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Situational Analysis on the Impact of Perinatal Deaths Among Bereaved Families in Ghana

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Abstract

Background: Annually, about 5.9 million perinatal deaths occur worldwide, leaving millions bereaved due to stillbirths or early neonatal deaths. The highest burden of stillbirths (97%) and newborn deaths (98%) occurs in lower- and middle-income countries, with the majority occurring in Sub-Saharan African countries.

Method: This cross-sectional qualitative study was conducted to identify existing policies and protocols to support bereaved families, explore the needs of bereaved families, and to also assess the impact of perinatal death on families in Ghana. All in-depth interviews were audio-recorded, transcribed verbatim and analyzed thematically. The results were presented in narratives and supported with illustrative quotes from respondents.

Results: In all, 42 in-depth interviews were conducted with 10 (23.8%) from the Northern belt (Upper East), 11 (26.2%) from the middle belt (Ashanti) and 21 (50.0%)

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from the Southern belt (Greater Accra). The study revealed that practicing health professionals and other stakeholders within the health service delivery chain were not aware of protocols, written guidelines or written documents to initiate counseling at the facility in the event of a mother losing a child. Most of the respondents did not know what to do in the event that a mother loses a baby during delivery or immediately after. Respondents were in favor of having a policy or guidelines which will help them to counsel families who go through perinatal bereavement. Respondents were of the view that it is important for families who experience perinatal grief to be supported.
Conclusion: All staff who meet the pregnant mother during her pre-and-post-delivery stages should be trained on the use of guidelines or policies. There is the need to have a policy, train and equip health staff to ensure that families experiencing perinatal grief are provided with effective counseling. Ghana Health Service should consider training and recruiting professional counselors who will support the health staff in dealing with perinatal grief.

Keywords
bereaved families, perinatal deaths, psychosocial support, counselling, bereavement guidelines

Background

The perinatal period commences at 28 completed weeks (196 days) of gestation and ends seven completed days after childbirth (MoH/GHS, 2019). Perinatal mortality refers to the number of stillbirths and deaths in the first week of life (Mills et al., 2010). About 5.9 million perinatal deaths occur worldwide every year and out of this number 3.2 million are stillbirths with 2.7 million being early neonatal deaths(Wall et al., 2010). The highest burden of stillbirths (97%) and newborn deaths (98%) occurs in lower- and middle-income countries, with most occurring in sub-Saharan African countries (Liu et al., 2016; Mohangoo et al., 2013). About 28.3 per 1000 births in sub-Saharan Africa are stillbirths, compared to only 3.1 in developed countries. In developed countries, the range of foetal deaths is between 1.6 to 4.7 per 1000 live and stillbirths and neonatal deaths is 1.1–4.3 per 1000 live births (Mohangoo et al., 2013). In Ghana, from 2012 to 2017, out of 26,062 women between the ages of 15–49 years interviewed, 76% of pregnancies ended up in a live birth, whilst 2% resulted in a stillbirth, 12% in a miscarriage and 10% ended in an induced abortion (GSS, GHS, 2018).

Despite the high burden of perinatal death in Sub–Saharan Africa (SSA) as compared with high income countries (HICs), and the psychosocial impact of perinatal death, families have few options for accessing bereavement care (Leon, 2009). In Ghana, for instance, families are advised not to talk about their loss (cite). Available research suggests that women in SSA are often discouraged from openly discussing or

mourning a perinatal death for fear of stigma, gossip and blame (Haws et al., 2010; Roro et al., 2018).

These conditions generate considerable barriers to treatment, compounded by a scarce literature base investigating the health consequences of perinatal bereavement among women and families in Ghana, and SSA more widely. This study aims to describe the experiences of couples and families following the loss of a pregnancy, foetus or infant in order to develop high-quality perinatal bereavement service (Aiyelaagbe et al., 2017) to develop an evidence base that can begin to address the unmet public health burden of post-bereavement adverse health outcomes.

