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# “The Health Caregivers Did Not Care about Me after the Loss”: Maternal Experiences of Perinatal Loss in the Kumasi Metropolitan Area, Ghana

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## ABSTRACT

One of the common undesirable outcomes of pregnancy is perinatal loss. Healthcare systems strive to reduce the incidence of perinatal loss but typically little attention is on the experiences of bereaved mothers following perinatal loss, particularly in low and middle-income countries where such deaths are common. This research explored the lived experiences of mothers with perinatal loss in the Kumasi metropolis, Ghana. A qualitative design was used to explore the experiences of nine (9) bereaved mothers from the Komfo Anokye Teaching Hospital's postnatal ward and the Mother and Baby Unit. Data were collected through face-to-face interviews using a semi-structured interview guide, audio-recorded, and thematically analyzed. One major finding was that mothers restricted mourning their dead babies based on fear of recurrent perinatal loss and traditional beliefs on delayed return to fertility. Mothers blamed healthcare providers for their loss due to their concerns about care received. Gaps in communication flow from healthcare professionals to bereaved mothers were commonly identified as mothers struggled to make meaning of their loss and coped with cultural restrictions and beliefs. Healthcare professionals must explore mothers' concerns and "gut-feelings," and pay attention to their communication needs following perinatal loss.

## KEYWORDS

Bereaved mothers;  
intrauterine fetal death;  
maternal experiences;  
perinatal loss

## Introduction

Pregnancy for most women signifies a lifetime gratification of attaining womanhood and for some who are unable to realize this dream, there are feelings of despair, anguish, emotional trauma, and recurrent fear.

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Women go through stages of pregnancy with practical and psychological preparations to welcome their babies into their new world (Thomadaki, 2012). However, mortality sometimes occur leaving negative implications on the women, parents, and families (Flenady et al., 2014). Measures to provide optimal healthcare and survival during intra-uterine life and following birth is very crucial to the prevention of perinatal deaths (WHO & JHPIEGO, 2015). Perinatal death or loss is a fetal death within 28 weeks of gestation or more, and infant deaths occurring at <7 days postpartum (WHO, 2015). Barfield (2016) however, argues that due to differences in the perception of gestational age at which a fetus is viable, no universally accepted definition of what constitutes a perinatal loss or fetal death exists. This difference in the definition of perinatal loss, he posits, is further affected by the variation in clinical expertise and medical technology among nations (Barfield, 2016).

Newborn deaths account for 45% of deaths in children under five globally (Maternal and Child Survival Program, 2017) with a total number of 2.9 million of newborns dying every year worldwide (Lawn et al., 2014). In Ghana, neonatal mortality rate accounted for 23.1 deaths per 1000 live births in 2019 (UNICEF, n.d.), and stillbirth rate of 23 per 1000 total births in 2017 (Healthy Newborn Network, 2021). These figures show stagnation in the reduction of perinatal deaths in Ghana.

Perinatal loss remains a source of emotional instability as mothers try to adjust to the loss within that painful reality with feelings of life being meaningless (Leonard, Bower, Peterson, & Leonard, 2000) which ignites the grieving process (Mughal, Azhar, & Siddiqui, 2022). In the acute grief phase, support needs to be sustained to help the affected person cope and re-integrate into daily life (Fenstermacher & Hupcey, 2013). In cases where the period of grief extends beyond six months, functional impairment and complicated grief become imminent (Kersting & Birgit, 2012). Perinatal loss has been documented by Koopmans, Wilson, Cacciatore, and Flenady (2013) to have a higher risk of progression to complicated grief. In a study by Kersting et al. (2007), among 62 women experiencing perinatal loss, 14% of the respondents were shown to have complicated grief and 17% manifested psychiatric disorders. Similarly, Korenromp, Page-Christiaens, van den Bout, Mulder, and Visser (2009) establish that among 147 women, 20% had symptoms of pathological stress over one year after experiencing loss.

