Midwives Perceptions on Perinatal Loss Care of Bereaved Mothers at KweKwe General Hospital, Zimbabwe

Abstract:
Painful, distressful and discomforting is the caring for women who have experienced perinatal loss and may be very challenging for bereaved women and the midwife as well. This requires a nurturing as well as a professional approach and facets that are mainly experienced than taught and learnt. Commonly, the area remained unresearched through the delicate intonations it bears and the sacrosanct perceptions surrounding death and loss of life and sacredness the subject.

An in-depth qualitative phenomenological study explored the midwives’ perceptions on perinatal loss care of the bereaved mothers. In-depth interviews were used to gather data from a sample of 10 participants who were selected among midwives at Kwekwe maternity unit using purposive sampling. The sample was determined by the data saturation point and the inclusion criteria was of those who had worked at the unit for at least 6 months. Thematic analysis was used to analyze the data which gave rise to identification of themes.

The findings revealed four emergent themes; knowledge and skills on bereavement care, psychological and emotional support, constraints to offering bereavement care and improving perinatal loss care. Midwives lacked requisite skills and knowledge to care for bereaved mothers, they void of care to bereaved mothers, inadequate psychological and emotional support from the family and midwives was of concern. Constraints were identified as shortage of staff, time, lack of continuity of care and inadequate infrastructure.

Recommendations were training of midwives on management of mothers who would have experienced perinatal loss, counselling, improving infrastructure for confidentiality and proper management of the bereaved mothers and probable co-option of the conceptual framework developed in this study. Further research should focus on exploring the views of the mothers themselves since they are the custodians of the perinatal loss.

Keywords: Midwifery, Stillbirths, Perinatal Deaths, Bereavement, KweKwe Hospital
1.0 Introduction

Midwifery care of the grieving mothers is a critical issue that should be handled by a competent midwife [1]. Failure by the midwife, described as a person qualified to practice midwifery, having received specialised training in obstetrics and childcare, to offer appropriate support and care during the loss can be traumatic to the bereaving parents [2]. Bereavement, defined as mourning and grieving which is a reaction to a major loss and is most often an unhappy and painful emotion which is distressing but common experience usually due to death and loss of close relation or any sort of loss [3], requires attending practitioners to have adequate knowledge and experience to handle such cases.

In perinatal loss, the focus is on care of the grieving parents [3, 4]. Perinatal loss defined as a non-voluntary end of a pregnancy from conception, during pregnancy, and up to 28 days of the new-born’s life, can have long lasting effects to the mother if the grieving process is not handled properly [5]. A mother who has experienced perinatal loss, losses what she would have expected or even planned and hoped for, thereby bringing in a sense of failure to become a parent, leading to feelings of hopelessness and helplessness at times [6]. In this scenario, neonatal death is loss of life occurring from time of birth to 28 days of life [7] with early neonatal death is the death that occurs within seven days after delivery and Late neonatal death occurs from seven days to 28 days of life [8]. Stillbirth occurs is late pregnancy loss that occurs after more than 20 weeks’ gestation [9].

The loss of a child is a high-risk variable for the development of complicated grieving [10]. When compared with other types of bereavement, parental grieving is particularly intense, complicated and long lasting, with major and unparalled symptom fluctuations over time [11]. Regardless of the child’s age, parents would have lost their hopes, dreams and expectations for the child including their family and their future. Their assumptive worlds would have been violated [12].

The death of an infant is a profound loss, and it is important and advantageous to acknowledge families’ appropriate need to grieve for their babies. The death of a baby is especially difficult to endure because parents envision an entire lifetime for their baby from the moment of the confirmation of the pregnancy, and because their expectations and vision
have been built over time [13]. Culturally, a couple who lose their first pregnancy would have not completed the rite of passage into parenthood, which symbolizes adult status [14].

The bereaved mothers with perinatal loss need support and counselling so that they go through the grieving process and accept the outcomes of the failed pregnancy since the unexpected nature of a perinatal loss may lead to prolonged or complicated grief and mental health challenges [5]. Puerperal depression, psychosis and other mental health problems that occur following perinatal loss can be averted if the midwives handle the grieving mothers properly and help them to come to terms with perinatal loss.

The loss occurring in a health institution and the responsibility of supporting the woman is borne by midwives [5]. However, limited information exists on how midwives should manage mothers who have experienced perinatal loss in a health institution [2]. Inadequate care and improper support can potentially lead to a maladaptation process that can result in unfavourable outcomes such as schizophrenia, divorce or suicidal ideation [15-17]. It is therefore apparent that midwives need to be equipped with adequate knowledge, skills, and attitudes in order to deal with grieving mothers adequately and provide care that meets international standards [18].

