MAT JOURNALS

Journal of Nursing Research, Education and Management
e-ISSN: 2582-001X
Volume 1 Issue 2

Perceptions Of Postnatal Mothers Regarding Perinatal Loss Management By Health Workers In The City Of Harare Zimbabwe

Shila Matsikwa
PG Student, Department of Nursing Sciences, College of Health Sciences, University of Zimbabwe, Zimbabwe
Email: *shiematsikwa@gmail.com*
DOI: http://doi.org/10.5281/zenodo.3346242

Abstract

Perinatal loss is defined as any loss, from conception through to the first 28 days of life, including miscarriage, stillbirth, and neonatal death and is considered as one of the most stressful moments in any mother's experience. Despite the increase of perinatal loss through abortions (17,8 per 1000 women 15-49), stillbirths (77 per 1000 live births), early neonatal deaths (140 per 1000 live births) and its devastating effects, there is death of information regarding perception of post natal mother management following perinatal loss. Anecdotal evidence gathered from the study sites by the researcher suggests that, care rendered to bereaved mothers appears to be erratic, inconsistent and incomplete. The purpose of the study was to explore the perceptions of postnatal mothers regarding management following perinatal loss in the City of Harare Clinics, to identify gaps and improve the quality of care rendered. A descriptive qualitative study design was used to explore the perceptions of postnatal mothers regarding management following perinatal loss. Purposive sampling was used to select one key informant (midwife) and twelve (12) mothers who had experienced perinatal loss through abortion, stillbirths and early neonatal deaths. Data was analyzed manually using thematic analysis. The study findings generated two major themes, namely facilitating factors and barriers to the management of postnatal mothers regarding management. The overall discussion was that the majority of the women did not receive holistic care with regard to perinatal loss. The care was fragmented. The study recommended training of the midwives in bereavement counseling to ensure quality service was provided to the bereaved mothers.

Keywords: *Perinatal loss, Abortion, Stillbirths. Early neonatal death*

List of Abbreviations

WHO:*World Health Organisation,* ***MCHIP:*** *Maternal and Child Health Intergrated Programme,* ***UNICEF:*** *United Nations International Children's Emergency Fund,* ***ZDHS:*** *Zimbabwe Demographic Health Survey,* ***CDC:*** *Centre for Disease Controland Prevention*

BACKGROUND AND ORGANIZING FRAMEWORK

Perinatal loss is defined as any loss, from conception through to the first 28 days of life, including miscarriage, stillbirth, and neonatal death [1] and is considered as one of the most stressful moments in any mother's experience. Providing an empathetic, caring environment to support mothers who experience perinatal loss is thus viewed as an absolute necessity. Sereshti et al., (2016a) notes that despite the availability care protocols that support grieving families after experiencing a loss, most mothers frequently report dissatisfaction with care rendered following perinatal loss [1]. If parents feel that appropriate care is

not provided for them, great and unnecessary distress is imposed on them resulting in a wholly negative perception of care post-loss. Social, cultural, economic, environmental and genetic factors have been largely noted to determine the negative outcomes of pregnancies in most reviewed cases [2]

Global statistics on perinatal deaths indicates that an estimated 3,3 million stillbirths and 2,8 million early neonatal deaths occur worldwide every year, about 98% in low and middle-income countries [3]. Perinatal loss in high-income countries of the world has been estimated to be at about 10 per 1000 live births compared with 50 per 1000 live births in low-income countries [2].

Higher rates of perinatal loss have been noted to result from varied factors that may need to be included in the management process. The main contributory factors of perinatal loss were noted to be preterm birth, low birth weight, fetal growth restriction and congenital abnormalities [3]. It has been noted that, usually mothers have clear memory and can recall the loss and it has been found to be so disturbing if she perceives that the treatment offered was not appropriate.

WHO defined spontaneous abortion as the expulsion of an embryo or fetus weighing 500g or less. In developing countries like Latin America and the Caribbean, it is estimated that 3,7 million miscarriages take place each year. In Africa, 4,2 million miscarriages are estimated to take place with a ratio of 22 per 1000 women [4].

According to Polis et al., [5] 15% of pregnancies in Malawi ended in miscarriage. Miscarriage has been noted to be the most distressful pregnancy outcomes in African culture, as pregnancy is highly regarded as a blessing from God and its occurrence can affect the expecting mother and families psychologically.

Sully et al., (2018) [6]reported that in 2016 approximately 66,857 induced abortion happened in Zimbabwe which translates to 17,8 abortions per 1000 women. Though the report did not specify the consequences of abortion, most complications were considered as bleeding, infection. anemia, uterine atony and uterine perforation [7]

Stillbirth has been defined as a baby born with no signs of life at or after 28 weeks gestation and the stillbirths can be a fresh baby who dies soon after birth or macerated a baby who dies in the uterus [8]. Approximately 2,6 million stillbirths have been noted to occur globally with an average of 7178 deaths occurring daily in developing countries [8]. The major reasons for stillbirths has been noted to be congenital abnormalities, childbirth complications, maternal infections like malaria and syphilis and non-communicable disease like hypertension and diabetes mellitus [9]. About 24,000 babies are stillborn in the United States each year and causes were cited as birth defects or genetic problems, problems with the placenta or umbilical cord, maternal disorders [10]. In Sub-Saharan Africa, Nigeria has been noted to have the stillbirth rate of almost 43 stillbirths per 1000 [11].

In 2015, about 540,000 babies were born in Zimbabwe, 12,800 of these babies died in their first month of life and there were nearly 11,500 stillbirths with a rate of 21 per 1,000 births [12]. Preeclampsia, eclampsia, and placenta abruption were noted as the main causes of stillbirths [13].

Early neonatal death has been defined as the deaths of a newborn between zero to seven days after birth [14]. In 2017, 2,5 million children were noted to have died in the first month of life globally and out of these, about 1 million deaths taking

during the first week of life [15].

According to Maluleke [16], early neonatal death rates in South Africa were noted to be 7,7 per 1 000 live births in 2013 and 2016. The main causes of early neonatal deaths were cited as prematurity, birth asphyxia, and congenital abnormalities. According to the Zimbabwe Demographic Health Survey [17], the rate of early neonatal deaths was estimated to be 140 deaths per 1000.

Despite the increase in perinatal loss as depicted by the above statistics, it has been noted that little is known about how the mothers perceive management offered following perinatal loss. It has been noted through clinical practice that the care rendered to postnatal mothers following the loss appears to be erratic, inconsistence and incomplete, hence the need to explore how the postnatal mothers perceive management rendered following perinatal loss.

EFFECTS OF PERINATAL LOSS

Perinatal loss has been recognized as a very difficult life experience that can affect social, spiritual, psychological and physical wellbeing of would be parents [18]. Following a perinatal loss through abortion, some women have been noted to have emotional or psychological attachment with pregnancy and may prolong the grieving process [19]. Others have been noted to abort the grieving mainly because they did not feel the baby moving in their womb.

Loss of pregnancy has been recognized to have an effect on the parents and the entire the family including grandparents [20]. When a woman gets pregnant in an African context, the whole family looks forward to a newcomer in the home for the family to grow, then if this mishap occurs, this can negatively affect them.

It has been recognized that, even if the parents have not built up a relationship with their infant, grief after pregnancy loss seem not differ from when the parents lose a newborn baby. The woman has been noted to be equally distressed and is affected emotionally and psychologically [21]. From the clinical experience, the researcher noted that when a mother experiences perinatal loss, she may be admitted in a separate ward from mothers with live and healthy babies and at times mixed with mothers who have babies because of the shortage of rooms, this disparity in the management prompted the researcher to explore how they perceive such kind of management.

Perinatal loss effects have been seen to be aggravated when family members are not supportive or blaming the woman for the loss of pregnancy. Kersting & Wagner, [22] noted that just a small number of the women receive routine counseling soon after experiencing perinatal loss and routine follow up checks are not performed.

Mothers have been noted to react through a state of shock and grief, depression, guilt, anger following perinatal loss. A sense of failure has been noted to engulf the women as loss of pregnancy is so devastating as the hope of having the baby may be lost [23]. It has been noted that in this state, the mother may negatively perceive the management offered because of altered thinking process.