Mothers who lose their newborns experience classic grief symptoms, including shock and denial (Cacciatore & Bushfield, 2007) and are at risk for Prolonged Grief Disorder and related conditions (Lavin et al., 2016). Risk for adverse post-bereavement conditions depends on several factors, including the medical and mental condition, those around her, and access to care (Gilson, 1976). It has been shown that parents who lose their infants often suffer from post-traumatic stress, depression, anxiety, sleep disorder and poor mental health (Kersting & Wagner, 2012). Others experience spousal neglect, self-blame, and emotional pain (Asare et al., 2020). Evidence does not support the use of excessive sedation as pharmacological therapy (Gilson, 1976). However, prompt notification of death of the infant, giving reasonable explanation of the cause of death and repeating it as necessary has been shown to reduce adverse outcomes after perinatal bereavement. (Bishop et al., 2019). In developing countries, a miscarriage or death of a foetus/infant is considered normal, and the death is not grieved properly (CDC, 1984; Thearle et al., 1995). Meanwhile, the death of a foetus/infant has a significant impact on the health of bereaved families and the society at large (Harmon et al., 1984) and (Lang et al., 2004). Bereaved parents of an infant can report psychological symptoms many years after the death of the infant (DYREGROV & MATTHIESEN, 1987). The trauma of a stillbirth can have long-term effects on the family. About 20% of women have prolonged depression and 20% post-traumatic-stress disorder (PTSD) in the subsequent pregnancy (DYREGROV, 1990). Studies in developing countries identified cultural beliefs and perceptions about pregnancy as key influential factors for parental grief (Dako-Gyeke et al., 2013). In Ghana, pregnancy is considered a potentially dangerous period that needs spiritual protection. As a result, women resort to various means of seeking protection against these perceived threats from natural and supernatural forces. With the contemporary growth of charismatic and evangelical Christian churches new avenues of care have been made accessible to Ghanaian women to seek protection from forces including witches, wizards, sorcerers and enemies (Dako-Gyeke et al., 2013). There is the need to train health workers to enable them to provide the needed psychological support to couples and families during pregnancy, childbirth and especially when the couple or family loses a pregnancy, foetus or infant (Dako-Gyeke et al., 2013).

The burden of perinatal mortality is high in Low- and Middle-Income Countries (LMIC) including Ghana (Mekonnen et al., 2013). Despite this fact, there are inadequate studies in sub-Saharan Africa including Ghana that provide empirical evidence

for the development of interventions and policies needed to provide psychological support for families who experience perinatal loss. The Ghana National Newborn Health Strategy and Action Plan (2019–2023) reveals that there is; *''lack of activities to promote psychosocial support for parents with poor pregnancy outcomes and for early childhood development (ECD) issues''*(MoH/GHS, 2019). The training of doctors, nurses and midwives do not usually address the knowledge, attitude, and skills of service providers on the psychological need of parental grieving or stress following undesired pregnancy outcomes including miscarriages, abortions, stillbirths, and neonatal deaths in health care delivery centers. It is important to actively involve primary targets who are families of persons who experience perinatal death and healthcare workers to appropriately develop interventions to address the gap which this study seeks to do.

The importance of protocols and guidelines cannot be overemphasized. At every stage, during and immediately after the loss of pregnancy or the death of a baby, the actions or inactions of healthcare professionals and their timing are critical to the provision and experience of quality of care(Perinatal Society of Australia and New Zealand [PSANZ], 2019). Inadequate or inappropriate care can disempower parents and this can make the already potentially traumatic event even worse for the bereaved parents (Ávila et al., 2020); Perinatal Society of Australia and New Zealand [PSANZ], 2019).

Study Design, Location and Participants

This was a qualitative cross-sectional study undertaken via a purposive sampling of participants. The administrative regions of Ghana have been divided into three ecological zones (Northern, Middle, and Southern). One region was selected from each ecological zone: Upper East region for the Northern zone, Ashanti region for the middle zone and Greater Accra region for the Southern zone. The selection of these regions across these zones was to enable the research team to take into consideration a heterogeneous sample that will be representative of the Ghanaian population. This was to allow for generalizability of the findings. Each region was represented by six health facilities stratified by urban and rural. The selection of these facilities was influenced by the number of recorded perinatal mortalities they record every month. On this basis, all identified and relevant health care providers who have direct contact with pregnant women at the facilities were interviewed. The study involved families who experienced perinatal mortalities within the last 1 month prior to the commencement of the study, health care workers, individuals from the Ghana Ministry of Health, Ghana Health Service, organizations such as UNICEF and others as depicted in Figure 1. The inclusion criteria for participants (bereaved families) were reproductive age women 15–49 years and or their spouses, women and or their spouses who have experienced miscarriage or stillbirth or neonatal mortality within 1 month prior to the study and only women who have consented to take part. The exclusion criteria involved participants with post-traumatic stress disorder, personality disorder or mood disorder that posed a

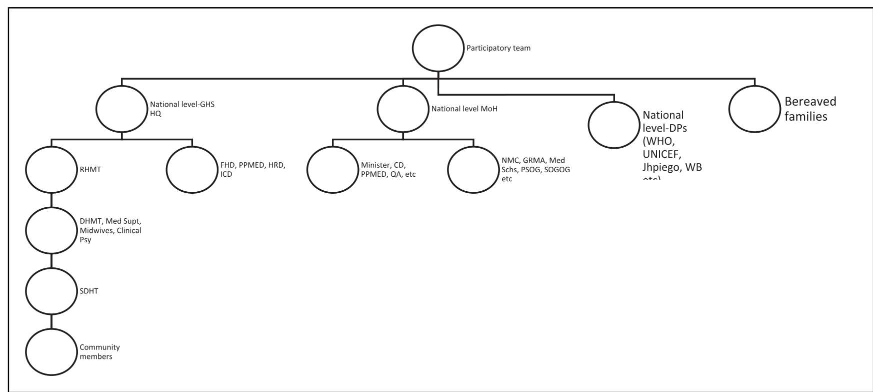

Figure 1. Framework for stakeholders' engagement and consultations.

strong likelihood of adversely impacting on their ability to respond or complete the study tools.