In Zimbabwe before independence perinatal bereavement was handled by the traditional birth attendants (TBAs) [19]. Following perinatal loss, the traditional practises discouraged mother from crying as they believed it was “not yet fully human” [20, 21]. In this case grief for the mother was bottled inside and the emotions had no vent as she was told that crying would make the problem repeat itself [22]. The mothers who experienced perinatal loss were not allowed to see the dead body after delivery, neither were they allowed to talk to anyone except to her husband but for a short time. Superstition, cultural norms and values during that time were referred to ancestors and traditional healers [5]. In this regard bereavement care for the mother was greatly dependent and controlled by cultural norms and values, regardless of emotional storm about the loss going on in the bereaved mother herself.

As birth and death were shifted from home to hospitals, traditional moaning and cultures were discarded in favour of midwifery scientific approaches where parents are allowed to grieve after perinatal loss for a baby they have never really got to know [5]. With the increase
in incidences of parents subscribing to ritualistic behaviours, the ministry of health no longer supports incineration of dead newborns who weigh 400g and above. However, they are documented in the birth and death register and certificates offered. Bereavement care should be handled by midwives following international standards [1].

Bereavement care globally has adopted Kubler Ross grieving process where a trained professional assists a mother who has lost a baby to go through the 5 stages of grieving [23]. Observations at Kwekwe General Hospital have shown that bereaved mothers are being nursed together with those with live babies in the same postnatal ward.

The bereaved mothers hear the cry of live babies and this can be upsetting and traumatic. This may prolong the grieving process and sometimes ultimately result in maladaptive responses such as perinatal depression, divorce and suicidal ideation.

There is a general confirmation that midwives attend to the grieving after perinatal loss. How specifically midwives who care for families with perinatal loss do this require the integration of their personal experience into practice which is not readily available. Therefore, there arises a quest towards attaining optimal care prompting investigations to explore the midwives’ perceptions on the care of the bereaved mothers so that a guiding framework can be developed. Unveiling the perceptions of midwives regarding perinatal loss care may facilitate review of strategies which may facilitate strengthening of bereavement care of mothers by midwives. Possible curriculum review of the educational component on perinatal loss may be necessary. Developing a conceptual model of perinatal loss care could possibly be co-opted into midwifery practice.

2.0 Materials and Methods (Methodology):

The research design, the population, study sample, sampling procedures, sample size, data presentation and analysis plan, research instruments and ethical consideration. An operational framework within which facts are placed so that their meaning may be seen more clearly is presented here [24].
2.1 Materials:

2.1.1 Research Design

The overall strategy that was chosen to integrate the different components of the study in a coherent and logical way, thereby, ensuring effective address of the research problem. It constituted the blueprint for the collection, measurement, and analysis of data [25]. The qualitative phenomenological design was the best for the study since experiences are unquantifiable. The design looked into how midwives understood how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences of dealing with grieving people during perinatal infant deaths.

2.1.2 Research setting

The study was carried out at Kwekwe General Hospital in maternity unit, where midwives are working. Kwekwe Hospital is a provincial hospital in Midlands Province of Zimbabwe. The hospital provides services focused around areas of general medicine and surgery, paediatrics, maternity and children’s services, specialist surgery, critical care services and ophthalmology. The number of deliveries at this institution exceeds 400 per month. The total number of midwives was 80 at the time of the study.

2.1.3 Study population

The target population of this research was all midwives at Kwekwe Hospital working in Maternity Department which were members that conformed to offering perinatal services to clients. These form a specially trained group of nursing staff to carter for perinatal activities including nursing bereaved perinatal mothers.

3.1. Sample size

Purposive sampling which is sometimes referred to as judgemental or selective sampling was used to consciously select certain or handpick midwives according to the inclusion criteria. The sample size in this research paradigm was open and judgments depended on the
adequacy of information. The sample size was a composite of 10 participants, achieved when data saturation occurred.

3.2. Sampling Method
The research under the foreseen circumstances adopted a non-probability sampling method, the purposive sampling type, where midwives from Kwekwe District Hospital maternity unit were selected based on the judgment of the researcher regarding the aims and objectives of the research.

3.2.1. The inclusion criteria
To achieve homogeneity, the inclusion criteria include essential characteristics of the target population such as one being a midwife trained and certified [26]. This criterion controlled for extraneous variables, provided a guideline for the sample recruitment and enabled replication of the study. All midwives who had worked in the maternity unit at KweKwe General Hospital for at least 6 months qualified to be in the study.

3.2.2 Exclusion criteria
The exclusion criteria entailed those who do not qualify to represent the target group [26]. All those midwives who had recently qualified, and those who had a clinical experience of below six months were excluded from the study.

3.3. Data collection instrument
Data was collected through in-depth interviews using interview guides. Open ended questions were used to allow the participants to relate their lived experiences on the subject matter. The interviews were conducted in a private place which was provided within the working environment to ensure confidentiality and freedom of expression by the participants. Interviews were conducted in English since the participants were professionals who understood English.