OBJECTIVES

The objective of the study was to explore the perceptions of postnatal mothers regarding management following perinatal loss in the City of Harare.

RESEARCH QUESTIONS

What are the perceptions of postnatal mothers regarding the management by health workers following a perinatal loss?

PURPOSE OF THE STUDY

The aim of the study was to explore the perceptions of postnatal mothers regarding management following a perinatal loss for the purpose of improving care.

PROBLEM STATEMENT

Despite the increase of perinatal loss through abortions (17,8 per 1000 women 15-49), stillbirths (77 per 1000 live births), early neonatal deaths (140 per 1000 live births) and its devastating effects, there is death of information regarding the perception of postnatal mothers management following perinatal loss [6]; [7]. Anectodotal evidence gathered from the study sites by the researcher suggests that despite perinatal loss having been associated with psychological disorders, care rendered to bereaved mothers remains erratic, inconsistent and incomplete, hence the need to explore how the postnatal mothers perceive management rendered following perinatal loss.

JUSTIFICATION

An in-depth description of the perinatal loss, sought to explore the perceptions of postnatal mothers regarding the management of mothers following the perinatal loss as the current care appears to be erratic, inconsistency and incomplete in most health centers in Zimbabwe as observed by the researcher from clinical practice. This study will provide an explicit picture of the strengths and gaps as regards to perceptions of post natal mother management following the perinatal loss as it aims to present a rich and comprehensive description of how the mothers perceive the management.

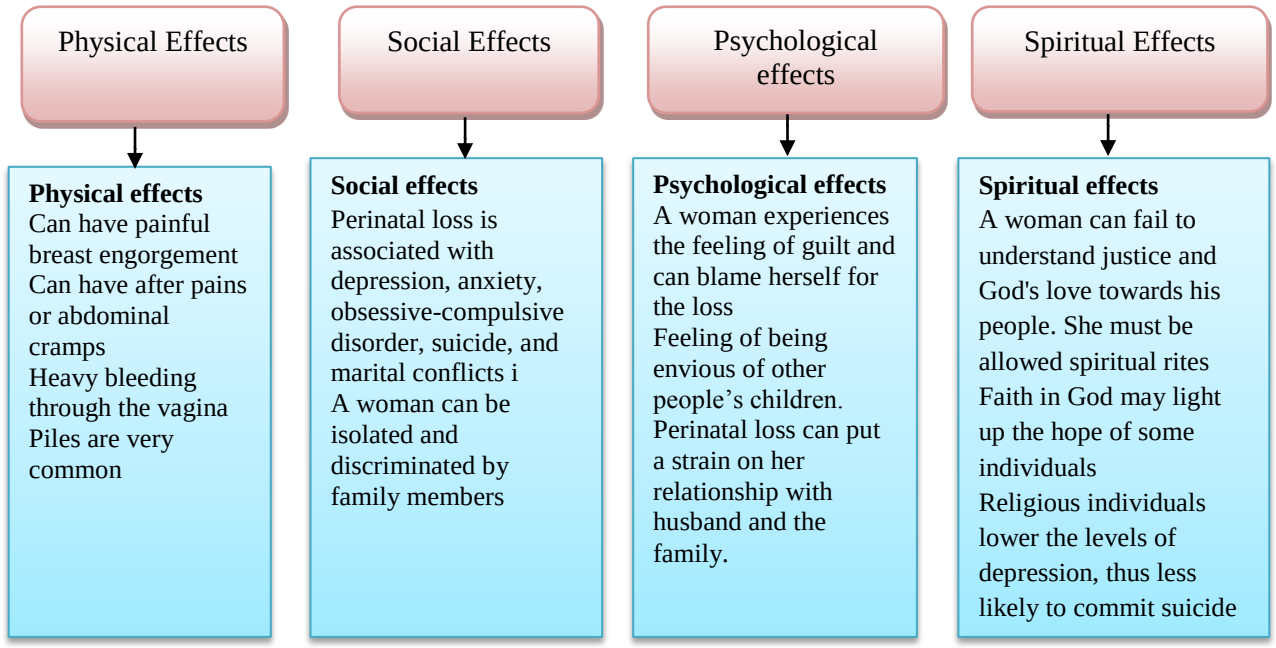
CONCEPTUAL FRAMEWORK

The study was guided by holistic nursing theory. Holistic nursing is defined as a practice of nursing, that focuses on healing the whole person [24]. The holistic nursing theory was derived from Neuman's System Model. According to the model a person is treated as a whole system and it focuses on the client's reaction to stress and the factors of reconstitution or adaptation. Neuman's framework is basically an open system model with major components of a stress reaction to stress and the person interacting with the environment [25]. All of these aspects combine to create the person and should be incorporated in perinatal loss management in order to heal the person.

Following a perinatal loss, the woman has been noted to suffer physically, psychologically, socially and spiritually hence the need to provide holistic care as outlined in the model. All of these aspects combine to create the person, so in order to heal the person, the holistic nursing looks at all aspects and how they can affect the patient's health, relationships, context, and environment [24].

The model has been recognized to be appropriate for this study as the perinatal loss is a crisis for the mother and the family. The mother should get psychological, emotional, social and spiritual assistance following perinatal loss. Using a conceptual framework to guide care, caregivers can facilitate grief and help the healing process of the mother and her family.

STUDY CONCEPTS



The Model Concept

Social Effects

Perinatal loss has been associated with psychological problems such as depression, anxiety, stigma, suicide, marital conflicts, and post-traumatic disorders. Usually the woman may be blamed for the loss and at times gets divorced. She can be isolated and discriminated from other family members [26]. These and many challenges mothers face, usually shape their world view and ultimately their perception of care. Most mothers affected by these challenges were noted to be very sensitive to their care, hence any slight detection of inappropriate treatment no matter how insignificant or unintentional may result in a full-blown negative perception of care.

SPIRITUAL EFFECTS

Religious societies are perceived as support centers with rich social support resources, and participation in these societies can help mothers process and accept their loss and their ultimate view of life. Faith in God has been noted to light up hope in some individuals thus helping them to experience a lower level of grief [27]. Religious individuals tend to feel more satisfied with life and experience lower levels of depression and have a more positive perception about life and in particular support services offered by others to them. Most studies have proved that most of these mothers have a positive view of their management by health workers following perinatal loss.

PSYCHOLOGICAL EFFECTS

Loss of an infant during pregnancy has been noted to deeply distress a woman and put a strain on her relationship with her spouse and family. Self-blame has been noted to further worsen the normal grieving process if the woman perceives herself to have contributed to the loss of pregnancy. The feeling of guilt, hurt and anger has often been proved to alter the perception of care offered to many such mothers. Most mothers experiencing the psychological effects seem to hold the notion that no one knows and feels what they are going through and as such no one is qualified to lecture them on the loss.

PHYSICAL EFFECTS

Perinatal loss has been noted to be very difficult to deal with and very disturbing to the mother as it keeps on reminding the mother of her loss [28]. Physical changes that happen to any mother after giving birth seem to haunt most mothers who suffer a loss. Changes such as breast engorgement, abdominal cramps, heavy bleeding through the vagina, pain on the episiotomy or caesarian section if performed together with piles, are some of the sad reminders that continue to taunt the mother. Most mothers experiencing such excruciating pain often feel that their pain and sorrows are a sad penance for their loss which they have to pay silently on their own without help from anyone, while some feel womanhood is all about enduring pain and hiding it from anyone from whom it might draw sympathy. Ultimately, most mothers experiencing physical pain following loss have been noted to have a low perception of care and management rendered to them.

SUMMARY

This chapter covered the background of the study, problem statement, objectives, research questions, and significance of the study, the theoretical and conceptual framework of the study. The next chapter will cover the review of relevant literature on how postnatal mothers perceive the management following perinatal loss.

LITERATURE REVIEW

Introduction

The purpose of this chapter is to review related literature to determine the extent to which the previous studies share common concerns with the present study and to obtain a broader overview of what was documented and researched in relation to the perceptions of postnatal mothers regarding the management health workers following perinatal loss. The literature review for this study focused on determinants of perinatal loss, effects of perinatal loss, how perinatal loss is perceived and how perinatal loss is managed

DETERMINANTS OF PERINATAL LOSS

Perinatal loss has multifactorial determinants which can be maternal, fetal, socioeconomic, facility and health care providers.

