

**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
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**MOTHERS' EXPERIENCES OF STILLBIRTH:
A STUDY IN THE ACCRA METROPOLIS**

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
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DECLARATION

I declare that this research study is a true work of mine; it has not been submitted in part or full for any degree or diploma at any university or educational institution. Information derived from published works and texts from books have been duly acknowledged.

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DEDICATION

This study is dedicated to Elikem, Tomefah and all the special angels who walked past this earth silently; those infants remembered in silence by the families who knew them. The thoughts of you gives pride and are boldly engraved on the hearts of the wombs that carried you, even though you passed in silence you are so close to the families and fondly remembered daily. Shine at rest!

It is also dedicated to all health professionals who go the extra mile to be there when they are most needed; in time of child loss. God bless you!



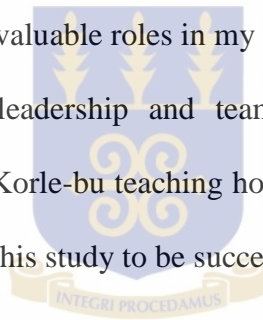
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This project is the culmination of effort and support of individuals who in varied positions were there when they were most needed. I am grateful to the fourteen gallant mothers who sacrificed to endure the pain of recollecting and sharing their valued experiences with me. I join my faith with yours and trust that there shall soon be the replacement of your joy.

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ABSTRACT

The purpose of the study is to explore and record experiences of mothers who lost their babies during delivery. Fourteen mothers in the Accra Metropolis were recruited, through purposive sampling, interviewed in English, Ga or Akan languages, using a semi-structured interview guide and analysed through content analysis. News of stillbirth and observing the dead babies is a painful experience for mothers; they mourn in unique ways based on their faith and or beliefs. Mourning in excess and talking about stillbirth is seen as a potential for sterility and invitation for a recurrence. The urgency to attend to clients has been observed as deficient and communication gaps have been recorded. There is no organised institutional support in time of their loss; available support was basically emotional in the form of encouragement and pieces of advice in addition to self-motivation which finally results in a normal grief process leading to a quick biopsychosocial recovery. Women who declined to be recruited as well as those who turned down the interview appointment could be in a psychologically challenging state therefore avoiding the researcher. There is the need for a customised stillbirth management protocol by stakeholders; a training programme on bereavement services is advocated for service providers.

CHAPTER ONE

BACKGROUND

1.0 Introduction

The expectation of every pregnant woman is to deliver safely after receiving antenatal care but in some pregnant women the outcome of pregnancy does not end in the delivery of a live baby; at times the babies are born still; with no life. When a baby dies in utero 24 hours before labour sets in, the result is a macerated baby and where the death occurs in the process of labour and delivery, a fresh stillbirth results (Kusiako, Ronsmans & Van der Paal, 2000). Stillbirth occurs globally but its incidence is unevenly distributed. It is widespread in low income countries, where it is believed that women have less access to good-quality reproductive health. Stillbirth is known to cause major emotional and social problems to women who experience it as well as their families (Leonard, Bower, Peterson & Leonard, 2000).

The WHO, (2006), define 'Stillbirth' as death of a baby before the complete spontaneous vaginal delivery or extraction from its mother, the product of conception which weighs at least 1000g or has at least 35cm body length, whose maturity is at least twenty-eight (28) completed weeks of gestation. The death is evidenced by no crying upon separation from mother.

Society diminishes the value of the baby when stillbirth occurs and may also devalue the bereaved mother as well (Cacciatore, 2007; Fahey-McCarthy, 2003; Fletcher, 2002; Samuelsson, Radestad, & Segesten, 2001). Most women have the belief that their babies are an extension of their bodies, therefore to deny the baby's worth has a negative implication on the value of the woman, (Theut, Pederson, Zaslow, Cain, Rabinovich & Morihisa, 1989).

The WHO, (2006), estimated that 3.3 million stillbirths occur worldwide each year. This accounts for more than half of all perinatal deaths. Furthermore, the Stillbirth and Neonatal Death Society (2011) indicate that more than 2.6 million stillbirths occur each year with at least 7,000 occurring each day where more than 1 million occur within the intra-partum (labour) period. Again, WHO in relation to this stipulates that almost 3 million families will be affected by third trimester stillbirth each year. Also the report indicates that 98 percent of these are expected to occur in low-income and middle-income countries. This report documents that occurrence of stillbirths has reduced drastically in the high income countries, with a rate of approximately 1 in every 320 babies (WHO, 2006).

According to Rohde, Cousens, Chopra, Tancharoensathien, Black, Bhutta, et al., (2008) and Ronsmans and Graham, (2006) there has been a thirty-year child survival interventions attention, and also, a period of more than twenty years of safe motherhood intervention and advocacy. Recently, there has been a surge of activities on survival of new-born babies after birth. However, stillbirth is ignored in policy programmes as well as on any investment agenda at local and international levels, (Lawn, Cousens & Zupan, 2005). It is evident that even when stillbirths are recorded, the data is frequently combined with early neonatal deaths and reported as perinatal mortality, (Kramer, Liu, Luo, Yuan, Platt and Joseph, 2002; Ghana Maternal Health Survey, 2007). This makes the incidence of stillbirth less visible in the African and Ghanaian society. Child loss during delivery is believed to be of less significance as compared to other types of losses (Kohner & Henley, 1997). However, since the early 1990s there has been a gradual upsurge of research investigating perinatal loss and bereavement and this has led to an awareness creation on the experiences of bereaved women, with emphasis on how devastating the experience is, without underestimating the emotional sequel and profound grief that follows such losses (Cohen & Slade, 2000; Janssen, Cuisinier, de-Graauw, & Hoogduin, 1997).

In her work on “What’s In a Name? Death before Birth”, Jutel, (2006) explained that women who have stillbirth babies do not only feel the loss of the pregnancy, they also often bear a sense of responsibility or shame for the death of the child and sometimes they are blamed by their husbands for failing to bring home a live child. Even before the general society’s emotional challenge to mothers who have experienced stillbirth, the health service providers are accused of being initiators of the emotional torture during their service provision as presented by Erlandsson, Lindgren, Malm, Davidsson-Bremborg & Radestad, (2011) in their study “The silent child: Mothers’ Experiences Before, During and After Stillbirth”. Therefore there is the need to gather information that will enlighten service providers, for a review of stillbirth management style so as to lessen the stigma associated with it. Bereavement support should not be underestimated in terms of its usefulness (Froen, Cacciatore, McClure, Kuti, Jokhio, Islam, & Shiffman, 2011).

More children die as a result of stillbirth than all other causes of infant death, almost one in three babies born dead was alive before labour begins, and dies as a result of causes often closely linked to maternal and neonatal deaths yet the mothers are often left with no support afterwards (Lawn, Blencowe & Pattinson, 2011; Cacciatore, 2007; Kubler-Ross, 1969). Froen Cacciatore, McClure, Kuti, Jokhio, Islam and Shiffman, (2011) and Mathers, Boerma and Fat, (2008), documented that stillbirth would rank fifth among the global health burdens, it even supersedes diarrhoea, HIV/AIDS, tuberculosis, road traffic accidents, and any form of cancer when global causes of death in all age categories are compared. It can therefore be said that it is an area that needs to be given attention. The search for literature showed paucity of reliable data on perinatal loss in Sub-Saharan Africa especially on the experiences of stillbirth on couples, families and the society. Therefore it is important that the phenomenon stillbirth, its incidence and prevalence in low-income countries is studied, especially in Sub-Saharan Africa, as emphasised by some authors (Fottrell, 2010; Badenhorst & Hughes, 2006; WHO, 2006).

Two thirds of all stillbirths occur in South Eastern Asia and Africa and the remaining one third spread across the other areas of the world. Within the African region, Sub-Saharan Africa is reported to have the highest perinatal mortality rate (PNMR) which is estimated to be 56 per 1000 births in 2004. The Central and West African regions recorded 74 and 69 per 1000 live birth respectively. The West African annual rate of stillbirth was 26 deaths per 1000 deliveries. The Ghana Maternal Health Survey, (2007) estimated the perinatal mortality rate for Ghana at 45 deaths per 1000 pregnancies of at least 7 months gestation, which is an improvement on that of 2003, being 46 deaths per 1000 pregnancies. The current rate of stillbirths in Ghana as presented by ChartsBin statistics collector team, (2011), which is sourced from the World Health Organization is 21.7 per 1000 live births and a total of 17,200 stillbirth deliveries in 2009.

Tables 1 and 2 indicate the prevalence of stillbirth in the Accra Metropolis over a period of five years presented in the annual report of Reproductive and Child Health for the years 2007 to 2011.

Table 1.1: The stillbirth rate of the Accra metropolis RCH Annual Report 2007-2011

Year	Total live births	Total Stillbirths	Fresh Stillbirths	Macerated Stillbirths	Percentage of stillbirth/total births
2007	44,645	974	575	399	2.1
2008	49,236	1,263	677	586	2.5
2009	49,264	1,289	690	599	2.6
2010	48,964	1,304	661	634	2.6
2011	52,228	1,302	711	591	2.4

Source: Greater Accra RCH Annual Report

Table 1.2: Comparison of prevalence of stillbirths in the Accra Metropolis and the rest of Greater Accra Region

Year	Prevalence in Accra metropolis	The rest of the Greater Accra Region	Difference between the Regional and Metropolis
2007	974	264	710
2008	1,263	347	916
2009	1,289	293	996
2010	1,304	450	854
2011	1,302	555	747

Source: RCH Annual Report

With reference to Tables 1.1 and 1.2, it is obvious that the stillbirth rate in the Accra Metropolis is high in comparison to the rest of the regions; this could be as a result of the referrals received from the peripheries of the Metropolis for specialist services. It could also be as a result of under reporting of the incidence of stillbirth since home deliveries are done in the rural areas; stillbirth may not have been reported, to be documented. Again, available Statistics from some health delivery institutions in the Accra Metropolis presented below indicate that the incidence of stillbirth is quite notable. These institutions were chosen because their strategic location enables a geographical representation of the Accra Metropolis.

Table1.3: Stillbirth prevalence in some Health Institutions in the Accra Metropolis

Institution	2009	2010	2011
Korle-Bu Teaching Hospital	523	572	556
Ridge Hospital	307	385	319
La General Hospital	188	147	64
Mamprobi Polyclinic	29	37	38
Kaneshie polyclinic	15	3	11
Achimota Hospital	25	35	13

Source: Annual Reports of Individual Institution

There is a clear indication that stillbirth rate in the Accra Metropolis is significant. As expressed earlier therefore the need to explore the mothers experiences.

Studies conducted on women who had stillbirth by Modiba and Nolte, (2007); Caelli and Letendre, (2002) report that mothers who have experienced stillbirth expressed their wish that people would acknowledge their losses, be considerate and sensitive, and give them a listening ear and emotional support in their critical period.

The current researcher believes that despite the fact that Stillbirths are invisible in many societies as well as the worldwide policy agenda, (Rajaratnam, Marcus, Flaxman, et al., 2010; Froen, Cacciatore, McClure, Kuti, Jokhio, Islam, & Shiffman, 2011) families who experience stillbirth find it very real therefore unless these experiences are explored by service providers and stakeholders to know how deep, serious and devastating stillbirth experience is, its effects will remain covert and the service being provided will not be up to the required standard.

The researcher who has practised midwifery for at least fifteen (15) years has observed in the maternity wards that some kind of profound silence concerning stillbirth exists, hence

health workers must endeavour to appreciate the agony experienced by the women and at times their men to enable them provide the mothers with the appropriate support to cope with perinatal loss. Furthermore, there is the need to research into the phenomenon to break this stillbirth silence among mothers to provide systematic evidence based information for midwives and other healthcare professionals to use. This will promote the provision of some psychological support for the bereaved women and their families. In the quest to obtain literature on stillbirth, the researcher observed that there seems to be paucity of literature regarding the experiences of stillbirth occurrences in Ghana. Therefore, the current study is intended at knowledge building.

1.1 Problem Statement

The loss of a child during delivery is very traumatic to those who experience it, especially for women who want children. Perinatal loss may cause major emotional problems in adjustment during the bereavement period. Feeling of unpreparedness to face the painful reality of loss, denial, and feeling that their world no longer makes sense are commonly expressed (Leonard, Bower, Peterson & Leonard, 2000). In some instances these women have been diagnosed as mentally ill until they found help through support groups (McCreight, 2007). Several studies related to stillbirth have been conducted. However, few of such research focus on psychological health needs assessment and little is known of the experiences of those who have had stillbirth in Ghana. Existing study in this area is heavily weighted in developed world than in developing world such as Africa (Froen, Cacciatore, McClure, Kuti, Jokhio, Islam, & Shiffman, 2011; Cohen & Slade, 2000; Modiba & Nolte, 2007; Trulsson, & Radestad, 2004; Turton & Hughes, 2009; Boyle, Vance, Najman & Thearle, 1996).

Mothers who encounter stillbirth are reported to experience depression, anxiety and in some cases, extended or complicated grief syndrome and as many as 20 to 30 percent of

women show some form of complicated grief especially in the first year following a perinatal loss (Sutan, Amin, Ariffin, Teng, Kamal & Rusli, 2010; Engler & Lasker 2000; Cacciatore, Schnebly & Froen, 2008). This could result in increased morbidity and the resultant adverse effect on productivity, that is, loss of man hours to the economy apart from the negative effect it has on the individual and the family at large. To manage this morbidity, there will be an increased demand on health professionals and also more funds will be needed to procure drugs.

Within the Ghana Health Service, there is not a well laid down guideline or protocol for managing women who have had stillbirth and their families psychologically hence no special arrangement of bereavement services for the women and their families. To access post natal health services these women would have to mingle with those who were successful with their babies; which could further torture them emotionally.

In most countries there are support groups existing to help the bereaved (Cacciatore, Schnebly & Froen, 2008; McCreight, 2007; Engler & Lasker, 2000; Riches & Dawson, 2000) but there is no such group in Ghana. Identifiable groups have been used to study stillbirth (Kelly & Trinidad, 2012) and this need to be duplicated in Ghana. In a correspondence to *The Lancet* (2002), Matthews and Kohner stated that in an effort to research into stillbirth, the prime focus should be on the parents' wishes, and to consider the profound complicated and individual nature of parents' experiences before researching into other areas of the phenomenon of stillbirth. The research findings will then help professionals better understand the implications of the occurrence, and provide evidence to guide practice.

What then are the experiences of women with stillbirth as they go through the grief regarding their psychological and social reintegration needs? The current study seeks to answer these questions in the Ghanaian context.

1.2 Purpose of the Study

The purpose of the study is to explore and record the stillbirth experiences of mothers within the Accra metropolis, Ghana.

1.3 Research Questions

What are the experiences (psychological, social) of women with stillbirth deliveries?

What are the social challenges of women with stillbirth?

What is the grieving pattern of these women?

What are the support systems available to the bereaved women?

What are the coping strategies of mothers with stillbirth?

What guidelines can be put in place to care for women who have had stillbirth?

1.4 Objective of the Study

1.4.1 Main Objective

The main objective of this exploratory qualitative study is to find what the experiences of mothers who have had stillbirth are, their expectation of society and the support available to them in their time of bereavement and to help provide good obstetric care to such women.

1.4.2 Specific Objectives

The specific objectives of this study are to:

- Explore problems encountered by women who have had stillbirth.
- Investigate the social effect of stillbirth incidence on the mothers.
- Determine the social support system available to women with stillbirth.
- Investigate grieving process of women with stillbirth.
- Explore the coping strategies of women who experience stillbirth.

1.5 Significance of the Study

It is evident that Ghanaian families have had stillbirths and may experience personal, family or relationship problems similar to other groups globally. However, there seems to be limited available evidence based studies to determine culture specific experiences and the commensurate support needed in such critical moments, therefore leading to improved nursing care of women with stillbirth. The researcher therefore believes that for lack of in-depth information regarding the parental experiences, health professionals would not be able to provide the adequate expected assistance to the families in their time of loss.

The findings of the study will help to guide service delivery where a lag is identified.

The facts of the findings could be incorporated into or used to modify the curriculum of trainees especially midwives.

A support group could be created to help meet some of the expressed needs that would be identified.

1.6 Scope of Work

The study involved women in their postnatal period of six to twenty four weeks, residing within the geographical boundaries of the Accra metropolis. The period of study from the time of recruitment was a minimum of eight months. The qualitative study basically explored the psychosocial experiences of the bereaved mothers by a semi-structured interview which helped to obtain narrations of how they felt about the loss, the things that helped them recover as well as those that were most offending to them and finally their perception of service provision. Data collection was largely at the residence of the participants.

1.7 Organization of Work

The work will advance in the following chapters described;

Chapter Two looks at works and studies done concerning stillbirth in line with the topic, it traces the concept of grief, looks at the experiences recorded, social problems identified by other studies, social support available and its effect on coping and finally it looks at management protocols available.

Chapter Three describes the methodology and the stepwise method applied to gain access and recruit participants to obtain data. It continues to describe how the data was managed, analysed and how through reflexive means conclusions were drawn.

The fourth chapter presents the findings from the study. They follow the form of participants' narratives to reflect the way they felt in the event of stillbirth in order to bring out those aspects of the bereavement experience that mattered most to them, the key areas that form the basis of this thesis arose from this chapter.

Chapter Five focuses on the experiences of the participants in relation to previous information available on the study topic, the meaning drawn by the researcher in relation to service provision.

The last chapter presents the conclusion drawn from the study in relation to knowledge available; its implication to nursing practice in general and also put forward recommendations to help improve service delivery as well as social relations.

1.8 Operational Definition

Bereaved - woman who have had a stillbirth.

