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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH IN THE EAST
MAMPRUSI DISTRICT

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DEDICATION

This study is dedicated to my wife for her moral support, my two daughters and to all mothers bereaved of stillbirth. I say God bless you all!

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LIST OF ABBREVIATIONS

EMD: East Mamprusi District

FSB: Fresh Stillbirth

GHS: Ghana Health Services

HICs: High Income Countries

LMICs: Lower and Middle Income Countries

MOH: Ministry of Health

MSB: Macerated Stillbirth

SB: Stillbirth

WHO: World Health Organization

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ABSTRACT

Stillbirth (SB) is a global issue; an estimated 2.6 million SB occur in a year. The highest rate of SB is recorded in Africa. Data on the postnatal experiences of mothers who have had SB in Ghana is lacking. The purpose of this study was to explore the postnatal mother's experience of SB in the East Mamprusi District of the Northern region of Ghana. Exploratory descriptive design was adopted for the study. Purposive sampling method was used to recruit fourteen (14) participants who met the inclusion criteria and were willing to participate in the study. Data was collected using interview guide which was pretested. Data was analysed using thematic content analysis guided by Elisabeth Kubler-Ross theoretical framework on grieving. The meaning attributed to SB pose a lot of challenges to women. Grieving mothers adopt coping strategies to overcome the burden of SB. Support from friends, family/neighbours, care providers, religion, community and spouses enable mothers to cope well with the loss. Grieving mothers expect care givers to demonstrate sensitivity and empathy and remain aware that stillbirth experience is distressing and traumatic. Findings of this study will help inform the provision of meaningful and culturally appropriate care for mothers following SB. In conclusion, the current study found that the care rendered to mothers after SB experience does not meet the expectations of mothers especially their psychological needs. Therefore there is the need for care providers to change their attitude, actions, communication and behaviour towards mothers after SB in order to provide competent and holistic care that meet the needs of mothers and families after SB.

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CHAPTER ONE INTRODUCTION

This chapter gives an in-depth description of the background to the study, the problem statement, purpose of the study, study objectives, and significance of the study. Also included in the chapter are the operational definitions of the study and the organization of the study.

1.1. Background of the Study

Losing a child to stillbirth (SB) is very distressing and painful (Bond et al., 2015; Cacciatore, 2012; Connell, Meaney, & Donoghue, 2016; Gerrish et al., 2017). Stillbirth is a period of meaningful loss to mothers (Gravensteen et al., 2013). A stillbirth is said to have occurred when a baby is born at or after 28 weeks of gestation with no signs of life (World Health Organization[WHO], 2016). Stillbirth remain a major public health and developmental challenge globally over the years (Hoope-bender, Stenberg, & Sweeny, 2016; Osman et al., 2017).

In the year 2015, about 2.6 million stillbirths (SBs) occurred globally, meaning more than seven thousand SBs occurred in a day (Cacciatore, 2013; Osman et al., 2017). Ninety eight percent (98%) of all these SBs were recorded in low and middle income countries (LMICs) such as Ghana, Pakistan and Bangladesh (World Health Organization[WHO], 2016). This phenomenon though predominant in LMICs, does not uniformly affect countries. In the year 2015, India reported the highest number of stillbirths (592,100) followed by Nigeria (314,000), Pakistan (243,000), China (122,000), and Bangladesh recording 83,000 (Lawn et al., 2011).

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The rates per anum also vary from about ten percent (10%) in High Income countries (HICs) to fifty nine percent(59%) in LMICs with majority of the deaths occurring in sub-Saharan Africa and Asia (WHO, 2016). Estimated rates of SBs from different surveys in Ghana range from about 14 to 22 per 1000 live births. Rates from Navrongo in the upper East region were 23 per 1000 live births, 32 per live births in Brong Ahafo region to a high of 59 per live births in tertiary health facilities across the country (Afulani, 2016). Stillbirths are prevalent in the Northern Region of Ghana.

With an annual live birth of 64148 in the year 2016, the Region recorded 1239 SBs for the same period. Out of this, EMD recorded ninety (90) SBs placing it third out of 28 districts in the Region with the highest numbers of SBs. Over the past five years, EMD recorded a number of SBs as shown in the Table 1 below(District Health Information Management Systems[DHIMS], 2016).

TABLE 1: Five year trend of SB in EMD

YEAR	LIVE BIRTHS	MACERATED SB	FRESH SB	TOTAL SB	SB RATES (%)
2016	4294	30	60	90	20.96
2015	4890	49	55	104	21.27
2014	5224	50	37	87	16.65
2013	5023	60	54	114	22.70
2012	4246	66	20	86	20.25

Source: (DHIMS, 2016).

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According to WHO, the rate of reduction in the number of stillbirths globally remained around two percent (2%) between the years 2000 to 2015. The WHO has therefore projected that given this rate of reduction, it will take about 160 years before a pregnant woman in Africa will have the probability of her baby born alive as compared to a woman in a high income country (WHO,2016). Stillbirth is a common opposing result of pregnancy with few women if not more being able to endure the circumstances. When a child is born dead, it has significant effects not only on the mother but on both parents and family at large. The effects on the family are usually emotional, psychosocial, spiritual, and biological and impact the psychological wellbeing, particularly the mother. Most often the response to this loss is shock, anger, emptiness, helplessness, and loneliness (Peters,et al., 2015).

However, less consideration is positioned on the baby by society when SB occurs with a matching lack of attention to the bereaved mother (Murphy & Cacciatore, 2017). These bereaved women are with the belief that babies are part of their bodies and hence not paying attention to the loss of a baby influences negatively on the mothers (Ugwumadu, 2015). There has been increasing research evidence in perinatal loss and bereavement in the early 1990s. These lead to awareness creation on the experiences of bereaved mothers. The evidence also unravelled the devastating emotional trauma and its corresponding grief when such losses occur (Peters etal, 2015). Society is said to contribute to the emotional encounters faced by mothers who experience SB. Care providers are often also accused of starting this emotional predicaments during the provision of care (Malm, Rådestad, Erlandsson, & Lindgren, 2011).

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It is reported in the literature that deaths ensuing from SB ranks fifth in the world's death burden leading deaths from diseases like diarrhoea, HIV/AIDS, tuberculosis, road traffic accidents and other forms of deaths related to cancer in all age groups compared (Frøen et al., 2011). With these huge death loads of stillbirth, insignificant responsiveness is given to stillbirth in terms of policy and investment (Lawn et al., 2011). Studies show that mothers who experienced SB wished people would acknowledge their losses and be compassionate with them by listening to them and providing emotional support (Caelli, Downie, & Letendre, 2002; Modiba, & Nolte, 2007). Studies equally show that SB in some communities is not noticeable and with no policy bearing (Frøen et al., 2011; Rajaratnam et al., 2010). Evidence from literature search provides little facts on perinatal loss experience in sub-Saharan Africa and Ghana especially on the experiences of mothers on SB.

It is necessary to gather data in Ghana that will help educate service providers to review their caring styles with emphasis on bereavement support services and its usefulness (Froen et al., 2011). Therefore there is the need to explore and comprehend the experiences of mothers with SB in the sub-Saharan Africa as emphasized in other works (Fottrell et al., 2010). Table one (1) above indicates that SB exist in the EMD. Exploring the experiences of postnatal mothers in the district is therefore necessary. The researcher's years of observation in the maternity unit of the Baptist Medical Centre (BMC), Nalerigu, the District Hospital of the EMD in the Northern Region, with anecdotal evidence at the facility indicate that there is no structured grieving support system following SB and its effects on mothers as well as spouses.

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It is imperative that direct health care providers focus on providing long term support for mothers following SB occurrence.

1.2. Problem Statement

Stillbirth is a traumatic state of affairs for mothers who experience it; more especially to first time expectant mothers. The losses result in emotional problems with mothers finding it difficult to adjust in the period of bereavement. Mothers are often not prepared to face the reality of the loss and the world make no meaning to their very existence (Leonard, Bower, Petterson, & Leonard, 2000). Mothers who have lost their children to SB are often mistakenly diagnosed as suffering from mental illness until help is sought for them through support groups (McCreight, 2008).

Although studies have given insight into women's individual experience to the care and support women received from health care providers following SB (Kelley & Trinidad, 2012), there is paucity of literature with a focus on postnatal mothers experience following SB (Roth, & Cohen, 1986). There are diverse cultures, beliefs and practices in Ghana. These cultures, beliefs and practices can influence the manner in which mothers respond to stillbirth and their expectation of care, yet little data exist on the Ghanaian woman's experience of SB. There is no data on the accounts of individual postnatal mother's experience of SB which will give an insight into the meaning of SB experience and the psychological troubles women go through following SB. Though so many children die during pregnancy and birth, the burden of the death on mothers is not given the needed consideration it deserves in some countries. At the point of any death in pregnancy or birth, respectful and supportive care is important (De Bernis et al., 2016).

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Increased data on the experiences of postnatal mothers with stillbirth can help address issues of supportive psychological, social, and emotional care associated with SB.

Mothers with SB during postnatal care are not emotionally at ease seeing their colleague women with their babies. There are no special clinics for these mothers to be attended to and given special attention. Support groups exist in countries such as United States of America and Northern Ireland to help bereaved mothers and families following SB (McCreight, 2008). However in Ghana, no such a group is known to exist. Some known support groups are also used in the study of SB in Australia (Kelley & Trinidad, 2012). These groups can be replicated in our Ghanaian setting however the lack of empirical data on the experiences of mothers following SB hinder the replication of the support groups hence the need for this study.

Mathew & Kohner (2002) in their correspondence to the Lancet on SB expressed the need for research on SB to focus on the wishes of parents and to also take into consideration the personal experiences of parents before studying the phenomenon of SB. This study therefore focuses on the postnatal mother's experience of SB. The psychological, social and health implications to their well-being in the Ghanaian context was explored and guided by the Elizabeth Kubler Ross (1969) model of grieving.

1.3. Purpose of the Study

The purpose of this study was to explore the experiences of postnatal mothers about stillbirth (SB) within the East Mamprusi District of the Northern Region of Ghana.

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1.4. Objectives of the Study

The objectives of the study were to:

- a. Explore the meaning of stillbirth (SB) related loss to a mother.
- b. Identify the challenges of women with SB.
- c. Describe the coping strategies of women with SB.
- d. Examine the grieving process of women with SB.
- e. Assess the support systems available to women with SB.

1.5. Research Questions

- i. What is the meaning of SB related loss to affected mothers?
- ii. What are the challenges that women with SB face?
- iii. What coping strategies do women with SB related loss adopt?
- iv. What grieving process do women with SB related loss go through?
- v. What support systems exist for women who have experienced SB?

1.6. Significance of the Study

Care given to parents during and after SB impacts significantly on women's psychological wellbeing, therefore care providers can help provide culturally appropriate and meaningful care that meet the needs of mothers (Lisy, Peters, Riitano, Jordan, & Aromataris, 2016).

This study therefore gives an opportunity to critically examine the experiences of postnatal mothers after SB and its implications to their wellbeing in the EMD of the northern region of Ghana. The findings of the study will enable health care providers render holistic care that will support mothers after SB cope well with the loss.

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Evidence from the study will potentially lead to the provision of information to inform caregivers and policy makers as to what the experiences of mothers are following SB. The information will help shape interventions regarding psychological, emotional and bereavement management for mothers and families in time of loss.

The study findings will contribute to enriching the existing literature regarding experiences of mothers with SB and also to stimulate further studies into the phenomena. The study also provides an insight to nurses, midwives and doctors which can help these care providers provide holistic care based on empirical evidence. Evidence from this study contributes significantly to knowledge on SB experience in the Ghanaian context especially in nursing practice, education, research and administration leading to improved care provision. Findings from this study also give an insight to policy makers like the Ministry of Health, Ghana Health Service and the Nursing and Midwifery Council of Ghana to shape policies regarding stillbirth care in Ghana.

According to Winch, Creedy, & Chaboyer (2002) and Walker (2003), sound professional practice is based on sound empirical evidence in the fluctuating multifaceted health atmosphere. Therefore, the overall findings of this research work provide evidence to guide the training of nurses, midwives, doctors and obstetricians in the provision of comprehensive and holistic health care to mothers following SB.

1.7. Operational Definitions

Care providers – Registered Nurses, Midwives, Doctors and Obstetricians.

Experience – Collection of events from which an individual gathers knowledge and opinion

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Postnatal mothers – Pregnant women who delivered and are within 6 weeks after delivery.

Postnatal period – Period which extend from birth to 6 weeks

Stillbirth - baby born with no signs of life at or after 28 weeks' gestation (WHO, 2016).

1.8. Organization of the Study

The study is organized into six chapters described as follows; Chapter One described the background to the study, the problem statement, purpose of the study, study objectives, research questions, significance of the study and the operational definitions of the study. Chapter Two dealt with how literature search was conducted and reviewed, theoretical framework guiding the study and its relevance and summary of the literature review. Chapter Three described the methodology of the study and how study participants were recruited to obtain relevant data. It also described how data was analysed and conclusions drawn from the data.

The Fourth chapter presented the findings of the study. The findings are presented in the participant's accounts to reveal how the participants sensed the period of the loss (SB) in order to unravel the mothers' bereavement experience that is of concern to mothers. Chapter Five discusses the study findings in relation to relevant literature available to the study topic, the meaning drawn by the researcher in relation to health care provision. The last chapter (Chapter Six) presented conclusion drawn from the study in relation to available knowledge, its implications to nursing and midwifery practice. Also, this chapter presents recommendations to help improve health care delivery to women with SB experience.

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CHAPTER TWO

THEORETICAL FRAMEWORK OF THE STUDY AND LITERATURE REVIEW

This chapter describes in detail the literature on the experiences of postnatal mothers with SB which are considered relevant to the study. A description is also given to the Kubler Ross (1969) model of the grieving process and all its constructs, a theoretical framework that guided the study. An empirical review of literature on the experiences of postnatal women with SB is then conducted based on the objectives of the study and the constructs of the model employed.

2.1. Theoretical/Conceptual Framework of the Study: Elisabeth Kubler Ross Model of the Grieving Process.

The model of the grieving process was developed by Elisabeth Kubler- Ross in her popular book on “Death and Dying” in 1969 (Kubler-Ross, 1969). It is a famous formulation on the stages of grief. Dr. Kubler-Ross describes the stages that dying people go through as they realize they will die. However, the stages of grief as formulated in the model have since been used in a broader context as a means of describing the grief process more generally. The model has five stages namely, the denial, anger, bargaining, depression and acceptance stage. Denial stage: denial is a conscious or unconscious refusal to accept facts, information, and reality relating to a situation concerned. It is a defence mechanism and perfectly natural. Some people can become stagnant in this stage when dealing with a traumatic change that can be ignored. The first stage which is the denial stage; grieving people are not able to accept the loss.

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It appears to them as though they are experiencing a dream, that the loss is not real and they will be waiting to wake up as though from a dream, expecting that things will be normal.

Anger stage: anger can manifest in different ways. People in dealing with emotional upset can be angry with themselves, and or with others, especially those close to them. Knowing this helps keep detached and non-judgemental when experiencing the anger of someone who is upset. The second stage, which is the anger stage, people accept that the loss has occurred and begins to be angry at the loss and the unfairness of it. They may be angry at the person who has been lost. Feeling of abandonment may also occur. Next to anger, comes bargaining. The bargaining phase for people facing death involves the individuals bargaining with God to postpone the loss. People facing less serious trauma can bargain or seek to negotiate a compromise. Bargaining rarely provides a sustainable solution, especially if it is a matter of life or death. In this stage, people start to beg their “higher power” to undo the loss, saying things like “I will change if you bring her or him back to me”.