Maternal Determinants

Perinatal loss has been noted to result from factors associated with the mother. An overview of global perinatal mortality studies conducted by Ezechi & David [2] in Ethopia and (Usynina et al.,) [29] attributed most perinatal loss cases to maternal determinants such as uterine rupture, obstructed labor, pregnancy-induced or essential hypertension, diabetes mellitus, anemia, and infection.

Studies consulted revealed that mothers, who considered themselves to have contributed to the loss, usually suffered from psychological problems such as stigma and isolation. Such conditions were noted to cloud their judgments with a lot of misconceptions and subsequently lead to a negative perception of perinatal loss management rendered by health workers.

Fetal Determinants

Prematurity, congenital anomaly, and low birth weight were some of the known fetal determinants that are associated with perinatal loss [30] Gharat et al., (2016) and Usynina et al., also cited sepsis and suspected fetal growth retardation as the most common causes of perinatal loss in Ethiopia [29, 31]. Studies conducted in other African countries such as Ghana by Nankabirwa et al., South Africa by Allanson et al., and Zimbabwe by Munjanja, [32-34] identified cord prolapse, preterm births, home deliveries, anemia, congenital anomaly, previous neonatal death and low birth weight,

infections, intrauterine growth restriction, fetal abnormality, trauma, intrapartum asphyxia as some of the most common causes of perinatal loss.

Fetal determinants of perinatal loss were seen to generate a lot of discomfort and negative feelings towards the care rendered to the mother following perinatal loss. Most mothers who experienced this type of loss were most likely to take the blame for the loss on the institution and the hospital staff who rendered care, hence generating a negative perception of the care offered.

Socioeconomic determinants

Low socioeconomic status is loosely defined as a lack of formal education and low family income [35]. Aminu et al., posited that most women who lacked formal education were less likely to recognize danger warning signs of pregnancy and would not visit the health centre early [29]. This could mostly result in a loss of pregnancy.

Further studies conducted in Russia by Usynina et al., (2017) also revealed that low educational level, together with unmarried status, smoking, alcohol abuse, and maternal age were likely causes of perinatal loss. In Zimbabwe, socioeconomic determinants like religious factors, having home delivery and late or no antenatal bookings were cited by (Tachiweyika et al.,) [36] as some of the leading determinants of perinatal loss. The study mentioned some religious sectors like Marange as they were observed to forbid their followers from having institutional deliveries resulting in a notable increase in perinatal loss cases. Most mothers who have experienced perinatal loss viewed institutional care, unexpected health care expenses like money needed for incineration and health workers with a negative attitude towards bereaved mothers as sad reminders of their loss.

Health care providers and facility determinants

Delay in seeking care has been seen as one of the major causes of perinatal loss. Upadhyay et al., explains the delay through the three delay model. The model relates the first delay as the delay to seek care [37]. This delay is mostly centred on the individual, the family or both. The second delay is the delay in reaching a health facility. This can be due to poor transport networks and remote location of health facilities. The third delay is the delay in receiving adequate care at the health facility. This delay may be attributed to a lack of human and material resources or failure to meet hospital expenses by the client.

A case-control study conducted in Brazil 2013 concluded that third delay factors were the most common contributors of perinatal loss in Brazil. The study highlighted inadequate staff to manage the delivery process and lack of equipment such as Ultra Sound Scan used to assess the fetus's condition [38]. The studies consulted revealed perinatal loss experienced by mothers as explained in the three delay model resulted in resentment by mothers to both self and the healthcare facilities in general. Most mothers blamed their poor economic background, and the failure of health facility staff to empathize with them for their loss. This resulted in negative perceptions about the care rendered as mothers felt a lot more could have been done to improve their situation by themselves and the institution.

EFFECTS OF PERINATAL LOSS

Loss of pregnancy or the death of a newborn baby is a tragedy for both the parents and other family members [39]. Shock, anger, emptiness helplessness, and loneliness are common response for mothers and father [40]. Following perinatal loss woman suffers varied effects which can be physical, psychological,

social and spiritual

Psychological effects

Perinatal loss has been noted to have tremendous effects and life-changing experiences of bereaved mothers [41]. A cross-sectional study that was carried out in America 2016 on African, American and Hispanic populations revealed that a miscarriage, maybe less of an identity relevant stressor than stillbirths and child loss [42]. This could be as a result that the mother who experienced a miscarriage did not feel the baby move in her abdomen as compared to a stillbirth where the mother experienced a baby's movement before the demise.The study indicated that women who had a miscarriage or neonatal deaths had low self-esteem associated with depressive symptoms and persistent emotional difficulties such as a sense of failure, guilt, and shame [42].

A cross-sectional study that was carried out in Nairobi by Mutiso et al., [29] revealed that there is an occurrence of depression after miscarriage and has been attributed to social-cultural beliefs [44]. In an African context, myths exist in regard to the cause of miscarriage [45]. These myths influence the ability of the women to seek psychological help after miscarriage and go through the proper grief process and subsequently explain the high prevalence of depression after miscarriage [46]. In more developed western societies where women experiencing a miscarriage understand better the implication of miscarriage to future pregnancy seek psychological help. This is in contrast with less developed societies where at times miscarriage is considered as a non-event as a result, most women do not seek treatment resulting in complications of miscarriages like sepsis which can lead to maternal death.

This was supported by a study that was carried out by Christian Medical College South India on the effects of bereavement counseling for women with psychological problems associated with late pregnancy loss. The study revealed psychological problems such as grief symptoms like sleeplessness at night, suicidal ideation, depression, and anxiety, at various levels during pre and post assessment [47]. These psychological problems coupled with the blame the women endure usually from the family following a perinatal loss can make the woman perceive the care rendered as poor during her stay in the hospital.

A qualitative study that was conducted in Zimbabwe on risk factors of anxiety among married and childless showed that a woman had negative emotions as indicated by depression, grief, low self-esteem, irritability and withdrawal [36]. However, it has been noted that when bereaved mothers are well supported, they can develop resilience cope very well with the loss.

Emotions that parents may feel as a result of the loss of a baby include denial, deep sadness, shock, numbness, anger, guilt, and depression. There is the risk of separation, divorce and the effects on intimacy as in most African societies regard having children as the only way to cement a relationship [48]. Following the perinatal loss, parents may show the same pattern of grief, but generally, the mother's distress is more intense hence the health workers should be sympathetic and reassure them that their feelings are normal and that recovery may take some time [49].

Social Effects Of Perinatal Loss

Perinatal loss has been found to have profound effects on family relationships [50]. Most of the time the woman is blamed for the loss, quarrels and even divorce are rampant.

This was supported by a study done in Kenya in 2013 which revealed that there is a stigma associated with miscarriages. The study indicated that some women were not allowed to come out of their homes until they had been cleansed by a spiritual healer. The study also revealed that some pregnant mothers refused to come into contact with the women who had experienced a perinatal loss as they had a belief that it might be passed on and cause them also to miscarry [51].

In another study on the psychosocial impact on mothers who had a perinatal loss and its contributing factors revealed that there was deterioration of relationships and support from members of the marital family including their husbands. The women was blamed for the loss and worse still if the pregnancy loss was frequent, some women were divorced [31]. In view of this it has been noted that the women can negatively perceive the care rendered as the mind is clouded with what will happen at home after discharge.

A qualitative study that was carried out in Zimbabwe on risk factors of anxiety among married, childless women revealed poor interpersonal relationships with spouses and in-laws, stigma. Following a perinatal loss the women may think that she might not be able to bear her own children and the husband can divorce her [36]. Because of these problems the mother can perceive the management offered by health personnel as negative as her mind will be occupied with what will happen after discharge from hospital.

Physical effects

When a woman falls pregnant, there are changes that a woman experience in her body in order to accommodate the pregnancy and in preparation of lactation. After birth, these changes are reversed naturally and the experience is at times painful or causes discomfort worse still if the woman has lost the pregnancy The common physical changes that occur after perinatal loss include breast engorgement, piles, after pains or abdominal cramps, heavy bleeding and pain on the episiotomy or cesarean section are performed [28]. All these physical effects can be distressful to the woman as they keep on reminding the woman of the pregnancy loss and this can make the woman perceive management rendered by a health worker as poor.

