The Impact of Culture on Grief Experiences After Stillbirth for Mothers Living in Sub-Saharan Africa: A Systematic Review and Meta-synthesis

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Declaration

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, contains no materials previously published except where due reference is made.

I give permission for the digital version of my dissertation to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the School to restrict access for a period of time.

October 2023

Contribution Statement

I proposed the original idea for the research topic, and my research supervisors assisted me in refining the research aims and study design. Guided by my research supervisors, I drafted the search grids used to gather data for this study, and a research librarian helped me finalise my search terms and syntax for each database. I conducted the database searches and a portion of title and abstract screening with my research supervisors. I completed the remainder of the title and abstract screening and all of the full-text screening independently. Quality appraisal was completed by myself and one of my research supervisors. I completed data extraction and analysis; my supervisors reviewed and assisted with refinement and verification of the synthesised findings. I wrote all components of this thesis.

The Impact of Culture on Grief Experiences After Stillbirth for Mothers Living in Sub-Saharan Africa: A Systematic Review and Meta-synthesis

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Keywords: stillbirth; sub-Saharan Africa; mothers; grief; culture; religion

Abstract

Objective: The highest burden of stillbirth occurs in sub-Saharan African countries, where cultural norms, religious beliefs and community understandings of stillbirth can significantly influence how the community may understand stillbirth, as well as how mothers grieve. Through four research questions, this study aimed to explore how culture impacts mothers' grief experiences after stillbirth.

Methods: A systematic review and meta-synthesis was conducted using a meta-aggregative approach to create synthesised findings. Five databases were searched from inception until January 2023, with eligible studies appraised for quality using the QualSyst Quality Assessment Checklist.

Results: Sixteen studies contributed to the four final synthesised findings: (i) after stillbirth, most mothers endure a complex and overwhelming emotional experience that encompasses blame, guilt, relationship impacts and long-term coping efforts including hope and gratitude; (ii) stillborn babies are often not recognised as human by communities, with mothers finding it difficult to understand their stillbirth, attributing it to religious or spiritual explanations; (iii) cultural and societal norms place high value on motherhood, with mothers questioning their identity and pressured to internalise their emotions; and (iv) mothers want accurate and timely information, consistent hospital care, opportunities for memory-making and support from family and community.

Conclusion: This meta-synthesis emphasises the need for guidelines to ensure appropriate and supportive care is provided to mothers in sub-Saharan Africa following stillbirth. Additional research across sub-Saharan Africa is required to understand the nuances in various cultural norms and religious beliefs regarding stillbirth and how this impacts mothers' grief experiences. Effective guidelines would consider these nuances and address the impact of cultural/societal norms on support provided.

Background

The loss of a baby due to stillbirth is a devasting and overwhelming experience for families. The World Health Organisation (2023) classifies stillbirth as a baby who dies after 28 weeks of pregnancy, before or during birth. More than 5400 stillbirths occur daily worldwide (Kwesiga et al., 2022). The highest number of stillbirths occur in sub-Saharan African countries, with approximately 28.3 stillbirths per 1000 births (most of which are in low-income sub-Saharan African countries), compared to 3.1 stillbirths per 1000 births in high-income countries (Kwesiga et al., 2022). However, these figures likely underestimate the number of stillbirths occurring in sub-Saharan Africa since research suggests stillbirth is under-reported in this region due to differing community definitions of stillbirth, cultural stigma regarding pregnancy loss, and inadequate reporting systems (Baffour-Awua & Richter, 2020; Bedwell et al., 2021; Haws et al., 2010).

Research in high-income countries demonstrates that after losing a baby to stillbirth, mothers experience a range of emotions, including shock, anger, guilt and pain (Bakhbakhi et al., 2017). Such outcomes are evident across stillbirth research, with multiple systematic reviews discussing various subsequent psychological issues for mothers, most commonly depression (Burden et al., 2016; Ellis et al., 2016). Additionally, grief can be complex and long-lasting, with many mothers experiencing disenfranchised grief, defined as grief that is not publicly acknowledged or socially supported (Flenady et al., 2014; Lang et al., 2011). Lack of legitimisation of grief and incongruent grieving styles with partners reported across the literature can significantly impact familial relationships (Burden et al., 2016; Ellis et al., 2016). Given these various impacts, stillbirth is considered a life-changing event that can represent the loss of an imagined future for some mothers, impacting their sense of self and further complicating their grief experience (Burden et al., 2016). As a result of research and sustained funding, in most high-income countries specific guidelines for compassionate

bereavement care are a standard part of healthcare providers' post-stillbirth practice (Kuti & Ilesanmi, 2011).

However, literature on stillbirth in sub-Saharan Africa commonly describes cultural norms and religious/spiritual beliefs that suggest the grieving for a stillborn baby is not part of standard cultural practice. This includes a belief that stillbirth may result from 'wicked spirits' (Adeyemi et al., 2008, p. 1463), as well as ongoing stigma more generally (Adeyemi et al., 2008; Bogee et al., 2023; Shakespeare et al., 2019). Research has also found that mothers from sub-Saharan Africa frequently experience blame for pregnancy losses and are subjected to social exclusion and gossip (Bogee et al., 2023). Across cultural/religious communities and countries, more generally, mothers are discouraged from openly speaking about their grief after stillbirth due to potential blame and fear, including that discussing their experience will lead to infertility in the future (Haws et al., 2010; Shakespeare et al., 2019). In the face of these views and beliefs, mothers from much of Sub-Saharan Africa are instead expected to internalise their emotions and or rely on their religion or spirituality to cope with their grief (Kwesiga et al., 2022).

Despite the high incidence of stillbirth in sub-Saharan Africa, limited options for bereavement care are available for families (Bogee et al., 2023). Mothers require support from close relatives such as partners, children and extended family (Kwesiga et al., 2022), but this may be limited due to issues such as stigma as highlighted above. Health professionals also play a key role, as compassionate care in the hours after a stillbirth is critical in minimising trauma for mothers (Mills et al., 2022). However, research regarding stillbirth in lower- and middle-income countries reports that healthcare professionals do not always recognise mothers' grief and/or there may be limited facilities to provide this support to women (Shakespeare et al., 2019). There is also limited evidence of social or bereavement

support groups where families can share their emotions, with cultural norms discouraging mothers from displays of emotion (Kwesiga et al., 2022).

The risk and intensity of mothers' psychological problems after stillbirth depends on their medical/mental condition, support provided by family and friends, and access to appropriate bereavement care (Bogee et al., 2023; Kuti & Ilesanmi, 2011). A substantial evidence base is required to further understand the complex, inter-related experiences of mothers from sub-Saharan Africa who have experienced a stillbirth, including the factors that may affect their grief and ongoing psychological wellbeing (Shakespeare et al., 2019). This systematic review and meta-synthesis aims to explore the impact of culture on grief experiences after stillbirth for mothers living in sub-Saharan Africa, through the following research questions: (i) How do mothers living in sub-Saharan Africa experience grief after stillbirth?; (ii) What explanations are used by mothers to make sense of stillbirth?; (iii) What cultural/religious norms and/or community understandings of stillbirth influence how mothers grieve after stillbirth?; (iv) What supports do mothers desire following stillbirth?

Methods

Design

This systematic review and meta-synthesis employed a meta-aggregative approach. It followed an a priori protocol, pre-registered with PROSPERO (ID: CRD42023431874) Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines (PRISMA; Page et al., 2020) guided searches and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ; Tong et al., 2012) guidelines informed the reporting of findings. An inductive approach was used to generate categories and sub-categories and synthesised findings from data extracted from the included studies. Using a meta-aggregative approach allows for the creation of generalisable statements in the form of synthesised findings and recommendations to guide policymakers and practitioners

(Lockwood et al., 2015). Ethics approval was not required as the study utilised pre-existing data from published qualitative studies.

Search Strategy and Data Collection

Five online databases (CINAHL, Embase, PsycInfo, PubMed and Web of Science) were searched from database inception to January 2023 for qualitative studies that examined sub-Saharan African mothers' grief experiences after stillbirth. The search terms were adapted to each database's indexing system and were refined by a research librarian to maximise accuracy. Searches included terms such as 'stillbirth', 'perinatal death', 'sub-Saharan Africa', 'qualitative', and other suitable variations of these terms (see Supplementary Table 1). Alerts were generated for each database to ensure that any studies published after the initial search could be considered for inclusion. Additionally, the reference lists of included articles were manually searched, and citation searching was conducted using Scopus to locate any relevant studies not discovered in the database searches. Identified records were imported into EndNote for screening.