This stage involves promises of good behaviour or life changes which will be made in exchange for the reversal of the loss. Once it is clear that anger and bargaining cannot reverse the loss, people sink into a depression stage where they confront the loss and their own helplessness to change. At this stage, grieving people begin to cry, experience sleep or eating habit changes or withdrawal from other relationships and activities. People may also blame themselves for having caused or contributed to the loss.

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Finally, people enter a stage of acceptance where they have processed their initial grief emotions, are able to accept that the loss has occurred and cannot be reversed, and therefore plan their future and re-engage in daily life. **Figure 2.1** below is the theoretical framework of the study.



FIGURE 2.1 Elisabeth Kubler-Ross (1969) Model of the Grieving Process

Source: Elisabeth Kubler –Ross Grief Cycle and Alan Chapman for Businessballs.Com

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2.2. Justification and Relevance of the Theoretical Framework

In searching for a theoretical framework to guide the study, two other frameworks; the Horowitz stages of grief model (Horowitz, 1986) and the Dual Process model of bereavement (Stroebe & Schut, 1999) were considered because both models also provides details on individuals grief after a loss however, the Elisabeth Kubler-Ross (EKR) model of the grieving process was deemed more relevant to the study. The EKR model presents a broader scope of grieving a loss and its constructs will assist in unveiling the grieving process of mothers after SB in the Ghanaian context. The death of a child through SB greatly affects family members; for care providers to assist in the grieving process, the care providers must have knowledge on grieving (Pauw, 2018) especially in the context in which care is provided. Psychologically, the task of grieving is difficult to understand (Hoeldtke & Calhoun, 2001), hence the theoretical framework, the five stages of the grieving process by Kubler- Ross (1969) describes the process of grieving a loss.

The grief model is of great benefit to care providers rendering care to bereaved people as it helps the caregivers understand the grieving process of the bereaved and help implement interventions to them (Davies, 2004). Also, care givers in understanding the grieving process of the bereaved promotes confidence and ability to be with the bereaved and to offer relevant interventions to the bereaved individual (Wendy, 2004). The model of the grieving process has been used widely (Buglass, 2010) but not used in studies related to women of African origin to ascertain their grieving pattern after a loss experience hence the relevance of the model in this study.

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Coming to terms with stillbirth is a loss experience and an occasion that can result in grief. There is therefore merit in using this model and reason to become familiar with the stages of grieving as outlined in the model in the Ghanaian context. Also the constructs of the model can adequately assist in exploring the experiences of postnatal mothers with stillbirth. This model will help care providers appreciate the grieving process of women after SB in the Ghanaian context by unveiling how this women grief a loss. These will enable care providers understand and render holistic care to women after SB.

2.3. Literature Search

A search for literature on the experiences of mothers with stillbirth was done. Databases used included, CINAHL, PubMed, Science Direct, Medline, HINARI, JSTOR, Scopus, Google search, Google scholar, SAGE and EBSCOHOST. Key terms such as experiences of mothers with stillbirth, impact of stillbirth, perinatal and intra-uterine death were combined and used to retrieve relevant literature for the study.

2.4. Literature Review Related to the Objectives of the Study

Literature review relevant to the study is organized under the following thematic areas out of the theoretical framework; meaning of stillbirth to a mother, challenges of women with stillbirth, coping strategies of women with stillbirth, grieving process of women with stillbirth and support systems available to women with stillbirth.

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2.5. Meaning of Stillbirth to a Mother

The meaning attached to a loss helps parents to accept changes in their identity as parents (Blood, Cacciatore, Blood, & Cacciatore, 2014; Lichtenthal, Neimeyer, & Keesee, 2010; Park, 2010). The meaning of a loss to mothers is also said to bring about grief (Keesee, Currier, & Neimeyer, 2008; Lichtenthal, Neimeyer, & Keesee, 2010). Finding meaning to a situation helps individuals to cope well, therefore human beings need to make meaning out of situations and maintain understanding of themselves through an experience to enable them tell stories about their experiences (Douglas, 2014). Loss is a challenging situation for an individual to understand him/herself and the world at large (Neimeyer, Burke, Mackay, & Van Dyke Stringer, 2010; Shear, Boelem, & Neimeyer, 2011).

Individuals in going through loss experience must either fit the loss implications into their understanding of the world and themselves or maintain consistently their individual identity and understanding of life. This enables the individuals make new narration and understanding of the loss (Douglas, 2014; Neimeyer, Burke, Mackay, & Van Dyke Stringer, 2010). The meaning assigned to SB related loss by mothers is based on religion, education, culture and family dimensions (Holland, & Neimeyer, 2010). Stillbirth means a lot to parents especially mothers who experience it. Common ways to make meaning out of a loss is sense making where an individual see the loss as a good thing based on spiritualism (Bakker & Paris, 2013; Neimeyer, & Sands, 2011). Stillbirth means an isolating moment for mothers putting so many burdens on their psychological and emotional resource (Joanne Cacciatore, 2010).

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Stillbirth also means the loss of a child or human being to mothers and family members (Hamid, Ullah Malik, & Richard, 2014; Simmons, Lead, & Goldberg, 2011). Stillbirth again means loss of future dreams, loss of womanhood and feeling of failure to mothers (Mehran, Simbar, Shams, & Ramezani-tehrani, 2013; Murphy, 2012; Roberts & Lee, 2014). To some mothers, stillbirth to their understanding means bad wife, bad luck, taboo, sin, and supernatural evil spirit (Roberts et al., 2017; Roberts, Anderson, Lee, & Montgomery, 2012). Additionally, mothers perceive stillbirth to be the loss of power, social value, humiliation, and the loss of authority in society (Ali et al., 2011; Fottrell et al., 2010; Roberts & Montgomery, 2016). Stillbirth is an overwhelming loss that denies parents the joy of celebration of parenthood and the sense of self (Downe, Schmidt, Kingdon, & Heazell, 2013; Kohner, & Henley, 2001; Murphy, 2012).

A study on mother's experience of the time after intra-uterine death until induction of delivery revealed that mothers felt responsible for letting their families and friends down after the death of a baby (Erlandsson, Lindgren, Malm, Davidsson-Bremborg, & Rådestad, 2011). In a metasynthesis on parent's experiences and expectations of care in pregnancy after stillbirth, the accumulated evidence disclosed that parents felt their babies were stolen by someone after stillbirth and were scared of losing subsequent pregnancies (Mills et al., 2014).

In a study on bereaved parents' experience of stillbirth in UK hospitals, it revealed that parents felt guilty, blamed, regretful, fearful and grieved following stillbirth. Some parents were reportedly incapacitated psychologically and had difficulty making decisions at the time of loss. Parents became frustrated, angry and presented aggressive behaviours.

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Also parents who experience stillbirth saw it as a life time loss of parenting a child who would have been part of the family (Downe, Schmidt, Kingdon, & Heazell, 2013).

A research on the unique experiences of women and families after the death of a baby revealed that women who lost their babies had a sense of failure and inadequate womanhood and questioned their ability as mothers to parent surviving children (Cacciatore, & Cacciatore, 2016). Additionally, a study to explore the experience of parents whose children died using memento mori photography revealed that parents saw their dead babies as irreplaceable, cherished and very important (Blood & Cacciatore, 2014). In a correspondence to the Lancet on stillbirth, why they matter, stillbirth was seen as a serious loss to parents which is not understood (Frøen et al., 2011). More so, reproductive loss such as stillbirth is seen as loss of hope and dreams to parents (Jones, 2001).

A different qualitative study involving 21 women on Taiwanese women's process of recovery from stillbirth also showed that stillbirth to parents means loss of creation of new life, loss of self-identity and loss of anticipated parenthood (Tseng, Chen, & Wang, 2014). In contrast to the above literature, the death of a child is seen as the will of God to some parents and some parents struggle to make meaning out of the loss (Lichtenthal, Currier, Neimeyer, & Keesee, 2010).

2.6. Challenges of Women with Stillbirth

The challenges women face following stillbirth ranges from avoidance from members of the society to a flagging marital relationship (Kiguli et al., 2017). Stillbirth experiences also result in isolation in the lives of bereaved mothers;

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Chandran, Tharyan, Muliyl, & Abraham, (2002), Patel, Rodrigires, & Densonza, (2000), in their studies reported a declining support and relationship of bereaved mothers with the marital family members and husbands. Studies in high income countries years back (Demontigny, Beandit, & Dumas, 1999) recognized that women during grieving face a range of negative social encounters after a perinatal loss such as isolation from family members, friends and society at large making them emotionally vulnerable. Studies equally have shown that issues surrounding stillbirth in societies make women with stillbirth experience socially isolated (Campbell-Jackson & Horsch, 2014; Fottrell et al., 2010; Frøen et al., 2011; Roberts, Montgomery, Lee, & Anderson, 2012).

There are also documented cases of marital breakdown, marital separation, divorce and risk of marital breakdown as some of the challenges also confronting women after stillbirth in some studies (Gold, Sen, & Hayward, 2010; Koopmans, Wilson, Cacciatore, & Flenady, 2013; Shreffler, Hill, & Cacciatore, 2012; Turton, Evans, & Hughes, 2009). Also of concern to women after stillbirth is the fact that women are barred from mourning and grieving a stillbirth in public in the Ugandan and Indian cultures as stillbirth is perceived as an insignificant loss that does not warrant grieving (Kiguli et al., 2016; Roberts et al., 2012).

While Cacciatore, DeFrain, Jonnes, & Jonnes (2008), in their study reported a positive social support from midwives and doctors following stillbirth, contrary findings on the support received from the same health workers in the study of Modiba, & Nolte (2007) when they did an exploratory descriptive study in South Africa with an objective to describe the experiences of mothers with the loss of a child during pregnancy and the

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care they received at that time. They reported that there was nobody to talk to at the time of loss, resulting in stress and frustrations.

Bereaved mothers further complained about the lack of good communication from midwives and doctors, bereaved mothers were not adequately given information about the death or not given at all. These bereaved mothers said all that midwives and doctors care about is the delivery of a baby after, they really do not care about the emotional challenges the labouring mothers are experiencing (Modiba, & Nolte, 2007).

In a study by Gauzia, Moran, Ali, Ryder, Fishser, & Koblinsky, (2011) on the psychological and social consequences among mothers suffering a perinatal loss in Bangladesh found a high rate of deteriorating relationships and withdrawal of support from marital family members including husbands. . In their findings, unbearable social consequences were high on bereaved women as compared to women with live babies. More also, the study showed higher worsening spousal challenges with the marital family members.

Another challenging issue that emerged from that study was the fact that bereaved mothers were considered worthless by husbands and family members in the society. The work of Badenhorst & Hughes (2007) found that perinatal loss can have negative implications on relationship between parents bereaved, more especially if the parents do not accord each other the needed support in their grieving times. For example if one parent is no more in the sad mood, the other may see that as being insensitive.

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In some instances both parents have marital dissatisfaction. In a cohort Swedish study of women for a period of seven (7) years following perinatal loss, poor partner support was a reason for marital breakdown (Turton et al., 2009). In another study of Taiwanese women's adaptation following stillbirth, it reported a cultural belief of "continuity" where married women are expected to give birth to a child for the continuity of family lineage, hence when SB happens, bereaved mothers are blamed by marital family members for not being able to bring forth a child to continue the family lineage (Hsu, Tseng, & Kuo, 2002; Mammen, 1995). Again a study by Kiguli et al (2017) in Uganda to explore the local definition and perceived causes of stillbirth as well as the coping mechanisms of affected families revealed that mothers of stillbirth are asked to perform the burial privately as stillborn is culturally considered a 'thing' that does not deserve community grieve. The same studies revealed that mothers wept in silence to avoid stigmatization from the public.

Different studies have also reported that women who suffer stillbirth encounter several challenges within their homes and communities including stigma, blame, guilt, abuse by husbands and in-laws, abandonment by husbands and in-laws and the challenge of having to accept a rival in a marital relationship (Arnold & Gemma, 2008; Gerrish et al., 2017; Murphy, 2012; Roberts et al., 2017; Roberts & Montgomery, 2016).

2.7. Coping Strategies of Women with Stillbirth

People have several ways of coping with a loss. It is believed that coping, using one's own inner strength along with external support help in managing the grieving process better (Rybarik, 2000). According to Lazarus, & Folkman (1984) coping with grief is in two folds; the problem focus coping and emotion focus coping.

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Attempting to do something to change the source of the stress is what is called the problem focused coping while the act of reducing or managing the distress is called the emotional focus coping. Found in these types of coping are denial, reinterpretation of events as well as looking forward to external help (social support). Carver, Schier, & Weintraub (1989) in describing coping came out with active coping; where the individual takes certain actions to reduce the stressors or control its effects.

Mothers look out for support socially in order to get moral support, sympathy and understanding. Also some amount of diversional therapy have been identified very vital in coping strategies such as watching television, attending religious activities (Hamama-Raz, Hartman, & Buchbinder, 2014) and unconsciously denying (Weaver-Hightower, 2012). A study by Huberty, Leiferman, Gold, Rowedder, & Cacciatore (2014) in their descriptive exploratory study on physical activity and depressive symptoms after SB found that physical activity improves depression following stillbirth and coping with SB. Physical activities like walking and jogging impacted positively on women coping ability. Furthermore, support from husbands and family plays a role in coping after SB. Physical activities like walking and jogging impacted positively on women coping ability. Furthermore, support from husbands and family plays a role in coping after SB. A study to explore the local definition and perceived causes of stillbirth as well as coping mechanisms in Uganda reported that support from husbands and extended family quickened the recovery process of mothers following SB. Also, the same study found that believing in God, and comfort and counselling from health care workers helped them coped well and stronger afterwards.

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The fact that mothers survived themselves equally helped them cope with the grief and pain especially those who already have children (Kiguli et al., 2017).

Another qualitative study in Japan to explore the experience of intra-uterine foetal death after 28 weeks of gestation showed that women coped well with the loss by joining a support group and talking with women who had the same loss experience (Yamazaki, 2010). In contrast, Dimarco, Menke, & McNamara (2001) found that participation in loss support groups made no impact on how mothers grieved following a perinatal loss. Furthermore, compassionate care following a loss can be very important towards coping with a loss. Studies have shown that providing clear and therapeutic communication, emotional and physical support, words of encouragement, from care providers played a significant role on how women coped with their losses after stillbirth (Allahdadian & Irajpour, 2015; Cacciatore, Erlandsson, & Ra, 2013; Williams, Munson, Zupancic, & Kirpalani, 2008). Again, receiving counselling services from the care providers also help women cope well with the loss (Allahdadian & Irajpour, 2015; Navidian, Saravani, & Shakiba, 2017). Husbands and family members also play a critical role in the way and manner women cope after stillbirth. Studies have reported that support from partners and family members helped a lot in the coping of women after stillbirth (Karin, Worker, & Wredling, 2013; Kiguli et al., 2017; Robinson, 2011).

The meanings assigned to a loss also help women to cope well after stillbirth. A study to explore the meaning of stillbirth among ultraorthodox women in Israel revealed that the death of a foetus is viewed as a test of faith in God. Women believed it was a time God intended testing their faith in Him and so the women coped well with the belief that there are benefits afterwards.

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This enabled them accept the loss without much difficulties (Hamama-Raz et al., 2014). Religious beliefs are not also left out in stillbirth coping; religion is said to contribute tremendously in coping after stillbirth. Studies have revealed that women after stillbirth recognise it as the will of God in their lives and this enable them cope better (Allahdadian & Irajpour, 2015; Sustain, R., Miskam, 2012; Whittaker, Kavanaugh, Kilma, 2010).