In Ghana, several barriers impact quality delivery of prenatal care. Lack of professional care at birth, inadequate resources such ultrasound machines and sonographers, finance and geographical access issues to care (Lawn et al., 2014; Maternal and Child Survival Program, 2017; Phelan, 2008). For instance, in view of limited number of sonographers and the

limited availability of ultrasound machines, most pregnant mothers do their ultrasound scan in diagnostic imaging centers outside the health facility. Secondly, most healthcare facilities operate a paper-based system where all requested laboratory and imaging investigations have to be taken to the imaging center by the patient and the results delivered by the patient to the doctor after the investigation.

Within Ghanaian cultural context, mothers are forbidden to cry out following perinatal loss. Women usually weep secretly and confide in close relations who usually console them using religious healing approaches. Research evidence establishes an increased risk of psychological and psychiatric disorders among mothers following perinatal loss. This is especially important to understand in the Ghanaian context where a holistic approach to helping mothers cope following perinatal loss is non-existent and socio-cultural factors may restrain some mothers from sharing their experiences related to the loss with healthcare providers. This study, therefore, was designed to explore the experiences of mothers who have experienced perinatal loss, to unveil the gaps in care provider roles toward optimal respectful maternal care following perinatal loss.

## **Methods**

### ***Study design***

In this qualitative research, an exploratory-descriptive design and a hermeneutic phenomenology were used. An exploratory descriptive research design allowed for a purposive sampling procedure and accessed participants who have experienced perinatal loss by exploring and defining the nature of the problem (Manerikar & Manerikar, 2014). A hermeneutic phenomenology enabled an in-depth study of the lived experiences of participants in the context of their lifeworld as well as offered researchers the opportunity to make interpretations from their perspective (Neubauer, Witkop, & Varpio, 2019). This qualitative inquiry offered participants opportunities to share their stories.

### ***Study setting and population***

The study was conducted among mothers who had suffered perinatal loss within the Kumasi Metropolis and the sample was taken from The Komfo Anokye Teaching Hospital. The Kumasi Metropolis is populated by the Asantes (80.7%), (sub-group of the larger Akan ethnic group), the Mole Dagbon (8.7%), and the Ewe (3.6%) (Ghana Statistical Service, 2014). The Komfo Anokye Teaching Hospital was built in 1954 and it is affiliated with the School of Medical Sciences (SMS) of the Kwame Nkrumah University

of Science and Technology (KNUST). The hospital currently has a bed capacity of 1000 with an annual hospital census of about 679,050 covering both in and out-patients.

The study sample included a purposive sample of mothers who had suffered perinatal loss within 6 months at the Obstetrics & Gynecology ward and Mother and Baby Unit of the Komfo Anokye Teaching Hospital. The hospital chart records of women who had been seen at the Mother & Baby Unit and the Obstetrics and Gynecology ward from January 2018 to June 2018 were screened. Those who had lost their babies *in-utero* after 28 weeks of gestation or within the first 7 days after birth were identified. Twelve (12) women were identified for potential recruitment by the researcher as they fell within the inclusion criteria. Nine (9) of the women were on admission and three (3) at home. The study purpose was explained by the researcher in-person for those on admission and on phone for those who had been discharged home. They were assured that their identity would be kept confidential and no identifiable information would be included in the write-up of their responses. They were also assured that they had the right to decline and that was not going to negatively affect the quality of care they received that at the hospital in any way. Of the twelve women, nine (seven in the hospital and two at home) agreed to voluntarily participate in the study.

Eligibility requirements included: women who experienced perinatal loss during the time of conducting research, either on admission at the obstetric and gynecological unit as well as mothers who had lost their babies at the Neonatal Intensive Care Unit up to six (6) months after loss; women who lived outside the Kumasi metropolis, had lost their pregnancies before 20 weeks gestation, pregnant women, as well as those who had experienced a loss more than six (6) months before the study, were not eligible for this current study.