Selection Criteria

Studies were included if they: (i) investigated Sub-Saharan African mothers' experiences of grief after stillbirth (studies that reported multiple forms of perinatal loss were eligible provided stillbirth data was reported separately and in sufficient detail to extract), (ii) presented qualitative data (mixed methods papers were eligible if qualitative data was reported separately and in sufficient detail to extract), and (iii) were published in English in a peer-reviewed journal. Studies were excluded if they (i) reported only quantitative data, (ii) were not published in English in a peer-reviewed journal, (iii) did not report primary data (e.g., editorials, opinion pieces, book reviews), (iv) did not report full data (e.g., conference abstracts, brief reports), (v) exclusively examined other forms of perinatal loss (i.e., miscarriage, neonatal death), (vi) examined grief among mothers who experienced stillbirth

in other geographic locations (i.e., not Sub-Saharan Africa), or (vii) examined non-grief related aspects of stillbirth.

Quality Appraisal

The Qualsyst Quality Assessment Checklist (13) was used to evaluate the quality of the eligible studies across 10 criteria (Kmet et al., 2004). Each study was appraised for quality with a full score (2 points), a partial score (1 point) or no score (0 points) allocated to each criterion. A summary score (sum of individual scores divided by a total possible score of 20) was calculated for each study, with higher scores indicating a higher quality paper. The first and third authors independently appraised a random sample of included studies, with all studies receiving the same scores for each criterion from both authors. The first author then independently appraised the remaining articles. Kmet et al. (2004) provide two options for cut-off scores: .55 as liberal and .75 as conservative. The conservative cut-off score was chosen to ensure that only high-quality papers were included in this review.

Data Extraction and Synthesis

Data were extracted from eligible studies and recorded on a study-specific data extraction sheet. Data extracted from each study included (i) study characteristics (e.g., region, data collection and analysis methods), (ii) participant characteristics (e.g., age, relationship status, education), (iii) stillbirth characteristics (e.g., type of stillbirth, number of stillbirths, time since stillbirth, previous births) and (iv) cultural characteristics of the country/countries where the research took place (e.g., main religion(s) and cultural group(s)). Findings from the qualitative studies were extracted verbatim in the form of categories or themes. Similar findings were grouped into categories and further combined to create synthesised findings that addressed the research aims. The author and the research supervisors reviewed, refined and agreed upon the synthesised findings.

Reflexivity

Self-reflexivity in qualitative research has been highlighted to show awareness of the ways in which the researcher's identity may impact the research (Tracy, 2010). The author is a young female without personal experience of pregnancy loss or stillbirth. They do not live in sub-Saharan Africa or a low- or middle-income country. All researchers examined the verbatim findings extracted from included articles to minimise potential biases before generating synthesised findings. The author and research supervisors checked the synthesised findings against the original data to minimise misinterpretation, and all agreed on the final synthesised findings.

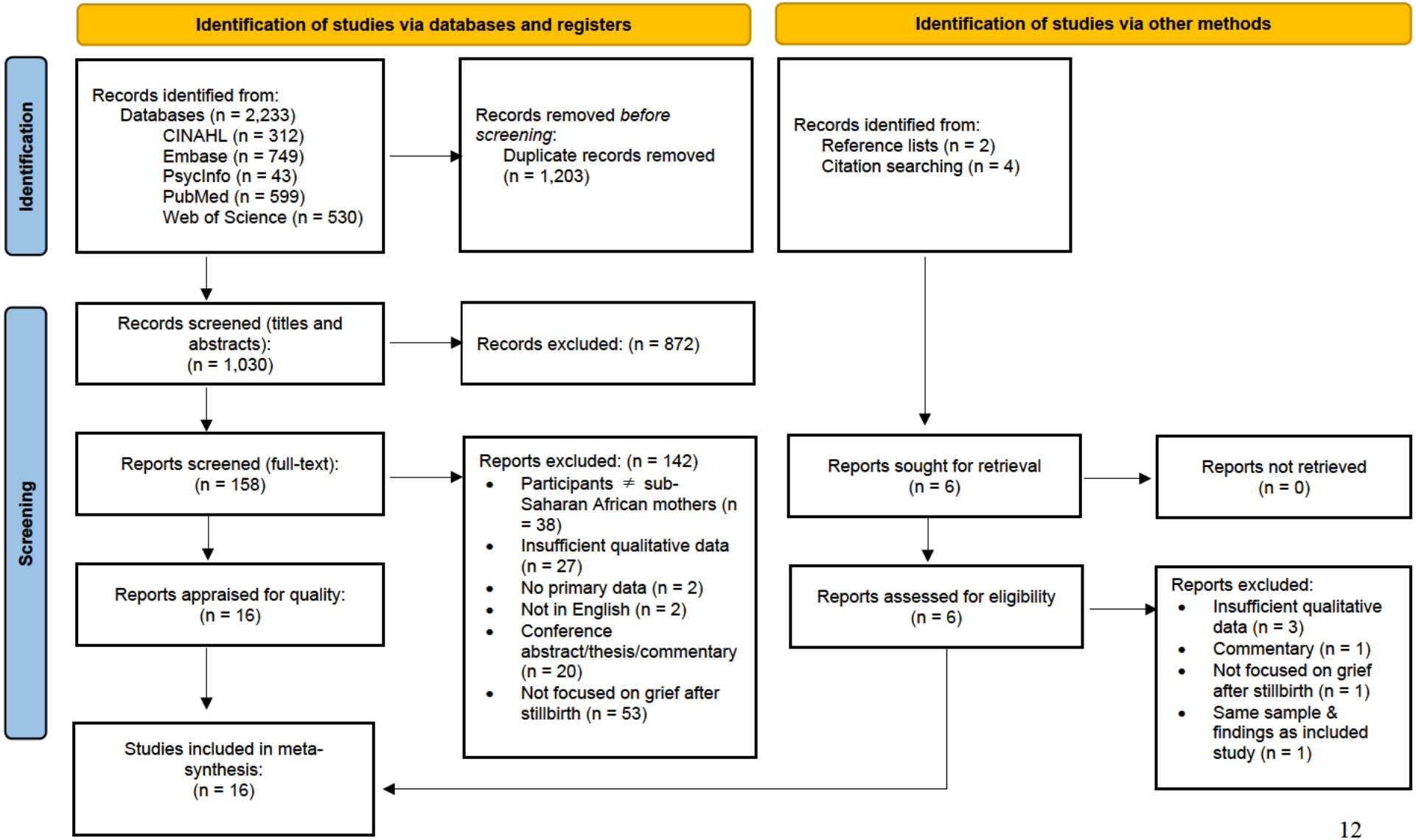
Results

Study Selection

The initial search yielded 2,233 records (see Figure 1). After removing 1,203 duplicates, the titles and abstracts of 1030 records were screened. The first and second authors co-screened the titles and abstracts of 10% of the records, achieving high inter-rater reliability. The first author independently screened the titles and abstracts of the remaining records, with 158 records progressing to full-text screening. During full-text screening, authors of 11 studies that focused on multiple types of pregnancy loss and/or multiple family members' perspectives were emailed to identify findings specific to mothers' experiences of stillbirth. Five authors responded, with two studies included. The remaining three articles for which replies were received, and the six articles where authors did not reply were excluded. After full-text screening, 16 articles remained eligible for inclusion. An additional six records were identified through the reference lists and citation searching of these 16 articles. The full-texts of the six records were screened, and five articles were excluded, with one author emailed to identify findings specific to mothers' experiences of stillbirth. No reply was received so this article was also excluded. All 16 of the included articles met the Qualsyst (Kmet et al., 2004) conservative cut-off score of .75 and were included in the meta-synthesis.

Figure 1.

PRISMA Flowchart for Article Selection and Screening



Study Characteristics

Table 1 summarises the key characteristics of the 16 included studies. The studies were published between 2001 and 2022, with most published in 2022 ($N_{studies}$ = 7). Qualitative data was collected primarily through interviews, with only two exceptions of focus groups. A range of approaches were used for data analysis across the included studies, with thematic analysis ($N_{studies}$ = 6) and comparative analysis ($N_{studies}$ = 2) most commonly utilised.

Reporting Quality of Included Studies

Figure 2 summarises the reporting quality of included studies, assessed using the Qualsyst Quality Assessment Checklist (Kmet et al., 2004; refer to Supplementary Table 2 for detailed criterion scores for each included study). All included studies had a clear question/objective, specified study design, comprehensive theoretical framework, a description of data collection methods and conclusions that were drawn from findings (*Items 1, 2, 4, 6 and 9*; 100% fulfilled). Most studies also provided a clear description of the study context (*Item 3*; 97% fulfilled) and analysis methods (*Item 7*; 97% fulfilled) and stated at least one verification procedure (*Item 8*; 94% fulfilled). However, only some studies met criteria for sampling strategy (*Item 5*; 88% fulfilled) and few satisfied reflexivity (*Item 9*; 22% fulfilled).

