https://nmsjournal.kaums.ac.ir/
Nursing and Midwifery Studies. 2023; 12(4): 247-253
https://doi.org/10.48307/nms.2023.412867.1252

Research Article Open Access

Exploring the community perceptions and understanding of stillbirth in South Africa: A qualitative study

Sindisiwe Patricia Malaza [1], **Maria Sonto Maputle** [1*], **Rachel Tsakani Lebese** [2]

[1] Department of Advanced Nursing, University of Venda, South Africa
[2] School of Health Sciences Research Office, University of Venda, South Africa

[*] **Corresponding author:** Maria Sonto Maputle, Department of Advanced Nursing Sciences, University of Venda, Thohoyandou 0950, South Africa. **Email:** sonto.maputle@univen.ac.za

Received: 22 August 2023 **Revised:** 10 September 2023 **Accepted:** 10 September 2023 **e-Published:** 2 December 2023

Abstract

Background: The stillbirth rate in Mpumalanga province, South Africa, ranges from 21 to 27 per 1000 total births.
Objectives: The objective was to determine the community perceptions and understanding of factors contributing to stillbirths.
Methods: A qualitative explorative study was conducted. The population comprised traditional birth attendants and women who had experienced a stillbirth in their lifetime. Purposive sampling was used to select the four hospitals and twelve women while snowball sampling was used to select five Traditional Birth Attendants. Data were collected through in-depth interviews and analyzed through Tesch's open coding method. Trustworthiness was ensured by considering the criteria of credibility, dependability, applicability, and transferability.
Results: The themes that emerged as general perceptions and understanding of stillbirth focused on participants' knowledge of stillbirth, perceived contributory causes, perceived prevention interventions, and traditional birth attendants' roles and interventions.
Conclusion: Lack of knowledge, cultural practices, and health workers' attitudes were perceived to be contributory causes of stillbirth. The antenatal care health education content for women of childbearing age and traditional birth attendants needs to include the medical diseases that cause stillbirth.

Keywords: Antenatal care, Contributory factors, Intrapartum care, Perceptions, Stillbirths.

Introduction

Stillbirth (SB), is defined as a baby's death before or during birth after 28 weeks gestation.[1] This is devastating to parents and their families, as it is associated with psychological, physical, social short and long-term adverse effects.[2] In most instances, a stillbirth is challenging to predict or prevent.[3] A recent study revealed that the stillbirth rate in South Africa is 23.3% per 1000 total births.[4] SB rate is a reasonable care indicator during the third trimester and intrapartum period. Stillbirth in many parts of the world has been unacknowledged grief and associated lack of public discourse.[5,6] Duryea *et al.*[7] elaborated on the causes of stillbirths as fetal, maternal nonmodifiable, and modifiable risk factors. The early identification of fetal growth restriction has been shown to contribute to the prevention of stillbirths, especially in typically formed singleton pregnancies.[8,9] Stillbirths constitute a large and invisible loss of life and a significant public health issue that must be addressed.[10] Effects of stillbirths may be anxiety, depression, and other bio-psychosocial maladies.[11,12] Das *et al.*[13] hold that tension in the family relationship may lead to couples' separation and dissolution of marriage.

Most studies about stillbirth knowledge have focused on bereaved parents and healthcare professionals.[14-17] In Mpumalanga province, where the study was conducted, the stillbirth rate was 27 per 1000 total births, above the national target of 21 per 1000 births. This coincided with the findings by Day *et al.*[18] that the rate of antenatal visits before 20 weeks was 38.3% in 2012/13 and was the lowest in the Mpumalanga province. Tveit, *et al.*[19] indicated that public health campaigns around stillbirth have, to date, focused mainly on reduced fetal movements during pregnancy. The research question was "what are the perceived contributory factors of stillbirth?

Objectives

The study aimed to explore the community perceptions and understanding of factors contributing to stillbirths at selected hospitals in a particular district, Municipality, Mpumalanga province, South Africa.

Methods

Study design and participants

A qualitative approach and explorative design were used to determine the depth and breadth of understanding of stillbirth by affected women and Traditional Birth Attendants (TBAs). The study was conducted at four hospitals based on a high number of stillbirths in 2020 and nearby villages of the selected district, Mpumalanga province, South Africa.