3.4. Data Collection procedures
Data collection started after the granting of ethical clearance from the following authorities: The Medical Research Council of Zimbabwe, the Medical Superintendent Kwekwe General Hospital, and permission from the heads of the respective departments. Interviews were
conducted in the maternity unit following obtaining informed consent from the participants, as well as consent to document and audio-tape the interviews. The interviews lasted for a duration range of 20 to 40 minutes.

3.5. Data analysis
Thematic analysis was used to analyse the data. Accordingly in transforming qualitative information, thematic analysis was used as a process of encoding information. The data was reviewed, notes made and data categorized. Codes were developed which are words or phrases served as labels for sections of data. Raw data were organized, coded, categorized and translated into meaningful data.

3.6. Trustworthiness
Defined as the integrity of findings in qualitative research and the extent to which readers had conviction in the research and its findings, trustworthiness was used as opposed to validity in the current study. The truth value as well as the methodological soundness and adequacy of the research was judged through the criteria of credibility, conformability and transferability of the research and its findings. Furthermore, the degrees of confidence in the data were expressed through its trustworthiness and that the captured perspectives of midwives on perinatal bereavement were true, dependable, credible, confirmable and transferable in other similar settings and populations.

3.6.1 Credibility
The confidence in the truth and interpretations of the data, that is the credibility, was addressed by conducting face-to-face interviews with information rich midwives included in the study. The face-to-face interviews ensured that participants' information was first-hand, and tape-recorded to ensure that participants, and those familiar with the study topic, recognise the information as demonstrating reliability. Fused with this aspect of data gathering, credibility was harnessed to inquiry audit which scrutinised data and relevant support documents by numbering data units so that they could be traced to their original location in the text and be read in context.
3.6.2 Conformability
The traditional concept of objectivity is captured by conformability. In other terms, conformability was defined as the objectivity or neutrality of data inquiry audit. An inquiry audit was used to assess conformability which was a record of the design decisions about gaining access, and selection of data collection methods. An audit trail was a systematic collection of transcripts and audiotapes to allow an independent auditor to come up with own conclusions about the trustworthiness of the data and the meanings attached to them. A decision trail was maintained to confirm data by categorising and making inferences in the analysis which would evaluate the soundness of decisions about the trustworthiness of the perceptions of midwives on perinatal bereavement.

3.6.3 Transferability
Transferability was defined as the extent to which findings from the data could be transposed to other settings or groups. This was greatly affected by the sample and the design rather than the soundness of the data [27]. A rich and thorough description of the research setting and the process observed during the inquiry was necessary to enable decision on the possibility of transferring findings. Transferability was equated to generalizability in quantitative research.

3.7. Ethical consideration
A system of moral values that is concerned with the degree to which procedures adhere to the professional, legal and social obligations was used. The participants’ rights and the rights of others in the research setting were protected against some risks associated with the study. Core issues of ethical considerations, pertaining to participants involved autonomy, informed consent and respect of individuals. Preliminary contact with the gatekeepers to ensure cooperation and access to participants took place before the study commenced. Ethical clearance was sought and obtained from the Medical Research Council of Zimbabwe. Anonymity and confidentiality protected participants’ identity by generating codes using numbers.
To ensure measures of anonymity and to observe the primary ethical principle of responsibility and concern for the clients, no names appeared on the transcripts and the information was treated with strict confidentiality. Participants were assured that no information would be used against them for confidentiality’s sake and also were assured that their identity would remain anonymous in presentations, reports and publications of the study. All recorded data was kept safely in a computer and a password was used to lock the computer to avoid access by unauthorised individuals.

There was no physical harm to the participants as interviews were only held in a private place to avoid discomfort. Informed consent from the participants was obtained. The interviews were carried out in confidential places where no one could hear what was being discussed.

Participation was voluntary and the participants were informed that at any time during the interviews they could decide to opt out at no cost and with no negative consequences. Each participant read and signed the consent form individually.

4.0 Data Analysis, Interpretation and Presentation
Data analysis was a process of bringing order, structure and meaning to the mass of collected data and transforming data into findings. The purpose of data analysis was to preserve the uniqueness of each participant’s lived experience while permitting the understanding of the phenomenon of interpreting perinatal bereavement amongst practicing midwives.

4.1. Data analysis
Raw data were collected using in-depth semi-structured interviews. Raw data was organized and presented in more compact forms. The data were categorized into major themes and sub themes using Colaizzi thematic analysis method. Each data unit quoted verbatim was given a reference number by which it could be identified in an audit trail.

Data analysis began during data collection and evolved throughout the data presentation and analysis period. The data consisted of interview written transcripts and audio tapes. Transcripts were reviewed and compared to the audiotapes followed by data coding, categorizing and theme formation.
Interviews were transcribed followed by data immersion and date reduction.

