Countr*. Specific keywords were used in each database.

Table 2. Keywords

Variable	
Postpartum mother	- *Postpartum* - *Postnatal* - *Wom?n*

Pregnant mother *IUFD/ Stillbirth*	- *Pregnant* - *Antenatal* - *IUFD* - *Stillbirth*
Developing country	*Developing Count**

The inclusion and exclusion criteria used in this review are as follows:

Table 3. Inclusion and Exclusion Criteria

No	Component	Discussion
1	Inclusion Criteria	1. Original article From 2015-2023 2. Article discussing the biological impact of IUFD on mothers in developing countries 3. Article discussing the psychological impact of IUFD on mothers in developing countries 4. Articles that discuss the social impact of maternal IUFD incidence in developing countries written in Indonesian/English/Texan languages 5. Articles are *Open Access*
2	Exclusion Criteria	*Sistematyc review* , case report, conference info, conference abstract

(2) **Identifying Relevant Studies**

After conducting a literature search using pre-defined keywords in several databases and manual search engines, the researchers identified 314 articles. These articles were then screened to select articles that were relevant to the topic of study, and after the screening process, 5 articles were found that met the predefined criteria. At this stage, we used a Prism Flow Chart to systematically illustrate the article selection process.

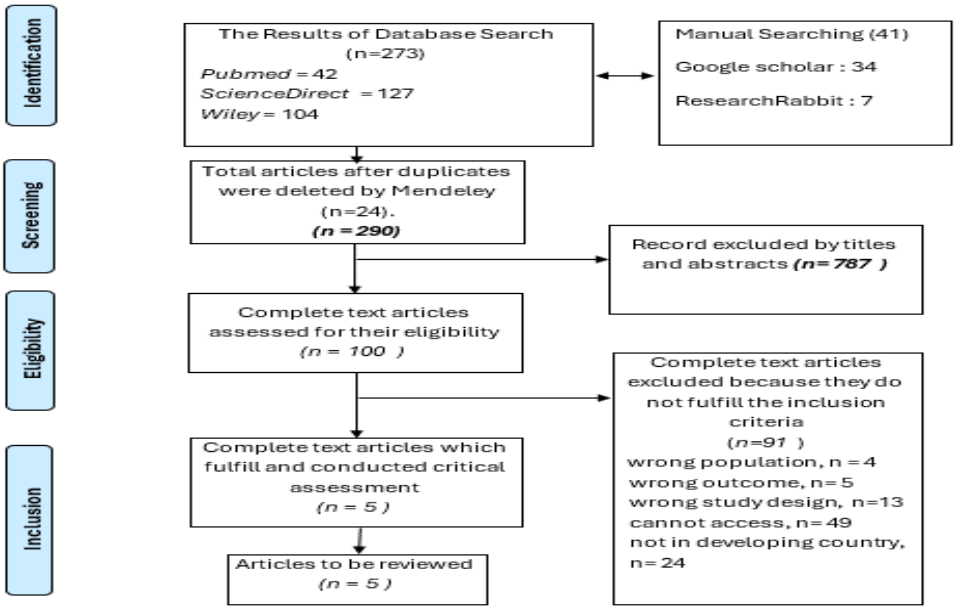

Figure 1. Flowchart Prism

(3) **Selecting Relevant Studies**

The extracted data included data relevant to the topic of the impact of maternal IUFD on the instruments used, country of origin, study objectives, study design, participants, sampling sample, and study outcomes (shown in table 4).