Caregivers - health service workers especially midwives and doctors

Early Neonatal death- death of a live born infant occurring fewer than 7 completed days (168 hours) from the time of birth

Experiences – the personal lived through encounter of the phenomenon.

Mothers – women who have been pregnant and delivered.

Stillbirth - foetal death before exiting the reproductive canal, maturity; after 28 complete weeks of conception. (WHO, 2006)

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviewed studies conducted in the research area through some databases including Jstor, Dogpile, Hinari, and SciVerse Science Direct, Pubmed, and other search engines using keywords such as 'experiences of mothers', 'impact of stillbirth', 'perinatal' and 'intra-uterine death'. The areas under which the literature was reviewed were: grief overview, the general experiences of mothers, psychological and social effect of stillbirth on the parent, the support systems available as well as their coping strategies. This chapter incorporated a good amount of historic work in addition to current ones to provide information on stillbirth trend.

In many settings, safe and effective health care is consistently provided for pregnant women and their unborn babies during the antenatal period. During the antenatal period the pregnant women are encouraged to think of the unborn baby as a precious person who deserves the best of life therefore they must endeavour to take in well nourishing diet, maintain good personal hygiene; and must be physically and psychology fit in readiness to receive the new-born. However when the pregnancy ends in a stillbirth, the once precious baby becomes undervalued through social reactions and responses. This implicitly, diminishes the dignity of the grieving mother; the caregivers who are the prime source of social support for such women often refer to this baby who died as a "foetus", even after birth instead of the expression "baby" (Cacciatore, 2007; Fletcher, 2002) making it sound like the baby was not up to the viable maturity. Mothers always want to understand the cause of death when stillbirth occurs, investigations and studies have attempted to explain the cause, morbidity and mortality rate for post-date babies increased in several folds as compared to term mothers; post maturity date is believed to be promoted to a high rate of stillbirth, (Beckmann, Ling, Smith, Barzansky, Herbert and Laube, (2006) Trulsson &

Radestad, 2004). The bereaved mothers are bound to mourn; grief is an inevitable phenomenon during such moments.

2.1 Grief Overview

It is important to look at the terms grief, mourning, bereavement and have a brief overview of grief so as to bring understanding in the proceeding literature. Mourning is defined as the “social expressions of grief or acts expressive of grief which are shaped by the practices of a given society or cultural group” (Stroebe, Hansson, Stroebe, & Schut, 2001), when a person is going through the objective situation of having lost someone significant that state is described as going through Bereavement, whereas Grief is described as a multifaceted response to a loss, particularly to the loss of someone or something with which one has formed a bond (Pilkington, 1993). Emotional reaction of grief encompasses the cognitive, behavioural, and physiological responses to the loss, (Keene Reder 2003; Zhang, El-Jawahri & Prigerson 2006). Therefore, grief whether openly demonstrated or covert in nature is a reality in time of death. To adequately and efficiently care for the bereaved the need to understand the phenomenon cannot be over emphasised.

Lindemann (1944); in a study investigating grief, interviewed victims of a fire outbreak disaster and came out with five ways that grief presents, which he documented as: somatic distress such as feeling of tightness in the throat, choking and shortness of breath. Psychologically, preoccupation with the image of the deceased, guilt, hostility towards others, and loss of patterns of conduct such as the inability to sit still, lack of ability to initiate and sustain normal activities of daily living was documented as well. These manifestations he classified as “normal grief”. It was explained that deviations from normal grief may come in the form of a delay of the expected grief reaction, distorted reactions like over activity without a sense of loss or acquisition of symptoms demonstrated by the deceased during the last illness. Several terms have been used to

classify an abnormal grief response, for example Pathological grief is a term used, others are Complicated, Disorganized, and Traumatic grief. Subsequently several research were undertaken to expand Lindemann's findings.

Worden (2008) explained that there are actions expected in people grieving, he stated that a broad range of feeling, sensation and behaviour is to be expected. Feeling numb, sad, lonely, guilty and anxious are some of the expected emotional reaction. Physical sensation of shock, fatigue, dry mouth and sensitivity to noise is normal as well as thoughts like disbelief, confusion, and disorientation. Finally behaviours such as sleep disturbance, lack of appetite, absent mindedness, crying, sighing and restless over activity are all to be expected as a normal response during this period.

Stroebe, Van Son, Stroebe, Kleber, Schut, and Van den Bout (2000) presented responses, not typical of normal grief such as excessive anger, self-blame and guilt as pathological. While Lindeman and Worden, recorded guilt as normal, Stroebe et al., (2000) presented prolonged guilt as an abnormal response. Furthermore abnormal grief may present in the form of absence or delay of expected affective responses such as sadness and or depressed mood (Bowlby, 1980; Osterweis, Solomon, & Green, 1984; Vachon, Sheldon, Lance, Lyall, Rogers, & Freeman, 1982) which if not considered could lead to trivialising the phenomenon grief.

The studies of some researchers like Bowlby and Parkes (1970) and Kubler-Ross (1969) investigating bereavement brought about the development of the stage theories of grief, where specific stages are associated with the particular grief process explained. This knowledge informed the belief among clinicians and researchers that individuals need to "work through" grief in order to adjust to the death of a loved one else one risks the danger of degenerating into a form of pathological grief (Wortman & Silver, 2001; Stroebe, 1992).

Stillbirth grief cannot be contained or restrained, in effect; even in areas where mourning of the stillborn baby is culturally suppressed grief response however persists in the life of the bereaved mothers. The grief felt and its accompanying depression experienced by these mothers with stillbirth is explained to exceed the grief that is associated with a neonatal death, (Hutti, dePacheco & Smith (1998). During the International Stillbirth Alliance Conference, Oslo 2008, in a presentation on Social Management of Pregnancy Loss in Rural Southern Tanzania; loss associated stigma and unmet psychological needs, Haws (2008) reported that in many traditional Societies, grieving openly is discouraged because it is believed that by so doing it guards against similar recurrent loss.

This researcher being a Ghanaian think this is a strong belief and practice in almost all regions in Ghana especially among the societies along the coast.

Grieving is believed to lead to depression, which consequently could delay physical recuperation. With reference to Lindemann's description of normal grief being an emotional reaction that encompasses the cognitive, behavioural, and physiological manifestation, the researcher searched for literature in that vein to support and guide the current study. Therefore the general experiences will be explored first.

2.2 General Experiences of Bereaved Women

These experiences ranges from physical challenges experienced, the care giving setup, the care received, as well as the attitude of the health service providers and any other phenomenon that the women deem important to mention. Outstanding in the findings of various studies is the attitude of service providers versus the wish of the women after diagnosis of stillbirth.

The event of stillbirth according to Frost, Bradley, Levitas, Smith and Garcia, (2007), has been over simplified by the medical reasoning and action, therefore the sense of child loss is trivialised, resulting in underestimating the pain or ignoring its seriousness to the

bereaved woman. As a result the services rendered by health service providers cannot be described as client tailored and client centred. Post-natal, it is believed that where a woman is cared for within the hospital could have an impact on the woman's grieving process. Many women have reported feeling upset and uncomfortable when placed within a ward with other mothers whose pregnancies have resulted in a live birth (Tsartsara & Johnson, 2002).

Gold, (2006) reviewed 1100 English articles published from 1996 to 2006. The sixty-one studies, covering over 6000 parents met the criteria that provision of care must be within the United States of America. Sample size not less than four was a guiding criterion, focused on miscarriages and perinatal losses in his systematic study named "Navigating care after a baby dies: a review of parents experiences with health providers". They reported that the loss rate was one in fifty births. Nurses as compared with physicians were reported to encourage parents to have contact with the baby (100% versus 15%), take photograph (100% versus 0%) and give emotional support (90% versus 3%) as recorded by Weinfeld, (1990). Despite the preceding report, several studies (Modiba & Nolte, 2007; Trulsson & Radestad, 2004; Caelli, Downie & Letendre, 2002) recorded that a higher number of parents experienced poor support from nurses. The provision of emotional care, information about birth event and outcome and physical attention to both mother and baby were presented as most helpful to the women, for example "Parents frequently described nurses bending hospital policies to accommodate them, such as expanding visiting hours or allowing children on the wards" (Modiba & Nolte, 2007; Trulsson & Radestad, 2004; Caelli, Downie & Letendre, 2002).

Avoidance, insensitivity, or lack of emotional support from service providers as well as interacting with service providers who were not aware of the loss was presented as distressing to the participants. Furthermore it was said that generally too many service

providers were uncomfortable with death and bereavement particularly of infants and children.

A qualitative study was undertaken by Trulsson and Radestad, (2004) in Sweden on mothers' experiences before, during and after stillbirth. They interviewed twelve women between 6 to 18 months after delivery, with a phenomenological methodology they analysed and reported the women express the fact that they had premonition that all was not well, even before they were diagnosed with intrauterine foetal death. They reported also of symptoms like less or absent foetal movement and heaviness in the abdomen and as a result visited the health institutions for care. At the hospital the women expected that the caregivers would communicate adequately with them, however according to the study report, after the ultrasound diagnosis of the death, verbal communication between the service providers and the women ceased which further gave those signals of an impending problem. Notably negative in the service provision is the issue of the professionals communicating among themselves rather than involve the women; which were most worrying to the women.

Similarly in an internet based qualitative study, the participants in Erlandsson, Lindgren, Malm, Davidsson-Bremborg and Radestad (2011), on Mothers' experiences of the time after the diagnosis of an intrauterine death until the induction of the delivery; the mothers reported that they were abandoned after they were informed about their ultra sound report of intra uterine death. The caregivers left them alone in the room to face a situation that is "out of their control" alone .

In both reports (Trulsson & Radestad, 2004; Erlandsson, Lindgren, Malm, Davidsson-Bremborg & Radestad, 2011), the mothers complained of not being involved in the decision making as to what the next plan of action was for them.

While they waited for the next action, some of the participants stated they were sent home; an experience they expressed was torturing, knowing that they were carrying a dead baby in their uterus. They said they wanted the babies out as early as possible however the caregivers were insensitive to their plight. In a similar study in the same year the following caption are some expression of the participants in response to some questions posed them;

“I wanted nothing to do with it. It was absurd sitting there, aware of having a dead baby inside my body. I sat on the couch and put a big blanket over my belly. I did not want to touch it, I was completely uninterested”.

To describe the psychological trauma of carrying a death infant in utero, one woman said; “it felt like I was hosting an alien inside me, I could not see it as my daughter; the whole situation is just gruesome” (Erlandsson, Lindgren, Malm, Davidsson-Bremborg & Radestad, 2011).

Contrary to the above study reports, in a Swedish study on the role of caregivers after a stillbirth: views and experiences, most of the participant thought the caregivers were warm towards them and helped them to understand the grieving process.

Therefore Benfield, Leib, and Vollman, (1978) reported that 95% of mothers had one or more somatic symptoms that were distressful; sleep disturbances, problem with appetite, fatigue chest pain, to mention a few, a report which was buttressed by the studies of Dyregrov and Matthiesen (1991) and Smith & Borgers (1988-1989).

2.3 Psychological Experiences

The complex physiological effects of pregnancy and childbirth, is a process and an event that leaves women particularly vulnerable to depression, suicidal ideation, mood disorders and dramatic biochemical changes. Carrying a dead foetus in the uterus and delivering such an infant could be traumatising to the expectant family, especially the mother; in the

event of a stillbirth, it is reported that the bereaved women experiences high levels of anxiety which could be reliably related to the adverse psychological and physiological outcome resulting from the loss (Affonso & Arizmendi, 1986; O'Hara, 1995), and the situation could deteriorate into post-traumatic stress disorder (Silver 2007, Slade 2006; Soet, Brack & Dilorio, 2003), in cases where there is poor level of physical and social support mental problems could ensue.

A gender based exploratory study on stillbirth and the couple by Cacciatore, De Frain, Jones and Jones, (2008) was undertaken in the United States of America. The researchers retrospectively analysed anonymous data collected by two Non profitable organisations that provided care and support to grieving families after child loss. The participants were recruited online; data was collected at an international conference of bereaved families and professionals as well as online. Twenty three (23) open ended questions were used to collect data, which were transcribed, themed and compared to existing works. The second theme derived was "sense of control", where a feeling of powerlessness was reported which was presented as struggling with their faith and identity crisis as to whether they were still on the mind of their supreme being as well as whether they were parents or not after the death of their child, especially if they had no other child.

Gauzia, Moran, Ali, Ryder, Fisher, and Koblinsky, (2011) in their prospective research to estimate the magnitude of psychosocial consequences of perinatal death in rural Bangladesh, recruited a total of 476 out of which 122 women with perinatal death, were assessed with the Edinburgh Postnatal Depression Scale (EPDS-B) between the period of 6 weeks and 6 months postpartum. The trained female interviewers collected the data at the homes of the participants. In their report it was evident that at 6 weeks a quarter of the women experienced postpartum depression. Depression was associated with negative life changes and guilt. They however indicated that there was no statistical significance in the

depression rate between the bereaved and non-bereaved women, 43 percent of women were found depressed at 6 weeks postpartum. However, women who were depressed at 6 weeks postpartum remained significantly depressed when they followed up. Age, educational status, family structure, residential area, and economic status had no effect on the outcome. Women who felt guilty about their results of last pregnancy outcome continued to be significantly depressed at 6 months postpartum. Some of the signs and symptoms recorded in their report were 'crying', 'being unable to laugh and see the funny side of things', they also experienced 'sleep problems'. The most remarkably reported symptom was the feelings of "helplessness" among depressed women; which was 14 times higher as compared to the women who were non-depressed.

Depressed women were 4 to 5 times more likely to report self-harm ideation, anxiety and panic attacks (Gauzia, Moran, Ali, Ryder, Fisher, & Koblinsky, 2011; Adeyemi, 2008; Turton, Evans, Hughes, & Fainman, 2001) this could possibly be a follow up reaction to the guilt feeling.

To study the psychological effect of stillbirth, a cohort study on assessment of guidelines for good practice in psychological care of mothers after stillbirth was undertaken by Turton, Evans & Hughes, (2009), pregnant women who had no live children whose previous pregnancy loss was more than 18 weeks gestation were studied. They used women who are pregnant for the first time as controls, both participants and control attended the same antenatal clinic. A combination of data collection tools was used based on psychological reaction to be measured; the EPDS to assess depression and Spielberger State Anxiety scale (SSA) was used to assess anxiety. For postnatal Trauma, the Post Traumatic Stress Disorder (PTSD)-1 interview profile was among others used for other areas of assessment. As part of their report it was documented that women who had experienced previous stillbirth had a significantly greater depression, anxiety and Post Traumatic Stress Disorder. Furthermore it reported that some bereaved women encounter

long term consequences, including depression in subsequent pregnancies and also have prolonged grief reactions. The western society practises more of nuclear family living unlike Africa and for that matter Ghana, where the extended family closely live with the bereaved and could provide some form of support to them.

However Gauzia Moran, Ali, Ryder, Fisher, and Koblinsky, (2011) stated that the higher rates of depression among bereaved mothers cannot be wholly attributed to the death of the baby, since no assessment prior to delivery was done. This was supported by the work of Turton and Hughes. (2009).

Wing, Clance, Burge-Callaway and Armistead, (2001) did a study to understand gender differences in bereavement following the death of an infant, they explored works done, (predominantly qualitative designed and longitudinal in nature) on infant death, bereavement and grief and reported of their effect in comparison on mothers and fathers. They explained that mothers often experience shock, numbness and disbelief after a baby's death; the works of (Stinson, Lasker, Lohmann, & Toedter, 1992; Kavanaugh, 1997 & Clyman, Green, Rowe, Mikkelsen, & Ataide, 1980) was cited in support of this proposition. Again Wing and colleagues, presented denial as an incident higher in fathers than mothers, however with time both mothers and fathers' denial levels come to a balance. Preoccupation with the thoughts and the images of the dead baby was presented to be common. Self-blame, guilt and shame was widespread in studies reviewed, which explained that between 1 and 12 months of the loss, 89% of women felt ashamed, guilty and thought they contributed to the death of the babies personally (Lang, Gottlieb & Amsel 1996; Clyman, Green, Rowe, Mikkelsen, & Ataide, 1980 & Benfield, Lieb & Vollman, 1978). Bereaved mothers feel guilty at times over issues such as medical conditions, eating, habits, exercise and intercourse to mention a few that may be believed to have caused the death (Fish, 1986; Leppert & Pahlka, 1984). Such women often think

they have failed in their role as a woman, a mother and in situations of genetic abnormalities they see themselves as biologically incompetent. Furthermore fathers were reported to have the tendency to blame the mothers. Self-blame was presented where the parents wondered what could have been done to avert or save the situation often lead to the guilt feeling or self-reproach (Dunn, Goldbach, Lasker, & Toedter, 1991; Giles, 1970; Kennell, Slyter, & Klaus, 1970)

Wolff, Nelson and Schiller (1970) discovered that 34% of the fifty women they studied directed the blame at themselves, 20% blamed God or fate and 18% blamed their spouses or physicians when they investigated ways in which blame was directed after perinatal death, in their study of emotional reaction to stillbirth.

The above mentioned studies were quantitative in nature, in most of the studies data collection tools like EPDS, PTSD, SSA to mention a few were used, in addition interviews were done which helped them theme the response; the result of the current qualitative research will help enrich information on mothers experiences of stillbirth bereavement.