### **Data collection**

A semi-structured interview guide was used to conduct face-to-face interviews from June 2018 to October 2018 with mothers who have suffered perinatal loss. Sample questions asked during the interviews were: could you share with me the circumstances of the loss of your baby; how did you feel about the news of your baby's death. Each interview session lasted between 30 min and 1 h in the Akan language and transcribed in English with acknowledgment and careful consideration of phrases that do not have direct translation into English. It is important to note that the researchers are natives of this local language and have full command over the language and its transcription processes. Participants were asked their

preference for location of the interview. Seven (7) participants chose to be interviewed in the hospital at their preferred places of communication outside the ward and two (2) women preferred to be interviewed in their homes.

### ***Data analysis***

The in-depth interviews were audio-recorded and manually transcribed verbatim into English language. Data were thematically analyzed in a descriptive manner by thoroughly reading the transcripts to identify concepts, coding, and grouping similar categories to generate themes using inductive approach (Vaismoradi et al., 2016) to offer insights into participants' experiences (Polit & Beck, 2012). Non-verbal expressions were noted in a reflective journal during the interviews and the information integrated into the women's narratives of experiencing perinatal loss. Participants were given pseudonyms which started with "EPL" an abbreviation derived from study title, then followed by the number in which they took turns for the interviews. Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability were used to ensure methodological rigor in the study (Nowell, Norris, White, & Moules, 2017). Supervisors and colleagues engaged in consistent and extensive review of the data with the researcher to ensure the dependability of study findings. To ensure the credibility of study findings, research findings as well as verbatim transcribed data from interviews were sent back to respondents and explained to them in their language of choice for their comments. Interview guide was extensively reviewed by supervisor, and participants were allowed to review conclusions drawn, to ensure the confirmability of findings. Transferability of study findings was increased by selecting participants from various wards till saturation was obtained.

### ***Ethics statement***

Ethical approval was granted by the Committee on Human Research, Publication and Ethics of the Kwame Nkrumah University of Science and Technology, Kumasi (Approval ID -CHRPE/361/18), and the Komfo Anokye Teaching Hospital (RD/CR18/153). The research committee of the Ghana College of Nurses and Midwives gave administrative approval for the study. Participants were guided to sign the informed consent forms after thorough explanations about the study were given to the women, and with anonymity and confidentiality were ensured. The prior discussion was held with a clinical psychologist at KATH and a counselor to engage them if any of the participants required their service.

## Findings

### *Participant characteristics*

The sample population consisted of nine women between the ages of 19 and 41 years. Eight (8) respondents were Christian and one (1) was a Muslim. Five (5) of the respondents were married and the other four (4) were not married but were co-habiting with their partners. All respondents had some formal education ranging from primary level to the tertiary level. Three (3) were unemployed, three (3) employed full-time in the public sector, and the remaining three (3) self-employed. Table 1 illustrates these demographic characteristics of study participants.

Three main themes and ten subthemes emerged from the study findings. The main themes were maternal experience of loss, maternal reaction to loss of baby, and poor communication and counseling. That is, the lived experiences describe by mothers in this study related to how mothers felt when they experienced the loss of their baby, how they reacted to the news of the loss of their baby, and their perspective of the quality of communication health care professionals had with them, respectively. Sub-themes included beliefs about perinatal loss, emotions seeing the baby dead, inadequate emergency care, impolite and neglectful care, maternal perceived cause of loss, maternal self-blame and healthcare provider blame (Table 2).

**Table 1.** Participants' profile.

No.	Age	Sex	Marital status	Occupation	Ethnicity	Religion	Educational background
1	33	F	Married	Unemployed	Ashanti	Christian	Tertiary
2	28	F	Not married	Unemployed	Ashanti	Christian	SHS
3	32	F	Not Married	Trader	Ashanti	Christian	Tertiary
4	25	F	Not married	Hairdresser	Bono	Christian	JHS
5	19	F	Not married	Unemployed	Ashanti	Christian	SHS
6	41	F	Married	Trader	Gonja	Muslim	SHS
7	38	F	Married	Pharmacy technician	Ashanti	Christian	Tertiary
8	31	F	Married	Nurse	Ashanti	Christian	Tertiary
9	29	F	Married	Teacher	Ashanti	Christian	Tertiary