Table 4. Data Charting

Study ID/Title/Purpose/ Design/Country/Author's Name and Year of Publication	Inclusion and exclusion criteria	Sampling Method	Sample Characteristics	Data collection and analysis	Results
A1/ The Experiences of Mothers with Intrauterine Fetal Death/Demise (IUFD) in Indonesia/This research aims to explore the experiences of mothers with Intrauterine Fetal Death/Demise in Indonesia/Phenome	Mothers who have experienced IUFD for more than six months correspond to the time in the loss process stage	Purposive Sampling	This research involved seven participants who had IUFD experience of more than six months according to the time in the loss process stage. Most of them were primiparas (57.2%) and aged 26-40 years	Deep interview The Colaizzi method was used to process and analyze data assisted by software to obtain themes and descriptions of the	The results showed four major themes, including mothers' responses to loss such as painful and traumatic experiences; moral support received by

nology/ (Dormian Sinaga et al., 2020)			(57.2%). In addition, most of them lose their fetuses at 8-9 months of gestation.	experiences of the participant mothers.	the mother; negative behavior from others such as stigma and lack of support; and physical and psychologica l changes that interfere with the role of wife and mother. Conclusion: A history of IUFD is a very traumatic experience and has quite a high emotional burden for mothers. Therefore, therapeutic support and communicati on need to be integrated into practice
A2/ Why do community members believe mothers and babies are dying? Behavioral versus situational attribution in rural northern Ghana/ This research aims to understand what is felt by communities in the northern region of Ghana who often experience maternal and newborn deaths or near death (near death) as the cause/ Exploratory descriptive study/	All interviews and discussions were conducted in the language and location chosen by the participants . Participants who met the inclusion criteria for FGD were traditional heads, traditional elders, women's group members, and traditional birth attendants. Meanwhile, participants who were included in	snowball sampling	12 FGDs involving five to fourteen people in each discussion with a total of 113 FGD respondents. Participants included village heads and traditional elders (3 FGDs, 26 respondents), traditional birth	The FGDs were attended by traditional heads and elders, women's group members, and traditional birth attendants in each of the four study communities. Face-to-face interviews were conducted with traditional birth	It was found that deaths experienced by mothers and babies were associated with mistakes, actions or delays by mothers (behavioral), or due to other factors such as poverty (situational). For example, some respondents

(Williams & Moyer, 2020)	the inclusion criteria for the in-depth interview session were Midwives, Nurses and Shamans.		attendants (4 FGDs, 29 respondents), and women's groups (5 FGDs, 58 respondents).	attendants who handle cases of mothers and newborns, public health nurses and midwives. Qualitative data were audio recorded, transcribed, and thematically analyzed using the Attride-Sterling analytical framework.	blamed mothers for poor diets, while others blamed a lack of money or household support to buy nutritious food. Blame is rarely attributed to fathers even though local gender norms dictate that men are the decision makers in the household when it comes to spending and childcare.
A3/ The psychosomatic experiences of women who experienced intrauterine fetal death in rural South Africa/ This study explores the psychosomatic experiences (mind-body connection) of women experiencing IUFD before labor begins in rural areas of Limpopo province, South Africa/ Qualitative approach with exploratory descriptive design (Kharivhe et al., 2023)	mothers who gave birth via normal vaginal delivery between January 2019 and June 2019; aged 18 years or over; have no record or history of mental health disorders; have complete information such as address and telephone number; and provide voluntary consent. They were included regardless of parity, marital status, religious background, educational	purposive sampling	Demographic information for 10 participants was obtained from birth registers at selected hospitals and confirmed with participants at the time of initial contact. Age ranged between 18 and 42 years, and parity ranged from primigravida to fifth delivery at the time of the study	Data were collected in participants' homes through in-depth individual interviews guided by one main open-ended question, namely, 'Please tell me about your experience of IUFD before you gave birth', and analyzed using Tesch's open coding method.	Results: Two themes reflect the psychosomatic experience of the mother experiencing IUFD: warning of danger and emotional response. Conclusion: This qualitative research reveals that mothers know that reduced fetal movement is a danger sign or a warning sign