2.4 Coping Strategies

When considering ways of coping, it is believed that people who cope by using their own inner strength along with the support offered by others generally manage the grief process better than those who try to cope on their own alone (Rybarik, 2000). Lazarus and Folkman, (1984) presented grief coping in two forms; the problem focus coping and emotion focus coping. An attempt to do something to change the source of the stress they called Problem focus while the act of managing or reducing the emotional distress is termed emotional focus coping. Embedded in this type of coping is denial, reinterpretation of events as well as looking forward to external help; social support. Carver, Schier and Weintraub, (1989) described as part of coping strategies, active coping; where the person

takes actions to reduce or stop the stressor or where one tries to control the effect of the stressor. Mothers look out for social support for emotional reason for instance to get moral support, sympathy and understanding. Again diversional activities have been identified by participants of various studies a vital form of coping strategy; by watching television, turning to religion and unconsciously demonstrating denial are all good examples of coping strategies which have been found helpful.

2.5 Social Support

A strong family and social support, as perceived by mothers, can make a significant difference in their ability to cope with grief. Also the of kind support that the mothers received in the hospital if positive becomes the foundation upon which a better coping strategy is built, therefore support services is essential if the grief process is to be well managed (Rich, 2000).

Engler and Lasker, (2000); Riches and Dawson (2000) and Rich (2000), explained that the experience of everyday support, patterns of family interactions, friends, relationships with people at work and in the neighbourhood, specialised agencies as well as self-help groups are crucial for people who are mourning to coming to terms with bereavement. When these are deficient the woman finds it challenging to maintain a balance psychologically. Another important support identified is a strong marital or couple relationship; where there is a deep understanding of each other, the grief process is aided and the duration is shorter.

The effect of social support on maternal anxiety and depression after stillbirth was studied in the United States of America, by Cacciatore, Schnebly and Froen (2008). Seven hundred and sixty-nine (769) women were sampled in their quest to find out whether anxiety and depression are lower amongst stillbirth mothers who received social support from doctors, nurses, families and support groups. It was revealed that support from

physicians, nurses and family members was associated with notably lower levels of both anxiety and depression; 91.7 percent of the respondents reported they received either great support' or 'support' from their family members in the period after stillbirth. The next most common sources of support, they said were provided by nurses 90 percent, doctors 67.9 percent and support groups 53.4 percent. The study further disclosed that the most important and impacting form of social support were provided by family members. Mothers of stillborn babies who perceived high family support in the period after stillbirth had mean anxiety and depression scores that were lower than those of their counterparts who did not.

In addition, it was reported that women who received support from support groups typically scored lower on the anxiety scale than those who did not, this difference in mean levels of anxiety however was not statistically significant implying that in the United States of America there is a better knowledge and understanding of stillbirth; the service providers are supportive socially and the families are also providing tremendous support. The Mothers expressed they had expectation of social support in various forms and from various society groups. In their comments on grief support they received, the women reported that some of them found good support from friends; others explained that the pastoral care they received helped them during their grief moments. Among the supports are linking up with other mothers who have had stillbirth on the internet and assistance received from church women groups were also found to be of help .

The cross sectional study conducted in University of Kebangsaan Malaysia Medical Centre (UKMMC) by Sutan, Amin, Ariffin, Teng, Kamal and Rusli (2010); on the psychosocial Impact of mothers with perinatal loss and its contributing factors on 62 respondents using Edinburgh Postnatal Depression Scale (EPDS) and self-administered questionnaire revealed that almost all respondents received support from husband after

perinatal loss. Three quarters of the participants stated that they received support from their parents, and half of them also received support from friends and siblings. Even though most of them reported that they had enough support, more than half still requested additional help in the form of encouragement and counselling. They believe sessions of 'feeling expression' as well as group discussions could help them to cope with and recover faster from their grief.

2.6 Social Challenges

The social challenges ranged from avoidance from society members to deteriorating relationships and its resultant isolation in the lives of the bereaved; the studies of Chandra, Tharyan, Muliyl, Abraham (2002); Patel, Rodrigues, DeSouza, (2000) documented a deteriorating support and relationships from members of the marital family of the bereaved mother including their husbands. While these social consequences have been quite well studied in developed countries, there is considerably less information about these from developing countries, (Gauzia, Moran, Ali, Ryder, Fisher, & Koblinsky, 2011).

Studies and data in high income countries show that grieving women usually face a wide range of negative social consequences following a perinatal death, such as isolation from friends, extended family members, and others in their social networks making them more emotionally vulnerable (de Montigny, Beaudet, Dumas, 1999). These emotional challenges could promote morbidity in the lives of the bereaved. While the respondents in the study of Cacciatore and colleagues, (2008) gave a positive testimony of the midwives and doctors there was contrary findings on how much support was received from the health service providers in the report of Modiba and Nolte (2007) when they undertook an exploratory descriptive study in Gauteng, a province in South Africa with an objective to describe the experiences of mothers with the loss of a baby during pregnancy

and the professional care they received during this period. They stated that the mothers expressed their wish that the midwives and doctors could give them listening ear when they spoke about their loss. They reported that because most of the time there was nobody to talk to and the stress built up and this frustrated the bereaved women a lot. They further complained about lack of communication from the midwives and doctors, thereby implying that these mothers were not given enough information or possibly none at all.

These mothers expressed that all that the doctors and midwives seem to care about is that the baby has been delivered (the physical care), after which they apparently do not care about the emotional turmoil the mother is experiencing (Modiba & Nolte, 2007). A report of such nature, if replicated in other aspects of the world would inform the service providers of what is lacking in their service provision.

In a study on "Psychological and social consequences among mothers suffering from perinatal loss" in Bangladesh, the researchers were anticipating an under reporting of challenges with their marital families (because Asian traditional customs frowns on married women talking against their husband or marital family members to others), however on the contrary, they recorded a high rate of report on deteriorating relationships and withdrawal of support from members of the marital family including their husbands. This indicates how eager bereaved women are to verbalise their experiences. In the findings of the study, the negative social consequences were higher comparatively in the bereaved women than in women with live babies. Furthermore the study revealed that there was higher frequency of report on worsening spousal relationship in addition to the challenges with marital family members. Another challenge that emerged in their report was that the bereaved mothers were significantly less valued by society.

The work of Badenhorst, Hughes (2006) confirmed that perinatal loss can strain the relationship between bereaved parents, especially if parents do not support each other in

their grieving moments. For instance, when one parent is no longer feeling sad, the other may interpret it as insensitivity or not feeling the loss. In some cases both fathers and mothers have described higher levels of marital dissatisfaction than expected.

In relation to this some longitudinal studies have also identified an increase in relationship break-up in some couples. The Swedish study that followed a cohort of women for 7 years after perinatal loss, perceived poor partner support as a factor for marital breakdown, it reported a risk of marital breakdown to be four times higher among women with stillbirth as compared to women who had live birth (Turton & Hughes, 2009).

In another study of Taiwanese women with perinatal loss, it was reported that there is a cultural ideology of 'continuity' where women are expected to produce a child for the family to continue the lineage, therefore when stillbirth occurs, the marital family tend to blame the women for not producing a healthy child to continue the lineage (Hsu, Tseng, & Kuo, 2002; Mammen, 1995). This could be the reason why a defective relationship occurs; because the family will be seeing the mother as an obstruction to propagating their lineage. In West Africa, there is a traditional view that the spirits of the dead infant will seek a vulnerable new pregnancy, and therefore the tradition in western Ghana; not performing a burial ceremony for the stillborn baby is perceived as a preventive measure to discourage the spirit stillborn baby from coming back to the same mother, family or society (Van-Otoo & Adusei-Poku, 2010; Gottlieb, 2004; Adetunji, 1996).

Therefore Mander, (1999) recommend that mothers who have had stillbirth should be given a sympathetic listening ear, however in the absence of a human ear the women could use other means such as writing out what their feelings are, this may allow the necessary outpouring to help the mother to connect "the self" and "the experience", in other words journaling is found to be quite helpful. This clearly supports the need for the victims to voice out their pain.

Based on the preceding reports there is therefore, the need to review protocol or guidelines that helps service providers to manage the bereaved women and their families physically and psychologically.

2.7 Stillbirth Management Protocol /Guideline

A baby's death is vivid in the memories of most parents, even years after the death. The support that the mothers received in the hospital where her baby died, often has a bearing on the nature of her memories therefore support services is essential if the grief process is to be well managed (Rich, 2000). In providing health services the caregivers are often faced with the challenge of how to care for and help parents cope with perinatal loss. The process of providing holistic and spiritual care for bereaved women and their families should begin when there is indication of death of an unborn child and even during the antenatal period of care, pregnant women must be prepared for the sudden complications (Contin, 2002). When delivery of the dead baby is delayed more than 24 hours after diagnosis as a result of care routines, there is the risk of long term anxiety-related symptom that is usually above a cut-off point; this was found to be five times in women with delay as compared with those who had their induction within six hours of diagnosis (Trulsson and Radestad, 2004).

However opportunities to provide evidence-based guidelines for stillbirth prevention according to researchers have been missed, because stillbirth is frequently excluded as an area of research to reduce maternal and neonatal deaths (Flenady, Smith, Middleton, 2011; Bhuttah, Lawn, Yakoob, 2011).

A South African study on mothers' access to supportive health services after a perinatal death revealed that the Hospital had a protocol in use to manage perinatal loss, as evidenced in the report when they discussed the fact that all 15 respondents understudied were nursed in their own rooms after the death. One of the women had the hospital take a

photograph of the dead baby as a matter of hospital protocol while others took their own photographs. Fourteen of the mothers (93 percent) had the chance to hold their babies, twelve (80 percent) of them were given foot prints of their babies when they were being discharged home as mementos to carry, four mothers (26.7 percent) had their babies baptised according to their belief, out of which one was organised by the hospital. Furthermore seven women (46.7 percent) reported their satisfaction with the information (including causes of their babies' death) provided them. However eight (53.3 percent) were not provided such information and they reported their dissatisfaction, (Conry & Prinsloo, 2008).

This resulted in the emergence of four themes from how the mothers described the hospital staff based on their service delivery; Supportive, Compassionate and understanding, however some mothers found the service providers totally unsupportive therefore they described the hospital services as unsupportive as well. The 80 percent that reported that the hospital was supportive based their decision on the supportive staff and the opportunity offered them to make memories of their babies and the non-restriction of their visitors. Contrasting this report is 93 percent of mothers who were handled by unsupportive staff therefore did not have the opportunity to collect memories of their babies.

Counselling services was lacking in the service provision of the hospital, only one mother reported she had one session with the counsellor at a time when she was under medication hence she could not recollect the proceedings. Eleven of the participants (73.3%) expressed that they would have loved to receive sessions of counselling from the hospital counsellor, five (33%) received detailed information of the available support system at the hospital which included a support group who visited two of the women while at the hospital. It is evident that even where institutions were using a management protocol,

deficiencies were identified therefore as part of the responses from the participants; there were suggestions that hospitals should have a more structured procedure in place to handle bereaved mothers. Though the sample size of the study was quiet small to be generalised it provided rich information and knowledge for service delivery.

In a related qualitative study, done in a major university hospital in the United States of America by Sanchez, (2001), data was collected from twelve participants with gestational age beyond 20 week with an in-depth semi-structured interview guide to elicit their perception on loss support offered at that hospital. Their responses were transcribed and themed in relation to hospital support received by the women. Among themes that emerged was "Hospital support" which was spontaneously mentioned by eleven respondents and the other one commented on it during probing. The lack of good timing appeared to be important factors in a mother's perception of an experience as either positive or negative. Many of the respondents expressed untimely preparation of the mother for the event of loss; shorter duration allowed holding the baby, the time it took to get the news of the foetal demise from an ultrasound report and also the time of autopsy reporting were also mentioned as painful aspects of the hospital experience.

Nurturance was another strong theme which described the nurses' personal touch, sensitivity and kind words as well as dressing the baby. Some reports of non-nurturing actions which have negative effect on recovery were thoughtless expressions and signs of incompetence. Poor rooming arrangement was also cited as well as Non-preparation for the loss in the cases of the anticipated losses. These challenges could be minimised by the use of a protocol and also being sensitive to the feeling of the bereaved.

The American College of Obstetricians and Gynaecologists, in their new guidelines on Managing Stillbirths, issued on February 20, 2009 describes how stillbirth is to be managed. The risk factors, the causes, prevention and management of stillbirth were

elaborated; the management guideline focuses more on the physical and medical interventions to be given. It emphasised more on the need for obstetric and psychiatric history taking, general examination, genetic screening and autopsy to establish the cause and aid in medical counselling, however psychological care; the need to be sensitive to the family's emotional state and bereavement services was only mentioned as being important, no specific guidelines were spelt out concerning that aspect of the service delivery probably it falls within the domain of counselling. Health care providers are expected to evaluate the significance of parent's perception on perinatal loss before starting an intervention, or else their assumptions in giving care will cause additional pain to these parents (Hutti, 1992).

In their research to explore nurses' attitudes towards perinatal bereavement care and to identify factors associated with these attitudes, Chan, Lou, Cao, Li, Liu and Wu, (2009) conducted a survey with the use of a structured questionnaire on a population of 657 nurses, recruited from Obstetrics and Gynaecology units in two hospitals in Hong Kong. Outcome measures included attitudes towards perinatal bereavement care, importance of hospital policy and training support for bereavement care. In their report, majority of nurses in the study had a positive attitude to bereavement care. However they found only 21.6% (n = 141) of the nurses surveyed had bereavement-related training, about 89.8% (n = 300) believed they needed to be equipped with relevant knowledge, skills and understanding in the care and support of bereaved parents. They also reported that more than 88.5% (n = 592) were willing to share their experiences with their colleagues and seek support when feeling under stress.

Follow-up phone calls should be made to the parents after they leave the hospital (Ujda & Bendiksen, 2000). They recommended that Parents should only be encouraged, but not forced to hold or touch the baby following the death and this offer should remain open for

some time. According to Durlak (1998), preventing opportunities to see and hold the deceased baby complicates the mother's grief. The writer believes taking Photographs of the baby would provide the mother physical reminders of her child; many mothers who didn't take photographs of their child regret this later. The mothers could be advised on writing Journals, keeping memory boxes or memory book, also Significant mementos such as footprints, handprints, locks of hair, toys and worn clothing may be placed in such boxes. The weight of the baby and the measurement could also be included in the journals. Where the family wishes to perform, baptisms or religious ceremonies and funeral plans should be supported by the service providers. These activities the current writer believes if incorporated into a customised protocol or guideline for service provision could make lighter the burden for the women during the period of grief.

Therefore Caelli, Downie, and Letendre, (2002) emphasised the immense need for health professionals to recognize the intense anguish families face when they lose their children during birth. The report of the study indicate that for health professionals to be able to reach bereaved families and be of help to them there is the need for them to prepare to give specialized care and also be able to listen and empathize with their anguish. An evidence based practice guide is vital to render a holistic obstetric nursing care to mothers who experience stillbirth. Therefore the suggestions of Gold, (2007) that "any hospital which provides obstetrical or paediatric care should run training programmes and establish a protocol for foetal or infant death management. Not only should these include a concrete plan to help health care staff medically manage the demise, but there should be on-going training for staff on grief and bereavement issues and how to sensitively assist families experiencing these events". A number of national organizations have published recommendations for care in the event of perinatal death which may be useful for hospitals developing bereavement programs; stillbirth and neonatal death society as well American College of Obstetricians and Gynaecologists, are examples.

2.8 Summary

Stillbirth is a painful experience to all mothers who fall victim, no matter the parity, age, marital status or level of education. Grief is a natural reaction to a loss, the grief reactions of these women accepted as normal grief response included guilt, shock, denial and attempt to find meaning to the loss. Provision of support from various sources is identified as vital to recovery from grief. Deficient or lack of support often leads to delayed grief recovery and in some cases prolonged grief, post-traumatic stress disorder or other mental disorders ensues. Support in the form of emotional care was predominantly rendered by family members and in some cases established support groups, it was also established that spousal support was a vital means of bereaved women's grief recovery. Challenges of bereaved mothers ranged from management style or method of service delivery to social abandonment. A fair amount of deficiencies in service delivery was recorded; poor timing of care, poor communication between the caregivers and mothers as well as the unfriendly nature of the set up was some of the challenges identified. Management protocol was found to be lacking in some areas of service provision. More of the physical and medical interventions were spelt out and the psychological aspect quite deficient. The Ghanaian health care system is observed not to have a protocol for management of stillbirth developed to suite our socio-cultural setting therefore the need for studies and the development of a protocol or guideline for services in time of bereavement.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter deals with the description of the methods and methodology used in attaining the stated objectives and it includes the research design used, research setting, target population, sample and sampling method that was used. It also looked at the tools used, the method of data collection, data analysis as well as data management. In addition it contains information on how ethical requirements were met and trustworthiness of the study.

3.1 Research Design

Qualitative research are based on a worldview that is holistic; it has the beliefs that there are multiple constructed realities in life where the knower and the known cannot be separated, inquiry is also value bound and all applicability are bounded by time and context (Burns & Grove 2007).

A qualitative research involves the act of perceptually putting pieces of information together to make wholes. When meaning is produced from varied individuals who have varied perception it becomes possible for many different and comprehensive meanings to be derived concerning the phenomenon in question (Munhall, 2001). The findings from a qualitative study usually directs the understanding of the phenomenon under study, develop new concepts (Leedy & Ormrod, 2010); it gives insight which can be applied in similar situations to guide nursing practice and also help in theory building or refining, providing avenues through which phenomenon outside the traditional view of nursing can be examined (Burns & Grove, 2007). Therefore the varied experiences that were collected were grouped and interpreted to make meaning about what the experiences of the mothers with stillbirth are.

In a qualitative study, the researcher apart from being involved from planning through data collection to analysis and discussion is also a data collecting instrument. The ability of the researcher to interpret, make meaning of what is seen and heard during data collection forms part of the data collection tools. Here, that role can be equated to that of a video recorder and this is critical for understanding the phenomenon.