The participants comprised twelve patients, three from each health facility, who had experienced a stillbirth in their lifetime. They were purposively sampled by obtaining their medical records through the professional nurse from the health facility who recruited participants on behalf of the researcher. Contact was made to make appointments and secure informed consent. To complement the participants' data, five TBAs staying in villages around the selected facility were purposively sampled through snowballing technique. The sampling of participants was continued until data saturation occurred.

Data collection

Data were collected through individual in-depth unstructured face-to-face interviews to gain a detailed narrative of perceptions and understanding of stillbirth. This was done at women's or TBAs' homes after the appointment was agreed upon. The question asked for a woman participant was, "*Can you share with me your understanding and perceptions on contributory factors of stillbirth?"* The TBAs were asked, "*Describe how you treat the mother who has delivered a stillbirth"*. Probing with follow-up questions was done. Field notes were made during and after each interview to capture nuances, including non-verbal cues. The interviews were conducted in the participants' local language (iSiSwati), each lasting between 30 and 45 minutes. A voice recorder was used to capture information after obtaining approval from the participants.

Ethical considerations

Ethical standards were ensured by obtaining ethical clearance (Ref: SHS/17/PDC/08/2403), from the University Ethics Committee, permission to conduct the study from the Provincial Department of Health, the hospital Chief Executive Officers, and the participants. Participants were coded as Woman Participant (WP), or TBA. Participants gave verbal and written, informed consent, and were informed of their right to withdraw from the study without any penalty. Adherence to ethical principles of fairness, privacy, confidentiality, anonymity as well as participants' rights to voluntarily participate was ensured.

Data analysis

The narrative data from the in-depth individual interviews were analyzed qualitatively using Tesch's open coding method as postulated by Creswell.[20] The recorded interviews were translated into English by language experts. They were transcribed word by word, and the nonverbal cues (for example, silence/sigh, frowns, and lean back) were included in the transcripts. All transcripts were read, and condensation was done to give meaning. Coding was done, where the names that mostly describe the condensed meaning and a list of similar topics were clustered. Data were grouped according to themes. Field notes were also coded.

Data trustworthiness

As outlined in Guba and Lincoln cited in Polit and Beck,[21] the criteria for ensuring trustworthiness were adhered to. Credibility was ensured through prolonged engagement with data. A member check was also conducted to validate the truth and confirm the findings. The voice recorder was used to capture data to ensure credibility. Thick descriptions of research methodology were used to ensure transferability. The recorded interviews were transcribed verbatim and the nonverbal cues were included in brackets of the transcripts to ensure authenticity.

Results

Five (5) TBAs and 12 women [Table 1] participated in the study. Data yielded four themes as perceptions and understanding of stillbirth; which were participants' understanding of a stillbirth, perceived contributory factors, perceived prevention interventions despite stillbirth occurrences, and TBAs' interventions to a client who present with SB. The perceptions of factors contributing to stillbirths were not different between women and TBAs.

Participants' understanding of stillbirth

The patient participants defined stillbirth as a dead baby with no breath of life and no movement at birth. This was confirmed by the TBAs. They said, "*What I know is that a baby comes out dead and doesn't cry or doesn't breathe"* WP aged 21. A WP aged 29 said, *"Stillbirth is when the baby does not make any movements when inside the uterus …no*

life ….". However, a WP aged 40 had a different view when saying, *"A stillbirth is a death that is wrongful and caused by negligence or improper actions by those who help us". A* WP aged 33 attached her experience when defining stillbirth, "*I felt very numb and I am still unable to discuss it with my family or any member of the community I don't know. I felt guilty*".

To both mothers and TBAs, it is culturally assumed that a community will not grieve the loss of '*a thing'*. The burial of a stillborn baby is done in private, mainly by women, with little opportunity for public mourning or condolence. Stillbirths are not announced in the village, and in most cases, people are not widely informed, which makes the woman suffer alone.

Perceived contributory causes of stillbirth.

Most of the participants cited a lack of knowledge, cultural and traditional beliefs, and health workers' treatment as contributory factors to stillbirths. Both groups did not cite the medical causes even after probing, so broadly, participants did not have accurate knowledge on other contributory causes. The importance of fetal movement monitoring was not emphasized, wherein the pregnant woman can actively participate in her care.

Lack of knowledge was one of the most important factors that made them not notice the warning signs that may contribute to stillbirth.