Spiritual effect

Following a perinatal loss, the woman can have a feeling of being let down by God that they relied on for comfort, protection, and blessings. This can cause the bereaved woman to feel not only distanced from God, but also angry with God [52].

In a study that was conducted on Irish women on the spiritual effects used in-depth interviews and phenomenological analysis revealed that still birth posed immense personal, spiritual challenges. Bereaved families revealed that stillbirths spiritually challenged their faith and belief and parents felt that their spiritual needs were not adequately addressed while in hospital .

Wright, (2017) in the study on perinatal loss and spirituality revealed that following a perinatal loss some women may feel abandoned by god they thought loved and protected them. Others believe that God is in control and knows what is best for them and there is a reason for everything. They assume that loss was a test of faith or god knew their circumstances and believed that the loss was in their best interest. Religious beliefs allowed the women to metaphysically relocate the baby in another place as the western paradise in God's hands. Some bereaved mothers believed that their babies not only existed in another way, but also were being cared for in the spiritual world. Some women prayed to deceased ancestors, asking them to care for the babies in the afterlife and burned ghost money to help ensure that the baby would

have good things in the afterlife.

HOW HAS PERINATAL LOSS BEEN PERCEIVED?

Following a perinatal loss, the woman can experience problems in adjusting to the loss since she was not prepared to face the painful reality of life. Providing an empathetic, caring environment to support mothers who experience perinatal loss has been noted to be very necessary.

A qualitative study that was conducted by Richards et al., [54] on the mother's perspective on the perinatal loss of a Co-twin revealed that mothers who experience a loss of a twin pregnancy have a specific set of needs which differ from parents who have experienced the loss of a singleton. The study indicated that bereaved mothers be provided with time and space to talk about the loss and continuity of the baby's care team can assist parents to deal with loss positively. The study indicated that it was important that health workers be sympathetic and to have a sensitive approach to bereaved parents on the day of the baby's funeral .

This was supported by a qualitative study carried out by Sanchez, with the objective of investigating the perception of mothers regarding hospital support after perinatal loss. The researcher conducted in-depth interviews with 12 women who experienced miscarriage, stillbirth and neonatal deaths. The study revealed that mothers felt that the timing of support, or lack of good timing appeared to be important factors in the mother's perception of experience as positive or negative. Some mothers wished they had been given more time with their baby. The sample size of participants appeared to be appropriate in comparison with other studies which had many participants. Studies suggest that emotional support is important in the management of the mother following perinatal loss as it assists the mother to perceive the care rendered as positively.

In a related study conducted by Gold, on a systematic review of parent's experiences with health providers after the baby dies, the study indicated that parents had varied feelings with their care provider with a high number indicating discomfort or discontent with specific communications or sensitive behaviors. Although nurses were considered to be more supportive than physicians in the study, a large number of mothers indicated that they experienced poor care from the nurses and there was lack of lack of communication between staff members about the death of the baby.

Sutan et al., [21] conducted a quantitative study in Malaysia to evaluate the psychosocial impact among 62 mothers who have experienced perinatal loss. Parents stated that health workers were not caring, did not have a listening ear and no emotional support was offered to the bereaved mothers. The Majority of the parents indicated that they only received support from their parents, friends and siblings which came through encouragement and counseling. Evidence suggests that those parents who perceived health care providers to be considerate and sympathetic were more likely able to open up and share their problems and ultimately perceive the care positively.

In a retrospective study carried out by Redshaw & Henderson, of the mother's experience of maternity and neonatal care when babies die noted that mothers were generally optimistic about the care they and their babies received after the loss as staff members were reported to be kind and respectful. However, some mothers narrated that they were admitted in the postnatal ward within sight and sound of other women who had delivered healthy

babies and there was no room where their partners could stay. This was noted to add distress to an already distressed mother. Mothers also mentioned other aspects of care which was not viewed such as the inclusion of the mothers in decision making during labor and birth. Studies suggest that the involvement of the mothers in decision making may be beneficial to the bereaved mother as she may have the sense of being cared and ultimately positively accept the loss.

PERINATAL LOSS MANAGEMENT

Management of the bereaved women should not only focus on the physical aspects only but must include, social, spiritual and psychological aspects in order to holistically manage the woman.

An online survey that was conducted in Australia among 189 mothers and fathers to evaluate the level of support and satisfaction among parents of stillbirths revealed that the support offered to the bereaved mother was inconsistent with guidelines implemented [21]

The survey noted areas of support regarding creating memories, birthing options and autopsy were most difficult. The gaps noted in this online survey are that despite the presence of guidelines, they were not implemented fully resulting in the mismanagement of patients. The use of an online survey was subject to bias and comments were done retrospectively, so there was a potential for recall bias.

Similar findings were noted by Ellis et al., (2016) from a study of the findings of systematic review to understand and improve care after stillbirth that was conducted in Europe, North America, Australia, and South Africa. The study revealed that some parents appreciated the availability of private rooms that were situated away from the main maternity where mothers could not hear the voices of babies crying or see mothers breastfeeding their babies. However, some mothers preferred to be admitted in the same ward with the mothers who had live babies as they cited that being alone in a room deepened their grief.

Another qualitative study using a phenomenological framework was conducted by Meaney et al., with the objective to explore the experiences of both men and women who experienced miscarriage. A purposive sample of 16 participants 10 women and 6 men were included in the study. The study revealed that the experience of miscarriage had a significant influence on both parents. The woman indicated undesirable experiences in the hospital, which was related to the administration, the physical design of the health facility, a lengthy period of time in the emergency department and general clinic before being seen by the Doctor. The study indicated the provision of appropriate clinical information to the bereaved mother that health workers and hospital administration should be sensitive, accommodating as well as when counseling individuals who have experienced miscarriage. In this study the inclusion of men was of paramount importance as views were heard from both parents and that on its own, have been noted to assist the health workers in the management of women who have experienced perinatal loss as perinatal loss was noted to have a significant influence on both parents. A related study was carried out in rural western Kenya using a focused group discussion to explore risk perceptions and attitudes to miscarriages and congenital anomaly. The participants were purposefully selected by village-based field workers. The study revealed that following a perinatal loss most mothers wanted to seek care from health facilities so that they could better understand the possible causes of pregnancy loss. Because of traditional or

religious beliefs, women tended to go to the trained birth attendants to get herbs or a spiritual healer who would pray for them or cleanse them of the curse. At times the women preffered to keep the miscarriage a secret and seek treatment when they perceived complications, as a result some women were noted to succumb to the complications associated with miscarriages. This practice has a lot of gaps as the woman is not allowed to discuss the circumstances around the stillbirths and perform burial ceremonies and that can traumatize the woman psychologically. If she is allowed to discuss and perform the rituals that can help her to go through the grieving process and accept the loss.

Similar findings were noted by Siassakos in 2017 in a study on all bereaved parents are entitled to good care after stillbirths. The findings indicated that the care rendered to the bereaved woman was poor as there was no good communication between bereaved parents and staff. This promoted the parents to avoid going to the hospital to seek help. There was no typical approach to how care was given. The study noted that sometimes they were long delays before the death of the baby was confirmed. After it had been confirmed that the baby had died, the staff focused on the mothers' needs, but the parents were deeply worried about the pregnancy loss. It was also noted that there was no consistent plan on how to conduct follow up care and parents would have liked more information about their next hospital appointment.

In view of the above, this study highlighted some of the gaps in the management as they were no follow-ups done to the women after discharge and no explanations of the nature and purpose of postmortem. It was also discovered that health workers focused on mothers only, excluding the rest of the family.

INTEGRATION OF THE CONCEPTUAL FRAMEWORK

The conceptual framework guided the literature search because when data was being searched the researcher focused on the concepts of the conceptual framework which were a psychological aspect of how psychological aspects affected the woman after perinatal loss. The researcher also looked at the impact of the spiritual effect on the mother following a perinatal loss, how the physical aspect how affected the woman and lastly how the social aspect affected the woman following the loss.

RESEARCH METHODOLOGY

RESEARCH DESIGN

Research design is defined as an overall plan for addressing research questions being studied for handling some challenges during a research process. It assists in a unique way or plan for answering a nursing research question. In this study, the researcher employed a descriptive qualitative design to explore the perceptions of postnatal mothers regarding management following perinatal loss.