Data analysis in qualitative study runs concurrently, therefore it allows for adjustment of the instrument during the process of data collection when a deficiency or inaccuracy of function is identified. This makes the design elastic and flexible to use and possible for any valuable information that emerges in the course of the data collection that will enrich the study and make it more meaningful to be incorporated in the study process (Polit, Beck & Hunglar, 2001). The researcher in a qualitative study can go back to the participant for clarification or more information when it becomes necessary thereby promoting prolonged contact with the participant as well as the setting which in turn could promote trustworthiness of the study.

An exploratory qualitative study is carried out when little is known about a phenomenon, a situation or a problem (Polit & Beck, 2008).

Qualitative exploratory study is conducted in a natural setting hence the homes of the participants in the Accra metropolis constituted the natural setting of the study. Experiences vary; therefore the researcher placed emphasis on understanding the participant's words, actions and expressions. For a study to be reliable and trustworthy it is expedient that a wide variety of individual experiences be collected; this informed the choice to do this qualitative study.

3.2 Research Setting

The study was conducted in the Accra Metropolis, in the capital of Ghana, in Africa, the eleventh largest metropolis in Africa with an estimated population of about 3.9 million, (Geo Names, 2010). Accra is today one of the cities that is growing fast and large with an annual growth rate of 3.36 percent. The Accra Metropolis is located on Longitude 05°35'N and on Latitude 00°06'W, it covers an area of 173sq km. The Metropolis is bounded on the East by the Ledzokuku-Krowo Municipal Assembly, on the South by the Gulf of Guinea, on the West by Ga South Municipal Assembly and on North by the Ga West Municipal Assembly. The population of Accra metropolitan area is 1,848,614 (GeoHive, 2013). The gross population density is currently estimated to be 250.73 per hectare in 2010 and is projected to increase to 292.50 by the end of the plan period in 2013. Accra's population like that of other urban centres is very youthful with 56% of the population under the age of 24 years. The age-sex ratio shows that 51% of the population are females and the rest 49% males. This gives a sex ratio of 1:1.04 males to females. The dominance of females over males is a reflection of the nationwide trend where the estimated ratio is 1:1.03. The need to target women in any development programme in the Metropolis can therefore not be overemphasised. The dependency ratio has been calculated to be approximately 60%. It follows that 60% of residents of Accra rely on the other 40% for their livelihood. The Capital of the Metropolis is Accra. There are 3 Government Hospitals, 6 Polyclinics, and 10 Smaller Facilities which are under the Ghana Health Service institutions that provide clinical service in the Accra Metropolitan area. Four Quasi-Governmental and a large number of private health care providers also offer clinical services. Services provided are Outpatient and In-patient, Public Health Services (Reproductive and child health services), Nutrition, Pharmacy, Laboratory and X-ray.

The major health problems of Accra are essentially communicable diseases due to poor environmental sanitation, ignorance, and poverty. Malaria has been the number one

disease, accounting for about 95.01 per cent of all the Out-Patient Department (OPD) cases (MoFEP. 2012).

The Korle-bu Teaching Hospital

Korle-Bu Teaching Hospital is the biggest health delivery facilities in the metropolis where recruitment for participants will take place. This hospital was founded in 1923. It is situated in the Ablekuma sub metro district in the western part of Accra the capital city of Ghana and about 0.5km from the Korle-Lagoon. It is the premier health care facility in Ghana. The Korle-bu Teaching Hospital covers an area of about 441 acres and bounded by the Korle Lagoon to the east and the following townships respectively; Korle-Gonnoor to the south, Lartebiorkorshie to the north and Mamprobi to the west. It is the first largest teaching hospital in Ghana and the second largest in the West African Sub-Region and the only tertiary hospital in the southern part of Ghana.

Korle-bu teaching hospital serves as the National Health Referral and Research Centre with an average daily out-patient attendance of about 1,500 and 1700 bed capacity. The hospital has three centres of excellence namely the National Cardiothoracic Centre, the National Plastic and Reconstructive surgery and the Radiotherapy centres in addition to units such as Paediatrics, Medicine, Surgery and Allied surgery, Accident and Emergency, Physiotherapy, Radiotherapy, Pharmacy, Nutrition, Rehabilitation, Pathology and Obstetrics and Gynaecology departments. Under the obstetrics and gynaecology department is the maternity unit which has 6 Maternity wards and 2 Labour Wards. It also serves as practical teaching grounds for Nursing, Medical and Allied Health Sciences students. The staff strength of the hospital is about 3,500 predominantly made up of 1,035 Nurses (840 professionals and 195 auxiliaries), 435 laboratory technicians, 390 Doctors and dentists, 58 Pharmacists, 5 Health administrators and the rest are made up of other categories of staff.

3.3 Target Population

The study population in a research is the entire set of persons or elements who meet the sampling criteria of the study. In the current study, all women at least 6 weeks postnatal who lost their babies during delivery and living in the Accra metropolis formed the target population.

Inclusion Criteria

Inclusion criteria is used to select samples from the collection of all possible units of the general population, it decides who qualifies to be in the target population. They are the characteristics that restrict the population to a homogenous group of participants; where homogeneity is not ensured in a study the ability to interpret finding meaningfully is challenged and likewise the act of transferability and applicability. Inclusion criteria are put in place to control biases as well as extraneous variables, therefore contributing to the accuracy and transferability of the findings (Polit, Beck & Hunglar, 2001); The study population involved puerperal women who have experienced stillbirth, resident in the Accra Metropolis, English, Ga, or Akan speaking and gave their consent to be participants. The eligible women were in a postnatal period between 6 weeks and 24 weeks (6 months) because it is evident that the challenges that are experienced after stillbirth delivery often starts after the 6th week post-delivery and it has also been documented that beyond 24 weeks (6 months) people tend to forget a greater percentage of these experiences (Badenhorst & Hughes, 2007).

Exclusion Criteria

Women known to have psychiatric problems, women whose gestation was less than 28 weeks were deaf and or dumb, women who cannot speak English, Ga and Twi as well as those below eighteen years were not recruited into the study. The mental state of these women must be a healthy one so that the data collected will be devoid of contamination from psychiatric symptoms; this was ensured by making reference to the antenatal document to establish their mental health status. Effective communication is vital to the outcome of the proposed study, barriers to communication such as languages other than those mentioned or deaf and dumb women were classified as excluded in the study and were avoided. Women who did not consent to participate were also not included in the study.

3.4 Sample Size Sampling Method

A purposive sampling method also known as judgemental sampling is a non-probability sampling method often used in qualitative studies. With the choice of purposive sampling, there is the assumption that a researcher's knowledge about the population and its elements is used to hand pick those deemed appropriate or typical for the study (Polit, Beck, & Hunglar, 2001). According to Wood and Haber, (1994), when a highly uncommon or unusual group is being studied purposive sampling is the ideal sampling method to be used. This type of sampling method also allows for a more homogenous group to be studied thereby increasing the ability to transfer findings as well as the ability to apply the knowledge gained in managing similar situations in the future.

A purposive sampling method was applied to contact 30 women out of which 19 were recruited at the maternity unit of the Korle-bu Teaching Hospital; this venue was chosen due to the fact that this hospital receives referrals from the other health institutions across the nation and also its strategic location makes it accessible to all districts therefore the sample would be geographically representative of the metropolis. The researcher, after

being granted the permission to undertake the study visited the labour ward at least once in a week and worked with the midwives on duty, she spent the rest of the week with the post natal clinic team at the OPD; by so doing was able to contact, establish rapport and also gain the confidence of the mothers who lost their babies at birth. In the process of working on the ward the researcher ensured that she did not in any way influence the practice on the ward. The intention of recruitment was declared to potential participants and those who showed interest, the researcher obtained detailed residential address as well as telephone numbers. As a backup method of recruitment in the absence of the researcher, a book was left with the midwives to document the contact addresses of women who lost their babies and the researcher contacted them and sought their interest to partake in the study.

3.5 Data Gathering

Burns and Grove, (2007), explained that data collection is the process of gathering relevant information in a precise and systematic way in line with the Research purpose, Research question or the Hypotheses of the study. Data gathering starts with the identification of subjects and runs along the analysis when a qualitative study is being done. Data gathering entails purposefully identifying the site and participants which Miles and Huberman, (1994) discussed under four heading namely the Setting, the Actors; being the researcher and participants, the Event; the observation of the actors and the Process; the nature of events undertaken by the actors in the research setting.

In a qualitative study data gathering can be done by various means, often a combination of methods are used to obtain the needed data based on the set objectives and the research design chosen. These means or methods range from Observation, Self-reports or Interviews transcripts, Written documents, Audio-visual materials and also Electronic documents, (Leedy & Ormrod, 2010). Most qualitative research uses multiple data collection methods to obtain information. The major tool often used is the interview method combined with

one or more of the other methods such as observation of subjective data; which is documented as memo or field notes, written documents like hospital records. These data collected from multiple sources makes the data rich and in turn promotes trustworthiness of the data. Qualitative studies are characterised by an emerging design therefore the data collected could influence what other data the researcher gathers subsequently.

A semi-structured interview is undertaken when the researcher has full knowledge of the questions to ask but cannot predict the response that will emerge. The researcher by using this method is assured that all information anticipated is obtained and it offers the participants the freedom of what response to give: they give description they think is best for the phenomenon under study (Morse & Field, 1998). Creswell, (2009) stated that the use of a protocol for observational method and an interview guide to conduct an interview, among others is key in qualitative data collection. In-depth interviews have the advantage of obtaining detailed information which is fuller and richer from the subjects (Polit & Beck, 2008).

3.6 Data Gathering Tool

To obtain data for this study an in-depth interview was conducted using an interview guide prepared in English, made up of open-ended questions. It had main question areas in line with research questions and also contained probing questions to elicit clarification to obtain detailed and accurate information.

The interview guide used, sought for information on their personal profile and some obstetric information, the general experiences of the mothers; information about their experience in the process of delivery, their perception of the service delivery point, support available among others. The psychological effect of the loss, social impact and also the coping strategies of the mothers were examples of the data collected.

Data was collected at a venue decided by the participants; these settings were predominantly outside the hospital and most of them were in the homes of the participants or where ever we agreed to meet, since they were better relaxed in their comfort zone. The interview lasted between 35 minutes and 90 minutes. With the interview guide to direct the questions to be asked information elicited were digitally recorded with the participants' consent.

As part of the preparation towards the implementation of this study, the interview guide was reviewed by two supervisors and peers for validity and reliability. A pilot interview was done on three (3) bereaved women to assess the reliability of the interview guide; questions that seem to be unclear or did not elicit the expected answers after the pilot test were reviewed for clarity and efficiency.

Preconceived ideas and especially personal views of the researcher about the stillbirth in the clinical area; was written down and shared with my supervisors to guard against being biased this is described as "Bracketing". Researcher bracketed the notion that, post natal care is often deficient, information on post-partum activities seems to be inadequate when stillbirth occurs and likewise the physical as well as psychological care given to such women.

In the process of interview and recording, nonverbal messages and objective pieces of information observed were recorded into a field note book, these pieces of information supported the data collected and helped to enrich it.

In the process of the data collection the need to break the interview process occurred with two participants; to have lunch (the interview was conducted at an eating place), in one instance and the second one, to relocate to a better side of the venue therefore the recorder was paused to allow for the break and resumed when both parties are set. Where the

response to the questions indicates a participant does not understand the question, clarification was given and this led to a successful data collection.

During the data collection it was observed that five of the interviews, worth reporting, fell out of the inclusive criteria and therefore were excluded from the analysis; three were neonatal losses while other two had maturity less than 28 weeks gestation. The collection of appropriate and adequate data always complements data analysis to ensure an excellent qualitative research.

3.7 Data Analysis

Data analysis in a qualitative study is an approach used to organise, reduce, provide structure and give meaning to the data collected. It is an on-going process which involves the researcher reflecting on the data, asking analytical questions, and writing memos in the process of study (Creswell, 2009). Data analysis was done concurrently with the interview.

An editing analysis approach as described by Polit, Beck and Hungler (2001) was used to analyse the data of the current study. The recorded interview was listened to over and over again and transcribed word-for-word. After reading the interview transcripts several times in search of meaning and deeper understanding (Morse & Field 1995), significant statements were identified, line by line, without making any assumptions. The data was compared between researcher and another transcriber for similarities and also to determine differences in the codes. The data file was imported unto the computer; the Nvivo version 7.0. Data reduction was done by loading portions of the transcribed data unto the software, on the computer; codes and groupings were compiled in the form of nodes; a table was generated to display the codes after which the codes were printed and sorted according the groupings. These statements were grouped according to the meaning derived from them. The most frequently occurring statements were considered strong and were therefore picked and themed. The loaded software helped me with easy access to

quotations needed to support the findings. The final step, interpretation of findings was done and conclusion was drawn based on the frame of reference defined by the research questions to categorize the data identified to enable description of the experiences of the mothers.

3.8 Data Management

The voice recordings and other soft copies were protected by a pass word, the transcribed scripts and other hard copies were kept under lock and key by the researcher. They were accessible to the researcher and supervisors only. The participants were given pseudonyms to promote easy identification and confidentiality. Transcripts will be stored for at least five years after the study is completed to enable availability if need be.

3.9 Methodological Rigour (Trustworthiness)

Trustworthiness refers to the extent to which a research study is worth paying attention to, worth taking note of, and the extent to which others are convinced that the findings are to be trusted (Babbie & Mouton, 2001). This is usually addressed during the planning stage to guide the study process. Hammersley, (1990), defines validity as 'the extent to which an account accurately represents the social phenomena to which it refers'. The researcher sought to ensure accurate findings by using a method that is consistent and can be used by researchers in other projects (Gibbs, 2007).

There are varied views on how to measure the trust worthiness of data in qualitative studies. Yin (2003), believes that documenting every step of the procedure is a means by which rigour can be ensured. Gibbs, (2007), presented four steps to ensure reliability which are, checking the transcript to ensure it is devoid of mistakes, ensuring a correct definition of the codes, communication among coders and cross checking codes among coders (inter-coder agreement). According to Miles and Huberman, (1994) if there is eighty percent (80%) inter-coder agreement the study can be said to be reliable.

Lincoln and Guba, (1985) and Creswell, (1998, 2009) suggests the use of the term Credibility, Confirmability and Transferability in place of the term validity.

Aside the triangulation of methods that is generally accepted and used by most qualitative researchers, Leedy and Ormrod (2010), recommends the use of the proceeding five areas to promote reliability; Extensive time in the field, Negative case analysis, Thick description, Feedback from others and respondent validation. Aspects of Leedy and Ormrod's approach that were suitable for this study were adopted to ensure trustworthiness of the current study in addition to other ones.

To enhance credibility the researcher had an extended time in the field; by working on the ward, acquaintance was struck with the participants. The researcher visited participants to locate them, the participants were met on the scheduled interview date and follow-up visits were made to obtain more information or clarification, this gave the researcher the opportunity to better familiarise with the site of study and have a long interaction with the participants (Leedy & Ormrod, 2010).

The researcher being a midwife has knowledge and clinical experience in this area, also the amount of literature that was reviewed helped to satisfy the criterion of being knowledgeable about the phenomenon under investigation (Lincoln & Guba, 1987).

Bracketing of existing knowledge and preconceived ideas and especially personal views about the existing problems in the clinical area; was written down. Some of the ideas bracketed by the researcher are the notion that post natal care to such women is deficient, information is limited to these women concerning post-partum activities and there is inadequate physical and psychological care given to such women. The review of interview guide by supervisors to devoid it of any form of bias was done (Lincoln and Guba 1985).

Respondent validation (Member checking): Researcher ensured that the conclusion was taken back to the participants to review for accuracy and representativeness.

Inter-coder agreement: the categories identified by the researcher in the analysis of the data were compared with those identified by the other coder. No major discrepancy was identified but rather additional information was obtained, as in the first participant who eventually explained that no indication was explained to her when she was being referred. Also an in-depth literature review further helped to confirm these categories.

Thick description of the activity and findings was ensured by the researcher explaining clearly the steps taken in data collection, data analysis and interpretation of the research findings, in the research report.

Feedback from others: the two supervisors of the current study consistently reviewed the study from proposal, through implementation to report writing. Constructive suggestions and inputs were made by them, also some colleagues read through the scripts as well and inputs were made. These series of actions by the various stake holders helped to ensure trustworthiness of this study.

3.10 Ethical Consideration

Prior to commencing any research, It is necessary for the researcher to consider whether the study is ethical or not, also the safety of all participants involved in the study needs to be ensured therefore ethical clearance and approval was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research.

Formal permission was obtained from the administration of the Korle-bu Teaching Hospital to recruit from the department of Obstetrics and Gynaecology. In addition, the objectives of the study were explained to the respondents and their informed consent was obtained before soliciting information on the scheduled date, these activities were done in respect of the participant's human dignity. They were made aware that they can decline to partake if they do not want to do so, they were also at liberty to withdraw from the study at

any time if they so wish, without any repercussions. The possible emotional effect the interview could have on them was explained to them and they were assured of counselling services available if the need arose.

Participants were also assured of their anonymity; pseudonyms were used to identify each of them. They were also reassured that the data that had been collected, that is their responses would be kept confidential and safely with the researcher and the supervisor to be used only for the research purposes.

An arrangement was made with a counsellor to provide support in case the process of data collection adversely affects any participant at the participant request.

CHAPTER FOUR

FINDINGS

4.0 Findings

Findings of the study are presented in this chapter. The first section of the chapter presents the personal and obstetric profiles of the participants of the study and the subsequent sections presents the key findings under varying themes and subthemes.