**Table 2.** Themes and sub-themes.

Main themes	Sub themes
1. Maternal experience of loss	a. Recall and awareness of loss b. Beliefs attached to perinatal loss c. Seeing the dead baby d. Inadequate emergency care e. Impolite and neglectful care f. Triggers
2. Poor communication and counseling	a. Medical cause of loss b. Maternal perceived cause of loss.
3. Maternal reaction to loss of baby	a. Hurtful emotional response b. Maternal self-blame c. Healthcare provider/staff blame

### **Maternal experience of loss**

Mothers related how they felt in the period their baby died by recollecting the events that had led them to think the baby was not well, healthcare professionals showing them their baby after its death, and their perspective of the quality of care they received that may have contributed to death.

### **Recall and awareness of loss**

All participants could recall the events leading to the loss irrespective of the duration since the death. The period of loss ranged from 2 to 46 days. Most mothers were aware of the danger sign of possible loss of baby and reported to the hospital to confirm their suspicion when they realized the baby was not kicking. A 33-year-old mother said:

*Normally, my baby kicks a lot in the evenings and I had normal kicks all of Saturday but it was Sunday evening that I didn't feel my baby move. So on Monday morning, I called the doctor that I didn't hear my baby move the whole of Sunday evening. He then asked me to go for a scan. So when I brought the scan back to him he told me that the baby had died in my womb so they had to operate on me and remove her.*

Another mother, a 29-year-old said:

*I was going to the hospital I put my hand on my stomach which was a routine for me to feel my baby move but this time, I didn't feel the baby move to the other side. So I asked the midwife to check whether the baby was ok and she told me the baby was ok. But I told her to call the senior nurse to come and check me so when she came and checked, she asked me to go for the scan which revealed it [death of fetus].*

However, in the case of a 19-year-old mother with twin gestation, she did not realize the loss of one child until abdominal ultrasound had been done. She said:

*I went there for an ultrasound scan during my usual visits in my last trimester and the sonographer wrote one dead, one alive on the report after scanning me for more than 3 times that day. Since I knew I was already carrying twins, I knew I had lost one from that report he wrote.*

### **Seeing the dead baby**

All mothers confirmed that they were shown their babies at birth for identification of sex and confirmation of death as per hospital protocol, except one who opted not to see the baby because she felt she did not have the courage to. A 28-year-old mother said:

*I was admitted at the labor ward where I delivered and the baby was shown to me at delivery and she was dead indeed!*

The 19-year-old mother who had a surviving second twin narrated:

*My baby was shown to me in theater [Operating room] for identification and confirmation of death; he was very little as compared to the live one and had all his skin gone like someone who has burns.*

One 31-year-old mother, however, spent a few hours with her dead child following delivery. She recounted:

*They showed the baby to me after delivery, and upon request I had the opportunity to spend about 30 minutes with him till they took him away so they could manage my PPH [postpartum hemorrhage] effectively.*

### **Inadequate emergency care**

Mothers complained that healthcare professionals paid no attention to their opinions and requests, contributing to the death of their child. A 25-year-old mother said:

*I came from Dominase SDA hospital with a referral for emergency C/S. When we got here, I told the doctor I met that they should operate on me but he said I should be patient, but I kept insisting which all turned into deaf ears. So when I was due for review, another doctor came to see me and he ordered that they should check my baby's breathing. From the look of things, I sensed that all was not well so when they checked it, they asked if I was feeling my baby's movement, but I told them I wasn't feeling it any longer. (EPL-004)*

Another mother, a 29-year-old, also related:

*A week before my due date I went for usual checkup, and they said my baby was not breathing so I should go for a scan which confirmed that the baby was no more (dead) on Thursday. I went to see the doctor with the scan and he said I should go home and come back on the following week Tuesday because of the Easter holidays for him to operate me but I told him I couldn't wait for that long so I insisted to be referred to KATH [Komfo Anokye Teaching Hospital] to seek prompt management there.*