A DESCRIPTIVE QUALITATIVE DESIGN

According to Polit & Beck, qualitative descriptive designs are descriptive in nature and tend to draw inquiry in a natural setting for the purposes of examining health care and nursing related phenomena. The qualitative descriptive study was found appropriate for answering research questions like the who, what, where and how the events occurred or were perceived thereby providing insight into how mothers perceived the management rendered to them following perinatal loss. The researcher used a qualitative descriptive study design as it was found to be suitable because of its ability to be used in a variety of approaches that included sampling technique, data collection, presentation of

data and data analysis strategies.

Features Of Qualitative Descriptive Approach

The qualitative approach has six features which include **First** According to Polit & Beck, the use of qualitative descriptive designs allows the researcher to draw inquiry in a natural environment. Likewise, the researcher carried out the study in a natural setting to gain insight into how the mothers perceived the management offered following perinatal loss. The process generated large amounts of data during an in-depth interview on how the participants perceived the management rendered following perinatal loss.

Second; At this stage, the researcher may decide whether or not to use theory to guide his or her study as a qualitative research design is less theory-driven. The researcher may or may not decide to begin with a theory of the targeted phenomenon as there might be no need to stay committed to theory or framework if the study takes another direction. However, for the purpose of this study, the researcher used the Holistic Nursing Theory to guide the study as it focuses on healing the whole person. Following the perinatal loss, the mother suffers physically, emotionally, psychological, socially and spiritually hence the need to provide holistic care as outlined in the model.

Third; This stage focuses on data collection and mainly involve individuals and focused groups with minimally structured and semi-structured interview guides. In this study, the researcher personally collected data from twelve postnatal mothers who experienced perinatal loss as follows; four postnatal mothers who had experienced early neonatal deaths, four postnatal mothers who had experienced stillbirths and for postnatal mothers who experienced abortions and one key informant who was a midwife utilizing in-depth interviews.

Fourth; Nergaard et al., Sandelowski, 2000 noted that the researcher commonly employs purposeful sampling techniques such as a maximum variation which has been described as being useful for obtaining broad insights and rich information. In this study, the researcher used maximum variation purposive sampling, a nonprobability sampling method to select the sample. The aim of using purposive sampling was to identify information-rich individuals that could be instrumental in bringing out useful manifestations of the phenomena of interest. In this study, the researcher collected data from participants who had experienced perinatal loss in less than six months and not more than six weeks as they were able to narrate how they perceived the care rendered vividly. The rich data led to important recommendations during data analysis as the participants were able to describe events as they occurred.

Fifth; Data analysis; Themetic analysis supplemented by descriptive statistics of the study sample is considered the common data analysis strategy in qualitative description design, however, thematic analysis may be used at times. These data approaches have been noted to allow the researcher to stay close to the data with minimal transformation during analysis, enabling the reader to be familiar with the topic to recognize their own experience of the phenomena findings. In this study, the researcher used thematic analysis, which is a flexible data analysis plan that qualitative researchers use to generate themes from the interview data.

Sixth; In the last stage, representation of study findings in published reports is

expected to be straightforward including comprehensive descriptive summaries and accurate details presented in a way that makes sense to the reader.

The other benefits of qualitative descriptive design included the provision of insight into gaps and strengths of how the mothers perceived the management offered following perinatal loss. It gave a broader view of the information thus can help improve the care rendered to the mothers who have experienced perinatal loss in the clinics, hospitals, and society at large for the benefit of mothers .
The other noted advantage of using qualitative descriptive design was that it was less dependent on the instrument, therefore, it helped in bridging the gap between research and practice. The postnatal mothers were able to describe and express using verbal, non-verbal communication how they perceived the management rendered following the loss.

Context
The context in research means the conditions and environment in which the research was done. It includes the participants' culture and geographical location. In this study, the participants were postnatal mothers who had experienced perinatal loss either by early neonatal death or stillbirth or abortion in the three selected Polyclinics in the City of Harare.

LITERATURE REVIEW
Some qualitative researchers are against the review of the literature before doing data collection as they are of the belief that it might influence the researcher during data collection thereby producing biased research. However, the researcher noted that a preliminary literature review provided necessary knowledge gaps from previous studies which were used of this research. After the data was collected, coded and analyzed, the literature was revisited in the discussion section of the study so as to correlate the findings in relation to the existing knowledge

Bracketing
Moule & Goodman, described bracketing as a way to remove the researcher's preconceptions from the field of data collection through phenomenological reduction. In this study, the researcher entered the field with an open mind and was able to study phenomena without the burden of preconception. To achieve bracketing, the researcher suspended her knowledge about the phenomena under study that was the knowledge of perinatal loss and set aside her own preconception and went with an open mind to ensure trustworthiness. The researcher also opened a dialogue with fellow researchers and took memos and bracketing journals and final the report was written on everything that was found during data collection.

Intuiting
Intuiting is the process of actually looking at the phenomenon. It focuses all attention and energy on the topic under study. It involves absolute concentration and absorption in phenomenon. The researcher, achieved this through concentrating on the perceptions of postnatal mothers regarding management following perinatal loss only during the interviews.

Research Approach
The researcher used a qualitative design with descriptive methodology so as to explore the perceptions of postnatal mothers regarding the perinatal loss. The research approach covered study population, sample, sampling size and setting of the study

STUDY POPULATION
Polit & Beck, defines population in

research as all the individuals or objects with common and defining characteristics and the study population as the people who are being studied. In this study, study populations included mothers who experienced perinatal loss through abortion, stillbirths and early neonatal deaths from the above-mentioned clinics. The target population was mothers who visited the clinics to book pregnancy, one who had come for family planning services or Visual Inspection of Cervix with Acetic Acid (VIAC) services from six weeks to six months following the loss. This period was chosen with an assumption that the mother could have recovered from the perinatal loss and was still remembering the events vividly so as to get accurate information. For the purpose of triangulation so as to improve credibility of the study, data was collected from three different clinics and from mothers who experienced perinatal loss through abortion, stillbirth and early neonatal death and one key informant who gave her analysis on how the mothers perceived the management rendered to them by health workers following perinatal loss.

Sampling Method

The sampling plan specifies how samples will be selected and how many participants will take part in the study. The researcher employed purposive sampling whereby participants were purposefully selected based on their availability and possession of rich data as they had experienced perinatal loss through abortion, stillbirths and early neonatal death in order to get factual data. Thus the researcher made use of the nurses who were on duty to identify the participants who met the criteria for the using the inclusion and exclusion criteria and phone calls were made to ask for permission to conduct an interview. Data was collected from the participants who agreed to be interviewed who met the inclusion criteria at their place of residents.

Inclusion criteria

Inclusion criteria are characteristics of an individual that qualifies a prospective participant to be included in the study. In this study, the researcher included all the mothers who experienced perinatal loss through abortion, stillbirths and neonatal natal deaths at Kuwadzana Polyclinic, Rutsanana Polyclinic, and Mbare Polyclinic. The researcher interviewed mothers who experienced perinatal loss from six weeks to six months with an assumption that they may have recovered from a loss and still remembering the events irrespective of age, parity.

Exclusion criteria

These are attributes that disqualify one to be in the study. The researcher did not include the following as participants in this study despite being chosen health centers; Mothers who came for medical attention. Mothers who did not recover from the loss, even the time period, which was more than six weeks. Mothers who experienced perinatal loss in less than six weeks. Mothers who were mentally challenged.

Sample size

A sample is a subset of the population selected through sampling technique. The Sample size should be large enough to obtain enough data to sufficiently describe a phenomenon of interest and address the research questions and avoid too many participants that will lead to repetitive findings which will end up unnecessary. However, data saturation should be taken into consideration to determine the actual sample size. Morse, defined data saturation as when no new facts are gathered on the matter under study. A sample size of twelve participants was reached through data saturation. The researcher interviewed; four mothers who had experienced stillbirth, four mothers

who had experienced neonatal deaths and four mothers who experienced abortions.

