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The psychological support for women who underwent a stillbirth during their pregnancy: the quality of midwifery care

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Summary. Purpose. This review aims to investigate the role of midwifery care in perinatal death. Specifically, it aims to investigate the type and implications in the clinical practice of psychological and psychiatric support interventions for women/couples. **Methods.** A scoping review was conducted following the PRISMA methodology. For this purpose, the following databases were queried: PubMed, APA PsycInfo, CINAHL Plus with Full Text, and ERIC, considering only studies published in the 2002-2022 time frame. **Results.** 14 studies were found to be eligible by the literature review. These researches were divided into 3 macro-topics representing the most crucial factors in influencing the quality of care: the healthcare setting, the experience and training of caregivers, and the experience of parents. **Discussion.** The healthcare figure who experiences such a tragic event most closely is the midwife. The health and geographic context in which care is provided – understood to be low-medium-high resources – have a fundamental impact on the quality of midwifery care and caregiver satisfaction. The training was found to be incomplete, and midwives' experiences revealed how they felt unprepared. Parents' experiences indicate the need for multidisciplinary care, better communicability, and follow-up including psychological/psychiatric support for mothers who are increasingly alone in coping with bereavement. To date, there are no guidelines for psychological support for this specific event in the literature. **Conclusions.** Birth-death management should be a structured part of professional courses so that new generations of midwives can improve the quality of care for affected families. Future research should focus on how to improve communication processes, and hospital centers should adopt protocols adapted to the needs of parents, including a midwifery-led model policy based on psychological support for the mothers/couples involved, as well as increase follow-ups.

Key words. Midwifery care, midwives, perinatal death, psychological support, stillbirth.

Sostegno psicologico per donne con esperienza di natimortalità durante la gravidanza: qualità delle cure in ostetricia.

Riassunto. Scopo. Obiettivo della presente revisione è quello di indagare il ruolo della *midwifery care* nella morte perinatale. Nello specifico si vogliono indagare la tipologia e le implicazioni che si possono avere nella pratica clinica, da interventi di sostegno psicologico e psichiatrico per le donne/coppie. **Metodi.** È stata condotta una scoping review secondo quanto previsto dalla metodologia PRISMA. A tal fine sono stati interrogati i seguenti database: PubMed, APA PsycInfo, CINAHL Plus with Full Text, e ERIC, considerando solo gli studi pubblicati nell'arco temporale 2002-2022. **Risultati.** 14 studi sono risultati eleggibili dalla revisione della letteratura. Tali ricerche sono state suddivise in 3 macroargomenti che rappresentano i fattori più determinanti nell'influenzare la qualità assistenziale: il contesto sanitario, il vissuto e la formazione degli operatori, il vissuto dei genitori. **Discussione**. La figura sanitaria che vive più da vicino tale tragico evento è l'ostetrica. Il contesto sanitario e geografico in cui si presta assistenza, inteso di basse-medie-alte risorse, ha un impatto fondamentale sulla qualità della midwifery care e della soddisfazione degli assistiti. La formazione è risultata incompleta e dalle esperienze delle ostetriche è emerso come si sentano impreparate. Dal vissuto dei genitori si evince la necessità di un'assistenza multidisciplinare, migliore comunicabilità e un follow-up che comprenda un sostegno psicologico/psichiatrico per le madri sempre più sole nell'affrontare il lutto. A oggi non sono presenti in letteratura linee guida per il sostegno psicologico per questo specifico evento. **Conclusione.** La gestione della natimortalità dovrebbe essere una parte strutturata dei corsi professionali in modo che le nuove generazioni di ostetriche possano migliorare la qualità dell'assistenza alle famiglie colpite. La ricerca futura dovrebbe concentrarsi su come migliorare i processi comunicativi e i centri ospedalieri dovrebbero adottare protocolli adattati alle esigenze dei genitori, comprendenti una midwifery-led model policy basata sul supporto psicologico per le madri/coppie coinvolte, così come incrementare i follow-up.

Parole chiave. Midwifery care, morte perinatale, natimortalità, ostetriche, sostegno psicologico.

Introduction

Stillbirth is typically defined as the fetus's death after the second quarter of pregnancy, during delivery, or immediately after birth[1-7]. The baby is born with no signs of life after a given threshold, usually related to the gestational age or weight of the baby. The gestational age from which stillbirth is defined differs in countries (in Italy, from 25 + 5 weeks of gestational age). According to World Health Organization's (WHO) report "A neglected tragedy, the global burden of stillbirths"[8], it is estimated that 2.6 million children worldwide die in utero, 98% in countries with low and medium economic development. About 800,000 occur during labor (intrapartum). Most deaths occur from unknown causes, without pre-existing fetal abnormalities and risk factors. The phenomenon is more common in low-income countries, which indicates that a substantial percentage of cases are preventable. The leading causes of stillbirth include complications of labor and delivery at birth, most often associated with post-term pregnancy, maternal infections (malaria, syphilis, and HIV), drug and alcohol consumption, certain maternal conditions (hypertension, obesity, and diabetes), restriction of fetal growth, and congenital anomalies[9-14]. One stillbirth occurs every 16 seconds, meaning about 2 million babies are stillborn yearly. The psychological effects, such as maternal depression, are profound; a stillborn baby can devastate women, their partners, and their families. The grief from a stillbirth is complicated and unusual, partly because of the not acceptation or legitimization of the grieving process by the community for society.