*"We are not informed about normal or abnormal expectations during pregnancy. We sometimes ignore warning signs like vaginal bleeding and severe headache, or that fetal movements are important. Some of us do not know how to monitor the fetus's survival" (*TBA 2 and WP aged 28).

Some pf the TBAs attached the cultural and traditional beliefs to be a contributor when saying, "*People have forsaken their cultural practices. They are disrespecting our ancestors in the process. One man may impregnate a woman but then wrongly hold another man accountable, this could result in stillbirth" (TBA - 4, village around Ermelo)*

Women participants also attached the contributory causes to cultural and traditional beliefs. A WP aged 26 said, "*Jealous, if you have a co-wife, she will bewitch you.*" The other WP aged 23 who was HIV seemed to blame her mother-in-law when saying, "*My mother-in-law did not believe that HIV exists, so I had to hide my ARVs as they thought its witchcraft. My immune system was compromised, and that increased the chances of stillbirth."* Some women participants also were not in favor of consulting TBAs said. They preferred not to use antenatal care, *"I don't want to consult TBAs for pregnancy. Some of us do not even come back until we deliver at home. This makes it impossible for a prior diagnosis of possible risk birth-related complications" (*WP aged 26).

Some women cited health workers' treatment as related risk factors for stillbirth: *"Nurses usually have negative attitudes towards us, and that is why we don't start antenatal care timeously." (*WP aged 18). *"Nurses are judgmental during the first visit. They will ask you how many kids if you say four, they will mock you saying four children are too many at such a tender age",* bewailed the ex-patient, (WP aged 32). Another woman participant who could not hold her tears while explaining the perceived negligence that contributed to her stillbirth said, *"I was in active labour and they were sitting, drinking coffee while others were eating and chatting. I called them to assist since my baby's head was already out and hanging. But the baby did not cry after delivery. The senior nurse came to deliver the sad news that my baby was no more"*, sobbed the WP aged 23.

Perceived preventive interventions despite stillbirth occurrences

Patient participants described different interventions that have been made to assist pregnant mothers like mom-connect. However, it was also indicated that the messages were not connected to stillbirths and they could not find help from this intervention. A WP aged 29 said, *"there is the mom-connect program on their first booking. The mom will get messages from the program reminding them about her estimated delivery date. Health information is also sent through the same program.*"

Participants appreciated the efforts by the government for care provided during antenatal care; however, attention must also be given to interventions to prevent the occurrence of stillbirths. A WP aged 28 said, *"I think the government is trying very hard since it is building clinics near our areas and mobile clinics in areas without clinics. This is helping us a lot since many pregnant women are becoming victims of stillbirths due to the unavailability of antenatal care facilities."* Referring to the same matter, a WP aged 40 commented, *"But I think practicing family planning, early antenatal care, and avoiding a heavy workload can also assist in preventing stillbirth."* A WP aged 28 also said, *"Some people have their own beliefs; for them, divine intervention, protective witchcraft, and the use of herbs during pregnancy can be regarded as important measures".*

Table 1. The demographic information of the participants

Participants	Age	Gender	Ethnic group	Marital status	Educational Background	Religious Affiliation	Place of residence	Parity	TBA work experience (years)	Number of Antenatal care visits	Taking traditional medicines when pregnant	Place of delivery
TBA 1	40	Female	Zulu	Married	Primary	Faith based	Urban	2	11	N/A	N/A	N/A
TBA 2	62	Female	Swati	Single	Primary	Traditional	Rural	7	19	N/A	N/A	N/A
TBA 3	65	Female	Swati	Married	No school	Traditional	Rural	5	23	N/A	N/A	N/A
TBA 4	48	Female	Swati	Married	Primary	Faith based	Rural	3	30	N/A	N/A	N/A
TBA 5	45	Female	Zulu	Divorced	Primary	Traditional	Rural	4	35	N/A	N/A	N/A
Woman 1	26	Female	Swati	Single	Tertiary	Roman	Rural	2	N/A	2	No	Hospital
Woman 2	29	Female	Zulu	Single	Primary	Apostolic	Rural	2	N/A	4	No	Hospital
Woman 3	33	Female	Zulu	Single	Primary	Traditional	Urban	1	N/A	4	No	Hospital
Woman 4	40	Female	Swati	Married	Matric	Apostoli	Urban	4	N/A	4	No	Hospital
Woman 5	18	Female	Zulu	Single	Primary	Traditional	Rural	1	N/A	2	Yes	Hospital
Woman 6	33	Female	Zulu	Single	Matric	Lutheran	Rural	2	N/A	4	No	Hospital
Woman 7	28	Female	Swati	Single	Matric	Traditional	Rural	3	N/A	2	Yes	Hospital
Woman 8	26	Female	Swati	Single	Primary	Christian	Rural	1	N/A	2	No	Hospital
Woman 9	35	Female	Swati	Single	Tertiary	Christian	Rural	1	N/A	4	No	Hospital
Woman 10	32	Female	Swati	Single	Primary	Apostolic	Rural	2	N/A	3	No	Hospital
Woman 11	36	Female	Swati	Married	Matric	Traditional	Rural	2	N/A	3	No	Hospital
Woman 12	35	Female	Swati	Single	Primary	Lutheran	Rural	1	N/A	3	No	Hospital