Stillbirth support groups in the form of group discussions, face to face discussions or internet based support groups is said to help women cope adequately after stillbirth. Studies have revealed that engaging in discussions with stillbirth support groups including internet based support groups have significantly assisted mothers to cope greatly after stillbirth (Betts, Acupuncture, Dahlen, Commn, & Smith, 2014; Christiansen et al., 2014; Katherine, Gold, Boggs, Mugisha, & Palladino, 2012; Nikkola, Kaunonen, & Aho, 2013; Paterson, Brewer, & Stamler, 2013). Also effective counselling coupled with faith in the supernatural God serves as a source of strength when it comes to issues of stillbirth and perinatal loss (Kiguli et al., 2017; Worden, 2008).

2.8. Grieving Process of Women with Stillbirth

Grief is an individual process and everybody handles grief differently (Avelin, Erlandsson, Hildingsson, & Radestad, 2011). The grieving process is complex and changing, and of course, there are several ways to every individual. Also, there are several ways of processing, understanding and integrating stillbirth experience in the family and in the context of individuals (Karin et al., 2013). Reactions to the loss of a very important person involves impairment of daily activities, social withdrawal, intrusive thoughts, yearning and numbness which can stay over a period of time (Kersting

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& Wagner, 2015). It is very necessary to look at the terms grief, mourning, and bereavement in order to have an overview of grief to get better understanding of the literature on grieving. According to Stroebe, Hansson, Stroebe, & Schut (2001), mourning is a social expression of grief which is shaped by the practices of a given society.

When an individual is going through an objective situation of losing a significant person, it is known as bereavement whereas grief is a multifaceted individual response to the loss of someone bonded to him/her (Pilkington, 1993). The reaction of individuals to grief is into three phases: the avoidance phase, the confrontation phase and the re-establishment phase (Rando, 1986). The avoidance phase is the period where parents are not able to comprehend the whole situation (Rando, 1998). Common reactions in the avoidance phase include numbness, shock, denial, disorientation, despair, anger and hostility. The confrontation phase is when the loss is seen as real. Parents at this stage become sorrowful, angry, guilty, blamed and yearning. The re-establishment phase which is the final phase is when the sorrow and grief begin to resolve.

This phase is also known as the acceptance phase. All the three phases of grieving is vital for parents to enable them accept the loss and progress with their lives (Peppers, & Knapp, 1984). Reaction to grief involves the cognitive, behavioural and psychological responses to the loss (Keene Reder, 2003; Zhang, B., E-Jawahri, A. & Prigerson, 2006). Hence whether grief is hidden or shown is a reality at the time of loss/death. To provide adequate and efficient care to bereaved persons as care providers, there is the need to have in-depth understanding of the grieving process.

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Depression, anxiety, social withdrawal, guilt, numbness, yearning, intrusive thoughts and impairment in daily activities are some of the characteristics exhibited by a grieving person (Burden et al., 2016; Evans, 2012).

Despair, panic behaviour and disorganization are also reported in some grieved persons (Barr, P., Cacciatore, 2007; Joanne Cacciatore, 2017; Werthmann, J., Smiths, L.J., & Li, 2010) Additionally, harmful mind, shock, denial, bitterness and feeling of emptiness were also established as a way of grieving (Scheidt et al., 2012). A study by Lindermann (1944) on grief following a fire disaster established five presenting ways of grief as: somatic distress which involves feeling of tightness in the throat, choking and difficulty in breathing. Pre-occupied mind with the image of the dead, guilt, hostility and physical instability such as inability to sit still, inability to initiate and maintain normal daily activities was equally documented. Lindermann classified these manifestations as 'normal' grief. He further enumerated that deviations from normal grief could come in the form of delayed expected grieving process, distorted response such as over-activity, with no sense of loss.

A lot of terminologies are used to describe abnormal grief response, for instance, pathological grief is a term used, and others use complicated, disorganized or traumatic grief. Subsequently a lot of studies were undertaken to broaden Lindeman's findings. According to Worden (2008) certain actions are expected in individuals who are grieving. These actions include numbness, sadness, loneliness, guilt, and anxiety. Feeling of shock, fatigue, dry mouth and sensitivity to noise was also identified as well as thoughts of disbelief, confusion, and disorientation.

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Lastly, sleep disturbance, loss of appetite, absent mindedness, crying, and restlessness over activity were also seen as normal responses to grieving. In contrast, Stroebe, Van Son, Stoebe, Kebler, Schut, & Van den Bout (2000) in their study came out with responses different from the normal grieving process such as anger, self-blame, and prolonged guilt. While guilt is recorded as a normal grief by Lindermann and Worden, (Stroebe, Van Son, Stoebe, Kebler, Schut, & Van den Bout (2000) presented it as abnormal grief response. Knowledge from these findings and others informed the belief of nurses, midwives, medical doctors and researchers that individuals need to overcome grief in order to adjust to the loss of a loved one else the risk of degenerating into pathological grief is high (Wortman & Silver, 2001). Also grieving is viewed as a normal process of adjusting to a new life therefore parents at a time of loss accepts the loss and adjusts to newer lives (Christensen, & Sandvick, 2014; Hård, Segerstad, & Kasperowski, 2017).

2.9. Support Systems Available to Women

A strong professional, family and social support system can bring about a significant positive impact in parent's ability to cope with a loss. Also, the type of support available to mothers bereaved or the bereaved in general if positive can be a strong foundation for better coping. The social environment in which people grief is very significant in the outcome of the grief (Koopmans et al., 2013). The role of social support in grieving is also well established (Hutti, 2005; Zeanah, & Harmon, 2006). Social support gives meaningful protection against the effects of stressful life situations and also helps in coping after a loss (Cacciatore, 2010; Nikkola et al., 2013).

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The significance of appropriate psychosocial support for women with stillbirth is also evident in some publications in the Lancet (Flenady et al., 2009; Froen et al., 2011).

Therefore support system is essential in managing the grief process (Rich, 2000). According to Engler, & Lasker (2000); Rich (2000); and Riches, & Dawson, 2000), experience of every day support from family and friends, relationship with colleagues at work and neighbours, specialized agencies and self-help groups are important for people at a point of loss to enable them come to terms with the bereavement. Deficiency in these support systems makes it difficult for women to maintain a psychological balance. Again, a strong marital relationship is seen as an important factor; where there is utmost understanding between husband and wife, the grieving process is supported and it stays shorter (Koopmans et al., 2013).

The effect of social support on maternal anxiety and depression after SB was conducted in the United States of America (Cacciatore, Schnebly, & Froen, 2008), in an attempt to find out whether anxiety and depression are lower among stillbirth mothers who had social support from families, support groups, doctors, nurses and midwives.

The study revealed that doctors, nurses, midwives, and family members' support following SB helped to lower levels of anxiety and depression; approximately 92% of the respondents reported they had either great support or support from the family members after SB. Additional support they received was provided by nurses and midwives, 90%, doctors, approximately 68% and support groups, 53%. The study further revealed that the important and influencing form of support came from family members.

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Mothers of stillborn babies who perceived to have gotten high family support had a mean anxiety and depression scores lower than their colleagues who did not receive family support.

Also, a cross sectional study conducted by Sutan, Amin, Ariffin, Teng, Kamal, & Rusli (2010). at the university of Malaysia medical centre (UKMMC), on the psychosocial impact of mothers with perinatal loss and its contributing factors using 62 participants and Edinburg postnatal depression scale (EPDS) and self-administered questionnaire; findings show most of the respondents received support from their parents, and half of the respondents had support from friends and siblings. Majority of the respondents received enough support; more still wanted additional support in the form of counselling and encouragement. Mothers believed having sessions to express their feelings as well as group discussions could help them cope with the loss and to recover quickly from the grieving moments. Supportive care from care providers can also be important in the grieving process of mothers with stillbirth.

Studies have established that care providers present at a time of loss were sensitive to mothers emotions, encouraging, counselling and caring (Gold, 2007; Johnson & Langford, 2010; Moore, Parrish, & Black, 2011; Puia, Lewis, & Beck, 2013). A study by Caelli et al. (2002), to explore women and their partner's experience of the care they received from midwives in Canada revealed that the midwives were understandable, empathetic, caring and communicated therapeutically. A similar study by Sanchez, (2001) in South Africa also revealed that midwives cared for the bereaved gently and nicely.

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It again stated that the bereaved were cared for by holding their hands, taking care of their hair and spending time talking to them. An exploratory study by (McGuinness, 2013), Nordlund, Borjesson, Cacciatore, Pappas, & Radestad (2012) reported contrary findings of negative emotional experience from care providers following stillbirth.

2.9.1 Summary of Literature Review

In summary, the literature review establishes that stillbirth is a great loss to mothers. Stillbirth can come with so many challenges such as despair, disorganized life, depression, social isolation, intrusive thoughts and hopelessness. Individual victims need a lot of support from care providers, families, husband, friends, religion and society at large to be able to overcome the burden of stillbirth. However, little data exist on the experiences of mothers with stillbirth in the African context. This study therefore fills a research gap on the experiences of postnatal mothers with stillbirth in the African context, specifically the East Mamprusi District of the Northern region of Ghana.

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CHAPTER THREE

METHODOLOGY

This section provides the description of the methodology that was used to achieve the study objectives. It includes the study design, the setting, target population, sample and sampling technique(s), data collection method, data analysis as well as data management. The chapter presents details on how ethical requirements were met and trustworthiness established in the study.

3.1. Research Design

A qualitative research approach in the form of explorative descriptive design was used for the study. This design enabled the researcher to explore the experiences of the mothers in their own words (Simwaka, Kok, & Chilemba, 2014). Qualitative research is based on a global view that is holistic; it is of the belief that there are multiple constructed realities in life where the known and the unknown cannot be separated, inquiry is also value bound and all applicability are time bound and contextual (Burns & Grove, 2007). A qualitative study is the act of perceptually putting together pieces of information to make a whole. When meaning is produced from varied individuals with varied perceptions, it is possible for different and comprehensive meanings to be made concerning the phenomena under study (Munhall, 2001; Vaismoradi, Turunen, & Bondas, 2013). The findings from a qualitative study directs the understanding of a phenomenon under study and generates new concepts (Leed, & Ormord, 2010); it gives in-depth insight which is applicable in similar instances to guide nursing practice and in theory building or providing opportunities where the phenomena outside the traditional view of nursing and midwifery can be examined (Burns & Grove, 2007).

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Therefore the varied individual experience that was gathered was grouped and interpreted to make meaning about what the experiences of the postnatal mothers with stillbirth are in the EMD of the northern region of Ghana. In qualitative study, the researcher is involved from the planning through data collection to analysis and discussion and is also a data collection instrument. An exploratory qualitative design was used because little is known about the phenomena (SB) under study (Polit, & Beck, 2008). This design was used because little is known about the experiences of mothers with stillbirth in the district. The grieving process of mothers with SB has not also been previously explored in the district. Qualitative exploratory study is also carried out in a natural setting; hence the homes of the participants were used as the natural setting. Experiences vary; therefore the researcher kept much emphasis on understanding participants' words, actions and expressions to be able to elicit required information. For a study to be reliable and trustworthy it is important that a variety of individual experiences are gathered; this guided the researcher in the recruitment and data gathering process.

3.2. Setting of the Study

The study was conducted in the East Mamprusi District (EMD) of Ghana. The District is one of the 26 Districts in the Northern Region with its capital in Gambaga. The EMD was established by Legislative Instrument (LI) 1776 (2004). Gambaga is a historic town close to the "Nayiri", king of Mamprugu traditional area. Gambaga was the first headquarters of the then Northern territory. It is one of the oldest Districts in the Northern Region; the West Mamprusi District was carved out of it in 1988 and Bunkpurugu-Yunyoo District in 2004 to promote development.

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The EMD served as the parent district for both the Bunkpurugu -Yunyoo and West Mamprusi Districts (Ghana Statistical Service, 2010) . The population of EMD, according to the 2010 population and housing census by the Ghana statistical service was 121,009 representing 4.9 percent of the Region's total population. Males constitute 49 percent and females represent 51 percent. The population of the District is youthful (0-14) years representing 47.6 percent and showing a broad base population pyramid which tapers off with a small number of elderly persons [60+ years](Ghana Statistical Service, 2010). The EMD is located in the North-Eastern part of the Northern Region. To the North, it borders Talensi and Nabdam districts, Bawku West and Garu-Tempane Districts; all in the upper East Region and to the East is the Bunkpurugu-Yunyoo District. It is bordered to the West by the West Mamprusi District and to the south by the Gusheigu and Karaga Districts. It covers a land mass of 1,706.8 square kilometres, representing about 2.2 percent of the total land mass of the northern region (Ghana Statistical Service, 2010).

There is one district hospital situated in Nalerigu, three (3) clinics and five (5) health centres at Langbensi, Gambaga, Gbintir, Sakogu and Namangu which take care of the health needs of the people. The District hospital in Nalerigu serves as a referral centre for the clinics and health centres and even sometimes for other nearby Districts such as Gusheigu/Karaga, Bunkpurugu, and West Mamprusi districts. The EMD is dominated by Muslims representing 58.1% of the population. Twenty two point six percent (22.6%) and 15.7% are Christians and Traditionalists respectively. Fifty seven percent (57%) of the population aged 12 years and above are married.

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Early marriage is a common phenomenon in communities such as Gbintir, Tuni and Nabori. Teenagers who marry and cannot meet their personal and family needs economically travel to the southern part of the country especially in the cities of Kumasi and Accra to engage in “kayaye” (headporter) business. “Kayaye” refers to adolescents and women who migrate to the southern part of Ghana to do menial jobs especially carrying people’s items for money in the cities.

Some of the residents in the District are engaged in farming, and rearing of animals representing 84.4%. Seven point one percent (7.1%) are engaged in the services and sales work and 3.9% are also engaged in craft and other related jobs. The EMD is rich with human and natural resources especially tourists attraction sites such as the “Naa Djeringa” walls (which was built without water but only milk and honey in Nalerigu) and labourers who complained of tiredness during the building of the wall were killed and their blood mixed with mortar to build the walls. The Gambaga witches camp and Moshie chiefs ancestry graves in Gambaga are also tourist attraction sites within the district.

3.3. Target Population

The study population in a study is the entire set of persons who meet the sampling criteria of the study. In this study, all women at least six (6) weeks postnatal who lost their babies through SB during pregnancy or delivery and living in the EMD were the target population.

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3.4. Inclusion and Exclusion Criteria

3.4.1. Inclusion Criteria

Inclusion criteria is used to select samples from all possible units in the general population, it tells who qualifies to be in the target population (Polit, Beck, and Hungler, 2001). Inclusion criteria restrict the population to make it homogeneous; where homogeneity is not ensured in a study, meaningful interpretation of findings is challenged, and likewise the transferability and applicability. Inclusion criteria are put in place to control biases and extraneous variables, hence contributing to the accuracy and transferability of the study (Polit, Beck, & Hungler, 2001). The study inclusion criteria were; women who have experienced SB, resident in the EMD, were English, Mamprulli or Moar speaking and who gave voluntary consent to participate in the study. The eligible women were within the postnatal period of 6 weeks and aged 19-45 years. This is because challenges following SB often begin in the postnatal period (Badenhorst & Hughes, 2007).