### **Neglectful care**

Mothers felt healthcare professionals neglected their physical pain concerns and psychological needs after learning their child had died. A 33-year-old mother of one child said:

*It was like health caregivers did not care about me after the loss. Most nurses didn't know what to tell me because they didn't even know what I was going through. No healthcare provider has talked to me about anything though I have been discharged. All that my doctor came to tell me was to make arrangements to visit the family planning unit for a method in order to prevent myself from getting pregnant now because the same thing might happen to me again. He just didn't say anything to console me, all that he was interested in was the family planning method and me seeing a dietician. That's all he had for me during discharge and then he left me.*

Another mother, a 39-year-old, also said nurses saw her as an attention seeker, hence being neglected to bear all the pain that she was going through at that stage alone. She recounted thus:

*When I was on admission and had not delivered, I thought nobody was minding me because the way I was in pain they all thought I was exaggerating issues and took my compliant like a normal laboring woman seeking for attention. I don't know if the staff who were on duty were not aware of my condition (abruption placenta) because even some doctors were not willing to come to aid when I requested for measures to ease my pain a bit. I don't know whether it was because the baby was already dead or not that was why they just ignored me.*

### **Triggers**

The sight and cry of other babies and repeated questioning from midwives about the whereabouts of the child reminded participants of their loss. A 33-year-old mother observed:

*I haven't had sleep since the day I was operated on because anytime I want to sleep, the cry of other babies startle me like it's my baby's cry. The sight of these babies alone makes me very sad, because we were nursed together in the same postnatal ward. Nurses who should know about your condition, just walk by and ask "where is your baby?" just like that, and having the courage to respond to that question over and over again was very difficult to deal with.*

Another mother, a 31-year-old, who had a stillbirth said:

*I cried in the hospital whenever I heard other babies cry and their mothers not paying any attention to them.*

### **Poor communication on cause of baby's death**

Participants in this study were not informed of the medical cause of loss but indicated that they felt the cause of death of the child was related to the presence of a co-morbid condition, sexual intercourse, or spiritual cause.

### **Medical cause of death of baby**

Mothers were not informed about possible underlying causes of their child's death and how to care for themselves at home and to reduce the risk of perinatal loss in future pregnancies. A 29-year-old mother remarked:

*The doctors and nurses couldn't tell me anything even though I wanted to know what caused the baby to die in my womb.*

Another mother, a 19-year-old, similarly said:

*I was not told exactly what killed my baby; my mother even wants to ask the doctors why the other one had to die since none of us have been informed by anybody. (EPL-005)*

### **Maternal perceived cause of loss**

Some mothers believed that their preexisting medical conditions they suffered, such as hypertension, diabetes, anemia, and epilepsy might have contributed to the loss. Others also thought spiritual factors and not having sexual intercourse throughout pregnancy were responsible for loss of their child. A 25-year-old mother said:

*I never had any sexual relations from the time I missed my period till delivery so my cervix wasn't dilating as it is supposed to be. I believe that also contributed to the death of the baby because his head kept long in my lower abdomen and pelvic floor for too long before I could finally deliver.*

Another mother, a 19-year-old, said:

*I believe that what has happened to me had already happened spiritually because a day prior to my delivery, my mother said she dreamt that we were in a forest where I was holding a basket and picked up one snail from the ground; I told her to wait for me try and look for another one but I searched and searched but I couldn't find it so I left with just one snail in my hand. The dream represented that I picked one baby and left the other baby because I couldn't find it.*

### **Mothers' reaction to loss**

Mothers reacted to the loss of their babies through the expression of emotions, blaming of one-self, and blaming of healthcare providers.