TBAs' interventions to a client who presents with SB

TBA from the village in Ermelo raised concerns about pregnant women's delay in consulting with them. They explained that pregnant women needed to consult early for their treatments and referral. The data shows that TBAs employ different treatment modalities to strengthen the mother's womb and baby during pregnancy. There are certain herbs that they need to take during the first few weeks of pregnancy. Failure to do so is commonly associated with stillbirth since the womb needs to be strengthened during pregnancy". The issue of herbs was corroborated by other TBAs when saying: "Long ago women were given traditional herbs called "Embumbwa" to drink during pregnancy to protect the baby and the mother from evil spirits." Another TBA also said, "The herbs help ease common pregnancy-related problems like morning sickness, backache, and swelling of feet and help babies born with skin rash, prevent malaria" (TBA 2). Another traditional herb that pregnant women use was "mululuza**"** (a small shrub called bitter leaf in Africa due to its bitter taste). Women used it as an anti-helminth, laxative, and anti-mutagenic, and anti-malaria effects. TBA 2 also administered "Ebombo": "I administer Ebombo (i.e. M. foetida) in a wide range of disorders including stomach troubles, emetic, vermifuge, smallpox, chickenpox, measles, body swellings, edema, gout, venomous sting, and also as a pain killer. TBA 3 (MB) also said, "I was also advised to use lizard and infant feces. These are thought to soften the pelvic bones thus enabling them to give birth easily."

Another traditional birth attendant from the village next to one hospital also believed that "Those who depend on herbs have successful pregnancies and their treatment seems to work more than western medication" (TBA 4). However, patient participant had a different perspective regarding the taking of the traditional treatment. A WP aged 28 said, "I think the traditional birth attendants are overdosing us with their herbs because today they will tell us to take their herbs using a spoon while their counterparts instruct us to use a cup." TBAs were providing traditional herbs; however, the patient participants were not sure whether this was not contributing to stillbirth, especially the dosage

Discussion

Most participants knew that when the baby is delivered with no life, that is, no crying and breathing, it is referred to as stillbirth. However, there was limited knowledge about the perceived contributory factors and causes.

Although participants had personally experienced stillbirth, they seem not free to talk about it openly. This was the same as the findings by Attachie *et al.*[22] that mourning or talking much about the stillborn one will welcome the recurrence. Still, there was a general perception and understanding concerning the existence of stillbirth when defining it. When asked about what contributes to babies dying before birth, participants mentioned delays in accessing health services due to financial constraints Some indicated the cause of stillbirths as being cursed. Attachie *et al.*[22] supported that stillbirth is believed to have a supernatural association. Lack of knowledge about when to seek care was cited as the source of many delays. Another aspect was the unfavorable attitude of health professionals, who were characterized as being haughty, arrogant, careless, and vulgar.[23] Findings show that midwives regularly questioned women in labor as to why they became pregnant while they were disturbing them. A few young midwives have also been accused of abusing expectant mothers, especially if the mother had a history of several pregnancies or had never attended antenatal care. Sharma *et al.*[24] also supported that sub-optimal maternal care, with women reporting clinical neglect, insufficient explanation, strained relationships, and verbal, and sometimes even physical abuse from nursing staff. This shows that midwives were not uncommon to ill-treat pregnant women, a practice that indirectly causes stillbirth.