Sample Size

The study utilized a convenient and purposive sampling approach with a sample size of 42. In-depth interviews across the three ecological zones were conducted. This sample was allocated to individuals or families (10) who experienced stillbirth and/or neonatal deaths between 22 weeks gestational age and 1 week postpartum and willingly consented to take part within the period of this study. Health care workers (24) and stakeholders (8) in Ghana's health system were interviewed. The individuals and institutions that were contacted and took part in this study are detailed in Figure 1.

Study Procedure and Data Collection

Data was collected in March and April 2021 concurrently across the three study sites. In this study (situational analysis), stakeholder (Ministry of Health, Ghana Health Service, UNICEF and the bereaved families, and others) engagements and consultations were conducted. Recruitment of participants was done at the surrounding communities where these selected facilities serve, having obtained from the facilities retrospective information of women who experienced perinatal mortality. This study was approved by the Ghana Health Service Ethics Review Committee (GHS-ERC 007/12/20). Contact information of only participants who had suffered perinatal mortality within the last one (1) month were obtained from the facilities with the help of the facility heads. This information was used to schedule place and time (where and when) to conduct the interviews with the respondents. Interviewers visited these bereaved families accompanied by one of the facility's health care providers. All two (2) field coordinators and eight (8) interviewers were trained to take care of their respective

allocated facilities and communities taking into consideration the objectives of the study, the processes and tools involved. They were also trained on proper human ethics and how to provide crisis counseling and referrals for mental health care. Training of field coordinators/interviewers was done for 3 days and organized at the zonal levels. All the interviewers were midwives or nurses either in active service or retired who held various positions in Ghana Health Services currently or prior to their retirement. The interviewers (nurses and midwives) were recruited by the study team with the help of the Family Health Division of the Ghana Health Service and also the Regional Health Directorates. The recruitment of the interviewers was based on, health care workers who were working or had worked at an antenatal care and/or family planning unit of a health facility and also those who have taken part previously in health data collection. Participants were asked a plethora of questions ranging from effects of perinatal loss on their families, responsibilities of loss, support received and from where, policies, standards and protocols governing perinatal loss and others. For the bereaved families, participants were either interviewed in the presence of their partners or a family member or alone or based on their preference. These interviews were conducted in private places as was deemed appropriate by the respondent. Interviews lasted between 30–40 minutes. Interviews were conducted in English language and three different dialects (Frafra, Twi and Ga). All interviews were audio recorded by the trained interviewers in different languages according to the participants preferences. The need to audio record was explained to the participants and they approved by consenting (signed or thumb printed) using the ethics review consent form.

Data analysis

Interviews were audio-recorded using a digital voice recorder. All the interviews were then transcribed into Microsoft Word. Interviews conducted in English were transcribed directly whilst interviews conducted in the local dialects (Twi, Frafra and Ga) were translated by an independent person via audio recording and later transcribed into the English language to ensure integrity of meaning. These translations and back translations were carried out by trained experts.

A line-by-line reading of all transcripts within the NVivo 12 software was done and relevant portions of statements made by respondents coded onto existing nodes and new nodes. The nodes were initially created as free nodes but as the coding progressed, relationships emerged, and the nodes were transformed into tree nodes to reflect the relationships. The results of the qualitative data were then presented in narratives and supported with illustrative quotes from respondents.

Data was then analyzed after transcription. Analysis included reading and rereading of the interviews and focusing on the identification of themes relating to the explanation of *Assessing the impact of perinatal death on families in Ghana*. The transcripts were imported into NVivo 12 Windows for analysis.

Thematic content analysis was adopted in analyzing the data delineated into four stages. Foremost, all retrieved transcripts were read and re-read by the data analysts for

familiarization. This was followed by taking notes with respect to the patterns and meanings of the information obtained and matching that against the research objectives.

A codebook was created with the codes organized into the main themes and subthemes. Two researchers carried out the codes with the help of two members of the research team and all themes and subthemes were discussed with the entire research team and they made inputs. The codebook defined the various themes that were used during coding, their definition, when to use and when not to use such a code and examples of statements that should be considered for coding unto a particular code. These codes were turned into nodes within the software for analyses.