More is studied about woman's care during pregnancy, labor and delivery, but there are no specific maternal support guidelines during this terrible event. Healthcare professionals are directly involved, particularly midwives, defined by WHO as «skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life». They are the first figures living with the women during stillbirth, and they had to assist them and care about their mental health and suddenly offer psychological support during hospitalization. This study aims to define the role of midwives during stillbirth from a psychological support point of view.

Aim and research question

According to Joanna Briggs Institute (JBI) proposed methodology, the objective and research questions were formulated using the acronym PCC (Problem, Concept and Contest).

In this scoping review, the main question this study aims to answer is: "What are the main assistance and/or psychological/psychiatric support interventions the midwife should implement with women who have had a stillbirth?". Specifically, we want to investigate the typology and implications that can be had in clinical practice, from psychological and psychiatric support interventions for women/couples.

Materials and methods

This scoping review was conducted by the PRISMA methodology (Scoping Review version)[15] and the structure proposed by Peters et al.[16].

Inclusion criteria

- *Type of participants.* For studies selection, all were considered eligible for inclusion, with no limitations related to gender, parity, age, sociocultural, or geographic factors.
- *Concept.* All studies focusing on events of late abortion and/or fetal endo-uterine deaths were considered eligible for inclusion. Stillbirth estimates refer to «late gestation fetal deaths as deaths occurring at/or after 28 weeks of gestation, which is in line with the International Classification of Diseases»[17], in which the focus is on obstetrical care, the caring skills and relationships of professionals, and the quality of care, including in the clinical-psychological domain.
- *Context.* The context was deliberately kept free in line with the objectives of the review, as studies relating to any other context (care setting, geographical and sociocultural characteristics of the population, gender characteristics) were deemed includable.
- *Type of studies.* The following sources were considered suitable for inclusion: 1) Clinical trials; 2) Randomized clinical trials; 3) Observational studies. English-language studies published in the last ten years (2012-2022) were considered attractive.

Exclusion criteria

- *Type of participants.* Studies of physicians and/or health care workers who are not midwives/obstetricians. Studies aimed at women who had early abortions before 20 weeks or infants delivered but died 28 days after birth
- *Concept.* In line with the objectives of the review, all studies focusing on: 1) experiences of family members that did not directly include the woman and/or partner involved; 2) experiential reflections, emotional and relational impacts of the

midwives/obstetricians and/or midwifery students involved; 3) measures and/or assessments and/or protocols proposed to reduce stillbirth; 4) studies in which the aim of the current study was not explicitly noted; 5) other birth-related conditions analyzed from a clinical, predictive, preventive, or therapeutic point of view; 6) prenatal interventions aimed at reducing adverse pregnancy and delivery outcomes; 7) birthing care in post stillbirth pregnancies.

- *Type of studies*. The following studies were excluded: 1) Secondary studies (narrative reviews, systematic reviews, meta-analyses of primary studies, clinical-economic modeling studies); 2) Gray literature; 3) Conference documents; 4) Degree thesis; 5) Studies not in English languages; 6) Proceedings of conferences; 7) Dissertations; 8) Pilot Studies; 9) Protocols; 10) Design studies; 11) Preliminary studies; 12) Extracts from letters; 13) Articles in which the Full Text could not be traced.

Search strategy

For constructing the search string, the acronym PCC (problem - concept - context) was taken as a reference. Two independent reviewers (SD, MP) developed the string keywords. Additional relevant keywords were placed and used to create a comprehensive search strategy. A second search including all identified terms (midwifery care, midwife, psychological care, psychiatric support, stillbirth), related synonyms, and, where possible, MeSH terms was conducted across all included databases. The words were combined through the Boolean operators "OR" and "AND". The search was conducted in the following databases: PubMed, EBSCO (including APA PsycInfo, CINAHL Plus with Full Text, ERIC) and involved English-language publications published in the decade 2010-2022. The decision to include only English-language studies was due to two reasons: the language skills of the authors and the predominant prevalence of English-language scientific publications. The decision to impose a time limit on the research takes into account the development that further study of interest in this field has had.

Selection of sources

The results obtained from the various databases were imported into Mendeley bibliographic management software. Based on the predetermined inclusion and exclusion criteria, relevant studies were selected through a first screening stage based on title\abstract analysis to identify relevant articles. Then, a second selection election stage (eligibility) stage was conducted based on a full-text analysis of the selected papers (table 1).

Data extraction

The process of data extraction from the included studies was conducted to extrinsic all elements responsive to the questions and objective of the review. The following data were extracted for each included analysis: 1) author 2) study design 3) type of participants (population) 4) study objective 5) implications for clinical practice.

