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# *Mothers' Experiences of Intrauterine Fetal Death (IUFD) at Eduardo Ximenes Regional Hospital (Horex), Baucau, Timor-Leste: A Descriptive Phenomenological Study*

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**Abstract:** *In 2023, almost two million babies were stillborn at or after 28 weeks of gestation worldwide, equivalent to 14 stillbirths per 1,000 total births. Timor-Leste reported a stillbirth rate of 14.38 per 1,000 total births in 2021, and Eduardo Ximenes Regional Hospital recorded 41 IUFD cases between January and August 2024. Despite this burden, mothers' lived experiences after IUFD in Timor-Leste remain insufficiently documented. To explore mothers' psychological, social, relational, spiritual, and meaning-making experiences, coping strategies, and support needs following IUFD in Timor-Leste. A descriptive phenomenological study was conducted at Eduardo Ximenes Regional Hospital, Baucau, in May 2025. Fifteen mothers who had experienced IUFD within the previous three months were recruited purposively. Data were generated through semi-structured in-depth interviews and analyzed using Colaizzi's seven-step phenomenological method. Five themes were identified: emotional shock and embodied grief; social support, stigma, and relational change; spiritual struggle and faith-based coping; continuing motherhood through memories and symbolic bonds; and reconstructing the loss through warning signs, bodily reactions, and self-blame. Grief was non-linear and was intensified or eased by the degree to which families, communities, partners, religious networks, and healthcare providers acknowledged the mother's loss. Post-IUFD care should combine grief-sensitive communication, psychosocial assessment and counseling, postpartum and lactation support, culturally appropriate spiritual care, family involvement, and structured follow-up. Healthcare services should also address stigma and provide clear, non-blaming explanations about fetal death and pregnancy danger signs.*

***Keywords:*** *intrauterine fetal death; lived experience; bereavement; social support; spiritual coping; Timor-Leste*
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## INTRODUCTION

Intrauterine fetal death (IUFD) refers to fetal death before birth, although clinical thresholds vary across settings. Some clinical definitions use a gestational age of at least 20 weeks or a fetal weight of at least 500 g, whereas international comparisons commonly define stillbirth as fetal death at or after 28 weeks of gestation and report the rate per 1,000 total births (Ridani et al., 2023; WHO, 2024). Distinguishing these definitions is important because stillbirth, neonatal mortality, and infant mortality are different indicators and should not be compared directly.

The global burden remains substantial. In 2023, almost two million babies were stillborn during the third trimester, corresponding to approximately 14 stillbirths per 1,000 total births, or one in every 69 births. More than four in ten stillbirths occurred during labour, when many deaths may be preventable through timely, high-quality obstetric care (UNICEF, 2025). Beyond mortality statistics, stillbirth can produce prolonged psychological distress, social isolation, stigma, financial strain, and disruption of parental identity (WHO, 2024; Westby et al., 2021).

Timor-Leste continues to face a considerable stillbirth burden. The WHO Global Health Observatory reported a stillbirth rate of 14.38 per 1,000 total births in 2021 (WHO, 2023). At Eduardo

Ximenes Regional Hospital in Baucau, hospital records documented 41 IUFD cases between January and August 2024. These national and facility-level data indicate a need not only for preventive maternal care, but also for responsive bereavement care after fetal death.

Mothers who experience IUFD commonly report shock, guilt, sadness, anxiety, sleep disturbance, depressive symptoms, post-traumatic stress, and difficulty resuming family and social roles. A systematic review found that psychological symptoms may persist well beyond the immediate post-loss period, while qualitative evidence shows that insensitive communication, social blame, and failure to acknowledge the baby can deepen grief (Westby et al., 2021; Persson et al., 2023). Conversely, empathetic listening, partner support, recognition of motherhood, memory-making, and culturally meaningful rituals may facilitate adaptation.

Qualitative studies in Indonesia, rural South Africa, and Bolivia have identified emotional devastation, bodily distress, stigma, disrupted relationships, spiritual questioning, and the importance of family or community support after fetal or perinatal death (Sinaga et al., 2020; Kharivhe et al., 2023; Fernández-Cox et al., 2025). However, these findings cannot simply be transferred to Timor-Leste, where Catholic spirituality, customary practices, close family networks, language, and local expectations concerning pregnancy and motherhood may shape grief in distinctive ways.