4.2 Data presentation

Data was presented as themes and subthemes which were further elaborated.

4.2.1 Description of the interviewees

Ten interviews were conducted on 10 qualified midwives within 5 days. For ease of interpretation, Participants were described as ‘M’ with M1 – (Midwife 1) First midwife to be interviewed up to M10 – (Midwife 10) tenth midwife to be interviewed.

Table 1: Frequency Distribution of Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Frequency n=10</th>
<th>Percentage %</th>
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<tbody>
<tr>
<td>Age (Years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-35</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>36-45</td>
<td>4</td>
<td>40</td>
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<td>46 and above</td>
<td>1</td>
<td>10</td>
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<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>90</td>
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<tr>
<td>Work experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>8</td>
<td>80</td>
</tr>
<tr>
<td>6-10 years</td>
<td>2</td>
<td>20</td>
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</tbody>
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Table 4.1 shows the demographic characteristics of the participating midwives

4.3 Themes and sub themes.

The findings were grouped into four main themes; two sub-themes under the first theme, four sub-theme under the second theme, four sub-themes under the third theme and four subthemes under the fourth theme.
Table 2: Thematic Mapping

<table>
<thead>
<tr>
<th>THEME 1: KNOWLEDGE AND SKILLS ON BEREAVEMENT CARE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtheme 1.1 Limited knowledge and skills.</td>
</tr>
<tr>
<td>Subtheme 1.2 Avoiding to offer care to bereaving mothers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THEME 2: PSYCHOLOGICAL AND EMOTIONAL SUPPORT</th>
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</thead>
<tbody>
<tr>
<td>Subtheme 2.1 Partner and family support.</td>
</tr>
<tr>
<td>Subtheme 2.2 Midwives support and emotional involvement.</td>
</tr>
<tr>
<td>Subtheme 2.3 Viewing the deceased.</td>
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<table>
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<tr>
<th>THEME 3: CONSTRAINTS TO OFFERING BEREAVEMENT CARE</th>
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<tbody>
<tr>
<td>Subtheme 3.1 Shortage of staff</td>
</tr>
<tr>
<td>Subtheme 3.2 Time constraints</td>
</tr>
<tr>
<td>Subtheme 3.3 Continuity of care</td>
</tr>
<tr>
<td>Subtheme 3.4 Infrastructure</td>
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<tr>
<th>THEME 4: IMPROVING PERINATAL LOSS CARE</th>
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<tr>
<td>Subtheme 4.1 Counselling</td>
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<tr>
<td>Subtheme 4.2 Training on perinatal loss care</td>
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<td>Subtheme 4.3 Availing choice or care options.</td>
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</tbody>
</table>

4.3.1 Presentation of themes and subthemes.

Theme 1: Knowledge and skills on bereavement care

The theme highlighted the midwives’ knowledge and skills of care during perinatal loss. The results revealed that midwives’ knowledge and skills of perinatal loss care is limited and it varies among the incumbents. The common trend for midwives was to focus on physical care, avoiding the emotional aspect in the attempt to decrease their own distraught and the bereaving’s suffering. Therefore, they put in practice different mechanisms, attitudes and behaviours in the experience of these situations. Two subthemes which are limited knowledge and skills and avoiding of care to bereaving mothers emerged.
Subtheme: 1.1 Limited knowledge and skills.

Studies reveal that caring for bereaved families is regarded as being emotional and stressful for midwives who also have to deal with their own grief simultaneously. A possibility exists of midwives having limited experience in working with bereaved parents, limited knowledge about the grief process, lack appropriate communication skills or do not receive necessary support from their colleagues [28]. Most of the participants in this study indicated that there is limited knowledge on how to facilitate coping with perinatal loss [29] as expressed by some of them:

‘I feel that my knowledge is not enough and am not quite sure about what to say…although I am somewhat aware of the general care of cleaning the woman up, and putting her on the bed to rest’ M2

‘…the aspect of perinatal loss is a difficult one so I wouldn’t say I am knowledgeable…’ M3

Participants also linked knowledge and skills to experience and exposure. One of them had this to say: ‘…junior midwives are not well versed with dealing with mothers according to the way that is required of these mothers who have experienced perinatal loss. Most of the times junior midwives forget about the psychological aspects and focus on the physical aspects, but that’s because they lack skills when they have to face such a situation and do not know how to act or what to say to these women. Some junior midwives call me as the senior to bail them out …’ M1

Subtheme 1.2 Avoiding to offer care to bereaved women.