Results

A total of 321 articles were retrieved. There were 96 duplicates removed; of the remaining 225 studies, another 203 were excluded from the title/abstract analysis. At the eligibility stage, 20 articles were analyzed, 9 of which were excluded. Fifteen studies were included in the review (figure 1).

Macro-areas

From the deep study of the selected articles (n=14), it emerged that the research question could be analyzed and addressed in macro-areas/topics that justify the broad and complex phenomenology that characterize it: the context in which care is provided, understood as a low-middle or high resources health care environment (n=5)[18-22]; the experience and training of providers, especially midwives (n=7)[20-26]; the experience of parents involved (n=5)[18,27-30]. A study may include multiple macro-areas.

Context

Healthcare facilities do not deliver the same quality of care worldwide, despite the presence of international guidelines, so care for women and families who have had stillbirths is undoubtedly influenced by the country's socioeconomic and cultural context.

Assistance to women who have a stillbirth depends on the country and the resources in which it is provided. A study conducted in Kabul province[20], including parents and healthcare providers, showed that improving staff interactions with patients can make a substantial difference and avoid causing unnecessary discomfort and long-term psychological stress. Midwives may be best suited and in the best position to direct such training at the facility level. Midwifery care cannot be good if the unit does not provide bereavement support or training, nor the presence of a support person. Many women have had moments of difficulty and anxiety caused by the lack of separate wards from other women with their babies. Given the high attendance at these hospitals and the high birth rate, women who have given birth to a dead child are discharged the same day, which profoundly marks families who cannot receive adequate support.

Table 1. Recruited studies in the review and with general findings, main results and implications for practice.

Ref	Aim	Study design	Population (sample)	Main results	Implications for practice
[18]	To explore the experiences of bereavement after the stillbirth of Pakistani, Bangladeshi and white British mothers in a town with multi-ethnic populations in England.	Qualitative methods using face-to-face semi-structured interviews undertaken, recorded and transcribed verbatim.	6 mothers aged over 16 (at the time of infant birth), who suffered a stillbirth in the preceding 6-24 months and residing in a specified postcode area.	3 main themes emerged from the data; knowledge and information about pregnancy and perinatal mortality, attitudes and perceptions of pregnancy and perinatal mortality, and mothers' experiences with maternity services. The findings revealed mostly similarities in the bereavement experiences of Pakistani, Bangladeshi and white British mothers. A few cultural and religious differences were identified.	This study found important similarities in bereavement experiences of Pakistani, Bangladeshi and White British mothers and highlights considerations for policymakers and maternity services in how the timing of bereavement aftercare is provided, including advice surrounding the infant post-mortem.
[23]	To understand the experiences of Australian early career midwives' clinical encounters with perinatal grief, loss and trauma.	A qualitative descriptive/ exploratory study using in-depth interviews.	15 early career midwives.	The research findings and titles of the themes and sub-themes resonated with the five participants confirming their experiences. Encounters considered perinatal grief, loss and trauma-related events included: miscarriage, medical and late-term termination, antenatal and intrapartum fetal death, and neonatal death.	This study identified that adequate pre-registration education and sufficient exposure to perinatal grief and loss and positive experiences within these encounters were associated with being better prepared and ready for these experiences once graduated. The perceived shortcoming of pre-registration education of the disproportionate emphasis on normal birth can be rectified by including targeted perinatal loss preparation in the curriculum. Support should be provided for all midwives.
[27]	To understand challenges in care after stillbirth and provide tailored solutions.	Multi-center case study.	Twenty-one women, 14 partners, and 22 staff (from two different hospitals).	Service provision: care for parents after stillbirth varies excessively; there are misconceptions; post-mortem does not delay follow-up. Presentation: women 'do not feel right' before stillbirth; their management is haphazard and should be standardized. Diagnosis: stillbirth is an emergency for parents but not always for staff; communication can seem cold; a well-designed bereavement space is critical. Birth: staff shift priorities to mother and future, but for parents their baby is still a baby; parents are not comfortable with the staff recommending vaginal birth as the norm; there are several reasons why parents ask for a cesarean; better care involves clear communication, normal behavior, and discussion of coping strategies. Post-mortem: parents are influenced by discussions with staff. Staff should 'sow seeds', clarify their respectful nature, delineate their purpose, and explain the timescale. Follow-up: it is not standardized; parents wish to see their multi-professional team.	Understanding parents' needs, including why they ask for cesarean birth, will facilitate joint decision-making. Every bereaved parent is entitled to good, respectful care. One-to-one care is as important for bereaved parents as for other women in labor; arguably even more so given their emotional strain. Recommendations for training, practice and policy.
[19]	Document and theorize how midwifery students at a PNG university understand, experience and manage the provision of care to women following stillbirth.	Constructivist grounded theory study (Charmaz, 2014) and decolonizing methodologies (Smith, 2012).	Phase 1: 7 female and 2 male midwifery students. Phase 2: 9 female and 2 male midwifery students Phase 3: 9 female midwifery students.	Students were learning about stillbirth as they progressed through the program, gradually gaining confidence in their ability to provide clinical care to women with pregnancy complications, including stillbirth. Low staff-to-patient ratios meant there was often insufficient time to spend with mothers following a stillbirth, other than to provide physical care.	"Balancing it Out" was the key social process by which midwifery students actualized their core concern of how to provide the best possible care to women following stillbirth. The provision of holistic care to women following stillbirth and cross-sector health promotion is crucial to attaining the best outcomes for women and the midwifery staff who provide their care.
[29]	Investigate which objective (actions/ interventions) and subjective (perceptions of care quality) outcomes of care following stillbirth or termination of pregnancy predict perceived care quality.	A cross-sectional descriptive study using an anonymous online survey.	610 women were analyzed.	In general, subjective evaluations of care are more potent predictors of perceived care quality than objective care interventions (e.g. autopsy performed). Feeling free to 'express emotions', 'teamwork between doctors and nurses/midwives', and 'being well-informed of all steps and procedures' were the three strongest predictors, followed by the perception of 'medical negligence'. Information provision and loss-focused interventions had the weakest influence, except in the specific 'loss-focused' model. The results also demonstrate considerable variations in expectations of the roles of nurses/midwives compared doctors, whose actions had a greater influence over ratings.	It indicates a requirement for stronger teamwork between professionals and that doctors validate or reinforce the role of midwives during initial interactions with women and their families. Given the impact of 'perceived negligence', future studies may consider including it as one way of measuring health outcome. On the other hand, the relatively low ranking of 'information' shows that other aspects of care are prioritized in the peritraumatic period. It seems relevant here that parallel qualitative research found that low cultural expectations of equity in decision-making and naturalized paternalism is common in obstetric care following pregnancy loss in Spanish hospitals.