Participant Characteristics

The sample comprised 281 mothers who had experienced a stillbirth ($N_{studies}$ = 12; four studies shared the same sample). Participants were aged 17-54 ($N_{studies}$ = 11; $N_{participants}$ = 199 participants), with a mean age of 29.44 years (*SD* =7.67; $N_{studies}$ = *8*; $N_{participants}$ = 172).

Table 1.

Characteristics of Included Studies

Lead Author (Year)	Country	Sample Size	Recruitment Strategy	Data Collection	Data Analysis	Quality Score
Arach (2022)	Uganda	14	Home visits to potential participants, identified from a previous trial, health facilities records and community leaders	Semi-structured interviews	Content thematic analysis	.95
Ayebare (2021)	Uganda; Kenya	75	Healthcare workers across five facilities provided consent from participants to be contacted by researchers	Semi-structured interviews	Descriptive thematic analysis	.90
Bedwell (2023)	Malawi; Tanzania; Zambia	33	Midwives and doctors in postnatal wards provided consent from participants to be contacted by researchers	Interviews	Comparative analysis	.90
Corbet-Owen (2001)	South Africa	3	Contacted participants of a larger qualitative study	Interviews	Constructionist grounded theory techniques	.90
Danna (2023)	Malawi; Tanzania; Zambia	33	Midwives and doctors in postnatal wards provided consent from participants to be contacted by researchers	Semi-structured interviews	Comparative analysis	1.0

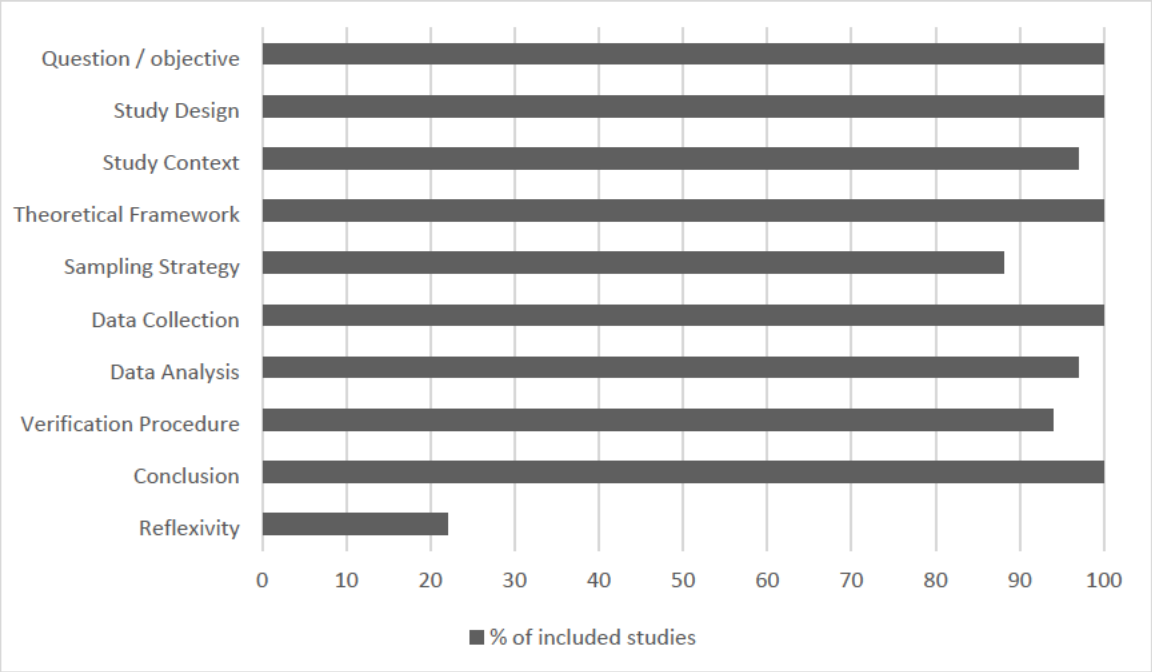
Jimoh (2022)	South Africa	30	Mothers who delivered stillborn babies at Steve Biko Academic Hospital were invited to participate	Semi-structured interviews	Colaizzi's phenomenological analysis	.85
Kiguli (2015)	Uganda	14	Hospital maternity ward register and through village community leaders	Interviews	Content analysis	.90
Lappeman (2022)	South Africa	10	Hospital records	Interviews	Free Association Narrative Interview method	.85
Mills (2020)	Kenya; Uganda	75	Healthcare workers across five facilities provided consent from participants to be contacted by researchers	Interviews	Van Manen's reflexive approach	.90
Milton (2021)	Nigeria	16	Phone calls to participants of a wider feasibility study	Focus groups	Thematic analysis	.95
Noge (2020)	South Africa	36	Phone calls and home visits to potential participants identified from hospital birth registers	Unstructured interviews	Wittmann Price's Emancipatory Decision Making conceptual framework	.85
Osman (2016)	Somalia	10	Traditional Birth Attendants across eight villages facilitated researcher contact with participants	Interviews	Giorgi's method of phenomenological description	.90

Popoola (2021)	Nigeria	20	Snowball sampling through social and professional networks of the researcher	Semi-structured interviews	Thematic analysis	.85
Popoola (2022a)	Nigeria	20	Snowball sampling through social and professional networks of the researcher	Semi-structured interviews; focus group	Alexandersson	.90
Popoola (2022b)	Nigeria	20	Snowball sampling through social and professional networks of the researcher	Semi-structured interviews	Thematic analysis	.85
Simawaka (2014)	Malawi	20	Hospital perinatal loss records used to identify potential participants, then snowball sampling	Semi-structured interviews	Thematic analysis	.90

Note. Multiple studies included mothers who did not experience a stillbirth, fathers and other family members as participants (Arach et al., 2022; Ayebare et al., 2021; Bedwell et al., 2023; Corbet-Owen & Kruger, 2001; Kiguli et al., 2015; Mills et al., 2020; Milton et al., 2021; Noge et al., 2020; Simwaka et al., 2014). For these studies, only participants who were mothers who had experienced a stillbirth are reported in the sample size.

Figure 2.

Quality of Included Studies Using the Qualsyst Quality Assessment Checklist (Kmet et al., 2004)



One-hundred and sixty-two participants were married or partnered (56.94%), seven were single (2.49%), and one was widowed (0.36%). The relationship status of 106 participants (37.72%) was not specified. Most studies did not report participants' religion ($N_{studies}$ = 9; $N_{participants}$ = 153). Where religion was reported ($N_{studies}$ = 7), 19 participants reported that they were Muslim (6.76%), and 109 reported that they were Christian (38.79%). Cultural group was not commonly reported.

The reporting of stillbirth characteristics varied across studies, with some studies providing no details ($N_{studies}$ = 3). Ninety-eight participants had experienced one stillbirth (34.88%; $N_{studies}$ = 4), and 20 participants had experienced multiple stillbirths (7.18%; $N_{studies}$ =4). Forty-five participants experienced an antepartum stillbirth (stillbirth occurring during pregnancy and prior to delivery, before the onset of labour (Tavares Da Silva, 2016; 16.01%; $N_{studies}$ = 3), and 83 participants experienced an intrapartum stillbirth (stillbirth occurring after the onset of labour and prior to delivery (Tavares Da Silva et al., 2016; 29.54%; $N_{studies}$ = 3).

Forty-one participants had experienced a stillbirth in their first pregnancy (14.59%; $N_{studies}$ = 7). Time since stillbirth ranged from six months to four years ($N_{studies}$=7 studies), with one study interviewing women as early as one month after stillbirth and another interviewing participants as late as 26 years after stillbirth.

Synthesised Findings

Using a meta-aggregative approach, 58 findings extracted from the included studies were combined to create four synthesised findings related to the research questions (See Table 3). Findings on mothers' experiences of grief were described in four categories: (i) Immediate emotions experienced after stillbirth are complex and overwhelming; (ii) Mothers often experienced blame and guilt; (iii) Relationships were significantly impacted after birth; (iv) Long-term coping with stillbirth included hope and gratitude for life. Findings concerning how mothers explain their stillbirth were covered by three categories: (i) Stillborn babies were considered a "thing"; (ii) Although common in the community, mothers found it difficult to make sense of the stillbirth; (iii) Stillbirth was interpreted to be a part of "God's plan" or "witchcraft". Two categories summarised findings for the influence of cultural/religious norms and community understandings of stillbirth on mothers' grief: (i) High value placed on motherhood by the community results in mothers questioning their own identity after stillbirth; (ii) Mothers are pressured to internalise grief and suppress their emotions. Finally, four categories described findings regarding the support desired by mothers after stillbirth: (i) To be informed of the stillbirth, without delays or misinformation; (ii) Hospital care that is consistent in quality with the care provided to mothers who have had live births; (iii) Opportunities to make memories with the stillborn baby; (iv) Support and connection from family/community members is critical for coping.