3.4.2. Exclusion criteria

Women who have experienced SB but have known mental health challenges, and postnatal women who could not speak English, Mamprulli, or Moar were not part of the study. Also, postnatal women with SB who were not resident in the EMD as well as those who were below the age of nineteen (19) years were not recruited into the study. All these were ensured by reviewing the antenatal records and folders of the women to establish their health histories and the languages they speak and also their ages or dates of birth. Effective communication is vital to the outcome of a proposed study. Women who could not speak English, Mamprulli or Moar, as mentioned were excluded in the study and avoided for the sake of effective communication.

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3.5. Sample size and Sampling Method

Sampling is the process of selecting part of a population with the intent of collecting information which will be used to examine the characteristics of the population being studied (Khan, 2012). Studying the entity of a population is usually difficult hence the need to select part of the population of interest for a study. A purposive sampling method was used for the study. Purposive sampling is a non-probability sampling method which is often used in qualitative studies. With this sampling method, it is assumed that the researcher's knowledge about the population and its elements are used to select appropriate participants for the study (Polit, Beck, & Hungler, 2001). According to Wood and Hungler (1994), when unusual group is studied, purposive sampling is the best method to use. This type of sampling method allows for homogenous groups to be studied increasing the ability to replicate findings as well as the ability to apply knowledge gained in dealing with similar situations in the future.

A purposive sampling approach was used to recruit women with SB experience who delivered at the maternity unit of the District hospital. A total of fourteen (14) women participated in the study. This venue was chosen due to the fact that it is a referral centre for all other health facilities in the District and is also strategically located and easy to access. Samples drawn from the district hospital will geographically be representative of the district. The researcher after gaining ethical clearance and permission to conduct the study visited the midwives at the maternity and labour wards at least twice every week to enable him establish rapport with mothers who had delivered and had stillbirths.

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The researcher again spent some time (twice a week) at the postnatal clinic to further contact potential participants and establish more rapport with the mothers and to gain the trust of the mothers who lost their babies at birth. The researcher in visiting the midwives in the ward ensured that he did not influence in any form the normal practice in the ward.

The intention of the recruitment was made known to all potential participants (women who have delivered and had stillbirth) and all those who showed interest, the researcher then obtained detailed residential addresses as well as telephone numbers if possible. These mothers were contacted later by the researcher for engagement. As a backup method of recruitment, the researcher in his absence in the ward contacted the admissions and discharges book in the ward for the contact addresses of women who lost their babies through SB. The researcher contacted these women later to make his intentions known to them and sought their consent to participate in the study.

3.6. Data Gathering Tool

Data gathering for this study was in the form of an interview using an interview guide (Attached as Appendix B) prepared in English, made up of open –ended questions. The interview guide was developed in line with research questions. Probing questions were asked based on what the participants said to elicit clarification to get detailed and accurate information. The interview guide was organized into components A, B, C, D, E, and F to seek information on participant’s personal profile and some obstetric information, the general experiences of the mothers following SB, information about their experiences in the delivery process, and their perception of the services rendered to them.

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Section A comprised of demographic and obstetric data of participants, section B consisted of questions that elicited information on the challenges participants face after stillbirth. Section C of the interview guide asked questions relating to coping strategies of mothers after SB experience, while sections D, E and F sought information on grieving, support systems and meaning of SB respectively. (See Appendix B for Interview Guide).

Data was collected at the homes of participants or where the researcher and participants agreed to meet and also where participants will be relaxed in their comfort zones. The time schedules for interview sessions was determined and agreed upon by the researcher and participants. The interviews were conducted in English, Mampruli and Moar. All the interviews lasted between 45 minutes and 60 minutes. The interview guide was used to guide the questions to be asked and information received were audio recorded with the consent of participants. As part of the preparations towards the start of the study, the interview guide was reviewed by my supervisors and peers to assess its ability to probe into the phenomena and to increase the trustworthiness of the study.

Also, a pilot interview was conducted on five (5) bereaved mothers in the west Mamprusi district to assess the reliability of the interview guide; questions that were not clear or were not eliciting the relevant responses after the piloting of the interview guide were reviewed for clarity and efficiency. Preconceived ideas and personal views of the researcher about the stillbirth care in the clinical area were put aside by writing them down and shared with my supervisors to prevent researcher bias. In addition to the interview and recording, nonverbal messages and objective information observed were recorded into field notes to support the data collection process and to enrich the data.

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Where responses by participants showed a participant does not understand the question, clarification was given by the researcher through explanation to enable successful data collection. The services of a clinical counsellor/psychologist were planned for however none of the participants broke down emotionally during the interview process.

3.7. Data Gathering Procedure

Access to participants for the study started with an introductory letter from the School of Nursing and Midwifery, University of Ghana to the institutional review board of the Noguchi Memorial Institute for Medical Research for ethical clearance (Attached as Appendix F). After the ethical clearance was granted, (NMIR-IRB CPN 039/17-18) the researcher visited the maternity ward of the baptist medical centre, Nalerigu daily to identify potential participants. Rapport was established with these potential participants who were then contacted later to seek their consent to participate in the study. All those who accepted to participate were made to sign or thump print on consent form after explaining to them the whole purpose of the study.

Interviews for the study were conducted in English, Mamprulli, and Moar translated into English (those interviews that were in Mamprulli and Moar) at the homes of the participants or where the researcher and participants agreed to meet and also where participants will be relaxed and transcribed verbatim. Data gathering ended when responses from participants kept repeating (saturation). According to Burns and Grove, (2007), data collection is a process of gathering relevant information in a precise and systematic way in line with the purpose of a study, research questions or hypotheses. Data collection starts with the identification of subjects and goes with the analysis in a case of qualitative studies.

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Data gathering deals purposely with the identification of the site and participants in which Miles, & Huberman (1994) put under four headings namely the setting, the actors; being the researcher and participants, the event; observation of the actors and the process, the nature of events undertaken by the actors in the study setting. In a qualitative research, data collection is done in various ways, often a combination of approaches are used to gather the needed information based on study objectives and study design. These methods range from observation, self-reports or interviews, transcripts, written documents, audio-visual materials or electronic documents (Leed, & Ormord, 2010).

The major tool for data collection in this study was the interview method combined with nonparticipant observation of the care rendered to women after SB in the ward which was documented as memo or field notes and written documents like hospital records. Data collected through this means is expected to make the data rich and promote the trustworthiness of the data. A semi structured interview guide is used when the researcher has knowledge of the questions to ask but cannot predict the response that will come. The researcher used interview guide to elicit information from fourteen (14) participants. The researcher used this method with the hope that all information anticipated is obtained and also offers the participants the freedom to give what response the participants have to give; the participants will give descriptions that is best for the phenomenon (Morse, & Field, 1998). According to Crewell, (2009), the use of an interview guide to conduct an interview, among others is key to qualitative data collection. In-depth interviews have the advantage of getting detailed information which is full and rich from the subjects (Polit, & Beck, 2008).

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3.8. Data Analysis

Data analysis is a process which involves the researcher reflecting on the data collected, ask analytical questions and writing memos in the process of the research (Crewell, 2009). Data analysis was done concurrently with the interview process to allow the researcher make adjustments in the subsequent interviews. Thematic content analysis method was used to analyse the data. This method enabled the researcher to critically examine the narratives of participants by breaking the data into smaller units for easy description and interpretation (Vaismoradi et al., 2013). Thematic content analysis also enabled the researcher classify data and deduce patterns in the unrefined form (Javadi & Zarea, 2016). Thematic content analysis is a procedure for identifying, analysing, and reporting patterns in data collected (Braun, & Clarke, 2006). Thematic content analysis provides flexibility in the researcher's choice of theoretical framework, provides for detail and rich descriptions of the data obtained. Thematic analyses vividly define steps to ensure data clarity and rigour in the process.

These steps include; the researcher familiarising with the data, generating initial codes, searching for themes, defining and naming themes and producing report. Initial interviews were transcribed verbatim, read and re-read many times to give direction for the conduct and questions of subsequent interviews to get better responses and outcome. At the end of each day, the researcher transcribed the recorded data from Mamprulli and Moar into English and translation compared with the field notes taken for consistency and revision if necessary. After transcription, data were read again and again to obtain in-depth meaning to aid the researcher identify concepts within and between participant's data.

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Coding was done where phrases, sentences, statements and paragraphs of interest to the researcher were taken note of and given a label code. The coded passages were compared and codes with common elements were grouped to form major themes and sub-themes (Bradbury-Jones, 2007). Also, a co-coder was used and an agreement obtained on the themes and sub-themes. If the researcher was convinced with the codes, themes, and sub-themes produced, final copies were printed out and cross checked again for oversights. Content analysis of data that emerged was done and presented as new data.

3.9. Data Management

The data collected from participants in the form of field notes and transcripts were stored in a locked cabinet by the researcher in the researcher's room. Data obtained electronically were also stored on the researcher's personal computer and protected by a password to prevent any person who is not part of the study from having access to it. Only the researcher and the supervisors had access to the data. The data is kept only by the researcher. All participants were given pseudonyms by the researcher to ensure confidentiality of the information. Transcriptions are being stored and protected by a password on the researcher's computer. These transcriptions will be stored for at least five (5) years by the researcher after the completion of the study to ensure its availability when the need arises and will be destroyed afterwards.

3.10. Methodological Rigour (Trustworthiness)

Trustworthiness is described as the degree to which a study is worth giving attention to, worth taking note of, and the degree to which others are convinced that study findings are trusted (Babbie, & Mouton, 2001).

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Varied views exist on how to measure the trustworthiness of data in qualitative research. According to Yin (2003), documenting every step of the procedure is a means by which trustworthiness can be ensured. Gibbs (2007), offered four steps to ensure reliability, which are checking the transcript to make sure it is free from mistakes, correctly defining the codes, communicating among codes and cross checking codes among codes (inter-Coder agreement). Miles, & Huberman (1994), said when a study has 80% inter-coder agreement, the study is said to be reliable. Lincoln, & Guba (1985) and Crewell (2009), proposed the use of credibility, transferability, dependability and confirmability in place of validity in qualitative studies. Leed, & Ormord (2010), recommended five areas to promote reliability; extensive time in the field, negative case analysis, thick descriptions, feedback from others and respondents validation. The criteria by Lincoln, & Guba (1985) to promote trustworthiness in a study was adopted; credibility, transferability, dependability and confirmability.

Credibility- this is an evaluation of whether or not study findings represent a reliable conceptual interpretation drawn from the original participant's data (Lincoln and Guba, 1985). It further assesses whether study findings make meaning and accurate representation of the participants (Rolfe, 2006). The researcher addressed this by asking relevant and probing questions, having prolonged engagement with participants in the interviews, holding debriefing sessions with participants, triangulation, member checking and peer scrutiny of the research report.

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Transferability – this is the degree to which study findings can be replicated or transferred beyond the initial boundary of the study. This was ensured by giving clear description of participant’s selection process and detail description of the study setting and how the entire study process was conducted to enhance applicability of findings.

Dependability- this is an evaluation of the quality of the integrated processes of data collection, data analysis and generation of theory (Hamama-raz et al., 2014; Lincoln,& Guba, 1985). The researcher addressed the issue of dependability by implementing data analysis systematically, based on participant’s narrations, interviewing all participants with the same interview guide, and maintaining all transcripts and audio recordings in order to make it accessible when the need arises. This increased the dependability of the study (Lincoln and Guba, 1985).

Confirmability- this is the measure of how well study findings are supported by the data gathered. It is required to ensure study findings are a true reflection of ideas and views of participants in a study. The researcher addressed the issue of confirmability by keeping audit trail of all transcripts and interviews, preparing a draft report for research supervisors to review and verify to ensure the path taken by the researcher from data collection to results followed due process. The interest of the researcher is not representativeness of the study but rather to gain in-depth information on the phenomenon to be explored.

3.1.1. Ethical Considerations

Ethics is concerned with how people act, judgements about the acts and developing rules for justifying actions(Jones, 2000). Ethical considerations ensure the protection of dignity and safety of participants.

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Ethical clearance and approval was sought for this study from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana (NMIR-IRB CPN 039/17-18 – Attached as Appendix C).

Permission was also sought from the District Health Directorate and the management of the Baptist medical centre with an introductory letter (Attached as Appendix D) from the School of Nursing and Midwifery, University of Ghana to recruit participants for the study. An information sheet was prepared for the participants stating clearly and adequately the research topic, purpose and objectives of the study, as well as how confidentiality and anonymity of their information would be observed. Also, risk, benefits and compensation packages were vividly explained to participants. The objectives of the study were equally explained to participants and their consent obtained (Information sheet and consent form attached as Appendix A) before taking any information from participants. These were done to respect participant's rights to information and human dignity. Participants were made aware that they have the right to decline to take part in the study if they felt like doing so. Participants were also told of their rights to withdraw from the study at any time. Anonymity of participants was ensured by using pseudonyms to avoid easy identification.

Data collected were kept confidential and safely by the researcher and was used only for the research purpose. It was anticipated that the services of a clinical psychologist or a counsellor will be needed to support postnatal mothers during the interview sessions.

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Therefore arrangement was made to make these services available to potential participants through a trained counsellor, Rev. Rebecca Ojebisi (Chaplain, Baptist medical centre, contact number: 0508489101/0244877578) if the need arose, however none of the participants broke down during the interview process so no counselling service was provided to any participant.

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CHAPTER FOUR FINDINGS

This chapter presents the study findings on the experiences of postnatal mothers with stillbirth experience in the East Mamprusi district of the Northern region of Ghana. The first section presents the demographic data and obstetric profiles of the study participants. The following section highlights the main themes and sub-themes that emerged from the data.

4.1. Demographic Data and Obstetric Profile of Participants

A total of fourteen (14) women with stillbirth experience participated in the study. Study participants were interviewed on their experiences of stillbirth at their individual homes and villages/towns in the east Mamprusi district. Out of the fourteen (14) study participants, the majority, nine (9) of the participants were Mamprusi by tribe-the predominant tribe in the district with the remaining participants being Kasena, one (1), Bisa, one (1), Bimoba, one (1), Moshie, one (1) and Kusasi, one (1). The study participants had varied ages with twenty (20) years being the youngest and forty three (43) years the oldest. All study participants were married and had experienced at least one stillbirth. Five (5) participants had no previous history of delivery, four (4) had one previous delivery, three (3) had three or more previous history of delivery and two (2) had two previous delivery. Majority, seven (7) of the stillbirths occurred in pregnancies with a gestational age of thirty eight (38) weeks, thirty six (36) weeks gestation, three (3), thirty four (34) weeks gestation , two (2), twenty nine (29) weeks gestation, one (1) and twenty eight (28) weeks gestation, one (1).

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Furthermore, most of the participants, eleven (11) had no previous history of SB experience with the remaining, three (3) having had one previous history of SB. Majority of the stillbirths that occurred were macerated stillbirths, nine (9) with the remaining five (5) being fresh stillbirths. In terms of religion, all study participants belonged to a religion. The majority, ten (10) of the participants were Muslims and the remaining four (4) were Christians. There was no participant who belonged to the traditional religion. With regards to the educational backgrounds of the study participants, five (5) had no formal education, four (4) had basic education, three (3) had tertiary and two (2) had secondary education. Also, seven (7) of the participants were house wives, Farmers were four (4), Caterer (1), Teacher (1) and Police officer (1). **See Table 4.1** below for the summary demographic data and obstetric profiles of the study participants. This chapter presents the main themes and sub-themes that emerged from the data analysis supported by quotations (verbatim) from the interview transcripts.