Published qualitative evidence specifically examining mothers' post-IUFD experiences in Timor-Leste remains scarce. Existing epidemiological reports describe the burden of fetal death but do not explain how mothers interpret the loss, respond to social and religious messages, preserve their maternal identity, or experience support from healthcare services. To our knowledge, this study is among the first descriptive phenomenological investigations to foreground the voices of mothers following IUFD in Baucau and to examine the interaction of psychological, relational, cultural, and spiritual experiences in this setting.

Accordingly, this study aimed to explore mothers' psychological, social, relational, and spiritual experiences after IUFD; the coping and meaning-making strategies they used; and the forms of support they needed from families, communities, religious networks, and healthcare providers.

## METHOD

### Study design and reporting

This study used a descriptive phenomenological design to describe the essential structure of mothers' lived experiences following IUFD. The approach was selected because the research question focused on how participants experienced and gave meaning to loss rather than on measuring predefined variables or generating a formal theory. Colaizzi's seven-step method was used consistently for data analysis (Colaizzi, 1978). Reporting was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) and the Standards for Reporting Qualitative Research (SRQR) (Tong et al., 2007; O'Brien et al., 2014).

### Setting, participants, and recruitment

The study was conducted at Eduardo Ximenes Regional Hospital (Horex), Baucau, Timor-Leste. The hospital recorded 41 IUFD cases between January and August 2024. Formal data collection was undertaken in May 2025. Participants were selected using purposive sampling because they had direct and recent experience of the phenomenon under investigation. Eligible participants were mothers diagnosed with IUFD, had experienced the event within the preceding three months, were able to communicate in Tetun, were medically and emotionally able to participate, and provided written informed consent. Mothers who were clinically unstable or unable to complete an interview were excluded.

Potential participants were identified through obstetric and midwifery records and were first approached by a ward midwife who was not involved in conducting the interviews. Women who expressed interest gave permission for the principal researcher to provide further information and obtain written consent. Recruitment continued alongside analysis. Fifteen mothers participated. Sample adequacy was evaluated using information power and thematic redundancy: the research team considered the specificity of the sample, the focused study aim, the richness of the interviews, and

whether later interviews contributed new meanings (Malterud et al., 2016). The final three interviews confirmed meanings already identified and did not generate a new theme; therefore, recruitment was concluded after the fifteenth interview. All 15 mothers who provided consent completed the interview, and none withdrew after enrollment.

**Research team and reflexivity**

The interviews were conducted by Helena Marques de Jesus, a female registered midwife working in maternal health and a master's student who had completed postgraduate preparation in qualitative research, phenomenological interviewing, and research ethics. The interviewer had no prior therapeutic, supervisory, or personal relationship with the participants. Before data collection, the researcher discussed assumptions about maternal grief with the supervisory team and maintained a reflexive journal throughout recruitment, interviewing, coding, and theme development. Bracketing notes were used to identify expectations arising from the researcher's professional background and to prevent these assumptions from replacing participants' descriptions. Supervisors Cesa Septiana Pratiwi and Askuri reviewed the analytic decisions and challenged interpretations that were not sufficiently grounded in the transcripts.

**Interview guide and preliminary interview**

A semi-structured interview guide was developed from the study objectives and literature on perinatal bereavement. Questions invited participants to describe: (1) the moment they learned of the fetal death; (2) emotional and bodily responses; (3) changes in family, partner, and community relationships; (4) cultural and religious experiences; (5) coping and memory-making; (6) understanding of pregnancy warning signs; and (7) support received or needed. Prompts such as "Can you tell me more about that experience?" were used to deepen descriptions. The guide was reviewed by experts in maternal mental health and sociology. One preliminary interview was conducted to assess clarity and sensitivity and was excluded from the final analysis. Minor wording adjustments were made to improve the clarity and emotional sensitivity of the guide; the preliminary activity was part of instrument refinement and was not a separate study phase.