Table 3.

Synthesised Findings and Categories Relating to Research Questions

Sub-Saharan African Women's Experiences of Grief after Stillbirth: After stillbirth, most mothers endure a complex and overwhelming emotional experience that encompasses blame, guilt, relationship impacts and long-term coping efforts including hope and gratitude
• Immediate emotions experienced after stillbirth are complex and overwhelming
• Mothers often experienced blame and guilt
• Relationships were significantly impacted after stillbirth
• Long-term coping with stillbirth included hope and gratitude for life
Mothers Explanations of Stillbirth: Stillborn babies are often not recognised as human by communities, with mothers finding it difficult to understand their stillbirth, attributing it to religious or spiritual explanations
• Stillborn babies were considered a "thing"
• Although common in the community, mothers found it difficult to make sense of the stillbirth
• Stillbirth was interpreted to be a part of "God's plan" or "witchcraft"

The Role of Cultural/Religious Norms and/or Community Understandings of Stillbirth in How Mothers Grieve after Stillbirth: Cultural and societal norms place high value on motherhood, with mothers questioning their identity and pressured to internalise their emotions

- High value placed on motherhood by the community results in mothers questioning their identity after stillbirth
- Mothers are pressured to internalise grief and supress their emotions

Supports Mothers Desire After Stillbirth: Mothers want accurate and timely information, consistent hospital care, opportunities for memory-making and support from family and community

- To be informed of the stillbirth, without delays or misinformation
- Hospital care that is consistent in quality with the care provided to mothers who have had live births
- Opportunities to make memories with the stillborn baby
- Support and connection from family/community members is critical for coping

Mothers' Experiences of Grief After Stillbirth

The meta-synthesis of mothers' experiences of grief after stillbirth was developed from 11 studies, grouped into four categories (Table 3), to provide the overall synthesised finding: *'After stillbirth, most mothers endure a complex and overwhelming emotional experience that encompasses blame, guilt, relationship impacts and long-term coping efforts including hope and gratitude'*.

Mothers experienced complex emotions after stillbirth (Danna et al., 2023; Osman et al., 2016; Popoola et al., 2022b). Despite the commonality of stillbirth in sub-Saharan Africa, many mothers described feeling shocked and unprepared (Danna et al., 2023; Mills et al., 2020; Osman et al., 2016; Popoola et al., 2022b); as highlighted by one woman who stated that she *"couldn't believe [her] ears when they [nurses] said [her] baby had died…it made no sense"* (Popoola et al., 2022b, p.9) and by other mothers who reported that they only believed that their baby had died after they saw their baby's body (Danna et al., 2023). Mothers also reported feeling completely *"heartbroken"* (Corbet-Owen & Kruger, 2001, p.417) after stillbirth or and/or interpreted their reaction as pain; as one woman described: *"the pain of stillbirth is not a physical pain that can be managed with just medical treatment, the pain is deep within the soul"* (Popoola et al., 2022b, p.7). Heartbreak and pain were reported across multiple studies (Danna et al., 2023; Jimoh et al., 2022; Osman et al., 2016; Simwaka et al., 2014), with experiences of pain also attributed to the sudden nature of stillbirth and lack of information regarding the cause (Popoola et al., 2022b). Overall, women expressed sadness and devastation (Corbet-Owen & Kruger, 2001; Danna et al., 2023; Popoola et al., 2022b; Simwaka et al., 2014) and feeling as though they *"had worked for nothing"* (Simwaka et al., 2014, p.9) and were "*going home empty-handed"* (Danna et al., 2023, p. 29). Where this was explored in the studies, women's emotions regarding their

stillbirth lasted a long time (Popoola et al., 2022b; Simwaka et al., 2014), with one woman sharing that she *"went home most days with a heavy heart"* (Popoola et al., 2022b, p.8).

In addition to the emotional experiences described above, the mothers in the included studies commonly reported experiencing blame and guilt (Arach et al., 2022; Jimoh et al., 2022; Milton et al., 2021; Popoola et al., 2022b; Simwaka et al., 2014), either from themselves, their more immediate families or broader communities (Jimoh et al., 2022). At times, mothers also blamed external factors such as their husbands' promiscuity or delays in healthcare provision (Milton et al., 2021; Simwaka et al., 2014). Instances of self-blame were described across studies, with mothers lamenting whether or not their baby would have survived had they made different choices (Arach et al., 2022; Jimoh et al., 2022; Popoola et al., 2022b). Some mothers attributed their loss to not having engaged healthcare support earlier, as reported by one mother: *"I regret that if I had been taken to a health centre that very night the labour pain had just started, perhaps it couldn't have happened that way"* (Arach et al., 2022, p.7). Members of the mothers' families and communities also examined mothers' choices before the stillbirth (Arach et al., 2022; Jimoh et al., 2022; Milton et al., 2021). In some cases, mothers expressed being blamed for not seeking "enough" healthcare; however, in other cases, women were also being blamed for seeking "too much" healthcare: *"They [husband's relatives] would mock me, saying I go to the hospital for the smallest sicknesses. When I gave birth to my first baby, it was stillborn. They blamed it on my frequent hospital visits"* (Milton et al., 2021, p.8).

Women experienced significant impacts on their close relationships after stillbirth (Mills et al., 2020; Milton et al., 2021; Noge et al., 2020; Popoola et al., 2021). Mothers in several studies reported abandonment or feared abandonment by their partners (Mills et al., 2020; Milton et al., 2021; Popoola et al., 2022b). Multiple mothers experienced family and community members advising their husbands to leave them after their stillbirth: *"you hear*

people's words, telling even your husband to just leave you and get another wife" (Arach et al., 2022, p.7) with husbands encouraged to find another wife *"that will give birth to live babies"* (Milton et al., 2021, p.7). This advice, coupled with gossip, blame and insensitive comments, created distrust for mothers, leading them to distance themselves from others, often leading to loneliness (Popoola et al., 2021; Simwaka et al., 2014). In contrast, where close family members and friends provided emotional support, mothers reported that their relationships were strengthened (Popoola et al., 2021).

Long-term coping after stillbirth was evident through reports of hope for the future and gratitude for life, both of which often had cultural/religious drivers (Mills et al., 2020; Osman et al., 2016; Popoola et al., 2022b). Mothers reported maintaining a sense of hope for a live birth in the future, with some mothers indicating that this would occur by God's will: *"I cope by reminding myself that I already lost another baby…I should not worry…God will give me more children if I want"* (Mills et al., 2020, p.106). Mothers also expressed gratitude for surviving childbirth themselves (Osman et al., 2016; Popoola et al., 2021), and again some mothers believed their survival was God's will (Osman et al., 2016; Popoola et al., 2022b), with one mother stating: *"I could have died with the baby if not for God's mercy…I considered myself lucky to be alive"* (Popoola et al., 2022b, p.10). Those who saw, touched or held their babies viewed these memories positively (Osman et al., 2016).

Mothers' Explanations of Stillbirth

The meta-synthesis of mothers' understandings of stillbirth was derived from eight studies, grouped into three categories (Table 3) to produce the overall synthesised finding: *'Stillborn babies are often not recognised as human by communities, with mothers finding it difficult to understand their stillbirth, attributing it to religious or spiritual explanations'.*

Multiple studies compared community perceptions of a stillborn baby with community perceptions of a live-born baby (Ayebare et al., 2021; Bedwell et al., 2023;

Kiguli et al., 2015; Popoola et al., 2022a), with stillborn babies referred to as *"a thing"* (Kiguli et al., 2015, p.3). One mother shared: *"One who has cried is a human while the stillbirth isn't regarded as a human since they haven't heard its cry"* (Ayebare et al., 2021, p.5). Naming the baby was described to be uncommon (Ayebare et al., 2021), with no included studies indicating a practice of naming stillborn babies. Hesitance to assign a name was also explained by the practice of passing down familial names and the belief that assigning these to a dead baby would bring "bad luck to the whole family" (Ayebare et al., 2021, p.5). Similarly, mothers were often excluded from burials or funerals for their babies (Kiguli et al., 2015) due to the belief that *"if the mother buries their baby, she will never conceive again in her life"* (Ayebare et al., 2021, p.6).