Results

A total of 10 bereaved families (comprising mothers and/or fathers), 24 Ghana Health Service staff and 8 other stakeholders' in-depth interviews were carried out across the three ecological zones of the country. In all, 42 in-depth interviews were conducted with 10 (23.8%) from the Northern belt (Upper East), 11 (26.2%) from the middle belt (Ashanti) and 21 (50.0%) from the Southern belt (Greater Accra). Details of the breakdown of the participants by region are provided in Table 1.

The study themes were developed and presented based on the tool used and as illustrated in the data analysis subsection. These were; *knowledge of the existence of guidelines or protocols for providing psychological support for families experiencing perinatal mortality, need for a Documented Policy/Guideline, Category of Staff Responsible for Counselling, Support to Families Experiencing Perinatal Grief, Curriculum to Train Health Workers on Perinatal Mortality, Suggestions for Improvements, impact of perinatal death on families and psychological support received*.

Bereaved Families

Effect of Perinatal Death on Families. This study reveals that victims, who experience perinatal deaths, were either pained or hurt by the incident. This was because they lost their babies even after going for antenatal care, which was to ensure that both the mother and the unborn baby are healthy throughout the stages of the pregnancy. Also,

Table 1. Stakeholders Interviewed by Zones for Situation Analysis on the Impact of Perinatal Death on Families in Ghana.

Stakeholder	Upper East	Ashanti	Greater Accra	Total
Bereaved families (5 expected)	3	4	3	10
Health staff (GHS)	7	7	10	24
Institutions	0	0	8	8
Total	10	11	21	42

they felt the pain due to the hormonal changes and experiences that they went through during the pregnancy. Though losing the baby is a painful experience most of them were consoled because they believe in the supreme God.

> "Oh, I would say I'm hurt till date, pregnancy comes in with a lot of problems, difficulties, not being able to eat and all that and then when you go to deliver expecting to have your baby and lose her it's very painful. Leaves you with sorrow but there's nothing you can do about it. We are not God, and His plans are different from ours." **Source, bereaved mother**

> "I still feel the pain because I returned home with tears and sorrow. Pregnancy is one of the most difficult moments in a woman's life so if you go to deliver and it happens this way it's very painful. The whole family was in sorrow. It still pains me whenever I remember." **Source bereaved mother**

Responsibility for Loss of the Baby

Respondents attributed the loss of their babies either to negligence on the part of the health workers or blamed themselves for not taking action when they experienced symptoms that required immediate attention. Some of these mothers believed that health workers should be able to detect when a pregnant mother has complications that may eventually lead to losing a baby ahead of time.

> "No, I wasn't but I said, they should have at least told me or identified that my baby was not well because I always come for antenatal care and I have been experiencing the pain for a while. I always report to the hospital, so I was expecting them to tell me beforehand if there was a problem but the only thing, they said was my sugar level was high, **Source, bereaved mother**

> ''I think I delayed in going to the hospital when I wasn't feeling the baby, I should have reported to the hospital earlier, maybe they could have taken the baby out through caesarian and maybe keep the baby in an incubator and the baby would have lived, that was what occurred to me, **Source, bereaved mother**

Support Received

Mothers who experienced perinatal grief received psychological support through words of encouragement and visits from family members, friends, and religious heads. These mothers believed that the support they received from these groups of people helped them to overcome their grief in a short time.

> "One thing that helped me most was because I'm very prayerful, so I called my pastor, he's no more here. When I called him, he told me that for whatever that has happened it was

> because God allowed it, if he didn't, it wouldn't have happened so I should be encouraged and have hope in God ". Based on what he told me I said to myself that it has already happened so I will stop living in the past and focus on the future and what's ahead of me", **Source, Bereaved mother**

> "a lot of my friends came around and they helped advise me. They were around supporting me in every aspect and that helped me a lot and because of that I felt that everything belongs to God whatever God says that's what it is so I give everything to God so if God says yes who can say no" **Source Bereaved mother**

Even though health facilities did not have departments or units solely responsible for counseling bereaved mothers and families, the nurses, midwives and doctors took them through some counseling at the time of the incidents

> "this actually disturbed me a lot so immediately after delivery when they picked up the baby and I saw that was my baby I actually cried but the nurses came around, consoled me and talked to me so the nurses did their job" **Source, bereaved mother**

Bereaved families also receive financial support from relatives to support expenses that were made at the facilities due to the process these mothers undergo to make sure that they are fine before discharge from the hospital.