Concerns were raised regarding the woman's lack of understanding of fetal movement monitoring, which is crucial because she would be involved in her care. This was the same as in the study by Smyth *et al.*[25] that; pregnant women have reported being unsure of what is expected and receiving vague or conflicting information about what they should be feeling. From the study findings, participants did not mention any medical condition lifestyle causes, like obesity, drugs, smoking, and alcohol use. Only one participant cited the association of stillbirth and HIV-positive status. Findings were like findings of Nuzum *et al.*[14-16] that early identification of risk factors like maternal obesity, diabetes, and smoking was not known as most respondents were unable to identify any risk factors for stillbirth. Given that the literature suggests that modifiable risk factors are present in up to 56% of stillbirths, the lack of knowledge about risk factors highlights the need for increased public health information to address this knowledge gap.[8,9]

Women participants were aware that, early antenatal education should be given to prevent stillbirth. Whereas the TBAs saw their role as crucial in preventing the occurrences of stillbirth by providing traditional herbs. TBAs tend to be older women, respected in the community for their knowledge and experience.[26,27]

TBAs cited using traditional herbs to strengthen the womb to prevent stillbirth. This was in line with the findings of Nergard *et al.*[28] and Nyeko[29] who cited reasons for traditional medicine use as general well-being during pregnancy, promotion of fetal growth, and spiritual cleansing to protect the pregnancy against evil influence. Whereas generally, the role of TBAs was viewed as to perform other roles depending on local custom, their interests, and expertise. However, the patient participants did not favor of taking these traditional herbs, especially the dosage, as they viewed this as contributing to stillbirth. Participants cited that at times using herbal medicines might cause the uterus to contract too early, suffocating the baby and leading to stillbirth. The findings by Rasch *et al.*,[30] confirm that the plants used were found to have a remarkable strong uterine contractive effect. It was also warned that in cases where herbs are inserted into the private parts, they do cause infections to the mother and baby. Such infections might lead to a miscarriage or the delivery of a baby with disorders like skin problems.[31]

The study was conducted in one of the three districts of Mpumalanga province and the sensitivity and unspoken of the subject may have prevented free participation from participants.

Conclusions

Women participants and TBAs displayed knowledge deficits on real contributory factors of stillbirths. Cultural practices, health workers' negligent and attitudes contributed to stillbirth. Community perceptions on the importance of preconception and antenatal care attendance are to be conducted. The ANC health education content for women of childbearing age and TBAs need to include the medical diseases that cause stillbirth. The interventions must consist of general supportive measures to improve environmental and social conditions and interventions that address maternal nutrition, prevention, and management of maternal and fetal infections and diseases during pregnancy and childbirth. Such interventions would reduce stillbirths and educate society on treating such individuals.

Acknowledgment

Researchers would like to acknowledge all TBAs and patients who experienced stillbirth who participated in this study, Mpumalanga Provincial Department of Health, the hospital managers, and the village headmen who granted permission to conduct the study.

Competing interests

The authors declare that they have no competing interests.

Abbreviations

Antenatal care: ANC;
Human Immunodeficiency virus: HIV;
Traditional Birth Attendants: TBAs.

Authors' contributions

S.P.M conducted the study and drafting of this manuscript. R.T.L was the co-supervisor and led the literature review, M.S.M for supervision and correcting and finalizing the article. All authors read and approved the final manuscript. All authors take responsibility for the integrity of the data and the accuracy of the data analysis.

Funding

This study was funded by the University of Venda Research and Publication Committee.

Role of the funding source

None.

Availability of data and materials

The data used in this study are available from the corresponding author on request.

Ethics approval and consent to participate

Ethical standards were ensured by obtaining ethical clearance (Ref: SHS/17/PDC/08/2403), from the University Ethics Committee, permission to conduct the study from the Provincial Department of Health, the hospital Chief Executive Officers, and the participants.

Consent for publication

By submitting this document, the authors declare their consent for the final accepted version of the manuscript to be considered for publication.

References

1. Ayebare E, Lavender T, Mweteise J, Nabisere A, Nendela A, Mukhwana R, *et al.* The impact of cultural beliefs and practices on parents' experiences of bereavement following stillbirth: a qualitative study in Uganda and Kenya. BMC Pregnancy Childbirth 2021;21(1);443. doi:10.1186/s12884-021-03912-4 PMid:34172018 PMCid:PMC8228937
2. Aminu M, Bar-Zeev S, van den Broek N. Cause of and factors associated with stillbirth: a systematic review of classification systems. Acta Obstet Gynecol Scand 2017; 96(5):519-528 doi:10.1111/aogs.13126 PMid:28295150 PMCid:PMC5413831