Table 4.1: Participants' Profile

PERSONAL PROFILE		OBSTETRIC PROFILE	
Age in years	Number of participants	Maturity	Number of participants
18-29	10	9 months	7
30-40	4	8 months	2
		7 months	5
Religion		Parity	
Christians	10	No previous delivery (primi para)	9
Muslims	4	One delivery	2
Education		Two previous deliveries	2
Tertiary	5	Three previous deliveries	1
Inter-mediary	4		
Basic	4	Previous Stillbirth (SB) experience	
No education	1	One previous Stillbirth	1
Marital status		Two previous Stillbirth	1
Married	11	Delivery outcome	
Not married	3	Fresh Stillborn babies	9
		Macerated Stillborn babies	5
Tribe		Indication for Admission	
Ewe	4	No foetal activity/ heart beat	6
Ga	3	Post maturity date	2
Gonja	2	Obstetric emergencies- bleeding, losing amniotic fluid	2
Hausa	2	Local Attendants on account of bad obstetric history	3
Akan	2	Not known	1
Nigerian (igbo)	1		

The fourteen women interviewed in their own environs predominantly, were at least six weeks post-delivery. These women were hairdressers, teachers, traders, housewives, a laboratory technician, a student, a seamstress, a caterer, a police officer and one was unemployed.

Table 4.2: Summary of Thematic Findings

	THEMES	SUB-THEMES
1	Poor care	Poor interaction Lack of enthusiasm Lack of urgency
2	Reactions to death of baby	Painful emotional response Mothers' Guilt Understanding the cause Denial of loss Numbness to pain Mixed feelings Behavioural responses
3	Coping strategies	Self-motivation Diversional activities Interaction Other children Mementos God factor Suppression of thought of loss
4	Support	Family Friends Support from health personnel Negative support
5	Beliefs	Cultural Faith
6	Grief pain activators (Painful reminders)	Sight , crying of babies and baby items Social avoidance (Attitudes of some husbands)

4.1 Poor Care

The participants described poor communication between them and the health personnel that might have resulted in stillbirth. Three sub-themes emerged from poor care: poor interaction, lack of enthusiasm, lack of concern.

4.1.1 Poor Interaction

There were no close interaction between the participants and health workers which posed difficulty for the participants to express their feelings.

Adom recounted:

, I had an encounter with this doctor who was giving me care and she was like "any question I ask you it should be yes or no". So she will pick my antenatal form and it's like "do you vomit? Yes! Do you have swollen feet? No!, so I couldn't establish a rapport with her and so when I realized I was taking too much water and I was urinating frequently, symptom of diabetes... couldn't tell her because there was tension between us anytime I go there...

Adom also said:

.... don't hear much from the nurses and the doctors so because of that when you come for ante-natal, it is your friend who will tell you their baby is 'this or that',and I read from a book when you are pregnant and the baby who has been kicking before and stop kicking, it doesn't mean the baby is dead....

Shola narrated her story thus:

They asked me if I didn't experience it (losing amniotic fluid) and I said I am taking in for the first time (prime-gravida)The nurse didn't tell me that when you see this come to me. The only thing I know is that they said if you are bleeding or vomiting, I was not vomiting I was not bleeding so (hits her fingers on the table).....

4.1.2 Lack of Enthusiasm

There was not much enthusiasm in the part of the health personnel's in taking action to help the clients.

Rita explained:

.... I became hot... my body was hot and painful so I went to the nurses and told her to give me a transfer letter ...She had already

written the letter but had not given it to me with the reason that I can deliver so she was waiting. When the night nurses cameI told the nurse that I can no longer bear it so she should do whatever she has to do for me to be safe, I asked be referred to korle-bu, they said I would be operated upon if I go to korle-bu.

Adom said:

I called them... nobody was there, nobody was there at that time so I shouted, I called the doctor they came around...there was no attendant because I was giving birth small, small [given birth to a little part of the baby at a time] they left me, I was alone there until you know the baby just came out once and I shouted, I shouted and the doctor came they did whatever they will do.

4.1.3 Lack of Urgency

The participants perceived that the health personnel were slow in things concerning their welfare.

Adjeley said:

based on how I was feeling they should have taken me straight to the theatre when I was brought in but I was kept waiting, any one I called told me to wait for a while. The senior doctor told me he will soon attend to me but when my brother; a doctor came in to visit me he informed them I am his sister and I was immediately taken into the theatre.

Rita also said:

I was taken there (korle-bu) in an ambulance, thinking they will treat the case there as an emergency I was taken there at twelve thirty (12.30) and I was attended to around 5.30 in the evening and the thing was, you know the walls of the womb was trying to expel the dead thing, my waist was splitting and I had to be in that condition for about three good days.

Halima recounted:

I was attending clinic... on the scheduled date for my antenatal visit, when I went they gave me a referral letter on Saturday' (next day) around 6, o'clock in the morning I went to the hospital...I was attended to around 10 am.

There was barely any rapport or communications between the health personnel and the patients. The participants find it difficult to approach nurses and doctors and express their feelings and complaints and the situation prevented early recognition of the problems. For example Adom couldn't explain to the doctor what she was going through though she knew there was something wrong. The health personnel's were not very much enthusiastic about the conditions of the women. The participants perceived the health personnel as not interested or were slow in taking actions concerning their welfare.

4.2 Reactions to Death of Baby

The participants reacted to death of their babies with varying emotional responses.

They expressed their feelings in words such as; "painful", "felt bad", "sad", "indescribable or inexplicable" numbness, surprise and guilt feeling or self-pity.

4.2.1 Painful Emotional Response

The word very painful and very bad reflected in the responses of almost all participants. The conversations have incomplete sentences indicating feelings of helplessness. The following are some of the responses of the participants:

It was painful anyway, very painful, very, very painful.....for the money aspect it should just be put aside.

...it was painful, it was painful but when I slept I visualized the sight and personally I had no "happiness"

It was bad, it's very, very bad....The baby was a very nice baby, very nice baby, he was fair and the hair too, [chuckles to denote dismay, had a low countenance] a very nice baby, he was huge.....

you know, stillbirth is in degrees, some people give birth through normal labour and had a stillbirth and others through CS

[Caesarean section], stillbirth through CS is very, very painful compared to normal deliverybecause you naked yourself and you see the scar but what is the testimony for that scar? It's not there and then people who had CS have the baby as a consolation for the scar but you see the scar there but there is nothing to console you.

I feel very bad, it pained me so much [with an anguished broad smile] but that is what God has done. So I started crying and it was really painful,

In one sentence Adjoa said:

Ahhhh Ok, I had pain, I felt it inside me!

4.2.2 Mothers' Guilt

Guilt was also identified in their narration when the woman introspectively tried to understand where they went wrong or what they could have done to have kept their babies alive. Fati explained:

If I had called my doctor I would not have lost my baby. If the surgery had taken place earlier I wouldn't have lost my baby.

Freda also said:

.....when I went to the hospital I couldn't tell her (doctor) then I see that if they had realized the situation and has rescued it early it could have rescued the situation altogether.

For Adom, her guilty feeling was demonstrated in her rationalization that she was a good

Antenatal attendant. She said:

I didn't miss ante-natal; I have not even absented myself from taking...I have not absented from going for antenatal, I have not ...missed one pill before. If I forgot I make sure I take it at that time,

4.2.3 Understanding the Cause

The women were trying to figure out the cause of losing their babies as they tried to understand what caused the death of these babies.

Rita explained:

so on the theatre bench when they showed me the foetus I don't know whether it is because of the cytotec [wondering whether the deformed look of the baby was as a result of the drug used to induce her labour?] or its been dead for a long time the body was macerated you can see the skin peeled off and I said Gosh so what happened to....., did he cry in there?

Fati also said:

....I often think, I think, I wonder why I came to give birth and lost it.

Adjeley who had stillbirth on two occasion responded:

And I was asked whether I would like to see the baby and I said yes; when they brought the baby to me it was dead. So I asked the doctor why I have delivered twice and both were stillborn?

4.2.4 Denial of Loss

Some of the participants demonstrated denial through their expressions and others had expectation that their babies would be brought out alive when they (mothers) had prior knowledge of the death of the babies.

Ramatu recounted:

*...She [the nurse] was told to show it to me that it is dead,.....
I was looking at where I can see his breathing I was looking at the nostrils to see if he was breathing.*

Isha narrated her own after recovering from general anaesthesia this way:

On my bed I turned left and right I couldn't find any baby because when was going [when I was going in for the surgery] I was thinking if God says the baby will live I'll be lucky to find my baby alive after the CS, I woke up and there was no baby by me, so from that moment I knew I was alone.

Shola said after she has been informed she was carrying a dead baby:

I just needed them to confirm for me because something was telling me that the baby is dead...So I came back home, when my husband came, he has the faith so we started praying if God can revive my baby back. pastors they prayed for me. And also I went to church, I was given anointing oil to practice, I was having that faith

.....*I was thinking that God can do a miracle, and the baby... will just be alive...*

4.2.5 Numbness to pain

Some participants also reported the feeling of numbness when the dead babies were shown to them. Rita stated:

That time I didn't feel anything, I gave everything to God and when I went to the ward, when some nurses came to attend to me and ask where my baby was, made me cry.

Freda also said:

They brought him for me to see but that day I did not feel anything. When they sent me to the ward was when I became sad [her countenance changed, voice changed]..... At that moment nothing happened to me, it was at the ward, where the women were all carrying their babies; that troubled me.

4.2.6 Mixed Feelings

The participants expressed various forms of reactions at the sight or thought of the dead babies and in response to whether they appreciate seeing their babies.

Isha had this to say:

I think it will worsen things, I wish I had seen my baby but for pain I felt for not seeing her, I soothe it with the thought that may be if I had seen her, I would be seeing her in my dream or vision.

Shola: *I have mixed feelings about the loss, but I had some friends there, I made some friends there and they were also encouraging me.*

Adom expressed herself in this way:

.....*I marvelled because I haven't seen some before, such a thing has not happened in my life before so I was very surprised. hmm, I was very surprised. I was shocked because I have never seen such a thing before.*

Feeling disenfranchised was expressed when they narrated how they felt deprived of what naturally they could have had:

Shola: *But seeing babies all around, I could not carry anybody's baby, so the emotion was really tough. Even sometimes when my husband comes we start talking about the loss; we start shedding tears. [Talked with a clap and clasp of hand; an effort to contain her emotion].*

Also presenting her experience Adom stated that:

People are going home in twos (2), or in threes (3), you are alone. You understand? Everybody is going home with his or her baby and you alone, you go empty handed, it's just painful no happiness at that time, no happiness, it's sad, sad and painful

Rita: *[Takes in a deep breath and sighed very audibly, sounding very low] Well, there I understood why they say stillbirth, because you feel the baby should cry you should hear the cry of your baby, but nothing, You don't hear anything and it is "still" and you ask yourself a lots of questions but these questions have remained unanswered till now, [giggles sarcastically] I just can't explain it.*

4.2.7 Behavioural responses

The women demonstrated outward open expression of responses such as crying or weeping, and moving about. The following were some of the responses:

Adjoa: *When I came to the ward the other women were all having their babies and [chuckled]. I usually feel sad and I move out and look for a place, place to sit,*

Shola: *... so that I won't start shedding the tears. I have shed before because I really cried a lot and I know how it affected me so I don't want to start crying all over, crying won't bring the baby back so I just have to calm down and pray to God.*

Rita: *I was asking God why me? so on the theatre bed, I was weeping, the attendants were saying I shouldn't weep and the surgeon said they should allow me to take the grief off. It hasn't been easy, and it's still not easy but time is the best healer so [takes in a deep breath, both eyes closed], it hasn't been easy [sighs] hmmm.*

Some of the participants were hopeful, and accepted the situation in good faith. Eno expressed this in local proverb and said that it is better to lose the baby than the mother.

She said:

“the water storage pot must remain for fresh water to be poured [stored] in it”[a Ga proverb establishing the fact that it is more accepted when the product is loss rather than the producer]

Helen also said:

What I can say is that whatever God did it was good. Because if maybe he is to come out alive maybe he would have been a problem.

Adom:*I felt this is not the end for me am still young I can, like, God can still do something.I can't just give up hope, being alive there is still more hope.*

Fati: *In fact, I had already given all to God and pray ...*

The experiences reported varied; they all described the experience of stillbirth as painful as they narrated what happened. Their reactions to the pain were guilt; they wondered where they went wrong, they thought of what they could have done to save their babies. Some women demonstrated initial numbness to the pain and there were record of denial in some of them. As a result some women said they found themselves weeping, moving away from the source of pain however hopefulness a coping strategy which helped the mothers to move on.

4.3 Coping

The participants described various activities that helped them to cope; alleviate their emotional pain. Some of these are self-motivation, diversional activities, interaction, keeping mementos, other children, God factor and suppression of thought of loss

4.3.1 Self-Motivation

This is the inner empowerment that majority (eight of the women), explained they engaged to enable them cope with the grief stressors. The women in varied ways presented it in their narrations:

***Rita:** you receive the support but the greater part of it, you will have to encourage yourself and console yourself with the word of God. For them to tell you that we know you are a strong girl is suggestive of the fact that you have to do it yourself, you have to encourage yourself to come out of it*

***Eno:** I do encourage myself and others also tell me to expect another one.*

***Shola:** I felt this is not the end for me; am still young I can't just like give up hope, you being alive there is still more hope. That is what I believe because if you start keeping it weighs you down and your health is at stake*

4.3.2 Diversional Activities

This was captured from the narrations of the women when they described what they physically did to lighten their grief burden

***Helen:** the TV, that's sometimes when I am thinking, I get relief from watching the movies on the TV that's what makes me feel better.*

***Freda:** I am most of the time at home so the television shows, religious programmes and at times some church members also gave me calls.*

Adom:

When we sometimes come for sports training, we laugh; and share jokes among our peers. Those things make me feel ok. And I keep moving on until maybe you I see one thing closer to "that side" (about pregnancy and childbirth) and will hit you again and you will remember. The sad time for me is not like the way I used to be happy [happy moments far outweigh the sad moments].

4.3.3 Interaction

The women explained that while on the ward and at home, interacting; chatting with friends, neighbours and peers (other patients on the ward) was another coping strategy used.

Adjeley: a friend has been taking me out and that keeps me from thinking. Our friendly conversations, advises have made me recover this much.

Adjoa: where I live with the woman, there is another girl, we often chat and that takes my mind off the loss and makes me forget but when I sit alone I remember and become sad and when they will ask me what the matter is I will say nothing but it is because my mind has gone back to it [the loss].

4.3.4 Other Children

For some of the women, having other children or taking care of other children was another thing that helped them cope with the loss.

Fati: I thought that I have already children; some will come and they will even have one and they will lose it at once. Me coming for the 4th born and I even loss it, I have three left.

Adjeley: my sister has a child who she leaves with me when she is going to work, taking care of the child comforts me.

Yaa who lost one of her twins while the other was in the Neonatal Intensive Care Unit said:

When I was first sent to the ward I did have my live baby with me so when I came to the ward the other women were all having their babies and (chuckled). I usually feel sadbut when I remember that I am fortunate to have a live baby, I ask myself why must I worry when other babies cry?

4.3.5 Mementos

Seeing the baby or keeping pictures of them according to most of the women was fulfilling, satisfying and consoled them. These report-worthy expressions by some of the participants were presented in their narrations this way.

***Ramatu:** you have carried her for nine good months you don't know how she looks; so seeing her will make one better.*

***Ramatu:** if you tell me to describe, What I saw was just briefly, as for that I wish I saw her, I even asked my husband why he didn't take her a picture..... you have carried her for nine good months you don't know how she looks, so seeing her will make one better.....*

My baby was buried in my father's house; it is comforting, am not that troubled.

***Adom:** am glad I saw him, not seeing him I will feel bad, I will not know how my baby looks like, how he is, so seeing him I am ok.*

Even women who had macerated babies and therefore the sight of their babies were not very pleasant also appreciated the worth of seeing their stillborn babies, **Adjoa** who stated that reflecting on the sight of her baby makes her lose appetite had this to say:

I think seeing her was good, at least you will have something to say if you are asked, if I had not seen and am asked what will I say? I won't have anything to say.

***Rita:** my sister took pictures of the baby and I really wanted to see to see the baby to feel a bit fulfilled, at least let me see what I gave birth to,,..... when am feeling so empty I go back and pick this picture I look at it and feel fulfilled and satisfied*

***Adom:** Am glad I saw him, not seeing him I will feel bad, I will not know how my baby looks like, how he is, so seeing him, am ok.*

4.3.6 God Factor

Almost all the women believed that God or Allah was in charge and had control over their affairs so they accept what came their way. This religious stance and expression featured in various aspects of their presentation.

Adom: Going through the bible quotations was the thing that was comforting me to have the hope to say I can move on and I just thank God for at least taking me out. There are some situations the mother and the child goes [dies]. God has been so good to me, he allowed me to come back

Shola: I just have to calm down, pray to God. I believe that... I do encourage myself. I am waiting to see what God will do.

Isha: I recovered by thinking and saying to myself it is the work of God and also giving thanks to Allah that I have once more opened my eyes to see his creations, the light, of the moon and sun, and being able to walk again. If you don't have God you will lose everything but if you have God and you know what God said you will and calm yourself hmm. My partner..... says God gives and God takes.

Halima: yes I know that God gave to me and he has taken back....

Some participants said their meeting other women who have experienced child loss made them accept the fact that they are not alone in this situation.