#### **Emotional response**

Mothers exhibited diverse emotional responses to the news of loss of their babies and expressed feeling hurt, sad, angry, upset, sorrowful, and in pain. The 19-year-old mother who had a twin gestation said:

*When they told me that one of my babies had died in my womb, I cried and still cry anytime I remember it spontaneously. (EPL-005)*

Other mothers also recounted:

*Even sitting down with the 'thing' in my womb after being told that she was dead was difficult for me. I was very upset with everyone and I just didn't want to talk to anybody nor see anybody. The one I wanted to talk to was my husband. (33-year-old mother).*

*Initially, I was hurting but now I am ok. I cried for some time after delivery for a long time but now I have stopped. (28-year-old mother)*

#### **Maternal self-blame about loss**

Mothers felt partly responsible for the death of their children and thought they could have done something better to keep their babies alive. In a regretful tone, 38-year-old mother uttered:

*I believe that if I had not stopped taking the medication for my high BP, this could not have happened. And if I had reported to the hospital earlier on Saturday when I didn't*

*feel the baby move after eating, something could have been done to save the baby. The doctor who saw me on Monday even said the same thing that I should have reported earlier.*

A 31-year-old mother of 3 children who had a previous history of a perinatal loss at 24 weeks also said:

*If I had done something earlier, I wouldn't have had a stillbirth. When the pains started, I thought it was labor that was why I stayed at home to ensure that I had advanced before reporting to this hospital. If I had not delayed, the problem of placenta separation could have been identified earlier for my baby to be saved.*

In a regretful tone, a 33-year-old mother uttered:

*I believe that if the doctor had educated me earlier that baby could survive after delivery by operation [caesarian section], and that a high blood sugar level could affect its survival, I would have insisted on operation [caesarian section] would not have gone home that very day when I was told my baby weighed 4kg.*

### **Healthcare providers blame**

Mothers thought healthcare professionals were also partly to blame for the loss of the child. A 29 year old mother said:

*With my first baby I had a C/S so when I was about 36 weeks, I went to the doctor that I wanted to do the C/S [caesarian section] but he told me that my scan and everything showed that my baby is healthy and my previous operation is 2 years and the fact that my first delivery was C/S wasn't an indication to have another one ... That one pains me because if they had allowed me to deliver then, I would have had my baby alive but the doctor told me to wait.*

A 33-year-old mother also expressed her sentiment:

*The doctor said that according to the scan I had presented, my baby weighed 4.00kg so I cannot have a normal delivery but rather a cesarean section. I then suggested to him that in that case since my baby weighed 4kg, he was already grown and big so he should go ahead and section me right away. But he said no I should wait for another week even though I was 36 wks plus 6 days pregnant. But my baby couldn't last that long.*

## **Discussion**

### **Maternal experiences of perinatal loss**

All participants had an immediate recall of their loss with the longest time since loss being 46 days before the day of interview while the shortest was 2 days. Most mothers suspected possible loss of their baby when they had not felt their baby move or kick for some time. This revealed that mothers were in constant bond and communication with the unborn child. This finding confirmed those from another qualitative study by Trulsson and

Radestad (2004) who explored the experiences of 15 bereaved mothers before, during, and after stillbirth and reported that women intuitively felt something not right even before they were diagnosed with intrauterine fetal death.

In a study in Northern Ireland, healthcare professionals were described as being insensitive to the emotions of mothers hospitalized for labor and neglected appropriate care of infants following stillbirth (McCreight, 2008). Modiba and Nolte (2007) and Thomadaki (2012) also found that it took several days to schedule a surgery after an intrauterine fetal death. The current study similarly found that mothers felt they were cared for with no sense of urgency, request for assistance or care was not listened to and delivery of the baby following intrauterine fetal death was postponed to a later day.

In this study, bereaved mothers highlighted the cry of other infants as a trigger for remembering their loss and heightening their grief while admitted to the postnatal ward. Cacciatore and Bushfield (2007) and Tsartsara and Johnson (2002) similarly found in their studies among mothers who had experienced stillbirth that feelings of upset and discomfort heightened or worsened when bereaved mothers were staying in the same ward with those who had live babies.

Grieving is a normal reaction that helps cope with an actual or anticipated loss. The grieving process is affected by an individual's culture, and this may either promote coping or cause grief to be prolonged. In this study, mothers were discouraged by some family members, friends, and healthcare professionals from mourning after perinatal loss as it was believed to increase the risk of recurrence and infertility. Meyer, Opoku, and Gold (2018) also highlighted the belief that grieving after perinatal loss is seen in the Ghanaian culture and some other cultures to cause a bad omen or infertility.