> "Regarding finances, it became a bit hard for us at a certain point because we were a newly married couple who had now started life together, but the family supported me in the little way they could." **Source Bereaved mother**

Health Staff

Policies, Standard or Protocols. The study found out that, practicing healthcare professionals and other stakeholders within the health service delivery system said that protocols, written guidelines or written documents did not exist to help healthcare providers initiate an intervention at the facility in the event of a mother losing a child. Health facility respondents opined that they did not know what to do per the standards or protocols. However, healthcare service delivery experience and academic training have provided some healthcare professionals the skills in grief care for the mother and the family and this is what is used most often than not. Some respondents had this to say.

> "None that I know of, in my entire practice I have not seen any policy that comes in managing the incident, when it happens how to manage the family, I've not seen anything like that…" **Source - Deputy Director, Public Health**

Further, respondents opined that, the ability to counsel families who experience perinatal death is because of training that they go through during their studies in the nursing school. Others support these families through experience gained on the job over the years of working as midwives or healthcare professionals as exemplified in this statement -

> "… personally, I have not come across any of these protocols or standards but in nursing we were taught how to support persons who are grieving so it is that knowledge that I will use to support anybody who has lost a baby". **Source - Public Health Nurse**

> "no there is no such policy there, even though as part of our training you are supposed to do some, give support to people who are grieving but there's no policy" **Source - Chief Nursing Officer**

Even though there exists no guidelines or service protocols on grief care, some health workers have adapted the knowledge acquired from the general guidelines available at the facility on maternal and child health and documents on safe motherhood at the facilities to help in supporting families who experience perinatal death. These documents are not designated guidelines or policies from the Ghana Health Service or the Ministry of Health to facilities to guide them on how to deal with families who experience perinatal death. In facilities where there is a psychologist most of these mothers and families who experience perinatal death are referred to the psychologist to provide counselling on possible ways to manage their emotions after the loss. A respondent had this to say.

> "not exactly. We do not have separate stand-alone policies or guidelines for providing psychological support, we use the general guidelines on maternal and child health but currently in the region now that we have a clinical psychologist this is the best time for us to start looking at developing policies and guidelines so that the clinical psychologist will start taking our health workers, all those who deal with maternal and childbirth issues through those policies. Currently there's no specific policy that is directed at providing psychological support." **Source - Deputy Director, Clinical Care**

Need for a Policy/Guideline to Manage Families Who Experience Perinatal Death

Generally, the study found out that respondents leaned towards or are in favour of having a policy or guideline which will help to counsel parents or families who go through perinatal grief. The document should be recognized and approved by the Ministry of Health and available for use by Ghana Health Service, the largest agency and circulated to the various health facilities, across all levels. This will enable health staff especially those who encounter such families to follow through to support them.

> “I think we need a policy guideline so that it will help us in case we get a case, we will be able to follow that protocol and counsel the families so that we have a satisfactory solution” **Source - Maternity In-Charge**

> “so we would need as a service agency like Ghana Health Service to have a policy that guides us and then once we have that policy in place, sometimes I know that coming up with policies take a while, this interview or research you are conducting for instance is one of the ways and bringing out the need for it because you obviously realize that there is a gap so once we’ve identified the gap what do we do? I think that before the policy can even come out there should be some on the job training for midwives and obstetricians that need to offer psychological counseling for the families who undergo such unfortunate situations **Source- Deputy Director Clinical Care**

Respondents also indicated that the majority of the mothers who had experienced loss of a baby go through a lot of psychological challenges. Availability of a policy on how to counsel families who experience perinatal grief empowers health workers to counsel effectively. This, they believe will help reduce the psychological trauma and stigmatization and also help the woman from being suppressed due to traditional customs and cultural beliefs when a woman loses a baby which may eventually lead to suicide. This will instead prepare the women physically and psychologically for their next pregnancy.

> “the reason is that when they deliver and then they lose the babies it has a lot of impact on them. Some of them feel like committing suicide, they feel like losing the babies that’s the end. For losing the baby they will never get anything again so I think that it would have been good that we have a policy and then we always take them through, counsel them while they run into such situations” **Source - Public Health Nurse**

> “yes, it is very necessary because it will relieve the family of the pain and help them to accept the loss that has happened. It is also necessary to do that so that it will prepare the woman psychologically and physically for another opportunity in childbirth. And then it is also necessary because in Ghana here, our cultural values pertaining to perinatal death are considered as something normal and therefore the customary and traditional rites that are performed for the woman who is bereaved is so suppressive. So, if we are to suppress the woman in the grieving process it’s even going to prolong another childbirth and delay another pregnancy and this is not going to auger well for the woman’s health” **Source** – **Deputy Director, Nursing Services**

Category of Staff to be Responsible for Counselling

It came out clearly that all staff who meet the pregnant mother during her pre-and-post stages should be trained on the use of the guidelines or policies. Additionally, some stakeholders such as the Ministry of Health, District Health Managers, Regional Health Managers among others indicated that *midwives* and *medical doctors* should be trained

on the policies and guidelines to counsel families who experience perinatal grief. These, they said, are the staff who often meet the pregnant women especially during labour and after delivery. The other category of staff who were also suggested to be trained on how to follow through the policy or guidelines are the *intensive care unit staff, the Nutrition staff, Psychiatric Nurses, Public Health Nurses* and the *Community Health Nurses and Psychologists*.