Thick descriptions of the Study setting

A qualitative researcher collects data in the real world, naturalistic settings. The study was conducted in the City of Harare at three purposefully selected clinics (Mbare, Rutsanana, KuwadzanaPolyclinics) on the basis of the high burden of perinatal loss experienced in these clinics as noted by the statistics. These clinics are found in the high-density suburbs of Harare and they also provide services to peri-urban areas that surround them and are among the busiest clinics in the City of Harare. The majority of the population in these suburbs survives on very little income which they get from selling market produce. The services offered at these clinics include antenatal care, delivery care, postnatal care as well as counseling services which are mainly concerned with HIV and AIDS issues. Preconception care is still to be introduced in the City of Harare.

The catchment population of these clinics as of 2018; Mbare Polyclinic Catchment population 91822, Women of childbearing age population 60602. Perinatal loss 2018 statistics abortions 80, Stillbirths 21 and Early Neonatal Deaths 1, Rutsanana Polyclinic Catchment Population 82283, Woman of Child Bearing Age 25097. Perinatal loss 2018 statistics Abortion 90, Stillbirths 27 and Early neonatal Deaths 3. Kuwadzana Polyclinics catchment 181364 Women of Child Bearing Age 55361; Perinatal loss 2018 statistics on abortion 90, stillbirths 14, and Early Neonatal Deaths 1.

It was imperative that a study is carried out to explore the perception of postnatal mothers regarding perinatal loss management in an effort to ensure quality care.

The Research Instrument

According to Burns and Grove, research instrument is defined as a tool of methodical collection of facts relevant to study goals and inquiries. The researcher used an interview guide as a research instrument. Twelve postnatal mothers from three different sites were interviewed face to face. Face to face interviews enables the researcher to interpret nonverbal communication Creswell.

Through face to face interviews, the researcher was able to explain clearly some of the questions the participants could not comprehend during the interviews and also was able to seek clarification on issues through probing. However, the researcher was aware of the limitations of this tool of which researcher bias is its major challenge Creswell. The researcher formulated the interview guide, guided by the research question, informed by the literature review as well as with the help of the research supervisor

DATA AND DATA COLLECTION PROCEDURE

According to Burns & Groove, data collection plan is a strategy for gathering information to address a research problem and it provides a detailed account of how the information will be collected. Before collection of data researcher visited the respective clinics to familiarize with the place, sensitize potential study participants in order to prepare the participants for the interview. In-depth interviews with mothers who experienced perinatal loss were done as well as one key informant who was a Nurse / Midwife. The in-depth interviews with participants from each study site were guided by a set of questions that guided the interviews for uniformity of questions among participants (see appendix). An interview guide was used to address, demographic variables, psychological effects, physical effects, social effects, spiritual effects of perinatal loss. The researcher managed to interview

one participant per day. The interview guide used the languages that study participants could comprehend, for example, the interview guide in this study was in English and Shona.

The researcher introduced herself and explained the purpose of the study to the participants so that they would agree to be included in the research study. The participants were told that there were no incentives in partaking in the study and could discontinue from the study whenever they so wished without any effect to them. The participants were told that the sessions were going to be voice recorded and were assured that the data was going to be kept in a safe place and will be shared with the supervisor only for clarity. Data were audio taped using a dictator phone and a transcriber assisted in transcribing the data into the local language. Approximately, the interview lasted for less than an hour, which was audio taped. Data was only collected from the participants who had consented to be audio taped.

Rigor

Rigor in research refers to the way in which a research study is carried out that ensures it is of good quality. Rigor is meant to authenticate one research so that the results may be replicated to the same group of women. In the context of this study, the researcher tried to ensure that the research was transparent and explicit so as to make it credible, dependable, conformable and transferable .

Credibility

Credibility is how confident the quality researcher is in the truth of the research study findings. In order to establish credibility in the study, the researcher carefully chose the study sites with a high burden of perinatal loss, the use of in-depth interviews and purposive sampling to ensure credible data was obtained. The researcher also included the use of triangulation to show the research was credible by involving participants themselves, three study sites and one key informant (midwife). They were allowed to ask questions and discussion time at the end of each interview to add material and offer possible scenario thus increasing credibility.

Transferability

According to Polit& Beck, transferability refers to how the researcher demonstrates that the research study's findings are applicable to other contexts. In this study, this was achieved through a thick description of the study site which showed that research study findings were applicable to other scenarios. The data were collected from the three busiest clinics in the City of Harare with a high burden of perinatal loss.

Conformability

Conformability refers to neutrality in the research study findings that is findings were based on the participant's response and not any potential bias or personal motivations of the researcher. To establish conformability, the researcher provided an audit trail where the researcher recorded topics that were unique and interesting during data collection, wrote down what the researcher thought about coding, provided a rationale for why the codes emerged together and explained what the themes meant.

Dependability

Dependability refers to the extent that the study will be repeated by other researcher and the findings would be consistent and obtain similar findings. To establish dependability in this study, the researcher asked fellow students to review the processes of sampling, data collection and analysis and explored recordings of audio to ensure that the study was of good quality. The researcher also used a peer student who reviewed and examined the

data collection tools to ensure that the findings were consistent and can be repeated.

Authenticity

Polit & Beck, refers to the authenticity as a research strategy that ensures the trustworthiness of results in that it expresses the extent to which the researcher accurately reflect participant's feelings and perceptions regarding the management following perinatal loss. In order to establish authenticity in this study, the researcher collected data from participants using dictator phone and kept audit trails of participants.

Trustworthiness

In an effort to establish trustworthiness in the study, the researcher employed techniques that included credibility, transferability, conformability, dependability, and authenticity to set standards for trustworthiness as described.

Ethical Considerations

Polit & Hungler, [64] refers to ethics as a system of moral values that are concerned with the degree to which research procedure adhere to professional, legal and social obligation to the participants. Ethical clearance was sought from the Joint Research Ethics Committee (JREC) and the Medical Research Council of Zimbabwe (MRCZ) that ensured that ethical considerations, requirements were addressed. Permission to access the study sites was sought from the Director of Health in the City of Harare and participant's ethical concerns were addressed. Each participant was given a number as the use of names was discouraged. Information was kept confidential under lock and key at the researcher home and the researcher was the only one who had access to the information. Mothers who were still grieving were referred to the counselors or psychologist for counseling sessions. If they settled down the interview continued and if not it was discontinued.

The following ethical issues were attended to in this research; informed consent, autonomy, beneficence, justice, and respect of the communities

Informed consent

Informed consent was signed before conducting the interview as recommended by Creswell. Participants were informed of nature and the purpose of the study in their language of choice. They were informed of their right to withdraw from the study at any stage. After the participant had agreed to participate in the study, they were asked to sign the consent form after it has been read to her and the participant had understood the contents of the study.

Autonomy

The self-esteem of all study participants needed to be valued. In this study, the participants were not forced to be part of the research. Research contents were first highlighted before partaking in the research study. They were made aware that they were free to withdraw from the study at any time.

Justice

Justice necessitated an obligation to the threats to safeguarding a just sharing of the threats and assistance consequential from the study. Participants who took on the burden of participating in the research study needed to be part of the advantages of the information added. The researcher advised them on the best method of family planning to use and to book their pregnancy early if they happen to fall pregnant.

Data analysis

Creswell, described data analysis as a process of systematically searching and arranging the interview scripts, observation notes, diary entries, pictorial

display, audio and video clips (audio and visual recordings of the patient) to make sense of the data. In this study, data were analyzed from audiotapes recorded during in-depth interviews through the use of thematic analysis, which is a method used for describing written verbal or graphic communication. Information that was collected was grouped, classified and coded to facilitate, processing, checking and cross-reference In this study, the researcher used thematic analysis.

According to Braun & Clarke there are six phases to guide thematic analysis; Step 1 Become familiar with the data, Step 2 Generate intial codes, Step 3 Search for themes, Step 4 Review themes, Step 5 Define themes, Step 6 write up

Step 1 familiarization with the data

In this phase the researcher becomes familiar with the data by listening to audio recorded data reading and rereading the data, The researcher also listens to audio recorded data and noting any analytic observation

Step 2 Coding

Coding is not simply a method of data reduction but an analytic process, Codes capture both a semantic and conceptual reading of data. Data should be clear and concise without ambiguity and with clear boundaries which then help to identify when it occurs. The collected data in this research were coded manually.

Step 3 Searching for Theme

Braun & Clarke defined a theme as a coherent and meaningful pattern in the data relevant to the research question. Searching for themes is more like coding the codes to identify similarities in the data. The researcher constructs themes from the codes and subthemes.