**Data collection and translation**

Interviews lasted approximately 40–60 minutes and were conducted face-to-face in a private consultation room at Eduardo Ximenes Regional Hospital. Only the participant and interviewer were present. Interviews were conducted in Tetun, audio-recorded with written permission, and supplemented by field notes documenting context, emotional cues, pauses, and reflexive observations. Each participant completed one interview; brief clarification was sought at the end of the session when an account required further detail. Medical records were reviewed only to verify relevant obstetric information after consent.

Audio recordings were transcribed verbatim in Tetun by the principal researcher and checked against the recordings for accuracy. Quotations selected for publication were translated into English by the bilingual principal researcher and back-translated by an independent bilingual health professional. Differences were resolved through discussion to preserve conceptual meaning rather than literal wording. Participants were identified by pseudonyms and participant codes.

**Data analysis**

Analysis followed Colaizzi's seven steps. First, the first author read each transcript repeatedly to become familiar with the whole account. Second, statements directly related to the experience of IUFD were extracted. Third, meanings were formulated while consulting reflexive and bracketing notes. Fourth, formulated meanings were organized into clusters of subthemes and themes, with repeated checking against the original transcripts. Fifth, the team developed an exhaustive description of the phenomenon. Sixth, the description was condensed into a fundamental structure representing the shared experience. Seventh, the fundamental structure was returned to five participants selected to represent different parity and gestational-age profiles for validation and refinement. Coding was

conducted primarily by the first author using manual coding matrices supported by Microsoft Excel. The two supervisors reviewed significant statements, formulated meanings, and theme boundaries. Differences were resolved by returning to the transcripts and reaching consensus.

**Trustworthiness**

Credibility was supported by prolonged engagement with the transcripts, end-of-interview summaries that participants could correct, follow-up validation of the fundamental structure with five participants, investigator review, and the use of verbatim quotations. Dependability and confirmability were strengthened through an audit trail containing interview-guide versions, field notes, reflexive entries, coding matrices, and records of analytic decisions. Transferability was addressed through description of the hospital setting, participant obstetric characteristics, cultural context, and the timing of interviews.

**Data management and ethics**

Digital recordings, transcripts, and coding files were stored on an encrypted, password-protected institutional drive. Consent forms and identifying information were stored separately from research data. Access was restricted to the first author and two academic supervisors, and data will be retained for five years after publication before secure destruction in accordance with institutional policy. Identifiers were removed from transcripts and quotations.

Ethical approval was obtained from the Research Ethics Committee of Universitas 'Aisyiyah Yogyakarta (UNISA) (No. 4116/KEP-UNISA/1/2025). All participants received oral and written information, provided written informed consent, and were informed that participation was voluntary and could be paused or discontinued without affecting care. Because IUFD is a sensitive experience, interviews were conducted using a distress-sensitive approach; participants could take breaks, decline questions, or stop the interview. Participants showing significant distress were offered referral to the hospital's midwifery service and available psychological or pastoral support. Confidentiality and anonymity were maintained throughout data collection, analysis, and reporting.

## RESULTS

Table 1 presents participant obstetric characteristics. Age is reported in categories to protect confidentiality and to avoid false precision where four source values were truncated. Education, occupation, marital status, religion, and the documented clinical cause of IUFD were not systematically collected in the research dataset and were therefore not retrospectively imputed. All interviews were conducted within three months of IUFD, as specified in the inclusion criteria.

**Overview of themes**

The analysis produced five interconnected themes. Mothers described an immediate emotional and bodily rupture, followed by grief that reappeared during daily activities. Their recovery was strongly shaped by whether partners, families, communities, and religious networks recognized or invalidated the loss. Faith and memory-making supported continuing bonds with the baby, while retrospective attention to warning signs often intensified guilt and self-blame. The themes are presented below with representative quotations translated into English.

**Theme 1: Emotional shock, embodied grief, and efforts to continue**

This theme describes the immediate shock of confirmation, bodily expressions of grief, recurrent longing, and participants' early attempts to continue living.