> "the first group of people are the doctors who come into contact, who conduct difficult deliveries, most of perinatal deaths are because of difficult deliveries which are usually conducted by doctors either emergency, caesarean section through either assisted by vaginal deliveries so we have to target the doctors, we need to target the midwives, the midwives are the front liners. In fact, from experience it's the midwives who disclose the birth outcome to the mothers, so they should be major stakeholders, because the doctor will deliver and then start running around doing other things and then it will be left with the midwives, so the midwives and the ICU staff. **Source - Deputy Director Clinical Care**

Need to Support Families Experiencing Perinatal Grief

Respondents were of the view that it is important for families who experience perinatal grief to be supported. This they attributed to the fact that a number of these families, especially the mother who lost her baby goes through emotional and psychological phases, such as being traumatized, depressed, stressed, among others. There is also the need to support these families to prepare them against any social or cultural means by which they will feel suppressed. Some indicated that once other members of the family are supported through counselling it aids the healing process especially for the mother.

> "oh definitely, every woman would want to have a good outcome in terms of pregnancy. Should you end up having a perinatal mortality it has a huge impact psychologically on the individual and on the entire family and some people never recover to be able to even move on with their lives. Sometimes, it even leads to divorce depending on the situation surrounding the mortality so definitely people need the support. The essential part is the traumatic effect, so once you've gone through a traumatic time then you need post traumatic support to get through that face**." Source - Regional Health Directorate**

Institutions

Curriculum to Train Health Workers on Perinatal Mortality

Training institutions did not have a curriculum for training health workers on providing psychological support for families experiencing perinatal mortality. However, as part of the training for health workers in these institutions, they are taken through neonatal care which has some guidelines embedded on how to console families who are grieved due to loss of their babies.

"no, we don't, aside the curriculum nothing is well spelt out in that curriculum, even though in the course of the teaching we ask questions and we give them guide as to how to counsel but we don't have anything explicitly spelt out in the curriculum, so the answer is no, we don't have anything in our curriculum for supporting those who lose their babies" **Source – Ghana College of Physicians and Surgeons**

Most respondents indicated that there was really no need for a separate curriculum but instead a module on counselling families who experience perinatal grief can be included in the existing curriculum.

"It's important, because we have the basic training on grieving when they were doing their basic nursing, that is the general nursing period, they have a knowledge on it already so well it can be placed under the clinical care, it can be spelt out so that we can treat it as a separate topic but not in as a full curriculum on its own because they do grieve and the process of grieving when they are in the nursing training school, ours is the post basic school". Source - **Tutor, Training School**

Suggestions for Improvement (Health Staff)

Respondents from the health facilities and stakeholders recommended that there is the need to have a policy, train and equip healthcare staff at all levels to ensure that families experiencing perinatal grief are provided with effective counselling. Training should include how to counsel the families involved, follow them up to ensure that they have overcome the psychological trauma.

"I think that 1, there should be a clear policy coming from the top, 2, once there is a policy there should be training to implement that policy and once the policy is being implemented people should be supported to be able to follow whatever they have been trained for, and the system should be decentralized so that you can have access to it whether you delivered at the CHPS or you deliver at the hospital. There should be counselors across, there should also be something like the hope restoration center or specific clinics that the people can go to not only phone calls, but the people can go to and they can be monitored over time". **Source - Regional Health Directorate**

As part of efforts to ensure that mothers who go through perinatal grief are not suppressed by society, there is the need for education on perinatal mortality to religious leaders, traditional leaders, authorities, and communities who suppress these women with customary rites.

"well, my recommendation is that we shouldn't tackle the bereaved family alone, but we should look at the religious authorities who are suppressing these women with their customary rites, we need to educate them, to let them understand that the grieving process is a normal thing that goes on when a person is in sorrow, it's necessary. We need to also

tackle the religious, that is the traditional authorities. We need to let them understand the need to let the family go through the grieving process to also help the system." **Source - Midwife**

Psychological support is one of the ways through which these victims can be helped. A respondent suggested that it should start as a form of education from the time the woman is pregnant till she delivers. It was also recommended that women who go through perinatal grief should be supported to go through preconception counselling for subsequent pregnancies.