3. Awoleke JO, Adanikin AI. Baird-Pattinson Aetiological Classification and Phases of Delay Contributing to Stillbirths in a Nigerian Tertiary Hospital. J Pregnancy 2016;2016:1703809 doi:10.1155/2016/1703809 PMid:26885395 PMCid:PMC4738935
4. World Health Organization. Making Every Baby Count Audit and review of stillbirths and neonatal deaths. 2017; [Available from: www.who.int/docs/default-source/mca-documents/maternal-nb/making-every-baby-count.pdf?Status=Master&sfvrsn=6936f980_2, Last access date: 10 April 2023]
5. McNamara K, Meaney S, O'Connell O, McCarthy M, Greene RA, O'Donoghue K. Healthcare professionals' response to intrapartum death: a cross-sectional study. Arch Gynecol Obstet 2017; 295 (4): 845-852. doi:10.1007/s00404-017-4309-9 PMid:28210863
6. Froen JF, Cacciatore J, McClure EM, Kuti O, Jokhio AH, Islam M, *et al.* Stillbirths: why they matter. Lancet 2011;377:1353-1366. doi:10.1016/S0140-6736(10)62232-5 PMid:21496915
7. Duryea EL, Happe SK, McIntire DD, Dashe JS. The natural history of twin-twin transfusion syndrome stratified by Quintero stage. J Matern Fetal Neonatal Med 2016;29(21):3411-3415. doi:10.3109/14767058.2015.1131263 PMid:26768418
8. Gardosi J, Madurasinghe V, Williams M, Malik A, Francis A. Maternal and fetal risk factors for stillbirth: a population-based study. BMJ 2013; 346: f108. doi:10.1136/bmj.f108 PMid:23349424 PMCid:PMC3554866
9. Tveit JV, Saastad E, Stray-Pedersen B, Børdahl PE, Frøen JF. Concerns for decreased foetal movements in uncomplicated pregnancies - increased risk of foetal growth restriction and stillbirth among women being overweight, advanced age, or smoking. J Matern Fetal Neonatal Med 2010;23(10):1129-1135 doi:10.3109/14767050903511578 PMid:20476880
10. World Health Organization. Newborns: improving survival and well-being. 2020. [Available from: http://www.who.int/mediacentre/factsheets/fs333/en/, [Last access date: 4 Oct 2021]
11. Kiguli J, Namusoko S, Kerber K, Peterson S, Waiswa P. Weeping in silence: community experiences of stillbirths in rural eastern Uganda. Glob Health Action 2015;8(1):24011. doi:10.3402/gha.v8.24011 PMid:25843493 PMCid:PMC4385210
12. Goldenberg RL, Griffin JB, Kamath-Rayne BD, Harrison M, Rouse DJ, Moran K, *et al.* Clinical interventions to reduce stillbirths in sub-Saharan Africa: a mathematical model to estimate the potential reduction of stillbirths associated with specific obstetric conditions. BJOG 2018; 125 (2):119-129. doi:10.1111/1471-0528.14304 PMid:27704677
13. Das MK, Arora NK, Gaikwad H, Chellani H, Debata P, Rasaily R, *et al.* Grief reaction and psychosocial impacts of child death and stillbirth on bereaved North Indian parents: A qualitative study. PLoS one 2021; 16(1): e0240270. doi:10.1371/journal.pone.0240270 PMid:33503017 PMCid:PMC7840017
14. Nuzum D, Meaney S, O'Donoghue K. The impact of stillbirth on consultant obstetrician gynaecologists: a qualitative study. BJOG 2014; 121(8):1020-1028. doi:10.1111/1471-0528.12695 PMid:24589177
15. Nuzum D, Meaney S, O'Donoghue K. The spiritual and theological challenges of stillbirth for bereaved parents. J Relig Health 2017; 56 (3): 1081-1095. doi:10.1007/s10943-017-0365-5 PMid:28154999
16. Nuzum D, Meaney S, O'Donoghue K. The provision of spiritual and pastoral care following stillbirth in Ireland: a mixed-methods study. BMJ Support Palliat Care 2016;6(2):194-200 doi:10.1136/bmjspcare-2013-000533 PMid:24916197
17. O'Connell O, Meaney S, O'Donoghue K. Caring for parents at the time of stillbirth: how can we do better?. Women Birth 2016; 29 (4):345-349. doi:10.1016/j.wombi.2016.01.003 PMid:26916147