Despite stillbirth being common in the community, mothers found it difficult to make sense of their stillbirth (Jimoh et al., 2022; Kiguli et al., 2015; Popoola et al., 2022a). Mothers reported knowing about family members who had experienced a stillbirth, with some believing that a woman would be lucky to have a live birth in her first pregnancy due to the prevalence of stillbirth in the community (Kiguli et al., 2015; Popoola et al., 2022a). In trying to make sense of their stillbirth, women sought to understand the causes both more generally as well as those that specifically applied to them (Arach et al., 2022; Jimoh et al., 2022; Kiguli et al., 2015; Popoola et al., 2022a). Some mothers considered factors such as delays in accessing healthcare, financial barriers and maternal infections (Kiguli et al., 2015; Popoola et al., 2022a). Others considered that the loss of their baby may be a direct consequence of going against religious or cultural practices, as articulated by one mother: *"The more I think about it, the more I think there is a spiritual dimension to the loss…in my mind it is not natural for a baby to die the day he was supposed to be born"* (Popoola et al., 2022a; p.6). The cause of stillbirth was sometimes challenging for mothers to comprehend as they found it difficult to understand the information given by healthcare providers despite frequently

seeking clarification (Jimoh et al., 2022). The fourth synthesised finding below further describes communication barriers with healthcare providers. When mothers could understand and make meaning of their loss, this was seen as helpful in coping with the grief of stillbirth (Corbet-Owen & Kruger, 2001).

Mothers often interpreted stillbirth as either witchcraft or a part of God's plan (Ayebare et al., 2021; Jimoh et al., 2022; Kiguli et al., 2015; Popoola et al., 2022a; Simwaka et al., 2014). When considering spiritual and social causes of stillbirth, some mothers expressed doubt: *"I convinced myself that God allowed it, but it was also possible that my husband's first wife was responsible for it. She never liked me and could have bewitched the pregnancy…but I still believed the baby would not have died if God has not permitted it"* (Popoola et al., 2022a, p.7). Witchcraft was particularly emphasised by mothers in polygamous relationships: *"If I had known of my co-wife's witchcraft, then I would have consulted with doctors and saved my baby"* (Kiguli et al., 2015, p.5). Mothers also attributed their stillbirths to witchcraft in cases where family members had evil intentions or had been possessed by evil spirits (Ayebare et al., 2021; Simwaka et al., 2014). Some mothers experienced gossiping among community members regarding witchcraft causing their stillbirth, exacerbating mothers' experience of isolation (Ayebare et al., 2021). Many studies described the belief that stillbirth was an event allowed by God (Ayebare et al., 2021; Jimoh et al., 2022; Popoola et al., 2022a; Simwaka et al., 2014), with religious perspectives sometimes provided by healthcare providers when providing support to parents immediately after the death of a baby (Ayebare et al., 2021). Mothers described feelings of gratitude to God that they had survived and that *"God is good all the time"* (Jimoh et al., 2022, p.18). Another mother expressed: *"In the first place the pregnancy does not belong to me, it is God's. When he decided to take the baby back, I cannot question him…he knows the best"* (Popoola et al., 2022a, p.7). However, not all mothers sought comfort from the idea that the

baby's death was out of their control, with some questioning God's choice: *"...am I really the one who gives birth to children and they die? What did I do to you God?"* (Ayebare et al., 2021, p.7).

The Role of Cultural and Societal Norms in Grief Expression

The meta-synthesis of cultural/religious norms and community understandings of stillbirth that influence how mothers grieve was derived from nine studies, grouped into two categories (Table 3), to produce the overall synthesised finding: *'Cultural and societal norms place high value on motherhood, with mothers questioning their identity and pressured to internalise their emotions'.*

Multiple studies emphasised the high value placed on motherhood by communities in sub-Saharan Africa (Corbet-Owen & Kruger, 2001; Kiguli et al., 2015; Mills et al., 2020; Popoola et al., 2021), with pregnancy considered a marker of a successful person and a good wife (Corbet-Owen & Kruger, 2001; Kiguli et al., 2015; Popoola et al., 2021). Women's ability to mother a baby was linked to status in their communities, power in their relationships, and formed a significant part of their identities (Corbet-Owen & Kruger, 2001; Mills et al., 2020), with one mother stating that *"every woman's happiness is giving birth"* (Kiguli et al., 2015, p.5). Within this cultural and social environment, mothers who had experienced stillbirth noted the opposite experience. They were considered weak, inadequate and *"like a waste"* (Corbet-Owen & Kruger, 2001, p.417). Given this key role of having children for women within many of the communities and cultures of Sub-Saharan Africa, studies reported that stillbirth altered the stability of women's lives, with mothers of stillborn babies often questioning their worth and why they had to experience this level of suffering (Corbet-Owen & Kruger, 2001; Kiguli et al., 2015; Mills et al., 2020; Osman et al., 2016).

Shame was also an emotion commonly reported by mothers, as community members – including family - ridiculed them, further exacerbating their trauma (Kiguli et al., 2015;

Milton et al., 2021; Popoola et al., 2021). One woman described her experience with her husband: *"these days he has few words…when he speaks to me, he always finds a way to say something like 'you are not like other women. I feed you, you keep well yet there is no baby in this house'…it hurt's so much"* (Mills et al., 2020, p.106). In some communities, women who experienced multiple stillbirths were considered cursed and a bad omen (Kiguli et al., 2015). Many mothers felt they had done something wrong: *"whenever I saw someone who was pregnant…I always tried to scurry away as if I had done something wrong…I felt like I had some impediments that I needed to be ashamed of"* (Popoola et al., 2021, p.5). One mother likened the social shame of stillbirth to the shame experienced by an ex-convict: *"what pride does an ex-convict have to raise shoulders in the community?"* (Popoola et al., 2021, p.5).

Mothers in sub-Saharan Africa expressed being pressured to internalise their grief and suppress their emotions after stillbirth (Danna et al., 2023; Osman et al., 2016; Popoola et al., 2022a). Some communities and cultures expected mothers to contain their emotions due to beliefs that if a mother cried for her stillborn baby, the spirit of her stillborn baby could prevent her from conceiving again (Ayebare et al., 2021; Danna et al., 2023). However, women who internalised their grief reported struggling alone: *"when everyone left and I was by myself, I cried"* (Popoola et al., 2022a, p.8). Another woman described the difficulties she experienced being trapped between competing expectations about expressing her grief in the community:

> *"…on the one hand, you cannot move on too quickly because people expect a lengthy and genuine portrayal of soberness from you…your conduct should convince people that the loss truly and deeply pained you. On the other hand, you also cannot dwell on it for too long because people expect you to be grateful for your own life…so, grieving a stillborn child is like a performance; the timing of your re-entrance into the society, the way you carry yourself and*

your countenance must genuinely reflect your sadness but also your gratitude. Performing this role is hard." (Osman et al., 2016, p.5).

Cultural norms and community beliefs also prevented mothers from creating and thinking about memories of their stillborn babies (Ayebare et al., 2021), with one mother explaining how this approach had been explicitly taught to her by women of previous generations: *"my grandmother told me that we should not have memories because the stillbirth's spirit will be following us, so I had to follow what my tradition says"* (Danna et al., 2023, p.31). Some women tried to hide their loss by avoiding social interactions and, on some occasions, relocating from their home for months and hoping people would forget about their stillbirth (Osman et al., 2016), as described by one mother: *"I hid the loss from people because I was ashamed that people might call me a failure"* (Popoola et al., 2021, p.106). Support from family and friends helped reduce shame and isolation: *"I felt like I was alone and I felt like there was nothing good about me anymore. But with the support of my mother, my level of shame started to become more comfortable in the presence of others"* (Osman et al., 2016, p.6).

Supports Mothers Desire After Stillbirth

The meta-synthesis of supports mothers desire following stillbirth was derived from 11 studies, grouped into four categories (Table 3), to produce the overall synthesised finding: *'Mothers want accurate and timely information, consistent hospital care, opportunities for memory making and support from family and community'*.

Mothers wished to be informed of their stillbirth without delays or misinformation (Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b). Many mothers reported that they were not immediately told of their baby's death and were left waiting hours after their baby was taken away (Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b). Mothers noted sometimes being ignored when they asked for their baby, which caused them

significant anxiety, worry and confusion (Danna et al., 2023; Mills et al., 2020). Mothers appreciated when healthcare providers delivered the news and provided explanations for the stillbirth (Bedwell et al., 2023; Danna et al., 2023; Simwaka et al., 2014); however, several mothers reported that the news was given to them by a family member: *"…my mother came to my bedside and said 'you will have to be strong; the child did not make it"* (Popoola et al., 2022b, p.6). In some cases, healthcare providers deliberately confused mothers to delay the news until a family member arrived (Mills et al., 2020; Popoola et al., 2022b), as reflected by this mother: *"even when I gained consciousness, I asked for my baby but they confused me around, they didn't want to tell me the truth"* (Mills et al., 2020, p.105).