"The loss of a newborn baby is very traumatic, so we have to find a very acceptable approach, both culturally and professionally, to disclose the unfavourable outcomes to mothers and their families. We need to counsel them within the facility. Sometimes when you meet them at the facility even 2, 3 or 4 years after losing a baby in that manner, they are still even scared to carry a pregnancy. A lot of them have the feeling that once it happens it's likely going to happen again so it heightens their anxiety, anxiety will worsen the course of the pregnancy that can bring in another complication, so immediate counseling follow ups, pre-conception counseling into the subsequent pregnancy and throughout all the other pregnancies." **Source - Deputy Director, Clinical Care**

To deal with the psychological issues that these women and families go through some respondents proposed that there is the need to recruit professional counsellors who will support the health staff in dealing with perinatal grief.

"I think within the Ghana Health Service, we don't have Professionals so maybe instead of just looking at health personnel who may be given additional skills to do counseling because of the fact that they will be combining clinical duties with counseling it might not be effective, so as a service we should look at how we can recruit professional counselors, even if we cannot get them for all the hospitals but at least at the regional level. We know that this is a professional counselor who has been given enough training to support people who are going through such experience and then they in turn can also train maybe the nurses or the clinicians so that they are in the position to support if the numbers are many." **Source-Deputy Director, Public Health**

Suggestions/Recommendations (Bereaved Families)

The study reveals that most health facilities lack a department that is responsible for counseling the bereaved mother. However, these mothers are consoled by the nurses who are usually present at the time of delivery, hence there is the need to have such a department within the health facility.

I think it's very necessary to have a department like that at the health facility so that they can support, help and advice because when it happens like that you can even fall sick and

> any other thing can happen to you. There are situations where other women are there, they don't have any support, they don't have any other family member apart from themselves and their husbands, **Source, Bereaved Mother**

Mothers were therefore of the view that psychological support in the form of counselling and follow-up after they have returned home from the facility is very important and should be supported by the government financially. They believe that it is important because going through perinatal grief can affect the health of the mother involved and the counseling will contribute to the recovery process.

> "The government should be able to take details of the families experiencing such that is their name, location, telephone number among others because the medical team would have to come with a car, and they would need fuel so the government should allocate monies for such so that they can visit from time to time to check on us. Because it will be very encouraging for a nurse to come visit you after coming back from the hospital." **Source, Bereaved mother**

Timely education and sensitization of mothers on pregnancy and childbirth is one of the ways respondents believed could help reduce the incidence of perinatal deaths.

> "I would recommend that there should be much education and sensitization on pregnancy and childbirth because I wasn't familiar with such things and had little knowledge on such. I didn't even notice the baby wasn't breathing anymore hence I didn't act fast. They should educate us more on the foods we eat, medicines we take and even how to take these medicines, especially with the breathing of the baby, you should know when your baby is breathing and kicking." **Source, Bereaved mother**

Discussion

Perinatal deaths are devastating to families across the world. The failure by countries to set up standards and protocols to help in the handling of families who experience these deaths can be devastating and may lead to a recurrence of the events and prolong morbidity in bereaved families. These study findings reveal that the Ghana Health Service, the largest agency of the Ministry of Health does not have protocols, written guidelines nor written policy regarding the necessary protocols to initiate at the facility in the event of a mother losing a child. Therefore, counselling of clients who experience perinatal mortality by Healthcare Workers (HCW) was based on either knowledge acquired from the general guidelines available at the facility or training that were received during pre-service studies in the nursing school. A study on perinatal audit in low-and high-income countries points to the nonavailability of many countries having their own national guidelines which allows clinical staff to adapt guidelines from abroad to manage their cases (Drife, 2006). This Drife, pointed out, has clinical implications since these protocols do not consider problems they have to cope with. The

authors suggest the need for these countries to dispassionately discuss by involving all the appropriate disciplines and come up with local protocols (Drife, 2006).

The study found the need for all staff who meet a pregnant woman during her pre-and-post-delivery stages to be trained on the use of available guidelines or policies. M*idwives* and the M*edical Doctors* are the immediate category of staff who should be trained on the policies and guidelines. Nurses and Midwives need to carry out perinatal bereavement care and this should be part of their regular practice (Van Aerde et al., 2001).

Respondents indicated the need for bereaved families who experience perinatal grief to be supported either psychologically, socially, or both. This they attributed to the fact that a number of these families, especially the mother who lost her baby goes through emotional and psychological phases, such as being traumatized, depressed and stressed. An empathetic, caring environment that aids bereaved families to accept the realities of death are part of standard perinatal care and support (Aerde et al., 2001). “Bereaved parents never forget the understanding, respect and genuine warmth they received from caregivers, which can become as lasting and important as any other memories of their lost pregnancy or their baby’s brief life” (Leon, 1992). It was further established that mothers who experience perinatal grief receive psychological support through words of encouragement and visits from family members, friends and religious heads. It has been established elsewhere that the death of an infant is a profound loss and therefore important to acknowledge families the need to grieve their loss (Aerde et al., 2001). There is a significant difference between mother’s and father’s reaction to a perinatal death with mothers experiencing a stronger and more prolonged grief (DYREGROV, 1990). An integrated effort by health care providers was recommended to help develop systematic ways of aiding families to cope (DYREGROV, 1990).