Continue

Continue **Table 1.**

Ref	Aim	Study design	Population (sample)	Main results	Implications for practice
[28]	To describe and understand the experiences and perceptions of parents who have suffered a perinatal death.	A qualitative study based on Gadamer's hermeneutic phenomenology.	21 couple of partners who had a stillbirth.	Eight sub-themes emerged, and they were grouped into three main themes: 'Perceiving the threat and anticipating the baby's death: "Something is going wrong in my pregnancy"'; 'Emotional outpouring: the shock of losing a baby and the pain of giving birth to a stillborn baby'; "We have had a baby": The need to give an identity to the baby and legitimize grief'.	The grief suffered after a perinatal death begins with the anticipation of the death, which relates to the mother's medical history, symptoms and premonitions. The confirmation of the death leads to emotional shock, characterized by pain and suffering. The chance to take part in mourning rituals and give the baby the identity of a deceased baby may help in the grieving and bereavement process. Having empathy for the parents and notifying them of the death straightaway can help ease the pain. Midwives can help in the grieving process by facilitating the farewell rituals, accompanying the family, helping in honoring the memory of the baby, and supporting parents in giving the deceased infant an identity that makes them a family member.
[20]	To explore bereaved parents' and healthcare providers experiences of care after stillbirth.	Qualitative study.	55 women, men, female elders, healthcare providers and key informants in Kabul province, Afghanistan between October and November 2017.	Inadequate and insensitive communication and practices by healthcare providers, including avoiding or delaying disclosing the stillbirth were recurring concerns. There was a disconnect between parents' desires and healthcare providers' perceptions. The absence of shared decision-making on seeing and holding the baby and memory-making manifested as profound regret. Health providers reported hospitals were not equipped to separate women who had a stillbirth and acknowledged that psychological support would be beneficial. However, the absence of trained personnel and resource constraints prevented the provision of such support.	Improving the interactions of staff with patients can make a substantial difference and avoid causing unnecessary distress and long-term psychological impact. Midwives may be most suitable and best placed to target such training at the facility level.
[24]	To explore the experiences of midwives regarding the attention given during labor in late fetal death.	Multi-center study within an interpretative phenomeno-logical research framework, based on Heidegger´s presupposition.	18 midwives.	Two main themes were identified: Professionals for Life Not Death; and Organizing the Work Without Guidelines. Midwives felt there is a lack of social awareness related to the possibility of antepartum death that keeps the mourning hidden and affects the midwives´ practice during the late fetal death process. Midwives recognize difficulties in coping with a process that ends in death: organizations are not prepared for these events (not suitable rooms), there is a lack of training to cope with them, and lack of continuity in the attention received by the parents when they are discharged.	Midwives need to be trained in mourning and communication skills to guarantee good practice when attending late fetal death. Intervention guidelines and support mechanisms are required, not only for the parents but also for the healthcare professionals.
[30]	To document who communicates the perinatal death to the families and who is present for support.	Cross-sectional observational study.	900 bereaved and 500 live-birth mothers.	Bereaved women were less likely to have hospital staff or family members present at delivery. African-American (versus Caucasian) mothers were half as likely to have first heard about their stillbirth from a physician or midwife.	Perinatal bereavement programs should focus on training health providers on communication about death, appropriate risk assessment to identify women likely to require additional resources for the resolution of maternal grief, and provision of necessary support for families at the time of diagnosis, death and delivery.
[21]	To explore the lived experiences of midwives, doctors and others, caring for women after stillbirth in Kenya and Uganda.	Qualitative, guided by Heideggerian phenomenology.	Sixty-one health workers, including nurse-midwives (n=37), midwives (n=12) and doctors (n=10), working in five facilities in Kenya and Uganda.	Three main themes summarized participants' experiences: 'In the mud and you learn to swim in it' reflected a perceived lack of preparation; skills were gained through experience and often without adequate support. The emotional and psychological impacts including sadness, frustration, guilt and shame were summarized in 'It's bad, it's a sad experience'. Deficiencies in organizational culture and support, which entrenched blame, fear and negative behaviors were encapsulated in Nobody asks 'how are you doing?'.	Interventions to support improved bereavement care in sub-Saharan Africa need to target increasing health worker knowledge and awareness and also embed supportive organizational cultures and processes.