Participants generally highlighted avoidance of caring for the mothers who are bereaving because of uncertainty. One of them expressed these sentiments:

‘I do not usually enter the room unless I have to measure the vital signs, or giving her medication, then I get in but I do not ask her anything, afraid to bother her and ashamed of not knowing what to say, at the same time not prepared to address the emotional aspects of perinatal loss’ M3
Some participants clarified on allocated isolated placement specifically for mothers who would have experienced perinatal loss which aggravated exclusion from care and support activities, thereby leaving them to cope on their own [30]. Participants had this to say:

‘...what usually happens is that when they deliver, the mothers who experienced a loss are placed in their own bay...there is little attention given to them...they are dealing and coping with the loss by themselves. And even if they are in labour ward nobody monitors them, midwives are not eager and it is frustrating and not enjoyable somehow to look after a woman who does not have a viable foetus, hence they are side lined’ M9.

‘We tend not to worry about the bereaving mothers the ward is usually full with even floor beds, also delivery rooms will be all occupied usually to the extent of some mothers delivering in the admission room instead of labour ward’ M7

‘...aaah maternity is a busy ward we cannot spend time with the bereaving mothers...we admit them in last bay while they are just waiting for processing of papers for burial depending with the weight of the deceased... ’ M4

Other studies have also suggested that midwives should be encouraged to focus on providing woman centred care; facilitating the grief process, acknowledging and validating the individual's experience, and providing continuing community care.

In addition, other authors, have argued that midwives in particular have a unique role in supporting recently bereaved families, as they are the ones mostly likely to be involved in the experience with the family [31].

Theme 2: Psychological and emotional support

This second theme gave rise to the following subthemes: partner and family support, midwives support and emotional involvement, letting mothers cope with perinatal loss on their own and viewing the deceased.

Subtheme 2.1 Partner and family support.

The partner and family play a key role in parental experiences in perinatal loss, particularly with respect to providing them with support [32]. Emotional support from partner, family and
friends listening and consoling, while tangible support is provided by assistance with daily needs [33]. Participants in this study echoed similar sentiments:

‘...these mothers need support from home...they need to find out how people at home are taking the loss... family should call to find out how they are doing’ M4

‘...like if one wants to cry, they (the relatives) should be there, especially the husband and that helps them grieve and also accept and understand the situation much faster’ M7

**Subtheme 2.2 Midwives support and emotional involvement:**

Care providers should be understanding and caring, with appropriate expression of empathy, feelings and concerns [34]. Emotional support predicts the nature of the grief process; however, midwives find caring for bereaved families stressful and emotionally challenging, and many experience difficulties in this area of practice and are unprepared due to a lack of support and training [34, 35].

Participants felt ill equipped, with some expressing that they would also undergo psychological trauma which would destabilize their aptitude to support the bereaved women, whilst they realise that it is their integral role.

This is how some participants expressed themselves:

‘It’s sad because failure to give moral support to the grieving woman is one of those things that you can’t go out and feel okay about...’ M3

‘...because it is pleasing to see an alive baby, but if the baby is not alive that really affects even the midwife...with me I kind of think about it even afterwards...and even battle to forget about it’ M10

‘You can never get comfortable attending to a stillbirth delivery, because even if the mother accepted that the baby has died but the time when the baby comes out the mother becomes more emotional and it becomes even more difficult for you because the mother is crying and you also feel emotional...but you can’t cry in front of her...you must be strong for her and it is more difficult...’ M4
‘...it was quite hard to kind of separate the fact that she was noticeably pregnant and that her baby has passed away. It was quite hard for me to see that and even come to terms with it...’

M9

Another participant explained how devastated she felt when asked to care for a woman in labour with an intrauterine death (IUD):

‘...when I find out that I was going to be delivering a mother with IUD it scared the life out of me because I've only ever dealt with babies being born alive. I just started to feel very unsettled when I knew I was going in to deliver a dead baby, I got really anxious and scared.’

M4

Apart from family members, midwives can also be shocked and upset when there is a neonatal loss, with inexperienced staff feeling even more lost as to what to say or do [36]. However, if there are protocols that give them reassurance and guide them through processes of how to manage the situation, coping with the experience would not be that traumatic [35].

Some participants felt that they first needed time to deal with their own emotions before dealing with the woman. One participant narrated how she needed to be alone:

‘...I delivered a fresh still birth and was confused there was a cord around the neck...it was like two times around the neck. So, I thought it was maybe the cause of the still birth...I was confused and disturbed I went to the toilet and came back. And then I couldn’t wrap the baby properly. I delivered the placenta, finished and then I wrapped the baby with a delivery towel and put it on the trolley and I left and I went to cry in the toilet again...I couldn’t take it’

M6

Subtheme 2.3. Viewing the deceased

Most midwives' states that they ask the mother if she wants to view the body despite how small it is. And always make sure the mother or the significant other sign the form that they have viewed the baby. Apparently, observations have revealed that those mothers who do not choose to view their deceased babies and keeping the memories may often tend to regret it later. Parents have consistently described the high value they place on this interaction of viewing the body of their babies after death. One participant in this study has this to say:
‘I have noticed that asking the mother to view the baby makes her feel better... for that mother it is very important because she lost a part of herself... so I act according the mother’s feeling and the mother’s question. If she doesn’t want to view the body, I respect her and take the baby away and after asking if there is any relative who can do that’ M2

According to a study which was done by Gold (2019) about hospital care for parents after perinatal death, Parents with foetal deaths like to view their infants to take pictures as well to have the memories and the qualitative study noted that nearly all parents who saw their infants found this experience valuable [5, 6].