When the news of stillbirth was delivered in open spaces, mothers described frustration and shame: *"I felt like that midwife did not mind my feelings by putting me next to a woman who had a baby. That was so devastating, I covered my face all the time"* (Danna et al., 2023, p.30). Several mothers reported accidentally learning of their baby's death by overhearing the conversations of others (Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b), with one mother overhearing her scan results as they were being explained to medical students before she *"realised that [her] baby was no more"* (Mills et al., 2020, p.105). In some of these cases, mothers also overheard spiritual explanations for their stillbirth: *"No one came to tell me. I just hear the nurses say 'how did it happen because the baby was fine. They must be something witchcraft'"* (Danna et al., 2023, p.30).

Whilst in the hospital, mothers wanted considerate care from healthcare providers, consistent with the type of care and support provided to mothers who had had live births (Danna et al., 2023; Jimoh et al., 2022; Lappeman & Swartz, 2022; Mills et al., 2020; Simwaka et al., 2014). Some mothers described inferior treatment and highlighted the need for additional care for women who have experienced a stillbirth: *"I needed more care because I was psychologically traumatised. I was so depressed giving birth to a dead child"*

(Danna et al., 2023, p.31). Several mothers reported being accommodated in open postnatal wards where the proximity of mothers with healthy newborns caused distress: *"I was being put in the same room with other women holding their baby. I felt very bad because I too wanted to hold mine and feel like them"* (Mills et al., 2020, p106). Mothers understood the limited resources and pressure on healthcare providers and appreciated their use of sensitive language and compassionate care (Corbet-Owen & Kruger, 2001; Danna et al., 2023; Mills et al., 2020; Simwaka et al., 2014). However, across the studies, mothers also reported feeling abandoned by healthcare providers at the time of their loss (Corbet-Owen & Kruger, 2001; Danna et al., 2023; Mills et al., 2020; Simwaka et al., 2014), with this example of insensitive communication by a nurse-midwife having a lasting impact on one mother: *"Your thing has already died, for us we save those who are still alive…so on that note, help yourself because we also have no way of saving you"* (Mills et al., 2020, p.105). While reporting effective communication methods such as focused attention on the mother and using sensitive language, mothers also emphasised the need for healthcare providers to involve them in decision-making about their care (Corbet-Owen & Kruger, 2001; Danna et al., 2023).

Mothers were provided with limited, if any, opportunities to make memories with their babies (Ayebare et al., 2021; Corbet-Owen & Kruger, 2001; Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b). One study reported that mothers were given the option to hold their babies (Lappeman & Swartz, 2022); however, many mothers across the other studies reported that they were not given this choice as healthcare providers felt that it would be distressing and/or detrimental to their mental health (Corbet-Owen & Kruger, 2001; Mills et al., 2020; Popoola et al., 2022b). Mothers reported additional frustration from not having any say, with one mother expressing: *"How dare he (the doctor) decide that I can't hold the baby and that I won't cope with what the baby looked like?"* (Corbet-Owen & Kruger, 2001, p.420). Another mother decided to act on her desire to see her baby despite healthcare

providers not supporting her decision: *"I lied to the nurse…while I was going to the bathroom I peeped through the room where the baby was kept because I just wanted to see what I carried for nine months of my life"* (Popoola et al., 2022b, p.7). On other occasions, culture was cited as a reason not to see the baby or keep anything related to the stillborn baby due to the belief that this could adversely impact fertility and future pregnancies (Ayebare et al., 2021; Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b).

Mothers frequently reported the importance of the support provided by family, friends and community members in coping with their grief (Ayebare et al., 2021; Corbet-Owen & Kruger, 2001; Jimoh et al., 2022; Kiguli et al., 2015). Support provided was emotional and practical, such as facilitating rituals for the baby or completing house chores for the mother (Ayebare et al., 2021; Kiguli et al., 2015). This support allowed mothers to focus on their emotional recovery and coping with their loss over time (Ayebare et al., 2021; Jimoh et al., 2022), as described by one mother: *"It strengthens you in a way; you slowly start to forget what happened"* (Ayebare et al., 2021, p.4). For some mothers, distance and transport costs served were a barrier to accessing family; in these cases, church/religious groups were important in avoiding isolation (Ayebare et al., 2021). Additionally, one mother expressed her desire to share with other mothers; however, there was no support group available to her: *"If there was a support group that I speak to some or listen or say…I know what you are talking about…because if there was a group like that where I could go, it would've been wonderful"* (Corbet-Owen & Kruger, 2001, p.423).

Discussion

This systematic review and meta-synthesis investigated the impact of culture on grief experiences after stillbirth for mothers living in sub-Saharan Africa. Mothers' emotional experiences and explanations of stillbirth, cultural/religious norms and community understandings of stillbirth, and supports that mothers desire were explored. Consistent with

previous findings, this review found that culture (including community perceptions, beliefs and religious norms) significantly influences practices, support and mothers' grief experiences after stillbirth (Adeyemi et al., 2008; Baffour-Awua & Richter, 2020; Bogee et al., 2023; Haws et al., 2010).

This review, consistent with previous literature (Burden et al., 2016; Kuti & Ilesanmi, 2011), demonstrated the complex and overwhelming emotions experienced by mothers after stillbirth, including heartbreak, shock and pain (Corbet-Owen & Kruger, 2001; Mills et al., 2020; Popoola et al., 2022b). Key emotions highlighted in this meta-synthesis included guilt and shame, with mothers' experiences evidenced across synthesised findings (Arach et al., 2022; Danna et al., 2023; Jimoh et al., 2022; Kiguli et al., 2015; Milton et al., 2021; Popoola et al., 2021; Popoola et al., 2022b; Simwaka et al., 2014). Similar to previous research in sub-Saharan African countries (Bogee et al., 2023), findings also demonstrated mothers' experiences of blame - both self-blame and blame imposed by others (Milton et al., 2021). Blame was also noted as a significant contributor to mothers' reporting experiencing significant changes in their relationships with their husbands/partners (Mills et al., 2020; Milton et al., 2021). This finding is inconsistent with outcomes in high-income countries, where incongruence in stillbirth grief experiences between partners is reflected as a primary reason for relationship changes (Burden et al., 2016). Incongruent grief experiences were not discussed in any of the included studies.

Mothers' explanations of stillbirth were mixed, with religious and spiritual explanations often used (Ayebare et al., 2021; Jimoh et al., 2022; Kiguli et al., 2015; Popoola et al., 2022a; Simwaka et al., 2014). This meta-synthesis found that stillbirth is commonly not explained to mothers in healthcare settings in sub-Saharan Africa, which makes it difficult for them to make sense of the loss (Danna et al., 2023; Mills et al., 2020; Popoola et al., 2022b). While factors regarding the delivery of stillbirth explanations (e.g., sensitive language,

private space) have been raised as a concern in high-income healthcare settings, the presence of an explanation of stillbirth has not been raised as an issue (Burden et al., 2016; Ellis et al., 2016). The broader literature has highlighted the need for understanding and knowledge regarding stillbirth, with greater community awareness desired (Burden et al., 2016). In sub-Saharan Africa, information about stillbirth is seen as having the ability to empower mothers to understand their grief and make subsequent decisions for their health and wellbeing (Shakespeare et al., 2019). Ensuring that this information is provided in cultural/religiously safe ways will be important and more research is needed in this area as the included studies did not provide sufficient information about specific religions or cultures to provide information at this level.

As seen in previous research in high-income countries, a failure to recognise the significant grief that follows a stillbirth can lead to the disenfranchisement of that grief (Flenady et al., 2014; Lang et al., 2011). High levels of disenfranchised grief were noted in this review, as cultural norms and expectations pressured mothers to internalise their emotions and expressions of grief (Danna et al., 2023; Osman et al., 2016; Popoola et al., 2022a). Social isolation and disconnection where the recognition of grief is limited has been reported in the broader literature (Burden et al., 2016), which is especially prevalent in this research due to dominant cultural norms in sub-Saharan African countries that resulted in limited recognition of a stillborn baby (Kiguli et al., 2015). Again, more research that really explores specific cultural elements would be useful here (Bakari et al., 2021).