**Subtheme 1.1: Initial shock, disbelief, and bodily collapse**

*"I wanted to believe it was just a mistake with the equipment, but I knew it was a reality I had to face." (P1)*

*"My world feels like it's crumbling… like a part of my soul is leaving with my child." (P2)*

*"I feel like I have no bones. My knees are weak, and my chest feels tight." (P6)*

*"My breasts are full, but there is no baby crying for milk. My body doesn't know that my child is gone." (P15)*

**Table 1. Clinical and obstetric characteristics of participants**

| No. | Alias | Age (years) | Parity | Gestational age | Date of IUFD | Initial emotional response |
|---|---|---|---|---|---|---|
| 1 | Alita | 20–29 | G1P0A0 | 36.2 weeks | 18 January 2025 | Overwhelmed; loss of motivation; shattered by loss of first child. |
| 2 | Celina | 20–29 | G1P0A0 | 40 weeks | 8 January 2025 | Broken, empty, and overwhelmed by sadness. |
| 3 | Lorita | 35–39 | G4P3A0 | 20.6 weeks | 4 February 2025 | Deep loss and hopelessness, while trying to continue for her children. |
| 4 | Julita | 20–29 | G2P1A0 | 38.5 weeks | 12 February 2025 | Silence and a sense of an irreparably shattered heart. |
| 5 | Esmeralda | 20–29 | G2P1A0 | 38.4 weeks | 23 February 2025 | Shock because the pregnancy had appeared normal. |
| 6 | Felicia | 25–29 | G1P0A0 | 40.3 weeks | 24 February 2025 | Deep sadness and disruption of daily life. |
| 7 | Inácia | 25–29 | G4P3A0 | 40.6 weeks | 28 February 2025 | Devastation and a home that changed from hope to silence. |
| 8 | Raimunda | 20–24 | G1P0A0 | 23.5 weeks | 3 March 2025 | Emptiness and feeling unprepared to lose her first baby. |
| 9 | Noélia | 30–34 | G3P2A1 | 39.4 weeks | 10 March 2025 | Disappointment and sadness after a highly anticipated pregnancy. |
| 10 | Adelina | 20–24 | G1P0A0 | 38.4 weeks | 21 March 2025 | Devastation as hope of welcoming a first child became grief. |
| 11 | Gracinha | 30–34 | G3P2A1 | 30.1 weeks | 24 March 2025 | Unexpected loss after a long wait and strong hopes. |
| 12 | Marcelina | 25–29 | G2P1A0 | 40.5 weeks | 26 March 2025 | Deep grief and feelings of failure as a mother. |
| 13 | Zelia | 25–29 | G2P1A0 | 40.2 weeks | 29 March 2025 | Guilt and severe loss before childbirth. |
| 14 | Josefina | 35–39 | G4P0A0 | 40 weeks | 30 March 2025 | Devastation, inability to hold the baby, and thoughts of giving up. |
| 15 | Teresinha | 35–39 | G4P4A0 | 40 weeks | 31 January 2025 | Deep guilt and devastation associated with a fourth loss. |

*Note. Ages are presented in categories to protect participant confidentiality and avoid false precision in truncated source values.*

**Subtheme 1.2: Grief intruding into everyday routines**

*"The feeling of longing comes suddenly while sweeping, while cooking." (P3)*

*"When I feed my youngest child… I imagine the one who is no longer here." (P6)*

**Subtheme 1.3: Holding on and beginning to rise**

*"I started trying to regulate my breathing, write prayers, and rise slowly. God is slowly restoring me." (P1)*

*"If only I had died too… but my second child was crying and looking for me. That made me hold on." (P15)*

*As mothers tried to continue daily life, their emotional responses were influenced by the reactions of people around them.*

**Theme 2: Social recognition, stigma, support, and relational change**

This theme captures how community judgments, cultural practices, family presence, and partner responses either deepened isolation or created space for grief.