	level or employment status.				that the baby is in danger before labor begins. After realizing that something is wrong with the baby, it also influences and activates their emotional dimension. It is advisable to investigate the type of support needed by the mother after being informed about IUFD.
A4/ “Your heart keeps bleeding”: lived experiences of parents with a perinatal death in Northern Uganda/ To describe parents' lived experiences following perinatal death in Lira district, Uganda /phenomenology/ (Agnes et al., 2022)	Participants were women and female partners who experienced stillbirth or early neonatal death in the last 2 years. Those living in the study area (Aromo, Agweng and Ogur sub-districts) from at least the third trimester (≥ 28 weeks of gestation) to 6 months after perinatal death were included in the study. Their participation was regardless of whether the perinatal death occurred in a health facility or at home. The length of stay in	purposive sampling	Thirty-two (32) participants consisting of 18 women and 14 men with an age range of 17-68 years were interviewed about their experiences after perinatal death. Almost all were married (93.8%) and were subsistence farmers (90.6%). Para	Data were collected using in-depth semi-structured interviews between August 2019 and September 2020 in participants' homes. Audio recordings and field notes were transcribed in the local language, Lango, and the transcripts were verified with audio recordings/field notes.	Results: Themes that emerged from the analysis included reactions to perinatal loss and desire for support. Participants' immediate reactions were pain, confusion, and feelings of guilt that were exacerbated by the unsupportive behavior of health care providers. Husbands lose financial resources and face various

	the area was to allow participants' experiences to emerge in the context of the research.		stressful roles from around them. The presence of pain and worry triggered by seeing a baby of the same age (as the baby who died), loss of a subsequent pregnancy, and marital conflict were also findings from this research. Participants recommended emotional support and management of postnatal complications for parents facing perinatal loss. Validation of pain and support for bereaved couples will strengthen their efforts to deal with loss in the perinatal period. Apart from family and community members, health workers also need to provide emotional support and postnatal care to parents who

					experience loss during the perinatal period.
A5/ Social support: An approach to maintaining the health of women who have experienced stillbirth/ This research aims to explore social support to help mothers adapt after experiencing IUFD/Iran/ (Allahdadian et al., 2015)	experience of at least one IUFD confirmed by an obstetrician in the medical record, no history of mental disorders, preferably the IUFD experienced occurred within the last 3 months, the cause of the IUFD is either known or unknown	purposive sampling	Participants consisted of 15 mothers who had experienced IUFD, and were selected using a purposive sampling method and according to maximum variation between individuals with various causes of stillbirth, different ages, at different stages of pregnancy, and previous experience of pregnancy and childbirth.	Data were collected through individual interviews that were audio recorded, transcribed, and analyzed.	Two main categories were found, namely support from family and support from the social system with two and three subcategories respectively. Mothers who experience IUFD need emotional, practical support and assistance from their partners, family and friends around them. These mothers need support from peer groups to exchange

	experiences and from trauma counseling centers to meet their needs.

1. Result

Out of the 314 articles identified, 5 articles were found that met the criteria corresponding to the inclusion criteria. These articles were written in English and published between 2015 and 2023. The following is a breakdown of the characteristics of these articles.

Table 5. Publication Year

No	Publication Year	Number of Articles
1	2015	1
2	2020	2
3	2022	1
4	2023	1
Total		5

Based on the table above, the articles reviewed are from 2015 to 2023. The details are: 1 article in 2015, 2 articles in 2020, 1 article in 2022, and 1 article in 2023.

Table 6. Country Classification

No	Country	Number of Articles
1	Indonesia	1
2	Uganda	1
3	South Africa	1
4	Iran	1
5	Ghana	1

Total	5

Based on the table above, the articles reviewed came from 5 countries. The details are: 1 article from Indonesia, 1 article from Uganda, 1 article from South Africa, 1 article from Iran, and 1 article from Ghana.

Table 7. Classification of Research Designs

No	Design	Number of Articles
1	Phenomenology	2
2	Exploratory descriptive	2
3	Qualitative content analysis	1
Total		5

Based on the table above, the articles reviewed consist of 3 types of research methods. The details are: 2 phenomenological articles, 2 exploratory descriptive articles, and 1 qualitative content analysis article.

Table 8. Theme Analysis

Theme	Subtheme	Article
Biological Impact	1. Disturbing physical changes	A1
	2. Danger warning	A3
Psychological impact	1. Mother's response	A1, A3, A4
Social impact	1. Moral Support	A4
	2. Negative stigma	A1, A2
	3. Poor behavior of health workers	A4
	4. Strengthening social protection	A5

a. Biological Impact

The study (A1) mentioned that physical and emotional changes that interfere with the role as a wife and mother are experienced by women who have experienced an IUFD. The study also found that women who have experienced an IUFD can face various challenges, both physical and psychological, which cause interference in carrying out daily activities as a wife or mother. Study (A3) highlighted women's experiences during pregnancy related to fetal movement. The participants reported that they usually felt regular fetal movements during pregnancy and became

accustomed to the pattern of movements. They recognized changes in fetal movements as warning signs that something was abnormal in the womb. Some of the symptoms reported included umbilical pain, nausea, headaches, and decreased fetal movement. Some mothers also revealed that their babies were not as active as usual, which made them feel the need to change positions to get the baby moving. The findings suggest that some participants did not always recognize changes in fetal movements on a daily basis but were aware of these changes from time to time.

b. Psychological Impact

In study (A1), the participants in the study revealed that they had a very painful experience when experiencing fetal death. They reported feeling deep sadness and trauma from the event, which included expressions of sadness, crying, anger and disappointment. Over time, the participants revealed that they began to accept the event.

Some participants in the study (A3) revealed during the interview that after hearing the news about IUFD, they felt devastated, like their hearts were ripped out. Research findings (A3) also revealed that some participants were more likely to blame themselves for the IUFD. Anger and self-blame are strong indicators of how women interpret their emotional experiences.

The participants in study (A4) revealed that they faced painful memories of their perinatal death. Challenges in the marital relationship, seeing another baby, and experiencing subsequent miscarriages triggered these memories. The majority of participants reported that they did not feel grief as strongly as when the event had just occurred when they were reminded of the loss. This may indicate that the intensity of the grief had lessened and their emotional reactions were not as strong at first. Some participants who did not experience a subsequent pregnancy after the loss reported ongoing thoughts and worries.

c. Social Impact

In Study (A1), mothers perceived that the treatment they received was not good, both from the family, medical team, and community, such as getting negative stigma, rejection, and even lack of communication delivered by the nurse. Some informants received support from those closest to them, such as from their family, medical team, and community, which could help the informants' health recovery. The assistance received by mothers can help them through the normal grieving process. In addition, assistance provided by the medical team, especially nurses, can help mothers find meaning from loss, and families can understand the conditions that occur in mothers with IUFD so that mothers can carry out normal activities.

Some respondents in study (A2) emphasized that heavy physical work can cause negative impacts, while some blamed women for continuing to work hard during pregnancy and the postpartum period. For example, in one community, there was a view that women who underwent heavy physical labor during pregnancy were significantly impacted. The opposing argument highlighted that women often have no other option to earn a living for their families other than physical labor, and they may not be able to rely on financial support from their partners.

However, in contrast to study (A4), participants expressed mixed reactions regarding the behavior of health care providers after perinatal death. Most parents who experienced a perinatal death in a health facility felt unsupported by health care

providers. The nurses or midwives never talked to them or communicated with them; moreover, the parents of the deceased infants felt in dire need of support and knowledge about the cause of death. Some participants felt that health care providers did not know what to say or were too busy with their duties. Confirmation of death was not even communicated to some mothers, and they found out on their own. Health workers only came to give them treatment. Other participants, however, felt comforted and consoled by the health workers. They were encouraged to take heart that such things happen, and they were neither the first nor the last. The mixed reactions could be because healthcare providers experience many perinatal deaths routinely amidst heavy workloads. Therefore, they may struggle to support grieving parents.

In study (A5) mothers revealed that related to their health promotion in order to return to normal life after experiencing stillbirth was support from family, in other words, the support they expected from the first moment of the incident until returning home. The majority of mothers said that when they heard the news of their baby's death, the presence and sympathy of their husbands were helpful in accepting the event. On the other hand, Iranian women, due to family ties, mentioned the need for family support during hospital delivery as crucial in helping them deal with the situation.

DISCUSSION

Study A1 revealed that mothers who experience fetal death face significant physical and emotional challenges, which disrupt their roles as wives and mothers. These changes included a profound impact on their daily activities, highlighting how complex their adaptation to this loss was in the context of family roles. Meanwhile, study A3 highlighted experiences during pregnancy related to fetal movement. Participants routinely felt fetal movements and recognized changes in movement patterns as potential signs of trouble. Symptoms such as umbilical pain, nausea, and decreased fetal movement were of primary concern, with some mothers experiencing concern if their baby was not as active as usual. The findings suggest that awareness of these changes develops over time, although not all participants were able to identify daily changes quickly. The importance of active monitoring of fetal movements as part of prenatal care to detect potential problems quickly.

Tabassum et al research (2024) highlighted the importance of developing a comprehensive system that includes non-invasive monitoring of vital signs and blood glucose. The research also proposes the use of a hybrid algorithm with two Inertial Measurement Units (IMU) to accurately detect fetal movement. The integration of these systems aims to improve the real-time link between healthcare providers and pregnant women, thus ensuring timely interventions to address any problems that may occur. This is also reinforced by research that reveals that mothers who experience fetal death face significant physical and emotional challenges. Research shows that these mothers often experience depression, anxiety, grief, and sadness, which can have a long-term impact on their lives. The emotional burden is heavy, and mothers may be enveloped in feelings of trauma and loss, which can affect their roles as wives and mothers (Sinaga et al., 2020). In addition, physical changes such as the need for medical intervention and the physical

impact of pregnancy complications can further complicate their recovery (Una et al., 2022).

This study showed that women who experienced IUFD (intrauterine fetal death) tended to have characteristics associated with lower socioeconomic status and poorer health assessment compared to controls. The health and functioning subscale scores of the Quality of Life Index (QLI) as well as the depressive affect score of the CES-D were lower in cases compared to controls, while the global score of the CES-D was higher in cases. Despite this, there was no significant difference in subjective well-being between the two groups. After adjusting for demographic variables and health factors, no association was found between IUFD and global quality of life, subjective well-being, or global depression scores. This suggests that women who experienced a previous IUFD, with most receiving short-term interventions, had long-term outcomes in quality of life, well-being, and depression similar to women who experienced a live birth alone, when confounding factors were considered (Gravensteen et al., 2012).

Study A1 highlighted that the experience of fetal death was very painful for the participants, which included feelings of deep sadness, trauma, and various emotional expressions such as sadness, crying, anger, and disappointment. The findings indicated that despite initially experiencing intense emotions, over time, most participants began to accept the event as part of their recovery process. Study A3 showed that the sudden news of the IUFD had a profound emotional impact on participants, with some feeling emotionally devastated and blaming themselves for the event. This anger and self-blame demonstrates how women interpreted and responded emotionally to their experiences. Study A4 showed that participants faced painful memories of perinatal death, triggered by challenges in the marital relationship, interactions with other babies, and subsequent miscarriage experiences. The majority of participants reported that the intensity of their grief subsided over time, although memories of the loss could still touch them deeply when recalled. Some who did not experience a subsequent pregnancy after the loss faced ongoing thoughts and worries, indicating the long-term impact of the experience in their lives.

Characteristics and data on grief were evaluated independently by two researchers from 13 cross-sectional and eight longitudinal studies conducted in 11 countries, with a total of 2597 participants. All studies used self-assessment instruments. Of the 21 studies analyzed, 17 of them (81%) showed a significant increase in the level of grief in women after experiencing a miscarriage or stillbirth. However, the studies varied widely in terms of sample, length of pregnancy, and timing of assessment of post-miscarriage grief. Most studies recorded high levels of grief and often severe grief reactions, although they decreased over time, in women who experienced miscarriage or stillbirth. However, there are no definitive conclusions regarding consistent differences between single and recurrent miscarriage experiences in terms of these emotional responses. The conclusion is that significant grief is often experienced by women following a miscarriage or stillbirth. However, further longitudinal research is needed to understand more deeply the course of grief in this cohort, as well as to identify women who may be experiencing prolonged grief disorder, depression or other mental health issues (Mergl et al., 2022). Longer gestational age before miscarriage, a more neurotic personality, more severe psychiatric symptoms before miscarriage, and the absence of a living child appear to be important risk factors for stronger emotional responses in women after miscarriage

(Widyawati et al., 2015). Early detection can help the mother's psychological problems in the early phase. As long as the case can still be handled with non-pharmacology, there is no need for pharmacology if the management of maternal acceptance derived from counseling and family support is sufficient and successful. This case would require support and assistance from a psychiatrist or psychologist if it is already in the moderate/severe category (Ganisia, 2022).