Midwives indicated that it was good for mother who had lost their infants to view the dead baby and keep memories to facilitate grieving and make the loss seem real so it is valuable to encourage parents to see, hold, and get to know their deceased baby. In order to make the loss more real, memories need to be provided to facilitate grieving, and, for many, identify the loss of a named family member, as a son or daughter [5].

**Theme 3: Constraints to offering bereavement care**

This third theme entailed challenges encountered when caring for the mothers who had experienced perinatal loss. They were viewed as barriers in caring for mothers. It was supported by the following subthemes: staff shortage, time constraints, continuity of care and infrastructure.

**Subtheme 3.1. Staff shortage**

All the participants mentioned shortage of staff during their interviews.

They alluded to the ever-growing workload which they said prevented them from rendering quality midwifery care that the mothers going through a perinatal loss deserved. For instance, some participants had this to say:

‘... because of shortage of staff we midwives cannot give whole quality care to a mother who lost a baby... as soon as I am done with delivering this mother the other one is waiting on the bench to deliver as well. It’s a matter of cleaning the room and putting another one at that
same bed and before you finish with her the other one is calling for help, I would say that is a real challenge’ M5

‘…shortage of staff, destroys me. Even if you feel you want to do more for the mother, at times if not most of the times you can’t even… so staff is important…If that can be sorted out…it is a big challenge for me. Ward accommodates times three the number whilst the number of midwives per shift doesn’t change… really, we can’t manage’ M4

‘…. there is high number of mothers who need care post-delivery and the postnatal wards are overwhelmingly full with even those who have live births and high care demands… can you imagine the limited midwives even worrying beyond these to co-opt the bereaved mothers’ M7

Participants generally perceived that the number of mothers who came for care was so high that they were often exhausted because the demand for care was very high. They also pointed out that staff shortage is something that midwives experience on a daily basis. Teamwork might be an effective way of improving the quality of care and patient safety as well as reducing staff shortages and stress and burnout among healthcare professionals.

Subtheme 3.2. Time constraints

Time seemed closely linked to staff shortages and heavy workload. Some of the participants articulated that even if they could be interested in spending more time with the mothers the zeal was destroyed by the excessive numbers of mothers against the limited time

‘…yes, there is no time for us to spend with mothers emotionally….’ M5

‘… the woman who has experienced a perinatal loss is not given enough time after experiencing the loss, because due to staff shortage and busy ward when she is delivering others are waiting on the bench for help and usually the ward if full with floor beds so no time with one mother’ M2

Midwives have the duty of looking after mothers who experience perinatal loss, as well as those who give birth to live babies. Due to the high number of mothers who come to maternity ward for help, they have less time to focus and support mothers going through a
loss. If time would allow them, midwives would have sufficient time to support mothers with prenatal loss without rustle to care for other mothers.

Subtheme 3.3 Continuity of care

Participants articulated that continuity of care allow them to meet the individual needs of women who have experienced perinatal loss. Continuity of midwifery care was considered by the midwives to be a channel for providing quality perinatal loss care, as it facilitates and enhances the mother and midwife relationship. Midwives in this study highlighted that they have not been able to continue the care of the mothers who experienced perinatal loss due to shortage of staff. Some participants had this to say:

‘...there is no time to do follow ups to check on these women after discharges and even if still in the ward and continue caring for the bereaving women...’ M10.

‘...we are short staffed we have a lot to do...’ M8.

Bereavement follow-up through telephone calls, emails, and mailed cards or letters is considered to be part of good medical care in perinatal loss [29]. Richards et al (2015) reiterated that Midwives and nurses in particular play a key role, as they must have daily contact with mothers which will also facilitate continuity of care and parents’ perceptions of support being provided. Continuity of care is important to parents, as parents appreciate and feel reassured by meeting with familiar staff throughout their care (O’Connell, 2012).

Subtheme 3.4 Infrastructure

Participants in this study states that there are different ways the hospital administration can put in place to improve the care like to put up structures where the mothers are admitted alone and can get full support and care before, during and after delivery.

‘...Because losing a baby is not easy and being in the same ward with those with the babies is not easy ...And I just imagine how I would feel if I had to go through that and admitted in the same ward with others. So, I don’t think that the hospital administration is doing enough’ M7

‘...I think it’s best if they are in their own ward ...there are no structures here...’ M5
Hospitals should have separate place for mothers with perinatal loss, which would help them overcome their grief [37, 38].