18. Day C, Gray A, Cois A, Ndlovu N. Health and related indicators: Interrogating the UHC service coverage index. S Afr Health Rev 2019; 2019(1):215-9
19. Tveit JV, Saastad E, Stray-Pedersen B, Børdahl PE, Flenady V, Fretts R, *et al.* Reduction of late stillbirth with the introduction of fetal movement information and guidelines - a clinical quality improvement. BMC Pregnancy Childbirth 2009;9:32. doi:10.1186/1471-2393-9-32 PMid:19624847 PMCid:PMC2734741
20. Creswell JW, Creswell JD. Research design: Qualitative, quantitative, and mixed methods approaches. 4th edition. Sage publications. 2018.
21. Beck CT. Polit DF, Essentials of Nursing Research: Appraising Evidence for Nursing Practice. (9th Ed). Philadelphia, Lippincott Williams, & Wilkins. United States of America; 2018.
22. Attachie I, Mwini-Nyaledzigbor P, Affram C, Adjei D. Mothers' experiences of stillbirth: A study in the Accra Metropolis (Socio-Cultural Implications). Adv Multidiscip Res J 2016;2(2):223-230.
23. Dapaah JM. Attitudes and Behaviours of Health Workers and the Use of HIV/AIDS Health Care Services. Nurs Res Pract 2016; 2016: 5172497. doi:10.1155/2016/5172497 PMid:28116154 PMCid:PMC5225383
24. Sharma B, Bhattarai S, Shrestha S, Joshi R, Tamrakar R, Singh P, *et al.* Maternal and fetal characteristics and causes of stillbirth in a tertiary care hospital of Nepal: secondary analysis of registry-based surveillance data. BMJ Open 2021;11(8):e045012. doi:10.1136/bmjopen-2020-045012 PMid:34373292 PMCid:PMC8354277
25. Smyth RM, Taylor W, Heazell AE, Furber C, Whitworth M, Lavender T. Women's and clinicians perspectives of presentation with reduced fetal movements: a qualitative study. BMC Pregnancy Childbirth 2016; 16(1): 280. doi:10.1186/s12884-016-1074-x PMid:27671523 PMCid:PMC5037887
26. Abdul-Mumin KH. Village midwives and their changing roles in Brunei Darussalam: a qualitative study. Women Birth 2016;29 (5): e73-81. doi:10.1016/j.wombi.2016.04.002 PMid:27105748
27. Aborigo RA, Allotey P, Reidpath DD. The traditional healer in obstetric care: a persistent wasted opportunity in maternal health. Soc Sci Med 2015; 133:59-66. doi:10.1016/j.socscimed.2015.03.046 PMid:25841096
28. Nergard CS, Ho TP, Diallo D, Ballo N, Paulsen BS, Nordeng H. Attitudes and use of medicinal plants during pregnancy among women at health care centers in three regions of Mali, West Africa. J Ethnobiol Ethnomed 2015: 11:73. doi:10.1186/s13002-015-0057-8 PMid:26453339 PMCid:PMC4600315
29. Nyeko R, Tumwesigye NM, Halage AA. Prevalence and factors associated with use of herbal medicines during pregnancy among women attending postnatal clinics in Gulu district, Northern Uganda. BMC Pregnancy Childbirth 2016;16(1):296. doi:10.1186/s12884-016-1095-5 PMid:27716105 PMCid:PMC5053208
30. Rasch V, Sørensen PH, Wang AR, Tibazarwa F, Jäger AK. Unsafe abortion in rural Tanzania - the use of traditional medicine from a patient and a provider perspective [published correction appears in BMC Pregnancy Childbirth. 2015;15:355]. BMC Pregnancy Childbirth 2014;14:419. doi:10.1186/s12884-014-0419-6 PMid:25524498 PMCid:PMC4279892
31. Steenkamp V. Traditional herbal remedies used by South African women for gynaecological complaints. J Ethnopharmacol 2003;86 (1): 97-108. doi:10.1016/S0378-8741(03)00053-9 PMid:12686447

How to Cite this Article:
Malaza SP, Maputle MS, Lebese RT. Exploring the community perceptions and understanding of stillbirth in South Africa: A qualitative study. Nurs Midwifery Stud 2023; 12(4):247-253 doi: 10.48307/nms.2023.412867.1252