Shola: just that after everything, after I delivered the nurses who came to me, encouraged me; she told me her own story. So I said if this nurse can lose her own baby, so who am I? I was just like this world you, this world is just full of misery so just have to take it the way it is, so thank God for things to come.

Adjeley: I gained some consolation in the fact that there are also others on the ward; they have also lost their babies. I am not alone

Fati: I was standing there and there was no chair so I was standing like this and she came and stood by my side. I look at her and said no! This woman too is my sister mmh! She has also lost her baby.

4.3.7 Suppression of Thought

Suppression of thought of loss was also a method of coping some women however contrary to that, other woman vehemently stated that the pain or the thought of losing a child must not be suppressed.

Ayekai: it was painful but I tried to take it off my mind

Rita: when I want to talk about mine my mummy will say oh, you don't talk about it, and it worsen the situation they made me bottle up my feeling and I keep asking myself so is it because still am a failure? I should not talk about anything?

Adom: well I am a human whenever I see the things and it pains me, I let it come.me the way I am, if something is paining [hurting] me and I don't bring it out, if it's there, it's like am dying inside and when I brings it out then I feel ok.

In their painful moments the women explained that motivation that came from within them, self-motivation was one strong support that helped them cope with the situation and diversional activities took their minds off the pain. Interacting with people was another strategy reported which was explained to have mostly occurred between the women and their fellow in patients, friends and neighbours. Taking care of other children was soothing, seeing the babies was good for some of them, most of them explained they believed God was in charge and trusted him for replacement. Still others thought suppressing the thought is not helpful.

4.4 Support

The participants received varied help which were predominantly expressed in words such as encouragement, advice, comforting word and assurance of fruitfulness. These were seen to have come from family members, mainly their husbands, father and sisters. Other support sources were chatting and interaction with others, healthcare professional, friends, neighbours as well as church members. Notwithstanding the participants also received negative comments that discouraged them.

4.4.1 Family Support

Adom had this to say:

My husband! I thank God for my husband, God gave him the heart [was courageous]; the heart was like stone so he didn't let me feel bad. He was also besides me like this. The way my husband do his things in the house, he is somehow funny so there are more things he will be saying you will even forget those things

And:

Yaa: my father, when I was at the hospital at the labour ward he came in with my mother. He encouraged me that I shouldn't let anything bother me. My father came back to the ward again to talk to me and told me that others went [into labour] and didn't get anything and so I should be grateful. So as for my father we always chat, anytime he sees me sitting idle he knows there is something bothering me and he will come and chat with me

Also:

Shola: the kind of man I have here he was there for me, he assured me we are so young, it will come back,

Rita: I received a lot of support from my sisters and brothers they were there for me; they called to encourage me.

4.4.2 Friends' Support

Another form of support described by the participants was the support they received from friend and acquaintances''.

Fati: we the patient. We advise each other.

Helena: one madam comforted me; she said that i will surely give birth again, also where I was lying there was one sister who told me that though it is painful I must give it to God. These sayings gave me comfort..... in the house two women who are usually nice to me encourages me not to be sad.

Ramatu: I was given advice, my friends and everybody who comes tells me it is the doing of the God, I should exercise patiencethat's what they often tell me.

4.4.3 Support from Health Personnel

Some health personnel were said to have been very supportive as madam Adjeley put her impression about the personnel:

They advised, even me some gave me their phone numbers to call them when I am in need.

Ayekai: I said I know God will do something special in my life and one said "yes God will give you bouncy babies". In fact they encouraged me that God will replace my loss. The first one, I was a bit..... second one I had no advice but this third one, it feels as if nothing happened, due to the encouragement I received, when I was coming home one nurse promised to visit me but maybe she is busy that is why she has not come.

Adom: well some of the nurses some of the nurses were very supportive and they reassure you oh! Don't worry in three months' time, it will come again and that....Even at the theatre the doctor who did the surgery told me look "I will want to deliver you same time next year", so it somehow consoled me, some of the medical staff are very, very good.

4.4.4 Negative Support

Some participants received negative comments, attitudes and social abandonment or avoidance and insensitivity from people and this discouraged them.

Rita: but the other tenants, nobody has ever asked "ohh we have seen that you have given birth, what did you get?" or nothing, I don't know what to say. People's attitude to the situation that worsens the case that worsens the case.....its pathetic nobody says congratulations, nobody said anything.

Eno: In the house it is not everybody who is in good term with us, so sometimes I had the feeling that they are happy that I lost my baby. The one could even call her child and exclaim "oh God I thank you oohh...!" They tease me by saying all sorts of things with their children

The sources of support to withstand the grief stressors as described by participants; they received support from spouses, other family members, friends, neighbours, some health personnel as well as inpatients. Support was largely in the form of encouragement and pieces of advice. However some also reported negative attitude of people towards them.

4.5 Beliefs Attached to Stillbirth

This conveys the socio-cultural and faith stance surrounding stillbirth. As the participants expressed what they know and what they were told during their bereavement period, socio-cultural and religious beliefs emerged.

4.5.1 Socio-Cultural

Socio-cultural it is believed that fertility is affected there one mourns the stillborn; there is the myth that the woman will become infertile therefore they were dissuaded from mourning. The participants presented their reports this way;

Adjoa: I cried and one midwife told me that if I cry too much it will affect my womb and will trouble me in future. So I said I have heard. So then I stopped crying but anytime I remember my eye wells with tears.

Freda: yes they say when you weep, your delivery will delay or you will not give birth again.

It is believed that the baby was a stranger, transiting through the earth therefore mourning it or talking much about the stillborn baby was not encouraged since it could welcome recurrence as evident by one participant's narration.

Rita: they think it is a dead baby so" you don't know him, we don't miss him, it is you we know so don't even talk about him" you see and this does not help situations.

It is part of the custom among the Ga people and some Akans that when a woman delivers a fowl is slaughtered to appreciate motherhood and to congratulate the mother. One woman appreciated the fact that her husband performed that rite for her despite the loss of her baby.

Eno: but after the losing my baby during delivery, my husband slaughtered 2 fowls for me.

However Freda said:

yes, usually when one delivers based on the sex of the baby a male of female fowl is slaughtered for the woman but because the baby didn't come home that was not done.

A woman, who goes to the labour ward, goes through labour but comes home without a live child is not acknowledged as a mother, but seen as barren. This is evident by the avoidance of the use of congratulatory expressions used for woman after delivery.

Eno: *no you are not acknowledged as such [as a mother],*

Rita: *I was thinking they should call me to congratulate me for carrying the baby up to full term because it was a matured baby before but because it's a dead baby so they feel I have failed, [sounding very emotional]. I have failed so there was nothing like congratulations. Some of them went ahead to ask me "oh so didn't your husband get angry with you that the baby is dead?"*

4.5.2 Faith

The Christians and Muslims have various beliefs surrounding stillbirth. The Muslims believe the source could be a spiritual attack and taking pictures of the dead was not accepted. They had this to say:

Isha: *They think if you are tempted by the devil, it [stillbirth] can follow you to where ever you go, you can lose your babies but if you are Godly the devil can't do it to you, God will help you*

Halima: *yes I know that God gave to me and he has taken back but some people often say that it was an attack from someone or.....*

Ramatu: *Through birth it came and God has taken back. So I don't have anything to do.*

Among the Muslim, also it is believed that pictures of the dead must not be taken therefore women who were unconscious, under General Anaesthesia (GA) at the time of delivery did not get the chance to see what their babies looked like.

Ramatu: *they say it is wrong; you don't take the picture of a dead person as a Muslim*

Prayer sessions were organized for spiritual intervention, in support of the belief of supernatural influence concerning the occurrence of stillbirth Shola and Adom respectively said:

we called so many pastors they prayed for me. And also I went to church, I was given anointing oil to practice, I was having that faith that if God can do something, but nothing happened, ahh!

..... I was saying God, this is what they are saying but I will be excluded, I will get an angel as a nurse or a doctor over there. Truly, truly when I went if they don't take good care I don't know. when I went God provided good nurses for me.

4.5.3 Disposal of the Dead

The participants did not value the need to have good burial services therefore to the disposal of the dead babies; they allowed the hospital to take care of them.

Adom: So my husband came and they asked him whether he wants to take the baby home or hospital will take care of it? He said the hospital should take care of it. So they said there is something supposed to be paid, so after he paid those things they took him.

Adjeley: I was still lying down when they showed it to me they showed me and asked whether we would want to bury it ourselves but my brother asked them to take care of that.

Ayekai: And when I asked my husband, when you paid money for the burial, did you see the baby? He said no and that the child is dead.

Rita explained the unpleasant reaction of her of the mother-law thus when the issue of disposal of the baby was raised:

The response my mother in law particularly gave was; "We were expecting a live baby and now the baby is dead what do you want us to do with it? You can do whatever you want with it"

Conclusively, mourning stillbirth was seen to either promote sterility, prolong infertility or in some instances recurring baby loss. The women were therefore encouraged not to cry much or mourn. The sources of this belief was predominantly among the social community in which the participants belonged however it was evident that some

professionals such as nurses also shared the same belief therefore encouraged the women to desist from crying. Talking about the stillbirth could bring recurrence therefore it is discouraged. As part of the various reports mothers with stillbirth were not acknowledged as mothers thus instances of maternal devaluation was reported. Stillbirth is believed to have supernatural association; some believed it was the doing of God while others explained it could be through evil forces. Among the Muslims taking pictures of the dead was not allowed however there was a positive observation made; the Muslim always took custody of their dead babies and disposed them off on their own, which promotes value of the baby.

4.6 Grief Pain Activators (Painful Reminders)

These are things that the bereaved women indicated ignited or brought back the pain of their losses. These came up as the women explained their experiences whiles on admission, at home and even during the postnatal clinic. Some of these activators were; crying of babies, seeing other peoples' children, and attitudes of some husbands'.

***Freda:** When they sent me to the ward was when I became sad [her countenance changed, voice changed, sobbing] [lowered the head, tears flowing, was silent for a while] When the babies are crying it sets me thinking and I begin to cry [starts sobbing again] I was sad at the way everyone was carrying their babies, and I*

***Adom:** yeah so if I will even come for [postnatal] review, I don't feel like.....you meet some people with their children, everybody with the baby. They will mention the name and mention that your own is dead. it's only that it's somehow painful, brings back the memories I think that's the most painful thing. If I come to the review and see them I always feel bad.*

***Halima:** when I went for the two weeks clinic I saw all those I was on the ward with, holding their babies and it was...*

Ayekai: *ahhh! At the hospital when the babies are crying and everybody was carrying her baby. I was the only person there not carrying a baby, so you can imagine! For instance when the babies are crying the mother cuddling them, speaking to them: "oh Afia, stop crying" "Kofi" [voice lowered] in fact when I blink, tears just flow out of my eyes, "ta ta-ta"[describing the speed at which the tears flow].*

The next offending thing described, was seeing the babies' items; this continuously reminds them of the emptiness created as a result of the death.

Halima: *yes when I open my bag to pick an item and I see my baby's things it brings back the pain.*

Ramatu: *.....or when I come across her things when working in the room I become very sad.*

Helen: *you brought things, things that you will wear for him, his clothes; you brought things that they would be proud of. When you see those items...*

Then emerged the sub theme avoidance; as some participants presented it in the ensuing varied narrations;

Isha: *yes because the same people, who know you, who you have been meeting when you are pregnant, they turn their back to you after delivery without a baby. Some people even reject you totally Some people can't even say sorry*

Rita: *So peoples attitude and from the office, well one or two people called to say sorry but the people I was rather expecting to call they did not, and up till now nobody has mentioned anything and in the family nobody call.*

The attitude of some husbands towards them after the loss gave them more pain than the baby loss. They explained;

Eno: *it is only my husband who can comfort me, but he too, of late is giving me problems, he does things that saddens me, and it made me cry, I really cried recently.*

Ayekai: *when I came home, I didn't find it easy, I went through hell with this one [the current baby loss, had two previous losses]*

I was in pain. It later happened that he [the husband] was not providing money to feed me.

Adjeley: when I go out there I come back without a baby, so eventually he told me to go to my parents and he meant it. To the extent that all our co-tenants saw it they pleaded with him but he refused.

The painful reminders were as immediate and close when the bereaved women initially went to mingle with the other mothers with their babies on the maternity wards, at home the sight of the babies' items were a strong trigger factor. The complained that being avoided is a painful experience, some utterances and spousal neglect were reported to be offending to the bereaved mothers.

4.7 The researcher's Reflections on the Findings

This covers the emotions and the mind of the researcher while she collected, and analysed the data as she listened to the participants' stories.

The researcher was emotionally affected while she listened to the mothers narrate their loss. She made a conscious effort to conceal these feelings by not showing it facially or shedding tears. However empathy was shown. A firm grip on the hand to say "I appreciate your feelings" was given to some women when it became necessary.

The emotional state of the women manifested in their pausing for a long time, gazing expressionlessly at nothing, as they stared into the eyes of the researcher without talking, and tapping their feet or tapping the table during the interaction. Deep feelings are at times presented with limited words therefore single sentences were valued and reported by the researcher.

The researcher believes that to some extent, exactly what they felt was not expressed since they knew the researcher as a nurse therefore they might try to avoid offending her. The thought that the mothers have failed was evident; during recruitment of participants, the

researcher greeted them with congratulatory messages; largely the instant response was “I lost my baby, (confirming that they see themselves as failure per social standards therefore not warranting congratulatory messages).

It was anticipated that the interview could adversely affect the participants. The outcome was otherwise; the participants were found not to be as troubled as anticipated. The participants when asked about the impact of the interview on them asserted that it was helpful. They found it as an avenue to express their feelings about the health services and appealed that the findings should be implemented to enable others benefit from their current losses. This response, the researcher believes is a sign that the women will not want others to go through their experiences.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

The research sought to explore and record the experiences of mothers who had stillbirth in the Accra Metropolis. This chapter discusses the findings in relation to relevant literature. The discussions are based on the main themes which are: poor care, reactions to death of baby, coping, support, social beliefs, perception of care received and grief pain activators (painful reminders).

5.1 Poor Care

The ability and the willingness of Health service personnel to engage a grieving parent with humility and mindfulness rather than with detached objectivity appears key to positive perceptions about care received (Pullen, Golden, & Cacciatore, 2012).

Poor communication and poor interpersonal relationship between service providers and their clients resulted in poor care. For example, there was a missed diagnosis recorded by the current study when the women explained they did not know of the risk of losing amniotic fluid. Another example is when the symptoms of excessive thirst and frequency of urination could not be communicated because of a communication standard set by the health service personnel. In another situation, clients resorted to obtaining information from sources rather than from the midwives which most often was inadequate and not reliable. They resorted to this method when the health service personnel did not provide them with information that they thought was needful. In some of the instances, urgency was not attached to the signs of obstetric challenges therefore, the mothers lost their babies. In the qualitative study of Modiba and Nolte (2007) which delved into issues of experiences of mothers with child loss and the care they received from doctors and midwives, a report of compromised communication between practitioners and their clients was made. The clients expressed that most of the time there was nobody to talk to and

their stress built up. This situation frustrated the informants. The Swedish women under study in Trulsson and Radestad, (2004) explained that they expected the caregivers to communicate adequately with them; nonetheless there were complaints of communication gaps.

Timing of care was another criterion the women used to assess the services they received. The enthusiasm of the service providers was observed here. The women used spontaneity on the part of the caregivers as a yardstick to measure quality of service. There were negative reports recorded. Some of the participants expected immediate feedback after examination. However, this was found to be lacking from the findings; in these instances, the Health service personnel did not immediately inform their clients of the diagnosis. As a result some participants did not attach the expected urgency in reporting at the referral point. Trulsson and Radestad, (2004) recorded that verbal communication ceased after diagnosis of the death. (Sanchez, 2001) also described as bad care the long duration it took to inform mothers of the foetal death. This finding is contrary to that of Erlandsson, Saflund, Wredling and Radestad, (2011) they reported a free flow of information from the Health service personnel to their clients. This flow of information issue as observed from the various findings, indicate that there may be some level of information given to the informants but it is not at its optimum.

Abandonment on the part of the Health service personnel was also noted significantly after the diagnosis of the death. The Health service personnel showed little concern about the participants' losses and seem to have abandoned them. Some women were left alone to deliver their dead babies; such an act may be described as insensitivity. This is confirmed by Modiba and Nolte, (2007). This situation agrees with the findings of Erlandson, Lindgren, Malm, Davidsson-Bremborg and Radestad, (2011) when they studied the experiences of mothers after foetal death diagnosis. They affirm that the women were left alone to their fate after they have been diagnosed of having intra-uterine death.

5.2 Reactions to Death of Baby

The study conducted shows that the participants react strongly to the death of their babies. The duration of grief, its severity as well as the personality of the individual determines the psychological health of the individual. In this instance grief is an internal environment of the bereaved women, the external environment include the hospital setting, the service providers and other stakeholders expected to form a support base to propel the mothers back or maintain them on the health continuum, correlating with Roy's (1970) description of the individual, environment and health in her metaparadigm of nursing.

The women used the word 'painful' to describe stillbirth experience. The findings revealed that most of the participants described their feelings and mental discomfort as pain; some said it felt bad, and others found it indescribable. Notably the participants who come from different ethnic groups literally use the expression "pain". An Ibo (Nigerian) participant also described the feeling as painful. Painful emotional encounter can then be used as most apt description of Stillbirth Experience. Kelley and Trinidad (2012) in support reported that their participants expressed the extent of pain in their moments of grief.