The concerns raised by mothers in this review regarding the provision of care and support by healthcare providers (decisions made without consultation, minimal/no opportunities to make memories with the baby, insensitive communication, no private space; Danna et al., 2023; Jimoh et al., 2022; Lappeman & Swartz, 2022; Mills et al., 2020) is similar to what has been reported across stillbirth research and is addressed by guidelines that

have been implemented in high-income countries (Ellis et al., 2016). However, this review demonstrated a variety of poor experiences endured by mothers in sub-Saharan Africa, exacerbated by beliefs of infertility regarding any contact with the baby (Corbet-Owen & Kruger, 2001; Danna et al., 2023; Mills et al., 2020).

At every stage, during and immediately after a stillbirth, healthcare providers' actions or inactions are critical to the provision and quality of care (Boyle et al., 2019). Across the included studies, no consistent support or care strategies used by healthcare providers or bereavement support groups were identified. This finding highlights the need for guidelines in sub-Saharan Africa, similar to those developed in high-income countries (Boyle et al., 2019; Health Service Executive, 2019; Henderson & Davies, 2020). However, healthcare in low-income countries, such as those in sub-Saharan Africa, face significant resource and funding limitations that may delay the development and implementation of support guidelines (Bedwell et al., 2021; Flenady et al., 2014). Funding constraints also contribute to the lack of investigation into the causes of stillbirth (Kwesiga et al., 2022), resulting in limited community understandings of the causes of stillbirth and potential blame for mothers.

Where guidelines can be developed, effective guidelines for sub-Saharan Africa must consider and integrate cultural beliefs with evidence on effective supports due to the impact of these beliefs on mothers' grief experiences. Exploring the integration of cultural beliefs with evidence on effective support in a way that does not immediately alienate traditional beliefs will prevent pressure on healthcare providers (Bakari et al., 2021). For example, a common support guideline in high-income countries is to encourage memory-making with the baby; however, this review described mothers and families that believed that contact with the baby may lead to infertility (Mills et al., 2022). Increased agency for mothers over their supports, including consultation for decision-making and having their emotional experience considered, should be the basis for developing guidelines for sub-Saharan Africa.

Additionally, education and support for healthcare providers and the wider community would likely foster more positive support for mothers (as opposed to stigmatisation and blame) and improve their bereavement experience.

Limitations

While this review focuses on culture, it only reports findings and data from mothers' perspectives and does not consider the views of fathers, family members, healthcare providers or wider communities. However, due to the high impact of culture on bereavement, these groups' perspectives must also be considered in developing support guidelines for stillbirth. Fathers' perspectives, in particular, must be captured, as support guidelines would ideally provide recommendations on caring for both parents. Additionally, the findings reported in this review may not represent the findings of all qualitative research about sub-Saharan mothers' experiences of stillbirth as several studies explored 'pregnancy loss' or 'perinatal loss' and data on stillbirth could not be distinguished and extracted. Also, due to reporting in included studies, the cultural and religious differences between regions/countries could not be examined in this review. As there are many countries in sub-Saharan Africa, differences in religious/cultural beliefs between ethnic groups and their impact on mothers' experiences of grief after stillbirth are likely significant. Future research on this topic will hopefully allow examination of nuances in the impact of culture on mothers' experiences of grief after stillbirth.

Implications and Conclusion

This systematic review and meta-synthesis contributes to the evidence base exploring experiences of grief after stillbirth for mothers in sub-Saharan Africa. It highlights the need for additional research and the development of culturally appropriate formalised bereavement guidelines. Healthcare providers require education, training and support and public education is needed to increase knowledge and reduce the stigma surrounding stillbirth. In the absence

of bereavement guidelines, the synthesised findings can assist healthcare providers in supporting mothers who have experienced a stillbirth. Future research should continue to investigate the impact of cultural and societal norms on grief experiences for mothers who have had a stillbirth, as this knowledge will be critical to providing effective bereavement support.

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* Denotes studies that are included in the review

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Supplementary Table 1

Logic Grids used to search databases

PsycInfo

Stillbirth AND →	Sub-Saharan African Countries AND →	Qualitative Research
(still birth* OR stillbirth OR stillborn* OR still born* OR fetal death* OR foetal death* OR fetus death* OR foetus death* OR perinatal death* OR peri natal death* OR peri-natal death* OR perinatal loss* OR peri natal loss* OR peri-natal loss* OR perinatal mortalit* OR peri natal mortalit* OR peri-natal mortalit* OR pregnancy loss*).ti,ab	(Africa OR Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR Cape Verde OR Central African Republic OR Chad OR Comoros OR Congo OR "Cote d'lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR Sierra Leone OR Somalia OR South Africa OR South Sudan OR Sudan OR Tanzania OR Togo OR Uganda OR Zambia OR Zimbabwe).ti,ab	Exp qualitative methods OR interviews.sh OR focus group interview.sh OR semi-structured interview.sh OR ethnography.sh OR content analysis.sh OR narratives.sh OR (qualitative* OR focus group* OR interview* OR thematic analys* OR content analys* OR experience* OR perspective* OR interpretative phenomenolog* OR ethnograph* OR case stud* OR narrative*).ti,ab

Embase

Stillbirth AND →	Sub-Saharan African Countries AND →	Qualitative Research
Stillbirth.sh OR (still birth* OR stillbirth OR stillborn* OR still born* OR fetal death* OR foetal death* OR fetus death* OR foetus death* OR perinatal death* OR peri natal death* OR peri-natal death* OR perinatal loss* OR peri natal loss* OR peri-natal loss* OR perinatal mortalit* OR peri natal mortalit* OR peri-natal mortalit* OR pregnancy loss*).ti,ab	Exp "Africa south of the Sahara" OR (Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR Cape Verde OR Central African Republic OR Chad OR Comoros OR Congo OR "Cote d'lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR Sierra Leone OR Somalia OR South Africa OR South Sudan OR Sudan OR Tanzania OR Togo OR Uganda OR Zambia OR Zimbabwe).ti,ab	Exp qualitative research OR exp interview OR (qualitative* OR focus group* OR interview* OR thematic analys* OR content analys* OR experience* OR perspective* OR interpretative phenomenolog* OR ethnograph* OR case stud* OR narrative*).ti,ab

CINAHL

Stillbirth AND →	Sub-Saharan African Countries AND →	Qualitative Research
MH “Perinatal death” OR TI ("still birth*" OR stillbirth OR stillborn* OR "still born*"OR “fetal death*” OR “foetal death*” OR “fetus death*” OR “foetus death*” OR “perinatal death*” OR “peri natal death*” OR “peri-natal death*” OR “perinatal loss*” OR “peri natal loss*” OR “peri-natal loss*” OR “perinatal mortalit*” OR “peri natal mortalit*” OR “peri-natal mortalit*” OR “pregnancy loss*”) OR AB ("still birth*" OR stillbirth OR stillborn* OR "still born*" OR “fetal death*” OR “foetal death*” OR “fetus death*” OR “foetus death*” OR “perinatal death*” OR “peri natal death*” OR “peri-natal death*” OR “perinatal loss*” OR “peri natal loss*” OR “peri-natal loss*” OR “perinatal mortalit*” OR “peri natal mortalit*” OR	MH “Africa South of the Sahara+” OR TI (Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR "Cape Verde" OR "Central African Republic" OR Chad OR Comoros OR Congo OR "Cote d’lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR "Guinea-Bissau" OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR "Sierra Leone" OR Somalia OR "South Africa" OR "South Sudan" OR Sudan OR Tanzania OR Togo OR Uganda OR Zambia OR Zimbabwe) OR AB (Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR "Cape Verde" OR "Central African Republic" OR Chad OR Comoros OR Congo OR "Cote d’lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR "Guinea-Bissau" OR Kenya OR Lesotho OR Liberia OR	MH “qualitative studies+” OR TI (qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR experience* OR perspective* OR "interpretative phenomenolog*" OR ethnograph* OR "case stud*" OR narrative*) OR AB (qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR experience* OR perspective* OR "interpretative phenomenolog*" OR ethnograph* OR "case stud*" OR narrative*)

“peri-natal mortalit*” OR “pregnancy loss*”)	Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR "Sierra Leone" OR Somalia OR "South Africa" OR "South Sudan" OR Sudan OR Tanzania OR Togo OR Uganda OR Zambia OR Zimbabwe)	