Continue

Continue **Table 1.**

Ref	Aim	Study design	Population (sample)	Main results	Implications for practice
[25]	To investigate the views of a range of hospital-based health professionals and healthcare staff involved in the management of stillbirth.	Qualitative pilot study.	21 consultant obstetricians, 3 trainees (including 1 senior trainee), 29 midwives, 3 midwife sonographers and 4 chaplains took part in six focus groups and two semi-structured interviews.	Two principal themes emerged from the focus groups and interviews. These were first, the nature of the evidence base and the (in)ability of mothers (and their partners) to make the 'right' decisions when faced with an emotive, stressful and time-pressured life event such as stillbirth. These themes emerged in the context of discussions in two substantive areas: cesarean section versus normal (vaginal) delivery in stillbirth and going home or remaining in the hospital for 48 h before delivery. Those health professionals citing the research evidence, whilst acknowledging its inadequacy, emphasized the need for patient choice, whereas those citing established, or traditional, practices and local contexts emphasized professional guidance.	Robust, high-quality evidence is needed regarding the longer-term psychological and emotional sequelae of different modes of delivery and varying time intervals and locations of women between diagnosis and delivery in stillbirth. Evidence implementation and training programs.
[22]	Explored health professionals' experiences of providing stillbirth care in the Lao People's Democratic Republic.	Qualitative study.	33 health professionals (doctors, midwives and nurses).	All participants acknowledged stillbirth as a concern, but its incidence and causes were largely undocumented and unknown. A lack of training in managing stillbirth left health professionals often ill-equipped to support mothers and provide responsive care. Social stigma surrounds stillbirth, meaning mothers found limited support or opportunities to openly express their grief.	Better awareness of stillbirth causes could promote more positive experiences for healthcare providers and parents and more responsive healthcare. This requires improved training for healthcare professionals and awareness raising in the wider community.
[26]	To assess current practices of health care providers (HCPs) caring for women experiencing a stillbirth and to explore their needs for training to better support bereaved families.	Nationwide cross-sectional survey.	750 HCPs.	Half of the respondents recommended immediate birth; only 55% routinely bathed and dressed stillborn babies for their parents to see, while 44.4% of HCPs immediately took the babies away without allowing parents to properly say goodbye to them. More than half felt in30adequate and some even reported having failed to provide support to the family when caring for a woman with stillbirth in the past. The need for professional training courses was expressed by 90.2%, and three-quarters had never previously attended a course on perinatal bereavement care. When answers by Italian HCPs are systematically evaluated concerning international guidelines, the results were very poor with only 27.9% of respondents reporting having created memories of the baby and less than 3% complied with all recommendations in the areas of respect for the baby and parents, appropriate birth options, and aftercare.	Italian HCPs feel an urgent need to be offered professional training courses to better meet the needs of grieving families.
[17]	Analyzes the experience of parents who have experienced a stillbirth and midwifery practice.	Clinical practice.	Articles review's sociological theory and research.	This article uses psychological and sociological theories and perspectives to examine grief following stillbirth, and look at how these findings relate to midwifery practice.	Midwives should support couples to start the grieving process together so as to continue on a trajectory of togetherness as they grieve. To facilitate this, it should recommend that all maternity units have dedicated bereavement rooms where couples can be together at all times, and away from other laboring women and babies. Anyway, using symbolic interactionism theory to examine grief following stillbirth can lead to greater understanding.

In Afghanistan, it is crucial, as in other developing countries, with inequalities and poorest use public health facilities; Christou et al.[20] conclude to sensitize maternity care providers to ensure that they are aware of their interactions and are sensitive in their communication with bereaved parents.

Similar conclusions are observed in the study conducted in Sub-Saharan Africa by Mills et al.[21]; through a qualitative analysis, 61 health workers from Kenya and Uganda are interviewed about their experiences caring for parents after stillbirth. Psychological impacts emerge, including sadness, frustration, and guilt, demonstrating health workers' enormous sensitivity to this event and constantly struggling with poor staff organization. The author concludes that interventions to support better bereavement care in sub-Saharan Africa should aim to increase knowledge and awareness of health workers and incorporate supportive organizational cultures and processes.