Step 4 Reviewing themes

The researcher in this stage checks if themes work in relation to both the coded extracts and the full data set. The researcher should reflect on whether the themes tell a convincing and compelling story about the data and begin to define the nature of individual theme and relationship. This can result in combining of two themes together or splitting the theme into two or more or discarding the candidate themes altogether and start afresh the process of theme development

Step 5 Defining and naming themes

The researcher is required to conduct and write a detailed analysis of each theme and come up with the meaning of the theme and how it fits into the overall story about the data

Step 6 Writing up

Writing is the integral part of the analytic process in thematic analysis. It involves combining together the analytic narrative and vivid data extracts to tell the reader a a coherent story about the data and contextualizing it in relation to existing literature.

INTEGRATION OF CONCEPTUAL FRAMEWORK

The conceptual framework guided the methodology of this study. The conceptual framework guided the choice of the design. The holistic nursing theory informed the formulation of the interview guide on what aspect to include in the interview guide. The interview guide had questions which were related to the social aspects, the physical aspect, psychological aspect and the spiritual aspects following perinatal loss.

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION OF FINDINGS

The aim of the descriptive qualitative study was on exploring the perceptions of postnatal mothers regarding management following the perinatal loss by health workers. The researcher

conducted in-depth interviews with postnatal mothers to understand how they perceived the management rendered to them following perinatal loss. The chapter focused on the presentation of data collected by the researcher, its analysis and interpretation. Detailed circumstances of each participant were presented prior to data analysis in order to trace their perceptions regarding management following perinatal loss. The chapter revealed categories, subthemes and themes based on the narration of stories on perceived experiences of postnatal mothers. The 12 postnatal mothers were coded as mother one to mother twelve and one key informant – Midwife

Participants Demographics

A total of 12 in-depth interviews were conducted from postnatal mothers who experienced perinatal loss to understand the perceptions of post natal mothers regarding management they were rendered a following perinatal loss. To increase the credibility of the study one key informant was included as a way of data source triangulation. The participant's demographic factors of postnatal mothers who experienced perinatal loss; age, marital status, employment parity, religion, number children alive and timing of loss were presented in Tables below

The demographic variable shows that participants were of varying ages and parity. The youngest participant was twenty-one years old who experienced neonatal death and the oldest was thirty-seven years old who experienced stillbirth. In terms of booking status, eight participants had booked their pregnancies with only four who did not manage to book their pregnancies because of various reasons. Eleven participants were Christian and only one was a non-Christian. One participant was a divorcee and eleven participants were married**.** The parity of the participants ranged from 0 to 4 children with the majority of the participants having one child (41.7%) followed by participants who had two children (33.3%). The majority of the participants were not employed ten (83.4%). One (8.3%) participant was a student and the other one (8.3%) was employed as a street cleaner. A number of children of the participants who had children who were alive ranged from zero to four children with the majority of the participants having one child (41.7%) followed by participants who had two children (33.3%)**.** The researcher interviewed four (33.3%) participants who experienced early neonatal deaths, four (33.3%) participants who experienced stillbirths and four (33.3%) participants who experienced abortions. The demographic variables were meant to give a background of the participants.

Table 1: *Demographic characteristics of the participants*

(N=12)

Variable	**Frequency**	**Percentage**
Age		
Below 25	2	16.6
Above 25	10	83.4
Total	12	100
Marital status		
Married	11	91.7

Single	1	8.3
Total	12	100
Parity		
Para 1and less	4	16.7
Para 2 and above	12	41.7
Total	12	33.3
Religion		
Christians	11	91.7
Non-Christians	1	8.3
Total	12	100
Employment	1	
Employed	1	8.3
Non employed	10	83.4
Student	1	8.3
Total	12	100
Number of children alive		
Below 1year	4	16.7
Above 2 years	12	41.7
Total	12	33.3
Timing of loss		
Stillbirth	4	33.3
Neonatal Deaths	4	33.3
Abortions	4	33.3
Total	12	100
Booking status		
Booked	8	66.7
Unbooked	4	33.3
Total	**12**	**100**

KEY INFORMANT

The key informant is a midwife and has eleven years of experience in midwifery practice. She is forty-six years old, married woman with three children. She has vast experience of midwifery, having worked in different departments during her practice as a midwife. She displayed sound knowledge on how the mothers perceive management rendered following perinatal loss.

FINDINGS FROM IN DEPTH INTERVIEWS

Data analysis revealed two major themes facilitating factors, barriers in the management of perinatal loss and recommendations from postnatal mothers. The findings were presented in the thematic categories gathered from in-depth interviews. Using the deductive approach in the form of thematic analysis data was coded and the following themes and sub-themes emerged.

Table 2: *Facilitating Factors*

Categories	Sub themes	Themes
Treated me well Treatment was ok Given tablets for pain Was asked to go and sleep Would frequently check on me Managed to explain what had happened Nurses were friendly Nurses were caring Was informed after one hour Was informed soon after delivery Was informed after 30minutes They did not take time to inform me They are people who accept other people' problems They managed to talk to my mother about the loss They talked to my husband They explained everything to my husband	A positive attitude of nurses	Facilitating Factors
Counseled by the nurse at the clinic Got counseling from my pastor Was counseled by church mates My family comforted me Resorted to Christianity for support	Support systems from family and others	

The following is the detailed narrative of the major themes and related subthemes.

Theme Facilitating factors

Facilitating factors were one of the major factors which emanated from the study had two subthemes, positive attitude of nurses and support systems for the family and others. Six participants out of twelve participants described with excitement how they perceived the management rendered following a perinatal loss by health workers following the loss. Two interview questions gave the participants the opportunity to give a comprehensive narration of their perception of management following perinatal loss. What are your perceptions regarding management following perinatal loss?. How did you perceive the care rendered following a perinatal loss (Refer to Appendix)? Two subthemes that were related to the perception of care as regards facilitating factors emerged (see Table 1)

Positive Attitude Of Nurses

Several positive accounts were given of individual nurses who displayed positive attitudes towards the mothers who had experienced perinatal loss. Mothers described the nurses as caring, friendly and understanding, Mother 9 expressed satisfaction with the treatment she received from the health workers. She said the nurses reassured her and comforted her husband as well

The nurses treated me well. The nurses managed to explain everything that had happened to my husband because he is the one I had gone with.

Another positive comment was raised by mother 8 when she gave an account of how she positively perceived the care rendered to her following the loss;

The nurses treated me well, when I arrived, have forgotten the day, they asked me to lie on the bed and sleep. After some time they called me to check whether I had sustained some vaginal tears.

A few participants were satisfied with the emotional support from the staff. Mother 4 narrated how she positively perceived the care rendered to her following perinatal loss;

My perception regarding management is that some people say the nurses are sometimes rough, but I do not want to lie, they treated me well. They told me soon

after delivery that I had a stillbirth.

The sensitivity and support of the nursing staff were frequently mentioned. Mother 11 narrated how she perceived the care she was offered after the loss;

Aa she was not rough. She was even worried about the bleeding as she told me that I was not supposed to bleed when pregnant. They managed to talk to my husband about the loss of pregnancy

This was supported by Mother 1who experienced early neonatal death who narrated;

I can say these are people who accept people's problems. She said *there is a nurse at the clinic who counseled me to accept the loss.*

Most of the positive comments included physical care aspects where Mother 6 She narrated;

….It was ok. After delivery, they gave me tablets and asked me to go and sleep. They would come and check on me

Support systems from family and others

Two interview questions gave the participants the opportunity to give a comprehensive narration of their perception of management following perinatal loss and problems they encountered regarding the above subtheme How did the health personnel involve the family in the loss? What other assistance did you get apart from the hospital?

Four Participants gave an account on they were assisted to accept the loss by their families and other people around them;

Mother 2 narrated that she did not receive any counseling from the nurses only received counseling from her mother and mother in law.

I can say the one who counseled me is my mother in law and my mother who told me that it happens in life and there was nothing we could do

Some participants after the loss who are Christians sort their support from God as mother 10 when she arrived home, she cried out to God and said;

When I arrived home, I asked God what I have done wrong.