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TABLE 4.1 Summaries of Demographic Data and Obstetric Profiles of Participants

Demographic Profile of Participants		Obstetric Profile of Participants	
Age (years)	No of participants	Gestational Age (weeks)	No of Participants
20-29	9	38	7
30-49	5	36	3
Religion		34	2
Christians	4	29	1
Muslims	10	28	1
Educational Level		Previous Delivery History	
Tertiary	3	No Previous Delivery	5
Secondary	2	One Previous Delivery	4
Basic Education	4	Two Previous Deliveries	2
No Education	5	Three or More Previous Deliveries	3
Marital Status		Previous SB History	
Married	14	Previous SB History	3
Not Married	0	No Previous SB History	11
Tribe		Outcome of Delivery	
Mamprusi	9	Macerated Stillbirth (MSB)	9
Bimoba	1	Fresh stillbirth (FSB)	5
Bisa	1		
Moshie	1		
Kasena	1		
Kusasi	1		
Occupation			
House wife	7		
Farmer	4		
Caterer	1		
Police Officer	1		
Teacher	1		

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4.2. Organization of Themes

Five main themes emerged from the data. Out the five main themes, one main theme (grieving process) was consistent with the constructs of the model used. The remaining themes (Meaning of stillbirth, challenges after SB, coping strategies and support systems) emerged from the data. In total, twenty one (21) sub-themes emerged. The study participants for the purpose of this study are identified by pseudonyms assigned to each interview transcript. The various themes and sub-themes are presented in **Table 4.2** below:

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Table 4.2 Main Themes and Sub-themes

NO.	THEMES	SUB-THEMES
1.	Meaning of Stillbirth	1. Loss of womanhood 2. Cultural encounter 3. Evil visitation 4. Loss of future dream
2.	Challenges of SB	1. Clinical neglect 2. Spousal/Partner challenges 3. Social withdrawal 4. Stigmatization
3.	Coping Strategies	1. spirituality 2. Diversional therapy 3. Comfort from own children 4. Self-motivation
4.	Grieving Process(Reaction to Loss)	1. Denial/ disbelief 2. Shock/sadness 3. Blame/anger 4. Bargaining 5. Acceptance
5.	Support Systems	1. Religious support 2. Care provider support 3. support from friends 4. Family/Spousal and Community support

4.3. Meaning of Stillbirth to Mothers

The participants gave varied meanings to the occurrence of stillbirth. The women used terms such as loss of womanhood, cultural encounter, evil visitations, and loss of future dreams to describe the meaning of stillbirth.

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4.3.1 Loss of Womanhood

Fertility is the key definition of womanhood in the African context. Every woman upon marriage is expected to give birth. The expectation of children from the woman comes from both the woman's family and the husband's family. In the unfortunate situation where the woman is not able to bring forth live children after marriage, it can be a challenging moment for the woman. When a woman gets pregnant and the pregnancy ends in a stillbirth, it is viewed as a serious loss and failure by the woman as she is expected as a woman to give birth. This belief of loss and failure featured in most of the narrations of the women interviewed:

Because we all know that a woman must give birth. I am a woman and every woman must give birth. So I am thinking that I am not sound to be a woman that is why I lost my baby (Konjit).

As a woman, it feels like you are not worthy of a woman, because it is only a woman who goes to the hospital in labour and goes home with a child but that moment [SB], it was like I am just a man (Dunwak).

Similarly, some other two women narrated their feeling as follows:

I felt like am not a woman because I went to the hospital in labour and came home without a baby. Does it mean I am not made to carry a baby? Truly I said to myself I was not capable of being a woman that is why (Feidiib).

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I am not a woman that is why they [family members] are saying he should marry in addition, she may deliver live babies but for me I cannot. This is what I hear them say.....Hymmmmm (Moiman).

4.3.2 Cultural Encounter

Socio-culturally, when stillbirth occurs it is seen as a taboo and therefore certain rituals must be performed on both the woman and her husband before they are allowed to stay together. Also, because stillbirth is perceived as a taboo, mothers are barred from mourning their losses. Study participants presented these expressions of their understanding of stillbirth and what they were told after the loss.

A participant said;

In our culture, when you give birth to such [SB], it is a taboo and certain rituals and performances must be carried out; The performance is that when you deliver a dead baby boy, three months you will not meet with your husband and if a female, for four months, but they didn't do the performance, it was only the shaving of my hair and that of my husband. That was all they did as part of the rituals (Kanboisua).

Another participant narrated her story as;

Hymm..... Everyone said I should not cry because it is a taboo to mourn such things [SB]. That I should not cry because if I weep, it is possible when I get pregnant in the future I will give birth to a dead baby again (Feidiib).

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One other woman had this to say about her experience;

Those mothers and grandmothers always tell me that I should not be in tears for it is a taboo. They say when you deliver a dead baby you don't have to be shedding tears (Daanoaman).

Stillbirth is seen as a taboo and mourning or weeping a stillbirth was something forbidden as it was perceived to have a possibility of recurrence when mourned. The mothers therefore after a stillbirth were always forbidden from crying, weeping or mourning.

4.3.3 Evil Visitation

To some mothers, stillbirth means the visitation of evil in the family or household.

Whiles expressing their views on what stillbirth means to mothers, some of the mothers had this to say about stillbirth occurrence;

Why me delivering dead baby, are my enemies at work or what (Kinansua).

Dunwak also said;

They see it [SB] as an evil child who doesn't want to stay. That is why it is dead on arrival (Dunwak).

Another participant in narrating her SB experience had this to say;

In our tribe or culture, when it [SB] happens, some people will say the baby doesn't want to live that is the reason for dying and others will say the baby is a bad baby (Tipoa).

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Yapoa equally expressed her SB experience as stated below:

When your baby is born dead, they say it is a bad thing. They say it is a bad luck to the family and you the mother is also seen as a bad luck woman (Yapoa).

4.3.4 Loss of Future Dreams

Some women described stillbirth as the loss of a baby. These were some of the expressions of the participants after experiencing stillbirth;

The meaning of it [SB] is just a woman giving birth to a baby and the baby passed on (Konjit).

It means delivering a dead baby. In my tribe (Kasem), it is called "Buture" meaning a dead baby or child. They will shave your hair to show that your baby is dead (Kanboisua).

Apart from the above narrations, two other women narrated their understanding of SB as follows:

My understanding..... the baby is not there, you just delivered the baby away (Dunwak).

Hymm, to me it means my child is dead; I will be going home without a baby in my hands (Feidiib).

The dream of every pregnant woman especially in Africa where children are so cherished is to give birth and hold a baby.

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This stems from the fact that children socio-culturally are seen as those who will continue the family lineage and those who will take care of their elderly parents when age catches up with their parents.

In the unfortunate situation where SB occurs thereby denying the mother of having a child, the SB is perceived as a dream not coming true. Some participants in the study had these to say about the meaning of stillbirth to them;

There was no baby, no baby, crying....., in the house it is only men who will just sit at home and they don't have anyone to talk to or play with but as a woman, every woman's dream is to be a mother one day, so that dream was just dead at that moment(Dunwak).

Yes, the regret I have is that I have suffered for months carrying nothing. It was a period of waste and dead dream; I wished I never even had such a pregnancy (Feidiib).

Similarly, **Diberiba** and **Soawusi** expressed their experience as follows:

I looked at myself like I was nothing because I lost the baby. Anytime we have the chance of having a baby it ends up in vain. I needed the baby badly, that was my dream (Diberiba).

Immediately I heard the news [SB] I thought of all that I went through from the time of pregnancy carrying it for nine months and everything ending this way....., it means my hope of having a baby has come to an end. No more dreaming of a baby, hymmmm (Soawusi).

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4.4 Challenges after Stillbirth

Life after a stillbirth can be a challenging moment for mothers who experience stillbirth. The participants of this study revealed they encountered numerous challenges after stillbirth ranging from clinical neglect, spousal/partner challenges, social withdrawal, and stigmatization.

4.4.1 Clinical Neglect

Participants described having experienced some form of neglect whilst in the hospital setting. Some of the participants expressed being neglected emotionally and physically. Participants gave their narrations as;

When I got to the hospital they told me that the baby was already dead inside before I came. So when the doctor is coming the care you will get is different from when the doctor comes and goes (Nayinpoa).

Whiles **Nayinpoa** narrated her feelings as above, **Moiman** also gave her feelings as stated below about her clinical experience;

I started experiencing pain and she [midwife] was informed but she never came, the pain started again and she was informed again but still she said I should wait. I was just left alone struggling on the floor till God favoured me and I delivered a dead baby myself (Moiman).

Some of the participants had feelings that nurses, midwives and doctors in attending to them were not sensitive to their individual feeling in the way and manner they cared for them. Participants expressed their sentiments this way; more especially in the presentation of information to mothers:

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I pleaded with her [midwife] to come and help me and she didn't mind me, the second time she shouted on me that the baby is dead and I am there disturbing them. She [midwife] will not waste her time on me. I was also there to give birth, how come I was treated this way, is it because my baby was dead? It was not my wish that the baby was dead. She just spoke anyhow and left me alone (Mampaya).

A participant also narrated her bitterness as:

There wasn't anything good in the hospital, I can remember because I didn't admire the treatment meted on me. It was more of creating confusion for me. There were times they are supposed to be patient but they were harsh telling me I cannot spoil their job, meanwhile it was not my making, I was in pain (Moiman).

Adequately giving clinical information to mothers about their loss of babies during delivery is very important in post stillbirth. Mothers after SB in the study narrated their ordeal of not giving timely information about the death of their babies. Some participants narrated their feelings as;

What happened was that I was in labour and I went to the hospital. So when I went they received me well and examined me. In the labour room with the labour pains they were consoling me and doing everything for me not knowing the baby was already dead inside. To me I thought I will give birth to my live baby. I really didn't know that the baby was dead and they didn't also tell me early (Diberiba).

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Some other women narrated their clinical encounters with care providers as:

Actually at the time I gave birth, I was thinking that the baby was alive, so they took the baby away and later on they came and told me that I lost the baby. I was thinking they will tell me at that instance that I lost the baby but they didn't tell me. When they finished cleaning me, dress me up, and then I was thinking that when I go out I will have my baby by me not knowing the baby was dead. I was not happy about that (Konjit).

After delivery I didn't know it was that way [SB]. So some of the pregnant women will come and deliver and I was just lying on my bed for some time. Then I asked my mother-in-law if she could go and bring my baby to breastfeed, so she told me to wait for some time. I got up and walked towards a basket that they kept the baby in and they shouted at me not to open. All that they were doing made me think otherwise and my mother did not also tell me anything (Nayinpoa).

4.4.2 Social Withdrawal

The common challenge that confronted mothers after a stillbirth was isolation and social withdrawal. The study findings showed that mothers after SB were socially withdrawn. Some participants shared their views as follows:

So when that [SB] happened, I used to sit alone, think, I don't mingle myself with people, I don't roam, I was just indoors alone (Konjit).

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This is what a participant said about her SB feeling:

Those days whenever I wake up from bed, I will stay indoors because I was unhappy and didn't want to talk to anyone. All this prevailed for some time before it finally stopped (Diberiba).

Another woman also expressed that:

For the actual fact, at home whenever I was in the midst of women holding their babies, it reminded me of my loss baby, so I will start weeping because of that I stopped going to gatherings and where women and their children will be. Also whenever I meet those I was pregnant with attending weighing backing their children, it always puts me into thinking, so because of those thoughts and feeling too I stopped going to the hospital after my first visit after delivery (Nayinpoa).

In the words of a participant, she asserted that she had decreased activity as described:

It [SB] has reduced my activity, I don't do a lot as I used to, I don't really feel free as I used to, I feel like when I am walking they will be pointing fingers at me that this is the woman who gave birth to the dead baby or something like that, so those thoughts actually made me to be indoors (Soawusi).

4.4.3 Spousal/Partner Challenges

Mothers are challenged with compromised marital relationships after stillbirth. Some participants revealed;

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What was worrying me after the second delivery [SB] was that some family members of my husband started treating and speaking to me in a way that was not making me happy and even my husband told me that I have to go back to my parents for them to check on me and treat me, that may be I was sick and that could be the cause of me delivering dead babies (Akongyani).

A woman after SB experience also said this:

My husband was not happy and so could not even welcome me back home and give me comfort as a wife for a successful delivery, because you deliver such a thing[SB], you will be in your mother-in-law room and will not go near your husband, your husband tend to misbehave in such a way that will hurt you (Kanboisua).

Moiman and Daanoaman also described their marital challenges after stillbirth as follows:

My husband's parents were insulting me. I cannot even count the insults; they were saying that he should leave me and go in for a different wife. What I have realized is that the man [husband] has actually accepted the allegations against me, that is why he went and married a second wife in addition to me. That if I will agree, we live together and if I will not agree then I should pack and go. Today I am that and that, once I am living with them, I am just there... (Moiman).

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Some will say the delivery of the dead baby is bad luck of the woman, so they will encourage your husband to marry a second wife for it could be that the new wife have good luck and can deliver live babies

(Daanoaman).

4.4.4 Stigmatization

Stigma is one of the challenges of women after stillbirth. Women after stillbirth are insulted, labelled as bad or wicked and people sometimes point accusing fingers at them. Women after stillbirth are the subject of discussion in some communities. The participants of the study gave varied expression on their stillbirth experience;

Those inside your house will send you outside and insult you to the community and the outsiders will be insulting you. So much was heard about me outside (Tipoa).

This was a similar stigma experience of a participant after SB:

Master, what do you want me to say, it was not easy, everybody saw me to be the woman who gives births to dead children. People will be talking about me and when they see me they will stop talking as if I intentionally killed my children. Hymmm, it is only God who knows why (Feidiib).

The stigma associated with SB make mothers mourn silently after the loss to avoid further accusations of being the cause of the loss. Mothers therefore tend to mourn their loss silently since mothers see SB as a major loss to them. Participants narrated their experience as;

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It was not easy but I had to receive whatever anyone was saying in good faith. I will hide and think over it [SB] and weep seriously. It affected me a lot but I had to hide the effect because of what people were saying. In fact I wept silently for days any way (Feidiib).

Another woman who shared similar experience just as above had this to say:

So because of that I just had to keep crying especially when no one is around but when people are around, I just co-operate with them for some time. The fact that they are saying do this and that so that people will not know that you are but inside you it will be like fire (Dunwak).

4.5 Coping Strategies

The study participants narrated diverse activities that assisted them to cope well after stillbirth and helped suppressed their emotional pain. Some of the activities that emerged according to study participants included spirituality, diversional therapies, and comfort from own children, and self-motivation.

4.5.1 Spirituality

Almost all the participants (both Muslims and Christians) believed in the fact that God existed and was in charge and had control over whatever situation they were facing.

The participants therefore accepted what came their way based on the spiritual stance.

This spiritual underpinning was described by a number of the women as follows;

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The word of God helped me, as I am sitting now. In my thinking, I know all this that has happened to me is the work of God. It is God who is going to help me in all, I have not much to say but to ask same God to take control, I will always pray in the night and all times talking to God
(Kanboisua).

This was how a participant coped with her loss:

If not because I believe in God and what He [God] can do, Hymmm, it wouldn't have been easy for me because I initially just couldn't take it, my mother-in-law who was around also said I should give it to God and that once I was alive I will give birth again. That was what helped me out
(Dunwak).

Tipoa also recounted:

They will always encourage me that God knows what is best and that when the time comes to have a baby in his own times He will give me. I accepted these messages because I had faith in God
(Tipoa).

4.5.2 Diversional Therapy as a Survival Strategy

These were the captured forms of the narrations of the participants when they described what they did to lessen the gravity of their grief after stillbirth;

I found to myself business that every day that I will go round villages to sell and get back in the evening to cook. I will always do that to engage myself but for sitting idle without doing anything you will by all means be thinking over it. The fact that you interact with people when selling and

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receiving monies and conversing with others, you will not think of anything at that point (Akongyani).