**Subtheme 2.1: Stigma, blame, and social withdrawal**

*"If you are legally married, maybe God won't take your child away." (P2, recalling a community comment)*

*"If you had prayed more, maybe your child wouldn't have died." (P7, recalling a community comment)*

*"I not only feel the loss of my child, but also the loss of a safe space in my own community." (P4)*

*"Many people have distanced themselves… I feel invisible." (P8)*

**Subtheme 2.2: Family, community, and customary responses**

*"You're not allowed to light a bonfire for seven days. I followed it, not out of fear, but out of respect as a mother." (P15)*

*"I am not asking for pity, but I also do not want to be blamed." (P7)*

*"My mother said, 'My daughter is still strong.' That was enough." (P11)*

*"Some just say, 'You have to be strong,' but they don't sit down and listen." (P13)*

**Subtheme 2.3: Changes in relationships with partners**

*"We started talking slowly… even crying together." (P4)*

*"He hugged me from behind and said, 'We're strong, okay?' That meant so much." (P10)*

*"We began to be more open and strengthen each other through gentle words." (P14)*

*Where social interactions were painful or insufficient, many participants turned toward faith and religious communities.*

**Theme 3: Spiritual struggle, renewed faith, and religious-community support**

Participants described both spiritual questioning and renewed trust. Prayer, religious leaders, communal worship, and sacred objects helped some mothers feel that their grief was recognized.

**Subtheme 3.1: Questioning God and rebuilding a spiritual relationship**

*"I drifted away from prayer… I wondered why God allowed this to happen." (P5)*

*"I feel as if God is silent when I need Him most." (P7)*

*"I asked, 'God, why?' But over time, I felt that God had not abandoned me." (P6)*

*"I believe that my child is now in His hands, protected and loved." (P4)*

**Subtheme 3.2: Changing prayer and interpreting life differently**

*"Now I speak directly to God as I would to a Father." (P8)*

*"I feel that God is present not through great miracles, but in a silent, faithful presence." (P11)*

**Subtheme 3.3: Support from the church and religious community**

*"I feel greatly strengthened through communal prayer and visits from the pastor." (P1)*

*"Praying together makes me feel that my sadness is valued." (P2)*

*"The nun gave me a rosary and said, 'Every time you feel lonely, hold this.'" (P7)*

*"The nurse came and prayed for me. It was very comforting." (P13)*

*Spiritual coping was closely linked to the ways mothers preserved a relationship with the baby and maintained a maternal identity.*

**Theme 4: Continuing motherhood through names, memories, and symbolic bonds**

This theme describes how participants continued to understand themselves as mothers and maintained connections with the baby through names, prayers, keepsakes, and everyday symbols.

**Subtheme 4.1: An enduring maternal identity**

*"Being a mother does not end with loss." (P1)*

*"Being a mother… also means loving the child we never got to hold." (P3)*

**Subtheme 4.2: Keepsakes and activities that revive memories**

*"I want to write a letter someday… as a symbol that my love continues to grow." (P5)*

*"I embroidered my baby's name on a small handkerchief. I keep it near my bed." (P15)*

*"I keep pieces of wool thread, a small cross… in a small batik bag for her." (P8)*

**Subtheme 4.3: Naming and remembering the baby**

*"Mateus means 'gift from God.' I mention it in my prayers every night." (P15)*

*"I named him Gabriel… that name is a prayer." (P4)*

*"'Rafael' means God heals… That name is a small light illuminating my darkness." (P7)*

*Alongside these continuing bonds, mothers repeatedly revisited the moment of diagnosis and questioned whether warning signs had been missed.*

**Theme 5: Reconstructing the loss through warning signs, bodily reactions, and self-blame**

This theme replaces the previous label 'Awareness of danger signs' to more accurately represent participants' post-loss experiences. Their accounts centered on receiving confirmation of fetal death, becoming physically overwhelmed, and retrospectively questioning whether they could have acted sooner.