Participants had the opportunity to see their dead babies after delivery and to spend time with them according to their wishes or requests. An Australian survey on the experiences of families following perinatal loss found that allowing time with their baby and mementos for parents helped mothers come to terms with their loss and cope better (Phillips et al., 2018).

### **Communication**

Following perinatal loss, mothers in this study expressed feeling the need to make meaning of their loss. They, therefore, wanted healthcare professionals to help them understand the cause of death of their baby to prevent future recurrence, to discuss some of their views for clarification, and for

healthcare professionals to have some time with them to listen to their concerns and offer words of encouragement to support them. However, these wishes were not realized. The desire for effective communication with healthcare professionals to find meaning for their loss has also been expressed by bereaved mothers in studies by Krueger (2006), Trulsson and Radestad (2004), and Willick (2006).

The gap created by the lack of effective communication between healthcare professionals and patients is widely documented in the Ghanaian literature (Adekunle & Mohammed, 2022; Ansah & Klugah, 2021; Peprah et al., 2020). Due to health information literacy gaps, bereaved mothers attributed perinatal loss to supernatural factors and lack of sex throughout pregnancy. This finding is consistent with studies by Neimeyer, Burke, Mackay, and van Dyke Stringer (2010) and Ugwumadu (2015) which similarly found that stillbirths are commonly attributed to supernatural causes and certain beliefs to make meaning of their loss.

### ***Mothers' reaction to loss of baby***

Kelly and Trinidad (2012) and Worden (2008) have reported from their studies that bereaved mothers feel emotional pain, sadness, and cry during the grieving period. Similarly, mothers in the current study were upset, hurt, felt sad and angry, and cried on account of the loss of their baby. Participants in this study apportioned blame for their loss partly to themselves because they felt they could have acted faster when they experienced danger signs of possible loss of their child, and partly to healthcare professionals because they did not listen to some requests to deliver the child earlier. Bangal, Sachdev, and Suryawanshi (2013) and Robinson (2014) have similarly found in their study that bereaved mothers tend to blame themselves, healthcare professionals, and friends for their loss.

In the few days preceding their loss, some mothers felt through intuition there was a problem and that early delivery should take place. However, the physicians did not listen to them. Though the phenomenon of intuition is not clearly understood, it cannot be denied that it plays an important role not only in parental care but also in providing healthcare (Birchey, 2015; Dugout, 2018; Melin-Johansson, Palmqvist, & Ronnberg, 2017; Van den Brink, Holbrechts, Brand, Stolper, & Van Royen, 2019). Healthcare professionals should therefore explore the expectant mothers' intuition, and come to an understanding with mothers the earliest possible time to deliver the baby. As such, if the baby is viable for survival following delivery, it may be that important to consider delivering the child in accordance with the wish of the mother.

## Conclusion

Perinatal loss is an unforeseeable but common experience in the healthcare delivery system despite measures put in place to reduce or prevent it. However, the enormity of this loss to the bereaved mother often goes unrecognized. This study identified areas of improvement in communication between healthcare professionals and bereaved mothers. Mothers were not talked with about the cause of perinatal loss and the fact that certain actions or inactions of theirs was not responsible for the loss of their babies. They, therefore, made meaning of their loss by drawing on their cultural and religious beliefs, and blamed themselves for contributing to the death of their child. Secondly, the apparent neglect of the mothers when their baby *in-utero* had been found dead, conveyed a state of lack of empathy and concern for their loss by healthcare professionals. It is therefore important that healthcare professionals pay special attention to mothers following their loss. The need for healthcare professionals to listen to the concerns of expectant mothers and explore their issues, worries, and anxieties concerning their unborn babies was also highlighted in this study. Lastly, healthcare institutions must explore, through research and meetings with parents who have experienced perinatal loss and psychologists or social workers, the pros and cons of caring for mothers following perinatal loss in the same postnatal ward as those who have had live babies.

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