**Theme 4: Improving perinatal loss care**

Under this fourth theme three subtheme emerged; counselling, training on perinatal loss care, availing choice or care options.

**Subtheme 4.1 Counselling**

Counselling affords complete and understandable information to mothers and diminishes the chances that parents will feel that midwives are hiding information from them [39]. Parents appreciate an honest discussion about why their baby died, including a humane overview of the problems, the actions taken and time, as well as allowing them to ask questions [40].

Midwives expressed the need for counselling and expounded on providing the ideal infrastructure for confidentiality. Some of them expressed the following sentiments: ‘…mothers who have experienced loss should go through the counselling before they give birth to the baby and continue afterwards because it gives them enough time to accept the loss and move on…’ M8

‘By ensuring counselling, we are able to facilitate quality care for mothers who deliver stillbirths or have miscarriages or neonatal deaths…there is need to lighten the experience through offering counselling’ M6

M2 states that “They don’t want to stay here they don’t want to be here after the loss. Some of them ask for the papers frequently even if you tell them they should rest and stop coming to the duty room to ask if we are done, when we would have told them we were going to bring them to you they keep coming. Also, it is wise for the mothers who have experienced perinatal loss to be counselled before during and after the loss so that they accept and that we cannot do it like that because there is no privacy”

O’Connell, (2012) concurred that, Bad news should be given by the attending midwife in a timely and unhurried manner, and in a private area [41]. It is advisable that both parents or
one parent with another support person will stay around for some time after the disturbing information has been delivered, should be present [42].

**Subtheme 4.2 Training on perinatal loss care**

Some midwives expressed that the hospital administration should allocate funds towards the training of midwives on how to manage mothers experiencing perinatal loss in order to broaden their knowledge on counselling and caring for these mothers. Bereavement counselling and perinatal loss care should be a part of the training program for new health care professionals, who should also have the opportunity to observe senior members of the team.

Some of the participants has this to say:

‘I think many of us need to have training on how to deal with such mothers without talking, discussing them or think bad about them. Whatever they did, whatever they went through – it’s nothing. As long as we can really know how to help them…because sometimes when you get to that mother and somebody hands over to you…that person didn’t even show the mother that baby’ M2

‘That mother didn’t even hold that baby no information whatsoever given to the mother again but signatures are there. You ask but why did you sign if you didn’t see your baby? So I think many of us really need training to…see…although I don’t feel maybe anything for that mother, but at least put yourself in that mother’s shoes and at list help her professionally that’s why I think training is the way to go ’M7

‘We do need training …I think it’s a need…I think it’s very necessary, we need to know and trained on how to do these things… ’M3

Many health professionals recognise that they have insufficient knowledge and understanding of grief counselling to be insufficient, which is compounded by lack of targeted training when they encounter the occasion and need to counsel a bereaving mother during perinatal loss [43]. The development of basic and advanced education would enable staff to adequately cope with their work [44] which needs to be coupled with multi professional training and
how to include parents [45] in this area for improvement of standards for bereavement care all round [46].

Subtheme 4.3 Availing choice or care options.

Participants expressed varied choices as they mentioned that some mothers preferred to be on their own alone in a room to deal with their grief while others preferred to be amongst people with the same predicament in order to share the experiences thereby facilitating coping. However, most of the participants advocated for mothers to be given a choice with the opportunity to spend time with the deceased baby should be offered on several occasions because some parents may need encouragement.

Midwives may need to ask the parents whether they want to be alone, or to have family or a nurse stay with them; some young parents may be frightened because they have no previous experience with death [45].

This is what some participants said:

‘I think if it was for me, I prefer to be left alone in a secluded room and my husband allowed to be with me so that we are in this together’ (M4)

‘I think mothers should have options, should be asked what they prefer whether they want to be in a bay in a ward with other mothers, in a room surrounded by family members or whether they want to be on their own or whether with the husband only or with the midwife. They also must be free to ask and midwives should be there to answer and refer ’ (M7)

‘Mothers should be allowed to choose and to decide on their own what they really want, because sometimes after the delivery of a stillborn baby, you would like to have a loved one around you all the time, to comfort you and to really see how they are also handling the situation’ (M8)

Flexibility may need be shown towards the mother's own needs instead of enforcing mourning rituals. Giving parent’s information and allowing them the time to consider the options empowers parents and enables them to be involved with decision making. Lack of information is perceived as an obstacle to parents’ participation and control [45].
4.4 Discussion

Thematic analysis has given rise to four themes which are the following knowledge and skills on bereavement care, psychological and emotional support, constraints to offering bereavement care improving perinatal loss care.