**Subtheme 5.1: Receiving confirmation that the baby had died**

*"When the doctor said, 'The baby's heartbeat has stopped,' I couldn't hear anything else." (P15)*

*"I felt like the world had stopped spinning. My head was empty, and my ears were ringing." (P11)*

*"It felt like my world collapsed instantly. All sounds and thoughts seemed to stop." (P12)*

**Subtheme 5.2: Freezing and postpartum bodily reminders**

*"I couldn't say anything at that moment. It was as if my body had frozen." (P13)*

*"I feel like time has stopped. I can only remain silent; my body feels empty." (P14)*

*"My breasts are full, but there is no baby crying for milk." (P15)*

**Subtheme 5.3: Retrospective regret and self-blame**

*"I'm sorry, Mom was too late to save you…" (P11)*

*"I hugged her and apologized for not being able to keep her alive until she was born." (P12)*

*"I know I tried my best, but I still feel like a failed mother." (P15)*

## DISCUSSION

This study identified a non-linear experience of grief that involved emotional shock, bodily disruption, social recognition or rejection, spiritual struggle, continuing maternal bonds, and retrospective self-blame. Rather than moving predictably through fixed stages, participants shifted between disbelief, longing, despair, faith, connection, and efforts to continue daily life. Kübler-Ross's work may help name some reactions to loss, but the present findings indicate that mothers' experiences were relational and culturally embedded rather than a sequential progression through universal stages (Kübler-Ross, 1969).

The first theme showed that IUFD was experienced through both emotion and the body. Weakness, chest tightness, lactation without a living baby, and recurrent reminders during household routines made the loss continuously present. Similar embodied and psychosomatic experiences were reported among women after IUFD in rural South Africa and Indonesia (Sinaga et al., 2020; Kharivhe et al., 2023). The findings also align with evidence that depression, anxiety, and post-traumatic stress may persist after stillbirth (Westby et al., 2021). The present study extends this literature by showing how postpartum bodily processes and ordinary caregiving activities can reactivate grief during the first three months after loss.

The second theme demonstrated that grief depended partly on whether the social environment recognized the mother's loss. Compassionate listening and partner closeness helped participants feel less alone, whereas moral judgments, pressure to be strong, and community withdrawal produced an additional loss of social safety. Similar patterns of stigma and insufficient recognition have been reported in South Africa, Ghana, and Bolivia (Aboungo et al., 2020; Kharivhe et al., 2023; Fernández-Cox et al., 2025). In the Timor-Leste context, customary practices and close family or neighborhood networks could provide belonging, but the same networks could also transmit blame or restrict how a mother remembered her baby. This dual role is important: culture should not be framed only as a protective factor or only as a barrier.

Partner support was often communicated through quiet presence, shared crying, physical affection, and gentle words rather than formal counseling. These interactions helped some couples move from emotional distance toward mutual recognition. However, the accounts also suggest that

families need guidance on how to listen without minimizing grief. Bereavement education for partners and relatives should therefore emphasize validation, avoidance of blame, and respect for differences in grieving style.

The third theme highlighted religion as both a site of struggle and a resource for recovery. Some mothers questioned why God permitted the death or interpreted community comments as spiritual judgment. Others described renewed prayer, surrender, visits from pastors or nuns, communal worship, rosaries, and prayers by nurses as sources of comfort. Qualitative studies in other religious and low-resource settings similarly show that spirituality can support meaning-making while also intensifying guilt when loss is interpreted as punishment (Kharivhe et al., 2023; Fernández-Cox et al., 2025). For maternity services in Timor-Leste, spiritual care should therefore be offered according to each mother's preference and should never substitute for psychological assessment or be used to imply responsibility for the death.

The fourth theme showed that maternal identity continued after the baby's death. Naming the baby, keeping handmade objects, praying, writing letters, and caring for symbolic items allowed mothers to acknowledge an ongoing bond. Reviews of care after stillbirth report that respectful memory-making and recognition of parenthood can be meaningful when offered sensitively and without pressure (Donegan et al., 2023; Persson et al., 2023). The findings add culturally specific examples from Timor-Leste, including embroidery, woven objects, religious symbols, and names with spiritual meaning. Healthcare providers should ask parents whether they wish to name, see, hold, photograph, pray for, or create keepsakes for the baby, while respecting decisions to decline.