Mothers have an inherent nature of nurturing and protection, there were efforts by some of the participants to obtain reasons for the loss of the lives they once nurtured and protected. Others sought to understand what caused the death of the babies. One mother expressed her intention to replace the amniotic fluid lost when she was told that she will lose her baby because the fluid surrounding the baby is diminished; and asked the nurse to give her some water to drink to replace the fluid, to sustain the baby. This woman had already experienced two perinatal deaths; this was an obvious moment of disorganisation (Stephenson, 1985). This clearly points that the mothers felt they failed their children, the work of Modiba and Nolte (2007) corroborates this assertion.

Guilt was presented by the participants in varied forms. Cacciatore, DeFrain, Jones & Jones (2008), cited Bohannon (1990) to have stated that bereaved mothers struggle more with guilt. This statement supports the current findings. Gauzia, Moran, Ali, Ryder, Fisher, and Koblinsky (2011) explained that guilt and negative life changes correlate with depression however there was no subjective report of depression. During participant recruitment at the post natal clinic, one participant was reported to be weeping regularly when the husband goes out to work. Her husband recounted how his wife, who was a naturally quiet woman, had become quieter and no longer lively. The researcher encouraged, counselled and frequently interacted subsequently with the couple. At the end, the potential depressive risk failed to persist.

Self-blame and the thought of what could have been done to avert or save the situation was presented in the studies of Dunn, Goldbach, Lasker, and Toedter, (1991), as cited by Wing et al (2001). In the current study one bereaved woman lamented that if she had called the doctor instead of the nurse she could have saved the baby. Some said if they had changed service providers or had not taken some medication or exercised when pregnant the situation could have been saved. These statements of self-blame are backed by the reports of Bennett, Litz, Sarnoff Lee and Maguen (2005) and Franche (2001).

Therefore there is the need for clinicians to give the bereaved mothers the assurance that they did nothing wrong to cause the death as advocated by Kelly and Trinidad 2012.

Denial is a form of defence for the body's homeostasis which is described as a coping strategy. The denial state, according to Lindeman (1944), takes the person out of the pain at the moment in time, for the body to be better adjusted to receive news later. Wing, Clance, Burge-Callaway and Armistead (2001) reported that incidence is initially high in the fathers but later the mothers' level come to a balance with the fathers' over a period of time. Information of child loss affected the current participants, their bodies sought to

avoid hurt in this instance. Unconsciously they demonstrated denial in varied ways, for example some of the women who have prior knowledge of the death, imagined the miracle of the baby being alive when it was taken out of the uterus. Another woman fantasized her recovery from anaesthesia to find her baby lying by her side but upon recovery when she did not see the baby she felt lonely. Another woman kept looking at the chest and nose of the dead baby in anticipation that there will be movement to indicate life. Prayers and spiritual practices were indulged in to virtually change the verdict of infant loss. There was no indication that these reactions went beyond the first week of the incident, this makes it a normal grief reaction.

Numbness is another normal grief reaction or response espoused by Worden (2008). This was evident in the current study. Some of the participants reacted to their loss and it was obvious that their bodies have been “anaesthetized” against the loss pain, an unconscious body reaction to control the mental impact of the loss on the women. After the news was broken to them and when they saw their babies, some of the women intimated that they instantly felt nothing, they did not cry and no thought run through their minds. This report is in consonance with Wing, Clance, Burge-Callaway and Armistead (2001), in their statement that participants did experience numbness among other reactions.

Furthermore, the findings of this study support the work of Worden (2008) because whiles one group of women felt nothing; other women expressed their shock and surprise on seeing the babies and at the news. Wing, Clance, Burge-Callaway and Armistead (2001); Stinson, Lasker, Lohmann, and Toedter, (1992) and Kavanaugh, (1997) reported of similar findings.

In all these instances, there were natural and spontaneous response to the loss which allowed the bodies of the respective women time to adjust and accept the painful situation; their defence mechanism can be said to be a healthy one. The internal and external environments are in a balance to maintain these women on the health continuum.

Worden (2008) in his work on grief counselling classified the reactions: tearfulness or crying, physically moving away, loss of sleep and loss of appetite as behavioural response to grief. The emotional reactions were interlaced with some behavioural response as the women described what went on at the hospital and in their homes. The women explained that they wept at the loss and wept again when the thoughts recurred. Others stated that memory of the sight of the baby took away their appetite. One woman explained that her instant reaction to being in the ward without her baby was so troublesome that she physically moved out of the ward periodically to sit elsewhere till she became better. This woman's first twin is at the neonatal intensive care unit but she lost her second one. Her plight was not as bleak as that of others, nonetheless her action portrays that every child is accounted for by the mother and valuable to the family. Thus, Health service providers must be empathetic in their handling of bereaved mothers, and avoid trivializing or rationalizing deaths.

The issue of reaction to death of baby brought out what the mothers go through while they are in grief, the successive reports more accurately fits in the expected grieving stages. The reactions of the various women and their various modes of grief are in tandem with what has been described by scholars in that specialised field like Kavanaugh (1974) and Worden (2008).

The participants' expression of how it felt when the news was broken or when they saw the babies was a demonstration of the first stage described by Kavanaugh (1974) as being shocked with a sense of guilt. The women expectation to see the dead baby breathe despite the prior information that they had intra uterine deaths was a clear demonstration of denial (a situation of real world colliding with and unreal world).

The second stage of disorientation however was not presented in the narrations; possibly it could have been observed and reported by others, and not the participants. Being disorganised can better be observed rather than subjectively presented.

The participants represented the stage of loss and loneliness when they expressed their dismay. One participant said "on my bed I turned left and right I couldn't find any baby, from that moment I knew I am alone".

At the time when the clients were interviewed most of them can be said to be at the stage of re-establishment because they have accepted the loss and are projecting into the future.

Some of the women reported that they were frightened at the sight of their dead babies. Two women explained that the sight of other women with their babies was offensive to them but they however intimated that they received encouragement from that same group of people. These they describe as mixed feeling.

The preceding reports in relation to some grief theories such as Worden (2008), Stephenson, (1985) and Kavanaugh (1974) indicate that all the participants grieved normally. No abnormal grief description like absence of grief or prolonged grief was identified in their narration. Sadness, guilt, and loneliness were documented in these situations which is in line with what Worden (2008) presented as normal expectation of a grieving person.

Though these women did not receive an organised or institutional support in their time of loss, they went through their grieving process normally. It was observed that the African family system is usually one of an extended type therefore the possibility that these women were not solitary during their grieving period is high. Also, because of the compound type of housing system, these women indirectly regularly related with others thereby keeping their mind busy. Support systems in the African context might have prevented them from becoming depressed as opposed to what has been found in other

studies like Evans and Hughes (2009), Gauzia, Moran, Ali, Ryder, Fisher and Koblinsky (2011) and Silver (2007) .

5.3. Coping Strategy

As the women narrated their painful and negative experiences, there were indicators of hope in their presentation. While some expressed that they have taken what happened in good faith, some stated they have more moments of happiness and less sad ones. Also, upon seeing their babies, most of them intimated that they were satisfied and felt fulfilled as mothers. This aspect of their presentation represents what is termed “working through grief” (Morris, 1986). Morris (1986) explains that people are able to adjust to the loss that confronts them when they work through grief. Coming to accept the loss and being hopeful to get pregnant again plus faith in the ability of God to replace the loss are good indicators (Stephenson, 1985). Therefore, Cacciatore, DeFrain, Jones and Jones (2008) described coping as struggling to create a “new normal life”, which they stated included relationships, role identity as well as faith.

Self-motivation is the bedrock or foundation upon which early recovery can be attained. The findings revealed that to be able to cope with stress of loss, most of the women stirred up encouragement from within; they encouraged themselves with various reasons. This is in agreement with the work of Rybarik, (2000) when he explained that participants who had self-motivation with social support recovered faster. Possibly this could be a factor that buffered the participants therefore precluding them of reports of anxious and depressive symptoms.

Aside the inner motivation, the women engaged in some physical activities that helped them to carry the grief burden in a lighter form. Various action and activities were described by the mothers as helping to comfort or relieve them of the pain. Watching television and movies, sports, reading scriptures were among the list of activities which is

in agreement with Carver, Scheire and Weintraub, (1989) and McCrae and Costa (1986) who presented work on coping tactics. Folkman and Lazarus, (1980), as cited by Curver, Schier and Weintraub, (1989) in description of how people cope with stressors, explained their second type of coping which is Emotion Focus Coping. This is most of the time applied by people who feel that the stressor is something that must be endured; the loss of a baby cannot be undone but rather be endured.

In situations where there is another child available to be taken care of was an avenue of solace to some women. Women who already had children consoled themselves with the thought that they were not deficient in that aspect of life.

Contrary to the findings of Hughes, Turton and Evans, (2007), most of the participants in the current study noted that the sight the babies or keeping pictures of them was fulfilling to them. Psychologically if a woman feels this way, she is less likely to demonstrate signs of depression. Similar situations have also documented in some studies (Cacciatore, Radestad & Froen, 2008; Conry & Prinsloo, 2008, Durlak, 1998). Hughes, Turton and Evans, (2007) reported that women experienced adverse effects when they had contact with their dead infants; they stated that images haunted the women. However, they did not establish the state of the baby, whether they were fresh or macerated stillborn babies and also whether these mothers were psychologically prepared prior to the exposure. In the current study, there was one report of image haunt nonetheless this woman expressed that it was good she saw her baby. She expressed that after carrying her for nine months she must see what the child looks like. The current researcher believes that psychological preparation to meet such a baby is vital. It prepares the mother against image haunt and this will amount to good care if the women have opted to see the baby. In the study of Kelley and Trinidad, (2012) it was recorded that some parents would prefer to have a

prolonged grief as a result of seeing their babies than live with perpetual regret that they never saw their babies.

In the study, some women explained that they allowed pain to come and in addition to that, they believe that talking about their loss emptied them of their pain, brought fulfilment and also promoted healing. Martin and Doka, (2000) cited by Cacciatore, De Frain, Jones and Jones, (2008) explained that the communication schema of the feminine is intuitive; they would want to narrate and openly express their feelings in addition to seeking social support. The mothers in the current study expressed greater need to talk about their loss and they review their details repeatedly just as those studied by Kelley and Trinidad, (2012) who recommended that there should come a time when stillbirth bereavement and remembrance will be openly discussed, understood and embraced by others. Contrarily some women said they tried to take off their minds, the thought and pain of the loss as an answer to how they managed to recover.

5.4 Support

After the death of their babies the mothers received support from varied sources which helped them to recover faster and better. Support described in the current study was in the verbal form: kind words, encouragement, expression of knowing how it feels as well as the expressions of hopefulness. The sources of support revealed were: family members and friends. Almost all the women, in one way or the other, received comforting words from their colleague patients in the ward.

Family support is one major form of social support that reduces levels of maternal anxiety and depression, as observed by Cacciatore, Schnebly and Froen, (2008) when they studied the effect of support on maternal anxiety and depression in the United States. They report that 91.7 percent of the women received great support from the family members. They further explained that the most important and impacting form of social support was

provided by family members; mothers who received high family support in the period after stillbirth demonstrated a depression scores lower than their counterparts. Likewise, the current study had a good record of family support.

Prominent in the current findings was the timely and immense effect of the availability of support from husbands, fathers, mothers and other siblings; which helped to hold up the distressed and bereaved women. Fathers and mothers were there for their daughters during that period. The participants also acknowledged the support of their siblings. Almost all the participants expressed how valuable spousal support had been to them. Studies conducted by Sutan, Amin, Ariffin, Teng, Kamal and Rusli, (2010) and Radestad, Sjogren, Nordin, and Steineck, (1997) supports the current report. It is noteworthy that almost all participants received support from husbands after perinatal loss, which promoted recovery and shortened the grief period.

The current study reports that whiles in the ward and after their discharge, support from friends and neighbours were in the form pieces of advice, keeping company and encouragement, as well as reports of outing sessions offered the bereaved; enabled them overcome their grief moments. Cacciatore, Schnebly and Froen, (2008) in their presentation reported such instances as receiving a fair amount of support.

Cacciatore, Schnebly and Froen, (2008) also stated that where physicians and nurses' support was available there was significant record of low anxiety and depression cases. In the current study, women who were satisfied with the care they received at the hospital explained that they found it supportive when the doctors and midwives spoke kindly to them, befriended them and even made their contact numbers available to them. The women receive hope when examples of what people went through and eventually had babies were cited. They also expressed how worse their situations could have been. Statements like "I will be expecting to deliver you next year", and "It will come back in

three months" were assuring to the women. However such words of hope given to the participants in the study of Kelly and Trinidad, (2012) were reported to have had opposite effect as reported by their participants; they stated that it was hurtful. Therefore, there is the need to study stillbirth experiences within a social context. Kelly and Trinidad therefore recommended non-verbal support, possibly holding hands or sitting by the client and not saying anything at all.

Contrary reports were presented in the study of Erlandsson, Saflund, Wredling and Radestad, (2011) and Gold, (2007), they explained that their participants' need for support was not met by the physicians who informed them of the death of their babies. Also Cacciatore, Schnebly and Froen, (2008) reported that this kind of support was the least received by their participants hence the high level of anxiety recorded.

For that reason Kelley and Trinidad, (2012) emphasized that Health service personnel should demonstrate empathy and grieve along with their clients. The current researcher believes that when this happens the women will enjoy the human aspect of the service providers and not feel alone in the situation. Therefore there is the need to study the stillbirth experience transculturally for a fuller understanding.

Spousal support is one major part of the family support, (Radestad, Sjogren, Nordin, and Steineck, 1997) and the current study report enormous spousal support after a stillbirth experience though there were two negative reports. One woman complained the husband no longer cares for her as he did previously and it gives her much more pain than the loss she has encountered. The second woman explained that the husband neglected her after her third stillbirth experience, and refused to replace the blood that was transfused to her. He also declined to settle her bills to take her out of the hospital and later threw her out of the house with the intent of marrying another woman. This finding supports the work of Badenhorst and Hughes, (2006), which explains that marital relationship can be strained if

both parents do not have the same grief pattern and possibly at the same period. Furthermore, in support of this are the works of Sutan, Amin, Ariffin, Teng, Kamal, (2010), Hsu, Tseng, and Kuo, (2002) and Gauzia et al, (2011), it can be noted that perinatal loss is significantly associated with the high rate of deteriorating relationship and the need of support from the husband and the marital family members. This report seems to be trans-cultural and the current researcher believes that the belief that the women have failed in their attempt to bring home a live child, to continue the lineage is the reason for the spousal neglect.

Social abandonment was recorded. In an effort to avoid hurting the bereaved further, some members of society were reported to have abandoned the bereaved: friends, neighbours and family members. In the current study, the social challenges the participants faced were with is in line with the report of Chandra, Tharyan, Muliylil and Abraham (2002), Patel, Rodrigues and DeSouza (2000) and de Montigny, Beaudet and Dumas, (1999); where reports of avoidance from some friends, co-workers and community members was evident. It was seen as an effort by the society to avoid "bruising their wounds" as one participant cited how her colleague put it.

5.5 Social Beliefs

The prevailing norms and beliefs that form social control in this study were explained as too much crying or mourning either prolongs the period of getting pregnant again or prevents fertility. This social belief was confirmed when the participants stated that some nurses used this information to dissuade them from crying. The current researcher believes that this may be possible, since prolonged grieving could physiologically promote hormonal imbalance and this could eventually affect their reproductive cycle therefore their fertility. This projection is upheld by Sander and Bruce (1997) cited by Franche

(2001); they believed that women who grieve intensely find it more difficult to conceive than those who grieve less.

Religion is important to many people; it serves as an emotional support (Carver, Schier & Weintraub 1987; Kavanaugh & Hershberger 2005). Generally, the narrations revealed the belief that there is a Supreme Being who is in charge of all that happens to humans therefore they submit to his will. Also, they had expectations of God to replace their loss. This clearly connotes that they have dissociated from the lost babies and were expecting their living and or subsequent babies to live with them in their current world. The belief that stillbirth has spiritual connotation led to a demonstration of faith when prayers were organized to supernaturally change the situation. These prayer sessions psychologically prolonged the duration for the woman to prepare for and accept the situation of child loss. The "belief in God" was presented by all participating women despite their religious affiliation. There were moments of self-encouragement through memorising scriptural quotations. The phenomenological exploration of forty seven women's experiences with stillbirth and its implication for care, undertaken by Cacciatore and Bushfield, (2007) saw spirituality emerging as a strong theme for many bereaved women in the study. In addition, it is concomitant to the findings of Pilkington (2006); the participants reached out to God for strength, they found acceptance and were able to pull through the pain. Contrary to the current and supporting studies, Modiba and Nolte (2007) indicated that their participants demonstrated some amount of anger against God, asking why they have to lose their babies. Their faith in the Supreme Being strengthened and comforted them. The Muslims had a belief that their babies have gone ahead of them into the next world (Heaven) and that they will welcome their parents into that world in the hereafter.

Congratulation and acknowledgement of motherhood was demonstrated among some ethnic groups by the slaughter of a fowl a week after delivery for the women. This rite was performed for one participant however; there was no report of such performance in the

other participants. A participant stated it was the practice but said “because the baby didn’t come home, it was not done for me”. The researcher believes that expectant acknowledgement which was not forthcoming duplicated the grief pain of the participant, she experienced a dual loss: loss of a child and loss of acknowledgement of motherhood.

A negative observation by the current researcher is the devaluation of the babies. The babies were disposed of without any burial rites. This absence of rites is at variance with Muslim burial practices for example. So, the Muslims ensured that they took custody of their babies and gave them the required burial ceremony in recognition that a life has passed on. The practice of the Muslims is in line with the Swedish practice of taking the dead baby home for burial ceremony, (Trulsson & Radestad, 2004).