4.4.1 Knowledge and skills on bereavement care.

Findings revealed that midwives lacked requisite skills and knowledge to care for bereaving mothers who would have experienced perinatal loss and yet they would feel better equipped to care for a woman with healthy pregnancies and babies. Participants also indicated the existence of unsuitable attitudes by midwives towards dealing with perinatal loss which they anchored on being unequipped with the relevant knowledge and skills. Lack of knowledge generates anxiety, helplessness and frustration which compromise professional competency. Midwives may tend to avoid talking to mothers following perinatal loss because of uncertainty on what to say and what to talk about. However, bereavement care should be warm, sensitive, compassionate, should necessitate listening to women and helping them identify their feelings and anxieties.

4.4.2 Psychological and emotional support

Provision of psychological and emotional support from partners and families during the grieving process is essential during perinatal bereavement. Partner and family played a key role in parental experiences in perinatal loss, particularly with respect to providing them with support while listening, consoling and providing tangible support through assistance with daily needs is key.

Midwives were ill equipped, such that some underwent psychological trauma following contact with perinatal loss and this would destabilize their aptitude to support the bereaved women despite the realisation of their integral role in this issue. Midwives could also be shocked and upset when there was a neonatal loss, with inexperienced staff feeling even more lost as to what to say or do.

Another important finding was that showing the dead baby to the mother and her significant others tended to reinforce the emotional support and psychological support whilst easing off
the grieving process such that parents who viewed their dead infants and took pictures remained with valuable memories.

4.4.3 Constraints to offering bereavement care

Participants cited shortage of staff as a constraint to rendering the midwifery care that the bereaving mothers deserve. The finding of heavy workload which prevented spending enough time with the bereaved mothers was also closely linked to staff shortage. Teamwork was an effective solution towards quality care improvement, reduction of stress and burnout among midwives.

Another constraint was on the infrastructure. The hospital management needed to put up structures that were private and separate from the maternity postnatal ward where those with live babies were admitted so that they got full support and care before, during and after delivery.

4.4.4 Improving perinatal loss care

There was need for counselling and providing the ideal infrastructure for confidentiality and proper management of mothers who have experienced perinatal loss. Mothers needed to receive counselling before, during and after delivery so that they would be able to properly and easily cope.

Counselling tends to afford complete and understandable information to mothers and diminishes the chances that parents will feel that midwives are hiding information from them. Further to this, parents appreciate an honest discussion about why their baby died, including a humane overview of the problems, the actions taken and time, as well as allowing them to ask questions.

The participants also proposed that the hospital administration allocate funds towards the training of midwives on management of mothers who have experienced perinatal loss so as to broaden their knowledge on counselling and caring for bereaved mothers. Bereavement counselling and perinatal loss care should be a part of the training program for new midwives, who should also have the opportunity to observe senior members of the team.
Health professionals recognise that they have insufficient knowledge and their understanding of grief counselling is insufficient, which is compounded by lack of targeted training.

4.4.5 Availing choice or care options

Mothers’ placement preferences should be respected since some mothers preferred to deal with their grief whilst alone in a room, and others preferred to be amongst people of the same predicament in order to share the experiences thereby facilitating coping. Midwives need to ask the parents whether they want to be alone, or to have family or a nurse stay with them; some young parents may even be frightened because they have no previous experience with death.

5.0 Conceptual Framework and Conclusions

The Input Throughput and Output (IPO) model by Samuel Shipp 1982 was adopted to create a theoretical conceptual would be ideal is a visual tool used to describe a workflow, the flow of information, or activities within the perinatal loss bereavement management system [47].

5.1 Inputs

From the study results, the input component of the model was to:

5.1.1 ensure adequate staff coverage,

5.1.2 ideal infrastructure,

5.1.3 training of midwives on perinatal loss care and

5.1.4 availing time to interact with the bereaved mothers.
Figure 1: Theoretical Framework for The Input Throughput and Output (IPO) model [47] showing how inputs yield throughputs that give rise to both positive and negative outputs.

Throughputs were the interventions to the process of perinatal bereaving care namely:

5.2.1 partner and family support and midwives need to have knowledge and skill on how to involve these,

5.2.2 support by midwives,

5.2.3 effective communication skills,

5.2.4 availing choices and care options and
5.2.5 viewing the deceased babies.

**5.3 Outputs**

The major and expected outputs are:

5.3.1 optimal perinatal loss care,

5.3.2 continuity of care,

5.3.2 coping positively as the mother goes through the stages of grieving,

5.3.3 midwives guide in adaptation process and

5.3.4 future plans to deal with possible relapse of the stressful situation.

**6.0 Declarations**

6.1 Conflict of Interest

Authors declare no conflict of interest

6.2 Funding options

The study was funded through the Department of Midwifery and Nursing Sciences program based budget allocations at National University of Science and Technology

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