Web of Science

Stillbirth AND →	Sub-Saharan African Countries AND →	Qualitative Research
TI=("still birth*" OR stillbirth OR stillborn* OR "still born*"OR “fetal death*” OR “foetal death*” OR “fetus death*” OR “foetus death*” OR “perinatal death*” OR “peri natal death*” OR “peri-natal death*” OR “perinatal loss*” OR “peri natal loss*” OR “peri-natal loss*” OR “perinatal mortalit*” OR “peri natal mortalit*” OR “peri-natal mortalit*” OR “pregnancy loss*”) OR AB=("still birth*" OR stillbirth OR	TI=(Africa OR Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR "Cape Verde" OR "Central African Republic" OR Chad OR Comoros OR Congo OR "Cote d’lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR "Guinea-Bissau" OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR "Sierra Leone" OR Somalia OR "South Africa" OR "South Sudan" OR Sudan OR Tanzania	TI=(qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR experience* OR perspective* OR "interpretative phenomenolog*" OR ethnograph* OR "case stud*" OR narrative*) OR AB=(qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR experience* OR

stillborn* OR "still born*" OR “fetal death*” OR “foetal death*” OR “fetus death*” OR “foetus death*” OR “perinatal death*” OR “peri natal death*” OR “peri-natal death*” OR “perinatal loss*” OR “peri natal loss*” OR “peri-natal loss*” OR “perinatal mortalit*” OR “peri natal mortalit*” OR “peri-natal mortalit*” OR “pregnancy loss*”)	OR Togo OR Uganda OR Zambia OR Zimbabwe) OR AB=(Africa OR Angola OR Benin OR Botswana OR Burkina Faso OR Burundi OR Cameroon OR "Cape Verde" OR "Central African Republic" OR Chad OR Comoros OR Congo OR "Cote d’lvoire" OR Djibouti OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR "Guinea-Bissau" OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR "Sierra Leone" OR Somalia OR "South Africa" OR "South Sudan" OR Sudan OR Tanzania OR Togo OR Uganda OR Zambia OR Zimbabwe)	perspective* OR "interpretative phenomenolog*" OR ethnograph* OR "case stud*" OR narrative*)

PubMed

Stillbirth AND →	Sub-Saharan African Countries AND →	Qualitative Research
“Stillbirth”[mh] OR still birth*[tiab] OR stillbirth [tiab] OR stillborn[tiab] OR still born*[tiab] OR fetal death*[tiab] OR foetal death*[tiab] OR fetus death*[tiab]	“Africa South of the Sahara”[mh] OR Angola[tiab] OR Benin[tiab] OR Botswana[tiab] OR Burkina Faso[tiab] OR Burundi[tiab] OR Cameroon[tiab] OR Cape Verde[tiab] OR Central African Republic[tiab] OR Chad[tiab] OR	"qualitative research"[mh] OR qualitative*[tiab] OR "focus groups"[mh] OR focus group*[tiab] OR interview*[tiab] OR thematic

OR foetus death*[tiab] OR perinatal death*[tiab] OR peri natal death*[tiab] OR peri-natal death*[tiab] OR perinatal loss*[tiab] OR peri natal loss*[tiab] OR peri-natal loss*[tiab] OR perinatal mortalit*[tiab] OR peri natal mortalit*[tiab] OR peri-natal mortalit*[tiab] OR pregnancy loss*[tiab]	Comoros[tiab] OR Congo[tiab] OR Cote d'lvoire[tiab] OR Eritrea[tiab] OR Ethiopia[tiab] OR Gabon[tiab] OR Gambia[tiab] OR Ghana[tiab] OR Guinea[tiab] OR Guinea-Bissau[tiab] OR Kenya[tiab] OR Lesotho[tiab] OR Liberia[tiab] OR Madagascar[tiab] OR Malawi[tiab] OR Mali[tiab] OR Mauritania[tiab] OR Mauritius[tiab] OR Mozambique[tiab] OR Namibia[tiab] OR Niger[tiab] OR Nigeria[tiab] OR Rwanda[tiab] OR Sao Tome and Principe[tiab] OR Senegal[tiab] OR Seychelles[tiab] OR Sierra Leone[tiab] OR Somalia[tiab] OR South Africa[tiab] OR South Sudan[tiab] OR Sudan[tiab] OR Tanzania[tiab] OR Togo[tiab] OR Uganda[tiab] OR Zambia[tiab] OR Zimbabwe[tiab]	analys*[tiab] OR content analys*[tiab] OR experience*[tiab] OR perspective*[tiab] OR interpretative phenomenolog*[tiab] OR ethnograph*[tiab] OR case stud*[tiab] OR narrative*[tiab]

Supplementary Table 2

QualSyst Quality Assessment Checklist (Detailed; Kmet et al., 2004)

Lead Author (Year)	Question/ Objective	Study Design	Context	Theoretical Framework	Sampling Strategy	Data Collection	Data Analysis	Verification Procedure	Conclusion	Reflexivity	Score
Arach (2022)	●	●	●	●	●	●	●	●	●	◖	.95
Ayebare (2021)	●	●	●	●	●	●	●	●	●	○	.90
Bedwell (2023)	●	●	●	●	●	●	●	●	●	○	.90
Corbert-Owen (2001)	●	●	●	●	●	●	●	●	●	○	.90
Danna (2023)	●	●	●	●	●	●	●	●	●	●	1.0
Jimoh (2022)	●	●	●	●	◖	●	●	●	●	○	.85
Kiguli (2015)	●	●	●	●	●	●	●	●	●	○	.90
Lappeman (2022)	●	●	●	●	◖	●	●	○	●	●	.85
Mills (2020)	●	●	●	●	●	●	●	●	●	○	.90
Milton (2021)	●	●	●	●	◖	●	●	●	●	●	.95
Noge (2020)	●	●	◖	●	●	●	●	●	●	○	.85
Osman (2016)	●	●	●	●	●	●	●	●	●	○	.90
Popoola (2021)	●	●	●	●	●	●	◖	●	●	○	.85
Popoola (2022a)	●	●	●	●	●	●	●	●	●	○	.90

Popoola (2022b)	●	●	●	●	◖	●	●	●	●	○	.85
Simawaka (2014)	●	●	●	●	●	●	●	●	●	○	.90

Note. A full circle denotes that the criteria has been met (score = 2), a half-circle denotes that the criteria has been partially met (score = 1) and an empty circle denotes that the criteria has not been met (score = 0).

Appendix A: Instructions to Authors (Social Science & Medicine)

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of **social science** research on **health**. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, **clinical practice**, and **health policy** and organization. We encourage material which is of general interest to an international readership.

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2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.

3) The *Health Psychology* section of the journal will also consider short communications of between 2000 and 4000 words, where a brief, focused dissemination of topical research findings is warranted and the scope and design of the research is appropriate for a shorter report. Please note that other sections do not publish Short Communications.

4) Submitted or invited commentaries and responses debating, and published alongside, selected articles.

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2) Systematic/scoping reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text. Systematic/scoping reviews must be reported according to PRISMA guidelines (see below for more details).

3) The Health Psychology section will also consider short communications of between 2000 and 4000 words, where a brief, focused dissemination of topical research findings is warranted and the scope and design of the research is appropriate for a shorter report. Please note that other sections do not publish short communications.

4) Submitted or invited commentaries and responses debating, and published alongside, selected articles.

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Item	Guide and Description	Reported on Page Number
Aim	State the research question the synthesis addresses.	9
Synthesis Methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis and describe the rationale for choice of methodology (e.g., meta ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	9
Approach to Searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	10
Inclusion Criteria	Specify the inclusion/exclusion criteria (e.g., in terms of population, language, year limits, type of publication, study type).	10
Data Sources	Describe the information sources used (e.g., electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organizational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	10
Electronic Search Strategy	Describe the literature search (e.g., provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	10; 46-52
Study Screening Methods	Describe the process of study screening and sifting (e.g., title, abstract and full text review, number of independent reviewers who screened studies.	12
Study Characteristics	Present the characteristics of the included studies (e.g., year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	13; 15-17
Study Selection Results	Identify the number of studies screened and provide reasons for study exclusion (e.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion	13-14

	and inclusion based on modifications to the research question and/or contribution to theory development).	
Rationale for Appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g., assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	11
Appraisal Items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g., Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	11
Appraisal Process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	13
Appraisal Results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	13; 18
Data Extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g., all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	11
Software	State the computer software used, if any.	10
Number of Reviewers	Identify who was involved in coding and analysis.	11
Coding	Describe the process for coding of data (e.g., line by line coding to search for concepts).	N/A
Study Comparison	Describe how were comparisons made within and across studies (e.g., subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	11
Derivation of Themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	9
Quotations	Provide quotations from the primary studies to illustrate themes/constructs and identify whether the quotations were participant quotations or the author’s interpretation.	23-34
Synthesis Output	Present rich, compelling, and useful results that go beyond a summary of the primary studies (e.g., new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	23-34