The fifth theme was not primarily about factual knowledge of pregnancy danger signs; it represented mothers' attempts to reconstruct the loss after receiving the diagnosis. Freezing, auditory narrowing, bodily emptiness, and repeated questions about missed signs reflected acute shock and retrospective guilt. Such self-blame should not be interpreted as evidence that mothers caused the fetal death. Clear explanations about known findings, uncertainty, and preventability are essential. Education on reduced fetal movement and other warning signs should be provided in a non-blaming manner during antenatal care and again after IUFD, together with an individualized review of events when clinically appropriate.

These findings have several implications for nursing, midwifery, and maternity care. Facilities should develop a culturally responsive bereavement pathway that includes private and compassionate communication of the diagnosis; opportunities for a support person to be present; assessment of acute distress, depression, anxiety, trauma symptoms, and self-harm risk; postpartum physical and lactation care; optional memory-making and spiritual support; written information in an accessible language; and planned follow-up after discharge. Referral mechanisms should connect mothers with counseling, mental health, social work, peer support, and pastoral services according to need and preference. Staff training should include therapeutic communication, recognition of disenfranchised grief, and strategies for responding to guilt and stigma.

This study contributes context-specific evidence from a hospital in Baucau and gives attention to the interaction of culture, religion, family relationships, bodily experience, and continuing motherhood. Nevertheless, several limitations should be considered. Participants were recruited from one hospital and interviewed within three months of IUFD, so the findings mainly reflect early grief and may not transfer to other municipalities or later stages of adaptation. The sample included mothers only and did not capture partners, family members, religious leaders, or healthcare providers. Translation from Tetun into English may have altered nuances despite transcript checking and back-translation. Education, occupation, marital status, religion, and the documented cause of IUFD were not systematically collected, limiting contextual comparison across participants. Future research could use longitudinal designs and include multiple sites and relational perspectives, but the immediate priority is to strengthen grief-sensitive care using the needs already identified in this study.

## CONCLUSION

Mothers' experiences following IUFD in Baucau involved intertwined emotional, bodily, social, relational, cultural, and spiritual processes. Recovery was not linear. It was supported when mothers'

grief and continuing identity as mothers were acknowledged, and it was hindered by blame, stigma, silence, and inadequate opportunities to discuss the loss. Maternity services should implement a grief-sensitive pathway that combines empathetic communication, psychosocial screening and counseling, postpartum and lactation care, optional memory-making, culturally appropriate spiritual support, family education, and structured follow-up. Information about pregnancy warning signs and possible causes of fetal death should be communicated clearly and without reinforcing maternal self-blame.

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## AUTHOR CONTRIBUTIONS

Conceptualization, Helena Marques de Jesus (HMJ), Cesa Septiana Pratiwi (CSP), and Askuri (A); Methodology, HMJ, CSP, and A; Investigation, HMJ; Formal Analysis, HMJ, CSP, and A; Data Curation, HMJ; Writing – Original Draft, HMJ; Writing – Review & Editing, HMJ, CSP, and A; Supervision, CSP and A; Project Administration, HMJ. All authors have read and approved the final manuscript.

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## DATA AVAILABILITY STATEMENT

The interview data are not publicly available because they contain sensitive narratives and contextual details that may compromise participant confidentiality. De-identified data or supporting analytic materials may be made available from the corresponding author upon reasonable request and subject to participant consent, institutional policy, and ethics approval.

## PROTOCOL REGISTRATION

This study was retrospectively registered with the Indonesia Clinical Research Registry (INA-CRR), Ministry of Health of the Republic of Indonesia, under Registry Number INA-092B103 on 26 February 2026.

## ETHICS STATEMENT

The study was approved by the Research Ethics Committee of Universitas 'Aisyiyah Yogyakarta (UNISA) (No. 4116/KEP-UNISA/1/2025). Written informed consent was obtained from every participant. Participation was voluntary, identifying details were removed, and data access was restricted to the authorized research team. Interviews were conducted using a distress-sensitive approach, with the option to pause or stop and referral to hospital midwifery, psychological, or pastoral support when additional assistance was required.

## CONFLICT OF INTEREST

The authors declare no conflicts of interest related to the research, authorship, or publication of this manuscript.

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