5.6 Grief Pain Activators (Painful Reminders)

Hearing the cry of babies and seeing other babies whilst in the ward and beyond was a major painful reminder. It was the most offensive period for the women who lost their babies during delivery. It is a reminder of how close to fruition they came and the disappointment of having no baby to cuddle. One woman recalled demanding that the doctor discharge her to go home because she found it unbearable. The study of Cacciatore and Bushfield, (2007) reported an open discussion of the disenfranchisement, expressed by their participants. This has been confirmed by this current study. The women were in anticipation of carrying their baby (an entitlement) in their arms to go home but the death of their baby placed them at the opposite side of the continuum. They had no baby to carry in their arms or to go home with. Such mothers could perceive having and carrying one’s child as a prestige and a privilege they have been deprived of. Policy makers and service providers therefore must be sensitive and consider actions to help curb these stressful moments in the life of these mothers.

Social avoidance, for example spousal neglect were also expressed as painful because it gave the bereaved mothers the impression that because they have failed people were not willing to associate with them. To avert this situation, the researcher believes awareness creation about stillbirth experiences within the various societies will sensitize the public to cause them to be more sensitive to the plight of the stillbirth bereaved women.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents an outline of the summary of the research conducted and the conclusions drawn, the implication for nursing practice, nursing management, nursing education, policy as well as further research based on the findings of this study are presented in this chapter. Limitations encountered in the course of the study plus suggested recommendations have been set down in this chapter.

6.1 Summary and Conclusion

Stillbirth is common in the Accra metropolis however due to socio-cultural beliefs and a general ignorance of stillbirth impact, medical personnel tend to see intra uterine death as a pre-established loss therefore the mothers are left to labour and deliver in solitude which was presented as a form of poor care by the women. Also intra-uterine death is seen as pregnancy loss therefore the expected value of the loss is reduced. Investigating into this phenomenon, it was expected that the women may not want to be reminded of their pain and therefore will shy away however; on the contrary they were eager to talk for society to know how they felt.

Considering the major themes, opportunities for improving communication and support for mothers of stillborn babies starting from the hospital to the community level was identified. The current finding is in consonance with other studies on stillbirth such as Modiba and Nolte, (2007), Kelly and Trinidad, (2012), Cacciatore, Schnebly and Froen, (2008), as well as other works on grief like Rybarik, (2000), Worden, Durlak, (1998), Carver, Schier & Weintraub, (1987). It was relatively contrary to one major finding of Hughes, Turton and Evans, (2007) which reported a negative reaction to seeing the babies.

News of intra-uterine death or stillbirth, as well as seeing the dead babies is a painful experience for mothers, they mourn in unique ways based on their faith and or beliefs; there is a continuous state of sorrowfulness and living with hurt when stillbirth occurs. The women demonstrated varied grief reactions during their loss nevertheless it was normal. In instances of loss, where encouragement from within the person (self-motivation) meets social support it results in a normal grief process leading to a quick bio-psychosocial recovery.

In this study sources of social support were primarily family then friends and health personnel. The support given in time of stillbirth was basically emotional support in the form of encouragement and pieces of advice.

Communication a vital tool for effective service delivery was presented as compromised. There were reports of communication lack or gaps; in some of the presentations when the death was diagnosed it was not communicated to the mother which was ethically challenging. The urgency to attend to client was deficient

The Ghanaian society, have some beliefs that have been handed down to members of the society, from observations and the report of this study and the need to avoid much crying, much thinking and talking less about the stillborn has been supported with the explanation that the baby is unknown to any member of the family for that reason, talking more about stillbirth means an invitation of a recurrence. It is also believed that mourning the stillbirth has a potential for rendering the woman sterile.

Devaluation of the baby begun at the health institution, through the community and to some extent by some actions of the parents of the baby also contributes to devaluation of the baby. Spousal rejection is a form of devaluation of the mothers.

In relation to Roy, (1971) metaparadigm of nursing, Grief in the life of the bereaved is an aspect of the internal environment of the individual. The severity of grief, the duration as well as the personality of the individual, in addition to the support available determines the

health state of this individual. These women's external environment were the hospital setting, the service providers and all those around them who were expected to form support to propel them back or keep them within the health continuum however this was found to be inadequate.

The findings of this study indicate that though these women did not receive an organised or institutional support in time of their loss, they went through their grieving process normally, guilt, loneliness were documented which is in line with what Worden, (2008) presented as normal expectation of a grieving person, however more investigations can be undertaken to confirm their psychological health status.

The Ghanaian family system is usually one of an extended type therefore the possibility that these women were not solitary during their grieving period is high, also the local housing for the middle class system is predominantly of the compound type of housing therefore these women indirectly, regularly related with others thereby keeping their mind busy which might have prevented them from becoming depressed as presented by other studies, (Evans & Hughes, 2009; Gauzia, Moran, Ali, Ryder, Fisher & Koblinsky, 2011; Silver, 2007).

6.2 Implication for nursing practice, Management, Education and Further Research

The result of this research has implication when it comes to obstetric nursing as well as service provision of other paramedics.

1. Obstetric nurses must learn to interact better with clients than they are currently doing. Pregnant women expect to go through labour and take home with them a live baby to fulfil social expectation.
2. Such women are not expecting intrauterine death or otherwise therefore they are shocked, demonstrate denial, feel guilty that they have failed and would want to

- understand the cause of death. Nurses must not only give clinical services and instructions. Nurses and Midwives must personalize the care, go an extra mile find out how the women feel and add a human face to the service they provide. This will enable them provide the needed support to their clients.
3. Findings of the study revealed that the communication challenge started from antenatal through to discharge of the clients. The risk of stillbirth is higher after 38 weeks therefore health information with regards to warning signs must not be overlooked during the prenatal period. Consequently it is vital that the indication for referral be explained and the need for urgent action must be told the clients in the language they understand.
 4. When stillbirth is diagnosed, the clients must be informed and supported throughout service delivery to maintain the mothers' psychological health at equilibrium and also to promote client satisfaction.
 5. Nurse administrators must select nurses and midwives who are inclined to stillbirth bereavement to be trained and these trained professionals must be put in charge of stillbirth bereavement management.
 6. It was also gathered that there is no established protocol for the management of stillbirth for Ghana Health Services, therefore drawing a customised guideline to manage stillbirth is recommended. This could be incorporated into the curriculum of the professionals during their training period.
 7. The current study focused on the Accra metropolis, therefore a regional replication of this study is recommended to obtain a National Stillbirth Experience data, also studies to assess the depression and anxiety state of stillbirth mothers in the Accra metropolis must be done to support the current findings or otherwise. Finally an inquiry into the knowledge and practice of Service Providers on Stillbirth management is important. The proposed research areas if studied will increase

knowledge and also to provide evidence for improvement of obstetric service delivery.

6.3 Limitations

1. Though the current findings were positive; the women demonstrated normal grief response, the possibility of psychosocial challenges cannot be ruled out. The women who declined to be recruited as well as those who turned down the interview appointment could be in a psychologically challenging state therefore avoiding the researcher.
2. Despite the rapport established with all the participants spontaneous response to the beginning of the interview was not achieved in some of the participants therefore a questioning and answering mode was adopted till the client spontaneously start flowing verbally with their experience.
3. The question posed to elicit response on activities that helped the women to recover faster did not, in most of the participants, yield the expected response. In most cases preventive precautions and also the need to abide by the post natal instructions were given probably the participants were not conscious of the things they did which helped them psychologically.
4. Two participants were interviewed in the hospital premise when they insisted they want to do that on their sixth week visits; an office at the out-patient department and a restaurant were used which were favourable but fell out of the prescribed venue.

6.4 Recommendation

Based on the finding of this study, the researcher suggests that the following could be done to help make the situation of losing a baby less troublesome:

1. A well-organized bereavement services must be provided at the Obstetrics and Gynaecology departments by midwives. As part of the bereavement services there could be a scheduled moment of “meeting the baby”; (the baby cleaned and groomed) well presented for viewing by the parent.
2. Counselling and support must begin at the hospital through to the community counselling by a trained professional should be offered to the parents (intra uterine death) prior to and immediately after the death with information on available support in the form of councillors, support groups and in addition website addresses could be provided for prompt linkage and help.
3. A training programme on bereavement services is advocated for service providers.
4. Social education is recommended to augment the effort of Health service personnel for a complete and efficient management of stillbirth. Organising talks, open forum, distribution of information leaflets can be a good beginning.
5. There is the need for the development of a local Stillbirth management protocol by through the Ghana health services by the various stake holders in obstetric, social and psychological service provision.

Stillbirth: Proposed psychological management guide

Women in labour must not be left alone during the process; psychological support is very vital during this period.

Delivering the babies into receivers have been presented as troublesome to the mothers therefore midwives must endeavour to receive the babies with their hands before transferring them unto linens, to give an amount of value to the babies.

Prior to moving them to the post natal ward, these women must be counselled as to what the ward would be like. Where possible, the women must be allowed to decide whether they would want to be secluded or not and the implications explained to them.

During the 'Meeting the baby' session, the women must be given the option to decide if they want to spend some time with the baby. They must be counselled prior to that especially where the babies are macerated (they must be told what to expect) to avoid putting them in a state of shock. The babies must be dressed up or wrapped up before sending them to the mothers to make it more pleasant.

In disposing of the dead babies personnel must allow the families enough time before discussing disposal services with them so that the families will have ample time to decide on a disposal method.

Just as there is a scheduled postnatal clinic for physiological puerperal assessment and care, there is the need for a scheduled psychological assessment and counselling to promote the psychological health of the mothers.

These suggestions are however not exhaustive.

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APPENDICES

APPENDIX A: INTERVIEW GUIDE

Introduction

I am going to ask you some question about the loss of your baby, take time in answering them and feel free to ask me to explain further if the question is not clear to you. You can skip question and return to it if you want to. If you don't want to comment on a question please say so. Please be assured that there are no wrong answers, so give me your honest response. Remember that whatever you share with me will not be identified with you but may be used as valuable information in the study.

1. Please tell me some few things about your self
2. Can you please tell me how old you are?
3. What work do you do?
4. In which part of Accra do you live?
5. What tribe do you belong to?
6. What is your religion?
7. Are you educated?
 - If yes (the level)
8. Please are you married?
9. Do you already have children?
 - How many children
 - Age and sex
10. Could you tell me something about the circumstances of the loss of your baby?
 - How old was the pregnancy?
 - Where did it happen?
11. Please describe what the experience of losing your baby during delivery was.
 - The care you received from the Doctors and midwives.
 - The hospital setting.
12. Would you say you received adequate concerning physical care post natally?
 - Tell me some of the support you received from the hospital.
 - What about society?
13. What are the things that soothed or aggravated your emotional pain or feeling?
 - Attitudes
 - Expressions.
 - Beliefs
14. What is the socio-cultural belief or practice concerning stillbirth in your tribe?
 - Did any of these hurt your feelings in any way?
15. Do you think you think you have recovered from the emotional hurt you went through?
 - How recovered do you consider yourself now?
 - Tell me of some of the ways you think you are recovering.

16. Can you please describe how you recovered from the emotional pain to me?
 - Did you receive any form of support that helped you pull through the emotional pain?
 - Tell me which people supported you
 - How did they do that?
17. Is there anything that makes you think you have not fully recovered?
18. Did you see your baby; was your baby shown to you?
 - (if yes); tell me what happened.
 - (if no); did you regret or feel good not seeing your baby?
 - Can you explain to me how you felt after seeing the baby?
19. Could you tell me about the hospital; the things that happened there.
 - How did it influence your loss and pain?
 - Can you remember what things were most helpful to you?
20. If you were to tell another woman with your experience about the kind of things that will help her feel better what will you say?
21. How has this interview been to you?
22. Is there anything else you would like to tell me about which you think would be important for me to know?

Closing

I am grateful for the time you have spent with me and the contribution you have made to the study. If you think now or in the next few days that our discussion has brought up things that needs to be talked about with the doctor or nurse please call me. I would be happy to send you the result of the study if you request for it. Thank you very much.

APPENDIX B: INFORM CONSENT**NMIMR-IRB CONSENT FORM TEMPLATE**

Title: Impact of stillbirth on mothers: a study in the Accra metropolis.

Principal Investigator: Irene Torshie Attachie

Address: School of Nursing, University of Ghana, Legon, P.O. Box 43, Legon

Telephone : 0277451127

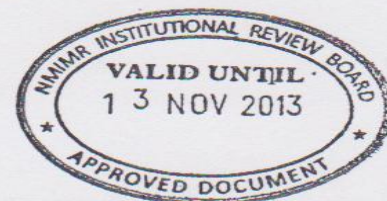
General Information about Research

This study is a qualitative descriptive research. It involves the use of an interview guide to elicit information from participants which will be audio recorded, translated word-for-word and interpreted to bring out what the impact of stillbirth is, on mothers who experience it. The objective of this research is to find out what the experiences of mothers who have had stillbirth are, their expectation of society and the support available to them in their time of bereavement, to help provide good care to such women.

The interview will last between 45 to 60 minutes; it will focus on what your experiences were when you lost your baby before or during delivery, what challenges you faced in that situation and how you managed to cope with it. The time and venue for the interview will be determined by you. There is no right or wrong answers; you are therefore free to express yourself in whatever way you wish.

Possible Risks and Discomforts

The researcher acknowledges that the interview could make you become emotionally affected however she believes people become better when they express their pain, therefore you will eventually feel much better after the interview. You will be allowed some time to put yourself together; the interview can be rescheduled for a more suitable time if necessary. There will also be counselling services available if you wish.



Possible Benefits

By doing this research healthcare providers will know more about mothers' experiences of having stillbirth and the measures to take when caring for any mother who find themselves in this situation. It might help other people who have had this type of loss in their grief moments and also society will know how to handle bereaved mothers.

Your personal benefit will be the relief you will experience after sharing your experience; it is reported that when people talk about their pain the degree of hurt reduces.

Confidentiality (protecting your information):

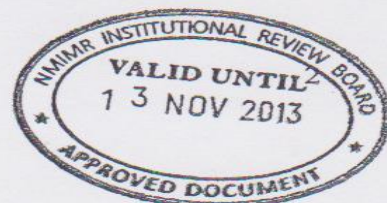
Your identity and privacy will be protected; a number will be used to identify you instead of your name on anything that will be written about our talk and the document bearing your name. The consent form will be handled by the researcher and the supervisors only and these will be kept under lock and key (safety).

Compensation

There is no reward in cash or kind; however it is envisaged that the findings will go a long way to increase knowledge, influence care-giving behaviour of professional, and provide information to society at large on what mothers go through when they lose their babies in the process of delivery and how they should be managed.

Voluntary Participation and Right to Leave the Research

Your participation in this research is voluntary and so if you don't want to participate, you are free to do so. You are not going to lose anything if you decide not to take part. If you



participate and in the process you want to stop you will be allowed to do so. You can contact the following persons or me if you have any questions.

Contacts for Additional Information

Mrs Comfort Afram, Primary Supervisor (Head of department, maternal and child health),
School of Nursing, University of Ghana, Legon.

P.O. Box 43, Legon,

Telephone number 0278153024.

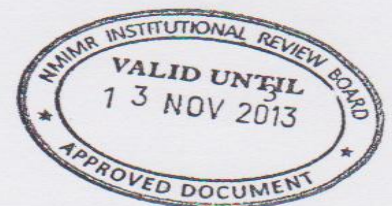
Mr David Nana Adjei, Secondary Supervisor, Lecturer, School of Allied Health Services,
University of Ghana, Legon.

P.O. Box Kb 143, Korle-bu

Telephone number: 0208230231

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org.



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title **Impact of Stillbirth on Mothers: A study in the Accra Metropolis** 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.

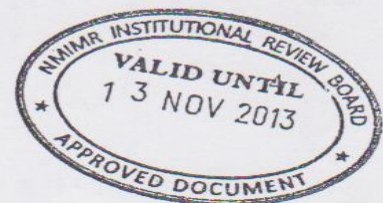
Date_____
Name and signature or mark of volunteer

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

APPENDIX C: SITE APPROVAL APPLICATION**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON**

Telephone: 021-513255 (Dean)
Ext. 6206
021-513250 } Secretary
028 9531213 }
Fax: 513255
E-mail: nursing@ug.edu.gh

P. O. Box LG 43
LEGON, GHANA

SON/F.11
Our Ref:.....
Your Ref:.....

October 12, 2012

The Chief Executive
Korle-Bu Teaching Hospital
Korle-Bu
Accra.

Dear Sir/Madam,

APPLICATION FOR SITE APPROVAL TO CONDUCT A RESEARCH STUDY

Title of Project: Impact of stillbirth on mothers: A study in the Accra Metropolis

Principal Investigator: Irene Torshie Attachie

This letter is to request your permission and assistance for the researcher for her study on **stillbirth mothers**. She is an M.Phil research student of the School of Nursing, College of Health Sciences, University of Ghana, Legon

Data collection will involve interview of mothers at the location of the participants' choice.

I kindly request your assistance to the researcher.

Yours faithfully,

Comfort Affram (Mrs)
SUPERVISOR

Cc: The DDNS i/c Maternity Unit
The ic, Labour wards

APPENDIX D: ETHICAL CLEARANCE**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH**
Established 1979 *A Constituent of the College of Health Sciences*
University of Ghana

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INSTITUTIONAL REVIEW BOARD

Post Office Box LG 581
Legon, Accra
Ghana

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

14th November, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 021/12-13

IORG 0000908

On 14th November, 2012, 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 : Impact of stillbirth on mothers: A study in the Accra Metropolis


PRINCIPAL INVESTIGATOR : Irene Torshie Attachie (MPhil Student)

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 13th November, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: 
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon