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.

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
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 thereafter 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 ...: |    |     |
| 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 |     |
| 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 |     |
| Negligence                  |  3 |  4.0|
| Lack of midwife             |  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 transport |  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 |    |     |
| Yes                         | 71 | 94.7|
| No                          | 5  | 6.7 |
| 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 Soomaaliiland ee umula ilmo mayd ah: Daraasad Baaris Sifeynaysa Xaaladda

SOOKOOBID

Hordhac: Haweenka Soomaaliyeed dhammaaantood oo ahayn keliya ku nool Somaliland, iyo xataa ku nool qurbaha, waxay la kulmi karaan natiijyooyinka caafimaad ee halis ah marka ay dhalooyin. Daryeelka ku dihsan xiriiraya iyo taakuleyntaa ayaa muhiim u ah dumar jireela ilmo mayd ah. Khaasatkan in la daryeelka murugada lasoo gudboonaata iyo in la xareeyo dheeleecyenta ku xeeran markii ay hoojyada dhasho ilmo mayd ah, taasoo ah mid adduunweynuhu mudnaan siyey. In la helo daryeel ku dihsan qaar dhaqameedka iyo deegaanka waa muhiim si loo fahmo baahida haweenka dhalay ilmo mayd ah, iyada oon loo eegin meesheey joogta iyo sabaabta.

Ujeeddo: Daraasad boothada ayaa loo yagaan iyo dhalay ilmo mayd ah. Iyo in la fahmo sababaha ay u maleynayaan in ay ku waayeekan ilmahaooda uruka ku jira, astaamaaha ay lahaaeyeen ka hor inta aysan dhalin iyo khibradaha ilmo dhalaynta wax la ahaa ilmo mayd ah, iyada oon loo gudbiyay haweenka ku dhalay cusbitaalka ilmo mayd ah. Sanadkii 2015 ayaa laga soo ururuuyay haweenka ku dhalay cusbitaalka ilmo mayd ah ama loo gudbiyay cusbitaalka markay dhaleeen kaddib. 75 haween ah ayaa ogolaaday inay ka qayb qaantaada dharasadda.

Hababka: Daraasad dib-u-eegii ah oo sharraxaad leh oo ahaan la genuunaay cusbitaalka gubolka Boorama ee Somaliland. Su’aalo daraasadaddan u gaar ah ayaa lasoo saaray, taasoo ku saleysan macluumada shakhsiyadeed iyo xog ku saabsan mowduucyada la xiriira khibradaha haweenka dhalay ilmo mayd ah. Sanadkii 2015 ayaa laga soo ururiyay haweenka ku dhalay cusbitaalka ilmo mayd ah ama loo gudbiyay cusbitaalka markay dhaleeen kaddib. 75 haween ah ayaa ogolaaday inay ka qayb qaantaada dharasadda.

Natiijyooyinka: Haweenka intooda badani waxay ahayeen kuwo cawroor badan dhalay oo lasoo kulmay in ay dhalaa ilmo mayd ah. Inta aad la xaqiijin in uu ilmahoodu caloosha ku dhintay, badii haweenka waxay soo sheeggeen inaysan dareemii wax dhaqdhagaagaah ah ilmaha uruka ku jira, oo aaney dareemii inay wax haldan yihiin. Sababta ugu badan ee ay haweenku u arkeen, in ilmiihi oo mayd uku dhasho waxay ahayd foonsha oo dheeraradaa, midda kalena waxay ahayd ‘ilmoy weyn’. Soddon iyo seddex haweenka ka mid ah ayaa sheегay inay muhiim tahay in ay ogaadaan sababta keenay ilmaha caloosha ku dhintay, qaay ka mid ahna waxay sheeggeen inay ka carroodeen ama ay ka niyad jaren xeefiradaayaasha daryeelka caafimaadka kuwaas oo ka caawiyey markii ay oo foonlayeen, dhaleeen, ama dhalmada kaddib. Inta badan haweenku waa sida qanacsanayeen daaweyntooda. Seddex meelood meel ka mid ah haweenku waxay isku eedeeyeen in ay dhalo ilmo mayd ah, badankoodna dadka kale ayay
kala hadleen arrintaas.

**Gunaanad**: Natijjooyinkayagu waxay muujinayaan in haweentu ku nool Soomaaliland wadaagaan aragtiyo la mid ah kuwa haweentu kasoo jeeda wadamada horumaray xagga dhalidda ilmo mayd ah. Tani waxay kor u qaadeysaa saarreyn muhiim ah oo ku saabsan daryeelka caafimaadka markey hoo yado uurka leeadhay, iyo wax ka qabadka ama ka hortaggaa.

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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.

**Funding information**

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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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