In another low-resource setting studied, Papua New Guinea (PNG), 85 percent of the population li-

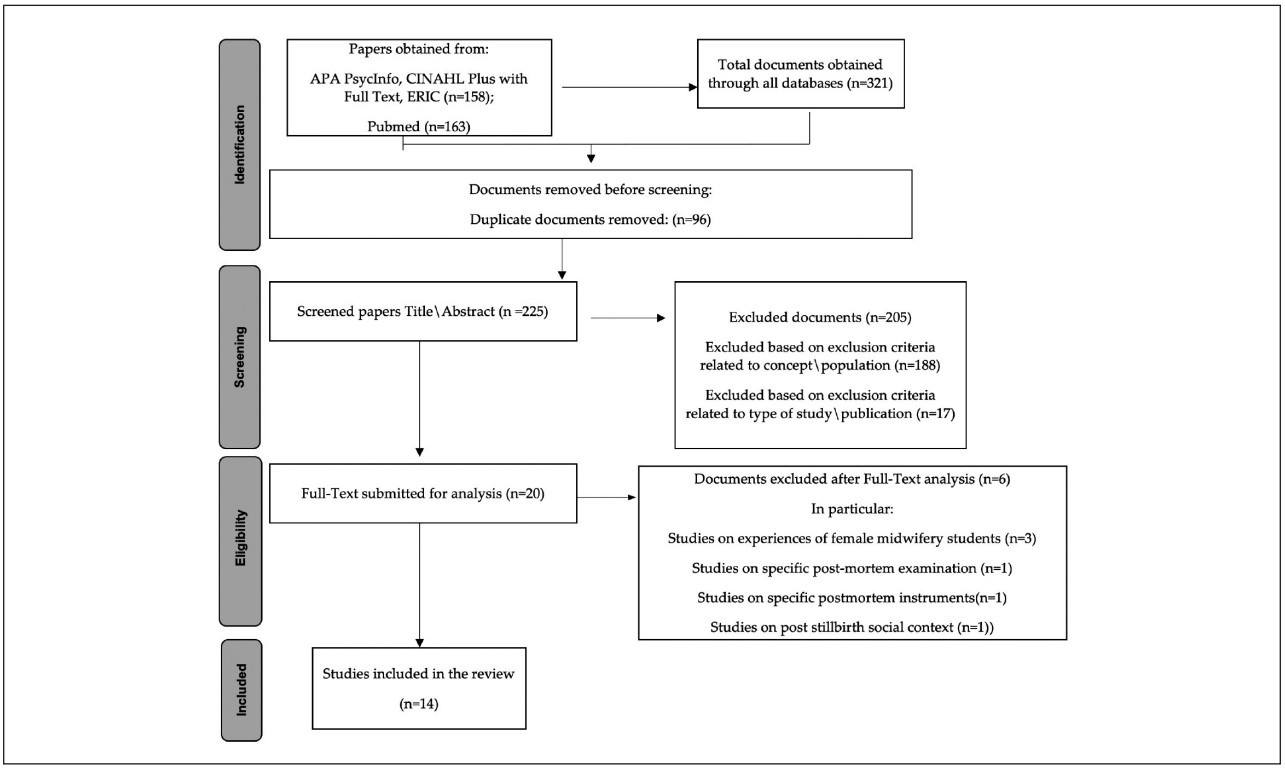

Figure 1. Flowchart of the search and selection of studies.

ves in rural areas and remote communities, and only 56 percent of women are cared for by trained maternity care providers. The overall national rate is 28.5 stillbirths per 1000 births, the highest among Pacific countries. The study by Cheer et al.[19] proposes a model called" Balancing Out" to respond to local care gaps for women who have experienced stillbirth. The sample features midwifery students, who study how to provide the best possible care for women after stillbirth through simulation, training, and supervision. Midwifery students in this study cared for women with a wide range of social, cultural, and spiritual experiences on stillbirth.

This is also evidenced by the qualitative study di Choummanivong et al.[22], whose focus this time is on the experience of healthcare providers in a low-to-medium resource context, Lao. Everyone knows about stillbirth, but no one has had targeted training on psychological and social support for mothers and families. "Better awareness of stillbirth causes could promote more positive experiences for healthcare providers and parents and more responsive healthcare. This requires improved training for healthcare professionals and awareness raising in the wider community".

Midwives training experience

The health of women is dependent on midwifery workforce stability[31-34]. Retaining new midwives is paramount; however, without support, the early career can be a vulnerable time for midwives. An Australian study[23] explored the awareness and feelings of 15 early-career midwives, focusing on their experience with perinatal grief, loss, and trauma[34-36]. Through a qualitative descriptive/exploratory study using in-depth interviews, it emerges that adequate pre-registration education, sufficient exposure to perinatal grief and loss, and positive experiences within these encounters were associated with being better prepared and ready for these experiences once graduated.