Some other women also recounted how they were able to cope with the loss:

Anytime I remember about it [SB] and I am feeling sad, I pick my Bible and when I am reading the Bible it takes my mind off the situation and further encourages me (Soawusi).

Sometimes too I just listen to music on my phone or just take a walk round if am sitting and thinking too much about the loss to just take my mind away from the sad situation (Danoaman).

This was also how prayer and activities helped another woman after SB;

It is prayer; I always attend prayer sessions and also engage myself in activities to take my mind off the loss (Feidiib).

4.5.3 Comfort from Own Children

For some of the participants, having existing children was another means that helped them cope with the stillbirth. The participants expressed their feelings this way;

Because I suffered with my pregnancy and finally delivered a dead baby, I was sad. I was thinking I will give birth to a baby to add to the children I already have but that didn't happen, so I was sad. That was a subtraction in my number of children. But eventually I thanked God because I still have children, what of those who don't even have one child (Nayinpoa).

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Also, another woman in the study narrated her story as:

Sadness.... I had it because of the difficulty I had during the nine months period of my pregnancy and only to give birth to a dead baby. It is painful thinking about it but after all thinking ends, because I see my children play in the house and I am relieved a bit (Kanboisua).

4.5.4 Self-Motivation

The inner empowerment of the participants enabled them to cope well after SB. The study participants in their varied ways presented their narrations this way:

I just encouraged myself with the fact that the baby I lost was not mine and that God will give me another baby and as an individual I accepted it as it was (Tipoa).

This participant also narrated how she finally motivated herself:

It was the same talking by people; there was nothing they will give you apart from the motivational talks that they gave. But I personally just told myself that it was okay, my life will have to continue and that was how I helped myself (Dunwak).

Similarly, another participant stated:

Whether change in life or no change in life, I have to just control myself to be able to live after all, it [SB] has happened (Moiman).

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The possibility of getting pregnant again and having another chance of giving birth also helped mothers after stillbirth cope with the loss. Some of the participants shared their experiences;

After I had, I tried to listen to what the midwives were saying actually, they told me that I was still young and I still have, I can still have a baby, so I thought about another chance since I am still alive and calmed myself down and I wasn't crying again (Soawusi).

Some other women who also motivated themselves shared their stories as these:

I just gave hope to myself that one day God will give me mine [child]. So that was what I used to console myself (Mampaya).

With time I was getting out of the sadness because I know that there was a way out so far as I was alive. I lost this one [child], the one who gave me can still give again (Konjit).

The fact that mothers survived the birthing process without dying themselves helped mothers to cope well with SB. Mothers believed they could equally have died during the delivery process and once they are alive and hoping to give birth one day, they were fine. Participants had this to say;

After the delivery of the dead baby, life was normal to me. When I was pregnant while in school, my father was not happy but for the fact that I delivered a dead baby and was alive myself they were happy. Even though it was dead, one cannot

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be happy over it but once I delivered successfully and in good health, I will continue my education (Akongyani).

Similarly, two (2) other participants also had their experience to share:

What worried me was the fact that I delivered a dead baby; also I thought of it that God does his work that way. It could be that during delivery I could die leaving the baby but the fact that the baby alone died and I was healthy alone makes me not to be worried much over it (Nayinpoa).

I had much thoughts and it was disturbing because the baby died inside and was to be delivered; this could cause my death too so I was afraid. After examining me and knowing that the baby was dead inside, I was now wondering if I will survive the delivering process too or not, till God and through the help of the nurses and midwives I survived. Even though I delivered successfully, I considered myself that I was dead and back to life (Diberiba).

4.6 Grieving Process (Reaction to Death)

The participants showed various expressions to the news of the loss such as denial/disbelief, shock/sad, openly weeping and crying in pain and anger, blaming others, bargaining for time and finally accepting the loss as real.

4.6.1 Denial/Disbelief

Participants in the study demonstrated some level of denial/disbelief in some of their expressions and others had the expectation that the news of the loss were not true.

Soawusi, Feidiib, Mampaya, and Dunwak recounted:

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When the baby came out dead and they told me, I didn't want to believe it, that my baby was actually dead because I was expecting a live baby not a dead one. I didn't see thelike they didn't tell me the truth when they examined me and realized the baby was not going to make it or the baby not breathing well or something like that, so I was not believing what they were telling me (Soawuasi).

Other women expressed the same feelings as above. This was how they expressed their feelings:

You know it is not easy, it is not...to give birth especially your first child and he dies... I wished to... It couldn't be true, awwww (Mampaya).

I initially didn't want to believe it, I thought it was a joke, in fact I couldn't understand the whole thing, I thought of it for some time, I became shocked that I had no baby (Feidiib).

I wished something could be done within minutes and the baby will start crying but..... initially did not want to hear that the baby was dead, Hymmm but when I finally saw the baby well it was clear that the baby was dead, so I began asking myself why me.... (Dunwak).

Denial as shown in some of the narrations of the participants above is consistent with the first stage of the normal grieving process as shown in the theoretical framework guiding the study.

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4.6.2 Shock and Sadness

The participants reacted in diverse ways upon the receipt of the news of the loss of their babies. Soawusi, Moiman, Akongyani, and Diberiba recounted:

I was shocked and didn't know what to do. It was very sad to me and the people around me made me to know that I had a great loss so those days were not interesting to me. I didn't find anything interesting to me.

It changed my mood; I have not been happy like I used to be before. It was a disappointing moment to me and really made me sad (Soawusi).

Shock and sadness were also evident in the narrations of some other women as:

I was sad and the doctor told me to exercise patience because how the whole thing happened, they too were not happy. It is really a shock to me making me shed tears at the end (Akongyani).

I needed the baby badly. How can you be happy after losing something you cherished so much? I will definitely be sad because I lost it [baby]. It is shocking to believe this (Diberiba).

4.6.3 Blame/Anger

Some of the participants in their reaction to the loss blamed care providers for the outcome of their pregnancy while some other participants were angry towards care givers. Here are the varied responses of the study participants:

What has disturbed me was that, during my antenatal care at Langbensi clinic, they never told me anything about what was happening to the baby inside me till it happened this way. When I started to labour at langbensi

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clinic then the midwives said the baby was not lying well so I should go to Nalerigu hospital meanwhile they were those attending to me anytime I visited the clinic for antenatal why didn't they identify this early (Nayinpoa).

A participant angrily recounted:

My brother, I can't say I received adequate care or not, I cannot say I adequate care because I don't know what the problem was and if anything at all, they [care provider] should have been able to identify it and help save my baby before my baby dies. Oh yes, I couldn't understand the reason....why they were not able to detect that the baby was not breathing before the labour started. How? I didn't want to talk to the midwives because I was not happy with them, then I started thinking about how God could treat me that way and wished He [God] will just say it is not true (Dunwak).

Another participant wished God could intervene as she said:

Oooh my God, then I was like the nurses and midwives didn't do their work well that is why my baby died. I wished God could do something about it so that it will not be true for some time (Konjit).

One woman openly described the expression of her anger through weeping or crying in pain as follows:

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I was in pain and regretted for being pregnant. I was weeping, the nurses and midwives were saying I shouldn't weep but it wasn't easy. It hasn't been easy still but God is taking care of me, I will be fine with time
(Konjit).

It is evident from the narrations of participants that some were angry at and blamed care providers for their loss while others were angry at and blamed God for their loss experience. This was a normal reaction to the loss.

4.6.4 Bargaining

Some of the participants after realizing they have lost their babies started bargaining with the supernatural powers or God to either delay the loss or postponed the loss. Mothers were not ready at that moment for the loss and wished something could be done about the loss. Participants gave their narrations as follows;

I was powerless; I didn't want to lose my baby at that moment. I wished God could just do something so that my baby will breathe again
(Dunwak).

The same experience as expressed above was recounted by another participant as:

I just kept quit and prayed to my God, saying God should change it[SB] for me because I am not ready for it[SB]now **(Moiman).**

Mothers in the study upon realizing their powerlessness started bargaining with the supernatural being (God) to either postpone or delay the loss as expressed in some of the narrations. This means that SB is not a friendly experience to mothers.

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4.6.5 Acceptance

Almost all the study participants accepted the loss situation in good faith at the end.

Having gone through various forms of reactions in response to the loss, some Participants narrated as follows:

...from there I realized that it is true I loss the baby and there was nothing I can do about it so I accepted it and started looking for ways to putting myself together again and to put my concentration on the future (Soawusi).

Other participants narrated differently how they accepted the loss as:

I received the information in as it was. I accepted the information that way having it in mind that it was the work of God (Danoaman).

I thought of it for some time, wept and decided to accept it for I couldn't change it. I had no option than accept it like that (Feidiib).

With time I got out of the sadness because I know that there was a way out so far as I lost this one. The one who gave me can give me again so I accepted the loss without many problems any more (Konjit).

4.7 Support Systems

Support system was also one of the main themes that emerged from the data collected and analysed. The women narrated the various support systems in words such as “help”, “comfort” or “resources” that also enabled them recover from the loss. The period shortly after the death of the baby and after discharge from the health care facility happened to be the most critical moment at which bereaved mothers needed a greater

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amount of emotional and psychosocial support. Four sub-themes emerged, comprising religious support, care provider support, friends support and family and community support.

4.7.1 Religious Support

Support system from the religious domain was very instrumental in the recovery of women after stillbirth. Mothers after stillbirth expressed how support systems from their respective religious backgrounds helped them in their recovery process.

When I got home from the hospital, they [church] came and prayed for me in order to enable me have comfort and not to be thinking so much over the incident (Nayinpoa).

Another woman said;

The church did well for me. My church members after they heard of the news came and visited me and prayed for me. The father blessed me and spoke some comforting and encouraging words to me and that kind of relieved me at that moment. Some church members even brought me gifts and money to support myself. They [church members] were always there for me encouraging me with the word of God and telling me about how miraculously our God works (Soawusi).

Some two (2) other women narrated how religious support benefitted them as:

On the side of my religion, they will always pray for me especially on Sundays, for instance, they will come to me after service in a group and pray for me and encouraging me that God is great and that our own

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[child] is on the way coming. They will sing praises songs to motivate me

(Danoaman).

A special prayer (“Adua”) session was organized for me by the Iman and colleague Muslims. It was just words of encouragement to me. They will

read from the holy book, the Quran to help me and some verses were

given to me to always recite as a way of helping me in this difficult time.

The women too were fetching water for me on daily basis and engaging

me in interactions (Feidiib).

4.7.2 Care Provider support

Functional support system at the health care setting delivered by care providers equally played a very important role in the recovery of women after stillbirth. Some participants had this to say about the support system they benefited from care providers at the health facility after stillbirth. A participant said:

What made me not sad at the hospital was the way they talked to me after

the death. They cared for me with kindness and sympathy. They will be

pleading and begging me to eat. They all [doctors and some midwives]

cared for me well and that helped me (Tipoa).

A woman also narrated:

I delivered at the hospital, so after the baby was out, they struggled and

the baby could not breathe so they showed it to me and said the baby was

dead. They spoke to me nicely and even looked for people to come and talk

to me.

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They ask of my religion and I told them I was a Christian so they brought one of their pastors in the hospital who consoled and talked to me
(Dunwak).

Some other women expressed their experience as:

People were counselling me and consoling me; the midwives tried, the doctor too also talked to me, they were having.... I don't know whether she was a pastor or counsellor, she too talked to me and encouraged me
(Konjit).

I received various forms of support. In the hospital they counselled me and encouraged me and gave me moral support which helped me somehow
(Feidiib).

4.7.3 Support from Friends

Another category of support system that was available and helpful to some of the participants was support from friends. Some of the participants narrated how they received and benefitted from support from friends and acquaintances after stillbirth.

My friends, those I am living with and neighbours were always there for me encouraging me daily, performing certain duties for me in the house like sweeping and washing bowls, after which they will chat with me throughout
(Kinansua).

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These are some other expressions of some women:

When I got home after discharge from the hospital, my friends will always visit me to converse with me and to keep me company. They will be with me from morning to evening, supporting me do my household chores and cooking. This care alone they gave always gave me comfort (Nayinpoa).

My friends used to come to me, sit with me, do everything for me, anything I want, they will do for me and where I find myself they were always around to support me. Whenever they are around I forget of all that happened and looked active (Kanboisua).

Friends play a key role in assisting women after SB as revealed in this current study. Friends therefore should be involved in the care of bereaved women.

4.7.4 Family and Community Support

Support systems in the community including family support played a significant role in how quick or fast mothers recovered from stillbirth. Some Mothers after stillbirth narrated their views as follows:

All my family members and the community people helped more. In Zarantinga here, whoever heard of the issue came and sympathized and will always advise that “it is the water that poured out but the pot is not broken, you will definitely fill it again” a local proverb in Mamprulli meaning once your baby is dead and you are alive, you will give birth again (Diberiba).

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Similar support was received by a participant; this was how she described it;

At home they treated me well. They said I was not strong at that moment to do anything so they will heat water for me to bath in the morning and evening, cook for me to eat and also give me words of encouragements (Tipoa).

Family and community support was also evident as a participant narrated:

My family members like my mother in-law, sister in-laws and brother in-laws helped by encouraging me and telling me it is the will of God. The community members visited me daily, engaged me in conversations just to divert my mind from the loss, they helped sometimes wash clothing, fetched water for me and even cooked sometimes. A lot of the people in the community sympathize with me by visiting me and fetching water for me (Feidiib).

Some spouses/partners were said to have been very supportive after stillbirth that helped mothers to recover quickly. Some of the participants put their impressions about their spousal/partner support as follows:

It was my husband who was also fetching water and even cooking sometimes for me to eat. I could not do anything by myself after discharge from the hospital, I didn't know why. I was so much disturbed. He will fetch corn and send to the grinding mill to grind and come back and prepare T.Z(Tuo Zaafti- locally prepared food) for me to eat especially T.Z with my favourite soup (Kanboisua).

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Another spousal support was recounted by a woman as:

After I delivered the dead baby, my husband was so much disturbed when he came to me, the whole incident disturbed my husband but he was able to gather courage to counsel me and was able to care for me successfully. When he noticed I was indoors he will encourage me to come out of the room (Diberiba).

Akongyani, a participant equally said:

The things that made me gather courage was the way I was cared for and also, the way I was with my husband didn't make me feel worried. After discharge whenever I was seated in a way that will make me uncomfortable, my husband will come and engage me in a conversation (Akongyani).

4.8 Summary of Findings

Stillbirth is a major loss to mothers with different meanings including loss or failure of womanhood, cultural encounter (taboo), evil visitation, and loss of future dreams. Due to the various meanings assigned to stillbirth mothers after stillbirth grief and equally face challenges such as clinical neglect, isolation or social withdrawal, insensitive care, spousal/partner challenges and stigma. Several coping strategies assist mothers after stillbirth adjust well. The coping strategies such as spirituality, individual survival, self-motivation, diversional therapy, and comfort from own children, and hope/second chance were deemed helpful to study participants in dealing with their loss experience.

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Additionally, support systems such as religious support, care provider support, support from friends, and family and community support aided mothers after stillbirth to recover faster. Five main themes and twenty one (21) sub-themes emerged from the data. One of themes (grieving process after stillbirth) revealed findings consistent with the constructs of the model used whilst findings from the rest of themes emerged as new data.

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CHAPTER FIVE DISCUSSION OF FINDINGS

This chapter discusses the findings of the study in relation to relevant literature.

The discussions are pinned on the main themes and sub-themes that emerged from the study. The discussion will centre on meaning of stillbirth, challenges of stillbirth, coping strategies, grieving process and support systems after stillbirth experience.