Study (A1) highlighted that mothers faced perceptions of unfavorable treatment from family, medical team, and community after experiencing fetal death. They reported experiences of negative stigma, rejection, and lack of effective communication from caregivers. Nonetheless, the support they received from their family, medical team, and community aided in their emotional recovery process, helping them get through the grieving process better. Mothers in Bangladesh who experienced fetal death reported that they received moral support from others. However, they also faced stigma and a lack of support, which compounded their emotional burden. Seeking social support and therapeutic communication were identified as particularly important to help cope with this traumatic experience (Chowdhury et al., 2015). Study A2 shows that society's view of women doing heavy physical labor during pregnancy highlights the negative impacts that may occur. However, in contrast to this view, other arguments emphasized that women often have no other options to earn a living and may not be able to rely on financial support from their partners. Study A4 revealed mixed reactions to the behavior of health care providers after a perinatal death. Most parents felt less supported by nurses or midwives, feeling that they did not get adequate communication or support. Some felt that healthcare providers were less prepared to provide information or emotional support, while others felt comforted and supported in dealing with their loss. These mixed reactions may be due to a variety of factors, including the high workload in perinatology units.

Study A5 highlighted the importance of family support in facilitating recovery and return to normal life after the loss of a baby. Mothers emphasized that emotional support from their husbands and families was instrumental in helping them accept and cope with the event, demonstrating the importance of social support in the experience of perinatal trauma. The study revealed that mothers who had experienced fetal death often emphasized the importance of talking about the child they had lost. This involved sharing experiences and feelings with others, which helped them process their grief and gain support from family and friends (Saccardo & Calvo, 2022).

The findings reveal that stillbirth is a distressing experience that can result in high levels of psychological symptoms, including anxiety, depression, distress, and negative well-being. These symptoms appear highest in the first few months after the loss, although there is evidence to suggest that for some people, these symptoms can persist for up to three years. The long-term impact of stillbirth on women is also in line with qualitative research. Risk factors for higher levels of anxious and depressive symptoms included higher parity at the time of loss and being unmarried. Social support was specifically identified as beneficial for women following bereavement (Jackson et al., 2012).

This study has some limitations, such as a stronger focus on developing countries, which may not fully represent experiences in developed countries or different cultural and social contexts. The in-depth interview method used may limit the variety and representativeness of the data obtained, as participants came from a specific region with

similar backgrounds. In addition, no experimental interventions were conducted to test the effectiveness of the recommendations provided, making it difficult to evaluate the direct impact of the recommendations on clinical practice.

Nonetheless, this review has some strengths. For example, it provides a comprehensive overview of the biological, psychological, and social impact of intrauterine fetal death on mothers in developing countries. The rapid review method used followed the PRISMA-ScR guidelines, which allowed for a systematic and structured presentation of evidence. In addition, the in-depth interview and field data collection approach provides an in-depth understanding of the lived experiences of mothers following perinatal death.

CONCLUSION

The experience of fetal death has a profound emotional impact on mothers, affecting their role in the family and society. Mothers often face complex physical and psychological challenges, including perceptions of mistreatment and stigmatization from the surrounding environment. The support provided by the family, medical team, and community plays an important role in assisting their recovery process. A specific recommendation for midwives is to improve empathic communication and understanding of parents' emotional experiences after perinatal death. Health workers need to be equipped with the skills and knowledge to provide adequate emotional support as well as clear and comprehensive information about the causes and next steps after fetal death. In situations that require the delivery of difficult news, midwives also need to have the sensitivity and skills to assist parents in managing and responding to their emotions appropriately and supportively.

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