Martínez-Serrano et al. study[24] explore the experiences of 18 midwives regarding the attention given during labor in late fetal death. Based on Heidegger's presupposition, a multi-center study within an interpretative phenomenological research framework is used to research stillbirth. Midwives understand that giving the woman psychological support is fundamental and must begin at the moment of diagnosis in the hospital and continue until she is discharged. There is a general perception of not being trained to manage this situation. Communication skills and grief training are required, together with the encouragement of continuing professional training. In this way, healthcare professionals can adequately address the care process in late fetal death. The midwives in this study were motivated to receive training on mourning and strategies to confront it and improve their communication skills.

In the research of Lyn Brierley-Jones et al.[25], 60 health professionals participated: 21 consultant obstetricians, 3 trainees (including 1 senior trainee), 29 midwives, 3 midwife sonographers, and 4 chaplains. Through six focus groups and two semi-structured interviews, they want to know the view of all these healthcare providers about the management of stillbirth management. Two approaches in stillbirth management emerge: one emphasizes the existing evidence base and patient-directed choice, whilst the other emphasizes tradition and profession-directed care. Robust, high-quality evidence is needed regarding the longer-term psychological and emotional sequelae of different delivery modes and varying time intervals and locations of women between diagnosis and delivery in stillbirth[25].

In the Italian study too[26], Ravaldi et al. ask 750 Health Care Providers (HCPs) if professionals are trained in perinatal care during stillbirth. This is the first study conducted in Italy that investigates HCPs' opinions and behaviors in caring for women and families experiencing stillbirth, examines HCPs' compliance with international guidelines, and explores HCPs' perceived need for specific post-graduate training on perinatal death. The midwife was more represented (72%). Most of them perceived certain situations – mainly communicating the tragic news to the parents and encountering the stillborn baby after birth – as extremely difficult and felt inadequately trained to deal with these events. Only 55% routinely bathed and dressed stillborn babies for their parents to see, while 44.4% of HCPs immediately took the babies away without allowing parents to say goodbye to them[26] correctly.

Parents experience

The studies included in this macro-area (n=5) mainly deal with qualitative investigations of the psychological impact and support the woman/couple had during the stillbirth event from HCPs, particularly obstetrical staff. Garcia et al.[18] studied how women of different ethnicities and religions react to bereavement after stillbirth in a multi-ethnic population in England. A qualitative study using semi-structured interviews emerged three primary themes: knowledge and information about pregnancy and perinatal mortality, attitudes and perceptions toward pregnancy and perinatal mortality, and experiences with maternity health services. On the first topic, most of the women interviewed say that they would have liked more information about the risks of pregnancy and that they were and are unprepared for a pregnancy-related adverse event. Both Pakistani, Bengali and British women experienced the same feelings and emotions while learning about the baby's death and grieving: anxiety and guilt. Most of the mothers said they had "good" or "excellent" midwifery care during hospitalization, that the midwife's closeness was crucial, and described as caring and attentive to their needs.

The study by Siassakos et al.[27] aims to provide tailored solutions for each couple who experienced stillbirth. The multicenter survey interviewed 21 women, 14 partners, and 22 healthcare providers from two hospitals. It emerged that caring for parents after stillbirth is excessively variable and not standardized. Women stated that communication is not always effective and is sometimes cold. Given the emotional tension, one-to-one care should be the foundation on which perinatal care is based, which is even more necessary in stillbirth. Follow-up is also not standardized, and parents wish for a multidisciplinary team and approach, taking into account psychological and psychiatric support.

Perceived quality in care during a stillbirth, in objective (action/intervention) and subjective (care quality) terms are investigated by Cassidy[28]; through a descriptive cross-sectional study, 610 women are involved with anonymous questionnaires. The model produced is robust: The study has implications for providing care and quality assessment. Although helpful, the results suggest that patient satisfaction tends toward overly optimistic ratings and should be balanced by a measure such as "willingness to recommend" and, much more importantly, a specific item to "measure", i.e., loss-focused care. The results also show significant variations in the role expectations of midwives compared with physicians, whose actions had a more substantial influence on the ratings: insensitivity to language was more present in physicians and highlights the challenge to gain more empathy and solidarity in stillbirth. From the perspective of the midwifery-led model, it emerges how more significant interactions between professionals are needed to create a multidisciplinary team suited to the needs of families.

The qualitative study, also from Spain, by Camacho-Ávila et al.[29], sought to describe and understand the experience and perceptions of parents who suffered a stillbirth. Twenty-one couples were interviewed. Analysis of the results revealed eight subthemes, grouped into three main ones: 1) "Perceiving the threat and anticipating the baby's death: 'Something is going wrong in my pregnancy'"; 2) "Emotional outpouring: the shock of losing a baby and the pain of giving birth to a stillborn baby; 3) "We have had a baby: the need to give an identity to the baby and legitimize grief"[29]. These times reflect the stages parents go through following the communication of perinatal death. The midwife's role is essential for the empathic meaning because she can help in the burial process, facilitating the separation rituals and honoring the baby's memory.