5.1 Meaning of Stillbirth

The meaning of SB is between the mother victim and the society in which the mother lives; thus the meaning of SB is based on the socio-cultural context from which the mother finds herself (Golan & Leichtentritt, 2016; Neimeyer, Prigerson, & Davies, 2002). The meaning or understanding surrounding death (SB) is very key to the total well-being of human beings (Barret, 2011; Sturrock & Louw, 2013). However the understanding surrounding death (SB) or meaning of death (SB) differ greatly based on society and culture (Neimeyer, 1994). The meanings mothers attach to SB in the study included loss of womanhood, cultural encounter, evil visitation and loss of future dreams.

The current study revealed that SB is perceived as a great loss and failure of womanhood. Womanhood in Africa is defined by the ability of the woman to give birth to live children. The expectation of most women therefore after years of marriage in the African setting is to deliver babies. If after marriage the woman is unable to give birth or gets pregnant and the pregnancy ends in stillbirth, the loss is viewed as a serious loss and failure on the part of the woman. This finding is consistent with a quantitative study by Mehran, Simbar, Shams, and Ramezani-tehran, (2013) among women with perinatal loss in Iran and Murphy, (2012) in the UK on the parental experience of stillbirth.

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Findings of that study suggest that parents (both) recounted SB as a failure in parenthood. Furthermore, the identity and worth of a woman is determined by her ability to give birth as reported by women in this study and in a previous study in India (Robert and Lee, 2014).

The current study found that experiencing SB in certain cultures and societies is a taboo committed. Therefore, cleansing must be done to purify individuals involved. The study revealed that in purifying the individual victims of stillbirth, rituals in the form of shaving hair and separating couples for about 3-4 days depending on the gender (3 days for male SB and 4 days for female SB) of the SB is done as part of the purification process as reported in the literature (Roberts et al., 2017; Roberts, Anderson, Lee, & Montgomery, 2012, Attachie & Mwini-nyaledzigbor, 2016). Similarly, the findings further support Holland and Neimeyer, (2010) who found cultural issues in relation to the meaning of stillbirth. Also, gender abuse was found in the current study as victims of SB were subjected to cultural purifications rites such as shaving of hair against their wish after the SB experience.

This study has again revealed that stillbirth is the visitation of evil spirits to the family. This finding collaborates with Bakker and Paris, (2013) study in the United States of America. Similar finding was revealed by Niemeyer and Sands, (2011) in the U.S that death in general was seen as crisis to the family. However, contrary findings were reported in the study of Lichtenthal, Currier, Neimeyer and Keese, (2010) in the US where that study found SB as the will of God.

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Additionally, the women ascribed the status of a full human being lost to SB as similarly reported in Pakistan (Hamid, Ullah, Malik, & Richard, 2014) and in the UK (Mills et al., 2014). The mothers explained that children are the continuation of familial lineage in the African society and SB cut that continuation of the family lineage. This seems to suggest that the cultural background of the women influenced the meaning assigned to SB.

5.2 Challenges after stillbirth

Life after stillbirth is a challenging moment for mothers who experienced (Attachie et al., 2016). The participants encountered numerous challenges after stillbirth ranging from clinical neglect, spousal/partner challenges, social withdrawal, and stigmatization.

The findings posit that women who had SB experienced clinical neglect from health care providers. The women asserted that they were left unattended to after they delivered dead babies. This was also a concern for women in South Africa (Modiba & Nolte, 2007). Contrary, this refutes the findings of Cacciatore, Defrain, Jonnes, and Jonnes (2008) in the US who reported that mothers after SB received positive support from the midwives and doctors. Also, majority of the women stated in this study that health personnel neglected their emotional feelings during care especially in informing them of the SB which is essential to their emotional well-being. This neglect seems to be a huge challenge to these women after SB delivery. Furthermore, the women in this study reported social isolation after SB. This was attributed to the devastating experience of the loss of babies and social stigma.

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Participants indicated that they found themselves withdrawn from the public anytime they were thinking and mourning over their lost babies as reported in previous studies (Cacciatore, J.(2010); Campbell-jackson, Bezance, & Horsch, 2014; Roberts et al., 2012).

This study identified marital and social consequences suffered by the women in their social context after SB. For some of these women, their in-laws were advocating a second wife for their sons to give birth to live children, others were confined to their mother in-laws' rooms without having access to their husbands, while others were sent back to their natal homes for ritual purification. This appears to propose that an unfriendly relationship existed between women and their husband/spouses and other family members after SB. These findings are consistent with the findings of other studies (Gauzia,Moran, Ali, Ryder, Fishser, & Koblinsky, 2011; Koopmans, Wilson, Cacciatore, & Flenady, 2013; Shreffler, Hill, & Cacciatore, 2012).

This study also uncovered social stigma among women after stillbirth. These women are relegated, labelled as wicked, become the subject of discussion in communities and are marginalised by the society. This gives the impression that mothers after SB can develop psychological problems due to the challenges they face. This finding supports the work of other researchers who also found social stigma among women after SB (Murphy, 2013; Roberts et al., 2017).

5.3 Coping Strategies

Women in this study devised various means of coping with SB encounter which are considered significant to their emotional well-being. Varied among them are spirituality, diversional therapies, comfort from own children, and self-motivation.

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Though, all the participants (both Muslims and Christians) sounded superstitious in associating meaning to SB. The women indicated that spirituality played a key role in their coping. They had comfort from the word of God who had control over whatever situation they were facing and through prayer they believed and hoped that God will surely blessed them with live babies. Women in Uganda (Kiguli et al., 2017) and Israel (Hamama-Raz et al., 2014) used similar coping strategies. It is therefore imperative that the role of spirituality and religiosity in grief should not be overlooked in the care of mothers after SB or loss experience in general.

Similarly, diversional therapy was revealed in this current study as a form of strategy women employed to cope with post SB consequences. Women resorted to reading of Bibles or Qurans, listening to music and engaging themselves in all kind of works that will limit them from thinking about SB. Also, the present study reported self-motivation as a key coping mechanism as the women go on with their daily lives after SB. Majority of the study participants demonstrated tremendous inner strength. The women had the will to live and believed that they will still deliver, which they felt made them move on with their lives. Again, the fact that women survived themselves without dying after SB encouraged and motivated women to cope well after SB. The hope of a second chance was also found to be motivating enough for mothers after SB to cope well.

Moreover, having existing children was a source of comfort for women and a means that helped them to cope with the lost. Some of the participants revealed that seeing their own other surviving children around them were comforted and relieved enough to overcome grief.

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Women who had children before experiencing the SB took solace and consolation from the fact that they had other living children and were not deficient as “mothers” as culturally perceived. However women with no existing children indicated how overwhelming it was to live without children, but had nothing than to distance themselves from situations that reminded them of their childlessness. The women reported that the sight of children reminded them of the loss and made them sad.

5.4. Grieving Process after Stillbirth

The study revealed that participants in grieving stillbirth first denied the loss, became shocked and sad, blamed significant others and became angry, bargained for time extension and finally accepted the loss as such. The mothers upon hearing the news of the SB exhibited denial and did not want to believe the news (SB) wishing it was not true. Mothers who experienced SB for the first time exhibited greater denial state and could not understand the concept of SB and therefore wished the babies could come back to life within minutes. These findings are in tandem with the finding of Scheidt et al., (2012) in Germany. The findings implies that the mothers cherished children so much that they did not want to lose them probably due to the socio-cultural implications of SB.

Furthermore, mothers after the SB experience became shocked and sad. Mothers perceived the SB as a great loss as much importance was attached to having babies. Mothers revealed that SB was a disappointing and sad moment for them. This resulted in the loss of interest of mothers with SB experience for everything around them. The study further revealed that some mothers after the stillbirth blamed care providers for causing the death of their babies. They were not happy with the midwives and doctors for not identifying early that the babies were dead and informing them.

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They equally could not understand why after several antenatal attendances they still had stillbirths. Contrary to the finding however, Modiba & Nolte, (2007) found that participants blamed God for their loss and demanded answers as to why they lost their babies. It is important for bereaved mothers and families to be educated on the cause of the stillbirth to reassure and to allay anxiety to mothers and families. Furthermore, the study revealed that mothers did not want to lose their babies. Therefore, mothers bargained with God to either delay the loss or postpone the loss. Mothers after the SB felt powerless at that moment and believed that it was only God who could change the situation of the loss (SB).

Lastly, the study found that mothers after bargaining with God for the loss finally accepted it. Almost all the participants after reacting to the lost news variedly accepted the loss as such. While some accepted the loss because they could not do anything about it, others said it was the work of God, and others revealed they could not even change anything if they continue to mourn and therefore had to accept it. This finding is consistent with the last stage of the grieving model underpinning the study.

5.5. Support Systems

Stillbirth represents an awaited birth that ends as death or a short life that is quenched with all its anticipations, hopes and dreams (Rapheal-Leff, 2009). It is a unique grieving period for the woman and in some instances the man. The provision of support as an intervention is therefore relevant after stillbirth. After the stillbirths experience, the mothers received support from different sources which enabled them to recover from their stillbirth loss.

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This study revealed that the support mothers received was in the form of encouragement, counselling, reassurance, good or nice care, and expressions of hopefulness. The sources of the support were from care providers, friends, family/spousal and community.

The current study documents that some of the mothers while in the hospital setting in the maternity ward before, during and after their loss received varied forms of support from the nurses, midwives and doctors. The support mothers purportedly received from the care providers were in the form of consolation, counselling, encouragement, hope, and nice communications which further strengthened their coping abilities after the loss and also helped in the reduction of the psychological effects of the stillbirth in their daily lives. Several studies have brought out findings consistent with the current findings (Allahdadian & Irajpour, 2015; Navidian, Saravani & Shakiba, 2017; Cacciatore, Erlandsson & Ra, 2013, and Williams, Munson, Zupanic & Kirpalani, 2008). Their studies highlighted the supportive role of care providers after stillbirth, perinatal loss or loss in general which helped in coping.

Similar findings were reported in others studies about the positive impact of care providers' support role in coping after stillbirth (Gold, 2007; Schnebly, & Froen, 2008; Caelli et al, 2002; Johnson & Langford, 2010; McGuinness, 2013; Moore, Parrish & Black, 2011; Puia, Lewish, & Beck, 2013; and Sanchez, (2001). However, contrary findings to the study were reported about the negative emotional support from care providers by Noredlund, Borjesson, Cacciatore, Pappas, and Radestad, (2012) when they studied the psychological care and negative effect on motherhood when a baby dies. Another contrarily finding (Erlandsson et al., 2011) reported the unmet needs of women with SB.

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There is therefore the need for care providers in the maternity setting to demonstrate empathetic care when caring for mothers after stillbirth as emphasized by Kelley and Trinidad, (2012).

The researcher believes placing emphasis on transcultural midwifery care among care providers in the maternity wards will provide an in-depth understanding of the caring needs of clients leading to the provision of holistic maternal health care to mothers after stillbirth. Also, the availability of support both physical and emotional from friends and acquaintances after stillbirth was prominent in the study. The support from these friends and acquaintances were in the form of encouragement, performance of household activities like fetching water, cooking, washing dishes, sweeping, spending time and engaging bereaved mothers in conversations. All these were helpful to mothers as they reported how they helped relieved them of the distressful moments as reported in the literature (Sutan, Amin, Arrifin, Teng, Kamal, & Rusli, 2010), Engler & Lasker, (2000), Rich, (2000). These scholars suggest that support from friends play a critical role in lessening the negative psychological impact of stillbirth to mothers and therefore the involvement of friends in the care of mothers after stillbirth should be looked at and utilized.

Moreover, support from family members particularly parents, mother and father in-laws, sister and brother in-laws, spouses/partners and the community at large were reported in this study to have helped mothers adjust faster to normal life after the stillbirth. The support that came from both the family and community level were demonstrated in the form of sympathizing, advise, encouragement, doing household chores for the bereaved, and engagement in conversation to divert the bereaved mind

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from the loss. As reported by Cacciatore, Schnebly, and Froen, (2008), family support has the ability to reduce anxiety and depression among women after SB.

Spousal/partner support is also very important in the handling of upsetting life situations (Engler & Lasker, 2000). The type of spousal support recorded in the study was in the form of emotional and financial. These forms of spousal support motivated and encouraged mothers to overcome psychological difficulties associated with the stillbirth, which is not different from reports in the literature (Karin, Worker, & Wredling, (2013), Kiguli, et al, (2017), Robinson, (2011), Sutan, Amin, Arrifin, Teng, Kamal, & Rusli, (2010). Additionally, Koopmans et al, (2013) have also reported that pleasant understanding between husband and wife after stillbirth shortens the length of grief in women. The support role of partners/spouses after stillbirth is evident and therefore should be encouraged, maintained and more education done on the valuable support of partners/spouses at the time of stillbirth as far as its positive psychological impact to mothers is concerned.

In summary, this study found that socio-cultural background of the mothers influenced the meaning assigned to SB. The mothers cherished children so much that they did not want to lose them due to the socio-cultural implications of the SB. The mothers after SB encounter several challenges resulting in unfriendly relationships between the bereaved women and their spouses/partners, family members and the community members at large. These mean that the women can develop psychological problems as a result of the challenges they encounter after SB.

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Furthermore, this study revealed that women devised several coping strategies with the help of varied support systems to overcome the burden of SB. It is therefore imperative to incorporate spiritual care, families, spouses/partners and friends in the care of these bereaved women. Additionally, it is important to educate bereaved mothers and families about the causes of SB to help reduce the anxiety associated with it and its psychological implications. Again, there is the need for care providers in the maternity settings to show empathy and emotional sensitivity in the care of women with SB experience since neglect and insensitive care are reported in the current study.

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CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

This chapter present the summary of the study, the implications of the study to nursing and midwifery practice, education, and research. Limitations of the study is also presented with conclusions drawn and some suggested recommendations.

6.1. Summary

Stillbirth is a global issue. An estimated 98% of the global stillbirths are from African mothers. It is a worrying, harrowing and heart breaking experience. The experience of stillbirth can impact negatively on the mind-set and emotions of mothers if appropriate support systems are not established. The study explored the postnatal mother's experience of stillbirth in the east Mamprusi district of the northern region. The model of the grieving process by Elisabeth Kubler-Ross (1969) was used as the organising framework for the study.

The study utilized the constructs of the model to assist in the achievement of the study objectives. The focus of the model is the general grieving process of the bereaved; the findings of the study have made available evidence for health promotion activities and education strategies to be implemented at the health care setting and society level at large. Empirical review of literature was conducted to assist the researcher present in-depth discussion of the findings. The study adopted a qualitative approach to explore the experiences of fourteen (14) postnatal mothers in the district who met the inclusion criteria and voluntarily participated in the study.

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The participants were all married and had experienced at least one stillbirth. The majority of the women were Muslims with the remaining minority being Christians. Purposive sampling technique was used to recruit participants; face to face interviews were done after participants consented to be part of the study. Interview guide designed based on the study objectives was used to elicit information from participants. Permission was sought from participants to audio record the interview session. Afterwards, each interview was transcribed verbatim and analysed using thematic content analysis. The main themes of the study were five (5) and a total of twenty one (21) sub-themes emerged. Findings of the study revealed that stillbirth had varied meaning to mothers including loss and failure of womanhood, cultural encounter (taboo), evil visitation, and loss of future dreams.