The need for training institutions to have a curriculum for training health workers on providing psychological support for families experiencing perinatal mortality is long overdue. Stakeholders recommended to have in place a policy and to train and equip health staff to care for families experiencing perinatal mortality (Fai and Arthur, 2009 (Perinatal Society of Australia and New Zealand [PSANZ], 2019)). Nursing educators need to include in their curricula, perinatal bereavement care which should be re-inforced by staff development workshops in the hospitals (Moon Fai & Gordon Arthur, 2009). All community health practitioners who support bereaved families should be given basic and post-basic in-service training that will equip them to offer adequate care to the families (Kohner & Henley, 1990). The need for education on perinatal mortality to religious leaders, traditional leaders, authorities, and communities came out strongly in this research. Language and cultural barriers influence nurses’ involvement in taking care of the bereaved (Engler et al., 2004).

To deal with the psychological issues that these women and families go through some respondents proposed having professional counsellors or training health care workers on how to handle or relate to the bereaved families. These findings are in accord with what has been established by Cacciatore (2013) that referrals should be made to counsellors specifically trained to handle perinatal deaths. This Cacciatore (2013)

believes will be very helpful for individuals, dyadic partnership, and surviving children. An early counselling program will be more beneficial because it allows the bereaved to express their emotions and retell stories of loss. Providers' ability to form bonds of compassionate solidarity with clients is also helpful (Coulehan, 2009).

Families who experience perinatal deaths, were either pained or hurt by the incident. Perinatal loss is generally viewed as the most painful form of bereavement due to its unexpected nature which is often sudden and sometimes unexplained (Chambers & Chan, 2000). With the death of a baby, most parents feel that they have lost an entire future (Aerde et al., 2001). Others grieve for the loss of their own parenthood (Ryan et al., 1997). Perinatal death represents multiple losses to parents which includes loss of a significant person, loss of some aspect of self, stage of life, a dream and creation (Kowalski, 1987). In comparison with other types of bereavement, parental grieving can be very intense and complicated and can take long with unparalleled symptoms of fluctuation over a period (Rando, 1986, 1993). There is a certain level of parent-child relationship which observably is the closest and most intense that life can generate (Rando, 2013). This type of relationship calls for a different type of disengagement after death because what has been lost is very much a part of the parent (Rando, 2013).

Majority of the mothers who experience loss of a baby go through a lot of psychological challenges. With the availability of standard protocols on how to counsel bereaved families, health workers will be well positioned to counsel this group of people. This will be very much helpful because long-term effect of perinatal death has been linked to depression, anxiety, obsessive-compulsive behaviors, suicide, substance use and post-traumatic stress (Barr & Cacciatore, 2008; De Frain et al., 1991; Cacciatore et al., 2008, Condon & Hutti, 1986).

Bereaved families attributed the loss of their babies mostly to negligence on the part of the health workers. Some blamed themselves for not taking the necessary actions at the time their immediate attention was required. Health care workers care and support before and during perinatal deaths is a very crucial effect on the family's response to the death (Engler & Lasker, 2000; Rowa-Dewar, 2002). Nurses typically receive no or little education on how to deal with the death of an infant for bereaved families (White et al., 2001; Engler et al., 2004). There is the need to put educational measures in place to help nurses deal with bereaved families (Rybarik, 1996; Szgalsky, 1989). A study on causes of stillbirth established that more than half of the respondents (bereaved) attributed the death to their negligence while others blamed the primary health care providers (Korde-Nayak et al., 2008).

Conclusion

There is the need to have a policy, train and equip health staff to ensure that families experiencing perinatal grief are provided with effective counselling. Also, Ghana Health Service, should consider training and recruiting professional counsellors who will support the health staff in dealing with perinatal grief. Victims who experience

perinatal deaths, were either pained or hurt by the incidence and therefore should be supported.

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Ethical approval

This study protocol was reviewed and approved by the Ghana Health Service Ethics Review Committee (GHS-ERC 007/12/20). All participants were provided with a written information that contained a summary of the research with an IRB approved consent form for them to sign prior to participating in the study. Participants who could not read had theirs translated into their respective dialects and after which they thumb printed in the presence of a witness prior to their participation in the study. The consent also allowed for retrospective data collection at the various health facilities.

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