The parental experience has much importance on who communicates the unpleasant event, but especially on how the bad news is delivered. Gold et al.[30] investigate just that; through a cross-sectional observational study, 900 mothers who have had a stillbirth or infant death child are interviewed. Focusing on the stillbirth group, most (62%, 120 of 193) said they had received the news from their doctor or midwife. It was also found that, compared with Caucasian women, African American women were less likely to receive a stillbirth diagnosis from a physician or midwife. Women with stillbirths are less likely to have social support/support persons present at delivery than those with live births. This determines a potent prognostic factor for bereavement complications, psychological trauma, and postpartum depression. It emerges how physicians and midwives are not always trained to communicate such news and how a qualified health care figure (physician or midwife) with appropriate background and training is needed in this area.

Discussion

From the analysis of eligible studies, it emerged that assistance to mothers and couples who have had a stillbirth is greatly influenced by the healthcare context in which the service is provided. If the request for more frequent training and multidisciplinary work on healthcare providers and women/couples already emerges in contexts with high-low-medium resources, this request becomes a necessity. In addition, the workload and available resources are determining factors for correct stillbirth care.

Emotionally, the death of a newborn baby can be a great tragedy for a mother because it breaks an existing strong bond and attachment between the developing fetus and mother. Physically, significant changes occur within the woman's body as she recovers from birth. The intensity of these physical symptoms may affect emotionally bereaved mothers during the postnatal period.

During this challenging time, it is recognized that parents value the emotional and physical support of health professionals: bereaved mothers are generally discharged home early from the hospital and will therefore require relevant and timely information which will enable them to support their own health and well-being. The focus of midwifery practice in relation to bereavement care is to provide woman-centered care which places emphasis on each woman's specific needs and situation[37].

Negative psychological symptoms after a stillbirth have been reported in almost all parents and about 95% of professionals involved; perinatal loss, mainly, is widely considered a highly stressful event by professionals[26].

Midwives have an essential role, as demonstrated in many research studies; they must facilitate memory-making and understand the importance of quality photographs and meaningful mementos.

Evidence-based guidelines suggest that the prudent management of the "first and last" meetings with the baby is essential. Care providers should prepare parents for the birth of their baby and should be able to explain what to expect during labor adequately. A gentle approach with parents during delivery, after birth, with the baby eases parents to meet and facilitates parents to meet with the baby[26]. It must be said, however, that many studies have investigated the mental health effects of allowing parents to see and hold their babies. Still, the evidence remains uncertain on the positive or negative impact, and so far, the recommendation is to offer parents a choice[20]. Midwives can help in the grieving process by facilitating the farewell rituals, accompanying the family, helping in honoring the memory of the baby, and supporting parents in giving the deceased infant an identity that makes them a family member[29].

Nurturance was a strong theme that emerged in many of these studies: mothers spoke positively about midwives completing nurturing tasks such as holding the mother's hand, brushing her hair and casually conversing. The analysis of the most often used words used to describe midwives by parents during stillbirth are "gently, very gently" and "sweet and understanding midwife". Health professionals should approach mothers with compassion, humility and mindfulness.

Communication is the masterpiece of quality care because sensitive verbal and non-verbal communication with the bereaved mother provides memories that will help her initiate mourning and facilitate the grieving process: mothers/parents appreciated who call their baby by their name and treat their dead baby with affection and respect[37].

Therefore, every midwife should receive support and training, including communication training, given the adverse consequences of using the insensitive language outlined in this essay[16]. Unfortunately, however, bereavement care training is not currently mandatory in most of the world. Students' involvement was also thought to not be desired by women and, secondly, midwives were perceived to be protecting students from the 'realities' of midwifery practice and psychological harm arising from inexperience. Many considered there to be absent opportunities for hands-on student learning within the safety of the student-midwife relationship. Research has suggested that pre-degree education, however, does not adequately respond to the clinical practice requirements of perinatal loss; there is a disproportionate focus on the 'normal', which may prohibit new-grad

preparedness for pathological events. Midwives care for women who experience poor perinatal outcomes like stillbirth and neonatal death. Midwifery care in these sentinel events is complex. There is a limited understanding of early career midwives' experiences within these encounters[23].

A transversal dimension, "atmosphere of care", is the most significant influence on satisfaction/quality, which probably relates to the unique context of loss, grief and trauma[28]. Bereaved parents never forget the understanding, respect and genuine warmth they receive from staff. The care can be as lasting and important as any other memory of their lost pregnancy or their baby's brief life.

Conclusions

The management of stillbirth and perinatal loss should be a structured part of professional courses in medical and midwifery curricula so that the new generations of healthcare providers and midwives can substantially improve the quality of care for families who experience stillbirth. Future research should focus on enhancing communication methods during these delicate events. Hospital centers/companies should adopt protocols adapted to the needs of parents and a midwifery-led model policy based on psychological and psychiatric support for mothers and couples who have experienced a stillbirth, as well as increased follow-ups.

Holistic midwifery care for women who have undergone a stillbirth and cross-sectoral health promotion, including psychological health, are crucial to achieve better outcomes for women and the midwifery staff who provide them with care.

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