It was also found that mothers after stillbirth encountered several challenges in their marital relationships, hospital setting and society in general such as clinical neglect, isolation, insensitive care, broken marital relationship, valueless, social withdrawal, the lack of support, weeping in silence, stigma and clinical communication barriers. It was also revealed that participants relied on coping strategies such as spirituality, self-motivation, hope of second chance, the fact that mothers survived themselves, and the receipt of good care from care providers to enable them cope well with the loss. Additionally, participants went through the normal grieving process which is consistent with the constructs of the model used for the study.

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The participants though adopted certain coping strategies to cope well, they were also of the view that support from the religion, care provider, friend, family and community and spouses/partners also assisted them to recover faster after their loss experience. The following suggestions were made by participants as interventions that would much help the mothers in their grieving period. These included education of spouses/partners who are not supportive on bereavement needs of mothers, training of health personnel on compassionate care, counselling, sensitivity of stillbirth and communication and disclosure of deaths.

6.2 Implications of the study

The findings of this study have implications for nursing and midwifery practice, research and education.

6.2.1 Nursing and Midwifery Practice

The study has established that there are varied meanings to stillbirth with each meaning coming with its psychological implications to mothers. Due to the various meanings assigned to stillbirth, mothers face series of challenges after stillbirth. This therefore is a call for nurses and midwives to inform and educate spouses, friends, families and communities at large about the causes of stillbirth and prevention by way of sensitization to remove the myths surrounding stillbirth. The nurses and midwives in the preventive domain such as the community health nurses, public health nurses and community midwives have a huge task of embarking on a proactive campaign on stillbirth and its causes, risk factors and the role of family, friends, spouses and community members after stillbirth experience to mothers.

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These practising care providers equally have a responsibility to bring to light the psychological effects of stigma, neglect, blame, the lack of support, and poor communication to mothers after stillbirth to families, friends, and community members. This can be done through community durbars, in the churches and mosques. Again, the provision of special training for nurses and midwives in the maternity setting on bereavement care, ethical issues and cultural needs of mothers is necessary to formalize bereavement care since the current care provision is inadequate and does not totally meet the needs of mothers after stillbirth.

6.2.2 Nursing and Midwifery Research

The current study has revealed that the care rendered to mothers after SB does not meet the expectations of mothers especially their psychological needs. Therefore future studies should explore further the psychosocial needs of mothers after SB in order to provide interventions. Also, scanty data exist in the Ghanaian setting on the experiences of mothers after SB, therefore more explorations should be done in different cultural settings in Ghana in order to generate more data on SB experience to aid in the provision of holistic care to mothers who suffer SB.

6.2.3 Nursing and Midwifery Education

The insensitive, unempathetic and neglectful attitude of some of the nurses and midwives at the maternity unit was reported as a challenge to some of the women after SB experience. It is therefore necessary to remedy these unethical and unprofessional attitude of some of the care providers.

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The nursing and midwifery curriculum therefore should be revised to incorporate bereavement care and professionalism in nursing and midwifery to help inculcate professionally appropriate values in the training of midwifery and nursing professionals.

The need for good interpersonal relationship, therapeutic communication in health and counselling in nursing and midwifery should also be incorporated in the curriculum in order to advance the knowledge and skills of these professionals to empower them provide competent quality health care services. Inservice training and continuous workshops should be well thought-out with emphasis on customer care for midwives, nurses and other health professionals in the maternity settings to enable them render care that meet the expectations of bereaved mothers.

6.3 Limitations

Though the participants demonstrated normal grieving pattern in the study, the possibility of adverse psychological implications cannot be ruled out. The mothers who did not participate in the study could be suffering the psychological consequences of the SB thereby avoiding sharing their experience with the researcher. Furthermore, the possibility of mothers also hiding some aspects of their experience to the researcher due to gender difference between the researcher and the participants cannot also be overruled. Again, the study participants were all married and staying with their husbands at the time of loss. This could have influenced their stillbirth experiences and their views on care and support because, almost all participants reported receiving support from their partners.

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6.4 Conclusion

The study found that stillbirth is a traumatic and heart breaking experience for mothers. The care and services rendered to mothers after stillbirth are not adequate in terms of quality. Appreciable degree of quality health care after stillbirth is needed as stillbirths are phenomena that are common globally with majority in Africa. To curtail the progression of normal grieving evolution to complications among bereaved mothers, there is the need for care and services especially, quality bereavement support services to be easily accessible to mothers after stillbirth in the health facility and community levels. Health facilities must also have laid down procedures in place to support mothers after stillbirth.

Care providers such as nurses, midwives, and doctors must be given formal specific training on bereavement care to empower them work with mothers after stillbirth. There is also the need to sensitize communities on the psychosocial burden of SB on mothers after SB and the role they can play to mitigate the burden of SB at the community settings. It is evident in the study that mothers after stillbirth are in shock and therefore the need for care providers to provide support after stillbirth. It is important to expand studies on stillbirth experiences in Ghana to explore the experiences of postnatal mothers after stillbirth further, which will assist in the formulation of a comprehensive and holistic bereavement care nationally.

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6.5 Recommendations

Based on the findings of the study, recommendations are made to the Ministry of Health, (MOH), Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Nursing and Midwifery Council (NMC), and the Ministry of Gender, Children and Social Protection (MGCSP).

To Ministry of Health (MOH)

The MOH should;

1. Formulate policies that would incorporate bereavement care in nursing and midwifery practice in Ghana to help in the management of mothers after SB.
2. Increase public education through the mass media on the causes and prevention of SB to help reduce stigma and myth surrounding SB.
3. Provide funding for more researches pertaining to SB and psychosocial needs in order to have an understanding of the needs of mothers after SB
4. Formulate policies that would ensure nursing and midwifery staff play key roles in bereavement support as well as providing mothers with the needed health information.

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To Ghana Health Service (GHS)/ Christian Health Association of Ghana (CHAG)

The GHS and CHAG should;

1. Train and empower community and public health nurses and midwives to embark on awareness creation on the causes of stillbirth and its psychological effects on mothers and families to help mitigate the devastating effects of stillbirth.
2. Provide Stillbirth education training targeted towards clinical staff to significantly increase their confidence and competence when dealing with bereaved mothers. A high degree of grief sensitivity training should be extended to all maternity care providers
3. Provide innovative family and community centred care giving programmes needed to support bereaved mothers after stillbirth and to help to reduce the effects of SB on mothers.
4. Create stillbirth bereavement support groups through community and religious partnership to augment the efforts of care providers for holistic management of stillbirths after discharge from the hospital.
5. Initiate community education and dialogue on how to prevent SB and the causes of SB to help in the care of SB mothers at the community level.

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To Nursing and Midwifery Council of Ghana (NMC)

The NMC should;

1. Include bereavement care nursing and midwifery in the nursing and midwifery curricula to assist in the training of upcoming professionals to be well equipped in bereavement care.
2. Ensure ethical principles are adhered to by nursing and midwifery practitioners by constantly doing monitoring and evaluation of nursing and midwifery practice.
3. Sanction nursing and midwifery staff who demonstrate unprofessional attitude in practice.

To Ministry of Gender, Children and Social Protection (MGCSPP)

The MGCSPP should;

1. Collaborate with the GHS to embark on community education on the effects of SB on mothers in the various communities.
2. Should also engage community leaders and community members on ways to assist mothers who suffer SB through community durbars and sensitization.

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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix A: Consent form



**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON**

INSTITUTIONAL REVIEW BOARD

Consent Form

TITLE: Experiences of Postnatal Mothers with Stillbirth in the East Mamprusi District

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GENERAL INFORMATION ABOUT THE STUDY

This study is a qualitative research. It entails the use of an interview guide to collect data from participants. The information will be audio-recorded with permission from participants, transcribed word for word and interpreted to bring out what the experiences of postnatal mothers with stillbirth are.

NMIMR-IRB Form A (Students Only)
Version Date: May, 2016



EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH



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The objectives of the study are to find out what the experiences of postnatal mothers with stillbirth are, their expectations from care providers, society, the support available to mothers after stillbirth, psychological effects of the loss, the coping strategies mothers with stillbirth adopt, the challenges confronting mothers with stillbirth and how mothers with stillbirth grief. The interview will last between 45 to 90 minutes; with a focus on what your experiences were at the time of loss, what challenges you faced, the support you received at the time of loss and after and how you coped. The time and venue for the interview will be decided by you. There is no wrong or correct answer to any of the questions asked; you are therefore encouraged to express yourself freely in whatever manner you so wish.

Possible Risk and Discomforts

The researcher admits that the interview may affect you emotionally however, the researcher equally think you will be better after you express your emotions. You will also be given some time period to put yourself together if you become emotionally destabilized; the interview can also be scheduled another time appropriate if necessary. You will be provided with clinical counselling services if the need arises.

Possible Benefits

The research will provide care providers with in-depth knowledge about stillbirth experience and the steps to take when rendering care to mothers with such experiences. The study will also help other mothers with similar loss experience in their grieving process and society at large will get to know how to handle bereaved mothers after a loss. Your individual benefit as a participant will be the relief you will get after sharing your experience; it is known that that when individuals talk about their emotional pain, the severity reduces.

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Version Date: May, 2016



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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH



**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON**

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Confidentiality

Your personal identity and privacy will be protected in this study; a code that will be known only by the researcher will be used to identify you without using your name on any information that will be documented about you on the study and any other interactions with you. The consent form will be seen only by the researcher and supervisor and will be kept safely in a locked cabinet by the researcher. The electronic data will equally be stored on the computer on the researcher with a password security feature making its accessibility difficult.

Compensation

You will not receive any form of reward in cash or in kind; however, findings of the study will go a long way to improve knowledge on stillbirth experience, guide the caring styles and behaviour of care providers and also provide information to the general society at large on the experiences of mothers when mothers lose their babies at delivery or immediately after delivery and how to manage the mothers.

Voluntary Participation and Right to Withdraw from the Study

Your participation in this study is purely voluntary and if at any point you do not want to participate, you are allowed to do so. You will not lose anything if you decide not to be part of the study anymore. You can contact the following person or the researcher if you have questions regarding the study.

Contact for Additional Information:

Dr. Mary Ani-Amposah,

Department of Maternal and Child Health

School of Nursing and Midwifery, University of Ghana, Legon.

P.O. Box 43, Legon.

Telephone: 0244368205.

Email: mani-amponsah@ug.edu.gh



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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH



**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON**

INSTITUTIONAL REVIEW BOARD

Rights as a Participant

This study was reviewed and approved by the institutional review board of the Noguchi memorial institute for medical research (NMIMR-IRB). Any questions about your rights as a participant in the study can be directed to the NMIMR-IRB office on working days between the hours 8am to 5pm through the office line 0302916438 or by email address nirb@noguchi.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*experiences of postnatal mothers with stillbirth*) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix B: Interview Guide



NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
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Data collection tool (interview guide)

Introduction

My Name is Samson Lambon, an MPhil Nursing student from the University of Ghana. I am conducting a study on the experiences of postnatal mothers with stillbirth. As part of collecting data for the study, I am going to ask you questions concerning the loss of your baby during your last birth, please take your time to respond to the questions and feel free to ask me for further explanations if some of the questions are not clear to you. You may skip any of the questions if you do not want to respond to them. You can also return later to respond to them if you so wish. There are no wrong answers to the questions being asked, so answer them with all the honesty it deserves. Your responses to the questions will not be identified with you but may be of great importance to this study by contributing to data generation. Thank you.

SECTION A - Personal Data

SECTION B

Challenges of Women with Stillbirth

1. What kind of care did you receive prior to notification?
2. Did you receive adequate care at the hospital? Describe the care you received from the Doctors, Midwives and Nurses and other healthcare providers?
3. Did the happenings in the hospital influence your loss? What things were not helpful?
4. What are some of the things that aggravated your emotional pain or feeling?

SECTION C

Coping Strategies of Women

5. Describe how you recovered from the emotional pain

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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH



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6. How did you manage your grief as an individual? What do you rely on in managing your grief?
7. What enabled you to manage your grief?
8. Are there pressures on you to grieve in a particular way? If yes from whom?
9. What are the sources of the pressures? Explain
10. How did you respond to the stressors cognitively or affectionately?

SECTION D

Grieving Process of Women

11. How were the early days of your loss like? Please describe
12. Has your loss changed you in any way? if yes in what way/ways
13. In your opinion, what factors do you believe are involved in creating individual unique response to a loss? Please describe/explain
14. How do you respond to a loss? Please describe

SECTION E

Support Systems Available

15. What do you feel most helped you deal with the death of your child?
16. Describe the care you received after the loss of your child
17. Was there any form of support from the hospital, family, church/religious body, community, social agency? Describe
18. What support did you get from your family, friends and the society? Describe
19. Please share with me any other information in your opinion that will be helpful in the study.

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EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH



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SECTION F.

Meaning of Stillbirth to Mothers

19. What is your understanding of stillbirth?
20. Can you please tell me the circumstances surrounding the death of your baby? When it happen?
21. Please describe what your feeling of losing a baby was like to you.
22. How did you see yourself at the point of loss?
23. Describe the immediate impact of the loss to you
24. What regrets, if any do you have related to the death of your child and events before and after the loss?
25. How do people perceive stillbirth in your tribe/community? Did any of these beliefs hurt you in any way?
26. Have there been any ways in which you are able to make sense out of the loss of your child? If so please describe your experience.



EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix C: Ethical Clearance Certificate

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

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+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH

INSTITUTIONAL REVIEW BOARD



Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

13th November, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 039/17-18

IORG 0000908

On 13th November, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Experiences of postnatal mothers with stillbirth in the East Mamprusi district.**


PRINCIPAL INVESTIGATOR : **Samson Lambon M.Phil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 12th November, 2018. You are to submit annual reports for continuing review.

Signature of Chair: 
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix D: Letter of Introduction



UNIVERSITY OF GHANA
SCHOOL OF NURSING

SONM/F.11

December 15, 2017

Ref. No.:

The District Director of Health Services
East Mamprusi District
Gambu Ga

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Lambon Samson, an M. Phil second year student of the School of Nursing and Midwifery, University of Ghana, Legon. As part of the M'Phil programme, he is conducting a research on "**Experiences of Postnatal Mothers with Stillbirth**". Your outfit has been chosen as his data collection outlet.

I would be grateful if you could kindly offer him the necessary assistance needed to enable him collect data for his thesis.

Thank you.

Yours faithfully,

A handwritten signature in blue ink, appearing to read 'M. Ani-Amponsah'.

Dr. Mary Ani-Amponsah
SUPERVISOR

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 43, Legon, Accra, Ghana.

• Tel: +233 (0) 302 513 250 / 0289 531 213

• Email: son@chs.ug.edu.gh

• Website: www.nursing.ug.edu.gh

EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix E: Thematic Code Frame

NO.	THEMES	SUB-THEMES
1.	Meaning of Stillbirth	<ol style="list-style-type: none"> 1. Loss of womanhood 2. Cultural encounter 3. Evil visitation 4. Loss of future dream
2.	Challenges of SB	<ol style="list-style-type: none"> 1. Clinical neglect 2. Spousal/Partner challenges 3. Social withdrawal 4. Stigmatization
3.	Coping Strategies	<ol style="list-style-type: none"> 1. spirituality 2. Diversional therapy 3. Comfort from own children 4. Self-motivation
4.	Grieving Process(Reaction to Loss)	<ol style="list-style-type: none"> 1. Denial/ disbelief 2. Shock/sadness 3. Blame/anger 4. Bargaining 5. Acceptance
5.	Support Systems	<ol style="list-style-type: none"> 1. Religious support 2. Care provider support 3. support from friends 4. Family/Spousal and Community support

EXPERIENCES OF POSTNATAL MOTHERS WITH STILLBIRTH

Appendix F: Departmental approval letter