Mother 7 who experienced an abortion narrated that her pastor explained to her that it's something that happens in life.

My pastor told me that it's something that happens in life God has his ways of dealing with some situations.

The same experience was narrated by Mother 4 who experienced stillbirth narrated that her church mates managed to provide counseling

My church mates counseled me. My parents are all late, but my mother's sisters and my father's relatives came and comforted me saying that it happens in life

BARRIERS TO PERINATAL LOSS MANAGEMENT

The second theme derived from data analysis was that of barriers to perinatal loss management. Three sub-themes were identified under this theme and these are as follows negative attitudes from nurses, unfavorable health facilities and economic factors. Participants were posed questions that asked them how they perceived the care rendered following the perinatal loss, how long it took for them to know about the loss, Did the health personnel involve the family in the loss and what other assistance did the mothers received apart from the Hospital

Table 3: *Barriers to perinatal loss management*

Categories	Sub themes	Themes
Hopelessness induced by health care workers The nurses were rough Nurses were rude Nurses were shouting Blaming Lack of explanation of procedures Nurses were insensitive Delay in disclosure Treatment was divided Sometimes they would shout at patients in the labor ward Not paying attention to the client needs Playing JahPrayzer and AlickMacheso songs Telling me to keep quiet The client got discharged with so many questions The client was asked to get to bed without assistance despite the pain she was experiencing. Ignored by nurses	Negative attitude from nurse	Barriers to perinatal loss management
Waiting time Time is taken to attend to clients very long, one can die in the queue Mixing of bereaved mothers (those who have undergone loss and with babies) Staff workload Rigid systems (unable to call a pastor to come and pray for the client) Attending to cell phones Nonavailability of counselors Non-availability of space to accommodate the pastor No involvement of the family in the loss Delayed in getting treatment No follow-ups are conducted to bereaved mothers Non availability of resources	Unfavorable health facilities	
No resources No user charges Fees charged for Incineration too high compared to hospital	Economic factors	

The Negative Attitude Of The Nurses

Participants expected better care and more appropriate emotional support from the health care team. Six participants narrated that the care they received following the perinatal loss was bad as evidenced by the following interviews Mother 7 narrated that the way nurses treat people was not good as they did not take time to explain to them what was happening. They just wrote the book and asked the client to go to the hospital

. *The health personnel did not talk to any of my relatives. It's like they wrote my complaints in my book and asked me to go to the hospital*

Mother 12 who was not satisfied with the treatment she got from the nurses narrated;

They did not treat me well because when one is in pain the person must be examined. If someone calls for help she does not just call for help for nothing. I got discharged with so many questions

Health care providers need to use a range of interpersonal and clinical skills as well as being sensitive to the needs of the mothers. Many participants were dissatisfied with the care provided following the loss. In this regard mother 2 narrated that the nurse who attended to her was very rough and not paying attention to her;

….. *So the nurse who assisted during delivery was very rough as she was shouting at me and pushing me and did not*

bother to listen to what I was saying.
Mother 3 narrated that the nurse displayed a different attitude;
The nurses who were on duty when arrived were shouting unlike the ones who replaced them

Unfavorable Health Facilities
Some participants expressed dissatisfaction with the health facility as they complained of being placed beside mothers who have just given birth to a healthy, live baby. Mother 8 narrated that she did not understand why she was admitted in the same ward with mothers who had babies
I was wondering why they decided to put me in that ward where mothers were delivering their babies. They were supposed to admit me in a separate ward
Unfavorable health facilities, like waiting time to be attended to was cited by most mothers. They narrated that time taken by nurses to attend to clients was very long as such a person can die in the queue because one nurse will be attending to many patients.

Mother 7 narrated that she took a long time to be treated despite the calls by her husband that she was in pain the nurse told her to follow the queue
.....She has to join the queue all these people are also in pain, but they did not bother to look at my situation. A person can die in the queue.
Similar sentiments were echoed by mother 10 who narrated that she delayed getting treatment when she was in the queue
I delayed in the queue because I arrived at 0900hours and left the clinic at 1200 noon because the day before was a holiday maybe that's the reason why there were a lot of patients

Non-availability of space to accommodate the pastor also posed as a barrier to perinatal management as almost all the mothers wished their pastors to have been called to come and pray for them. The restrictive clinic environment with a rigid timetable to see the clients hindered the client's fulfillment of spiritual needs.

Mother 6 when asked about whether a pastor was called after the loss her reply was;
……aaaa no it was done at the mortuary
Despite the perinatal loss having been associated with stress-related problems for mothers who have undergone a perinatal loss, most mothers indicated that they did not receive any counseling services from the health workers. Lack of counseling was also of major concern as counseling services at most clinics are for HIV/AIDS issues. Ten mothers narrated that they received no counseling after they experienced a perinatal loss with only two mothers narrated that they were counseled by the nurses When asked whether she received any counseling services from health worker mother 10 narrated that;
…. Aaa I received no counseling from the healthcare staff, but my mother counseled me,

Family plays a major role in supporting the mother in times of loss and are also affected equally the same with mothers who have experienced perinatal loss, therefore, should be included in the management following a loss. Most mothers narrated that the family members were not involved in the management following perinatal loss.
Mother 5 narrated that her family was not involved in the management following the loss.
They did not talk to them unless they talked to them in private
Mother 12 narrated that the health personnel did not involve the family in the loss instead only managed to talk about the money for the baby to be incinerated
They only managed to talk about the

money for the baby to be incinerated

Economic factors

High medical expenses or imposition of unexpected costs or the lack of attention to the patient's economic situation of health workers were some causes of dissatisfaction of participants. Some mothers cited lack of user charges and money to meet hospital expenses

Mother 8 when asked why she booked her pregnancy at Harare Hospital leaving the nearest clinic, She said had no money to book the pregnancy since the clinic wanted twenty-five dollars

I booked my pregnancy at Harare Hospital because it's free

No resources at the health facility were noted by bereaved mother as a barrier to perinatal loss management. Mothers who experienced abortion narrated that they were asked to buy a pregnancy kit to confirm their pregnancies since the clinic did not have any.

Mother 9 narrated that; *they asked me to buy a pregnancy kit to check whether I had an abortion or not.* Same as Mother 11; *they told me to buy a pregnancy kit*

The imposition of unexpected costs like charges for the incineration of the baby were some causes of dissatisfaction of participants as the mother was expecting to have a live baby. After the loss mothers cited that charges demanded at Wilkins Hospital were too high compared to that charged at Hospitals and moreover, it was an expense which she did not anticipate

Mother narrated that; Charges for incineration are too much as compared to a hospital, which charges thirty dollars for the baby to be incinerated

Some mothers did not have the money for incineration so she had to ask her relatives to help her pay the charges wanted at Wilkins Hospital when they were still mourning the loss of the baby.

Mother 5 who experienced stillbirth mentioned that that her relatives had to make some contribution plus the little money they had served to pay for the charges for the incineration of the baby.

….Made some contributions with my relatives, plus the little money we had served and the baby was incinerated

Mother 12 who experienced early neonatal death, narrated that she told the nurses that she did not have the money for the baby to be incinerated as her husband was not employed

I told them that we were unable to pay the money because we did not have the money because my husband was not employed

City Clinics appeared to have no systems in place of making follow-ups to mothers who have experienced perinatal loss. All twelve mothers narrated that no one made a follow-up visit to check on them at home with some asking whether that service exists in the clinics.

Recommendations To Perinatal Management

The following were recommendations made by the mothers on the challenges they face after experiencing perinatal loss as regards to management rendered following perinatal loss.

Mother 12*; the recommendations I can give is that if someone experiences perinatal you must be admitted with other mothers where you will be talking and laughing to other mothers as that can reduce stress. You can have stress and blood pressure can rise*

Mother 6*; the recommendation I can give is nurses should talk to the bereaved mothers nicely treat well, understand her situation and provide counseling like what they did to me.*

Mother*; since I was in pain and they were saying labor was not progressing well, with the knowledge I have, when labor is not progressing as they were supposed to refer me to Harare Hospital and have a caesarean section*

Mother 1*; they have to minimize their*

shouting
Mother 8; *It was going to be better if they admitted me in a separate ward because there was a ward which was empty, seeing mothers with babies doing this and that, they would ask me the sex of my baby then I would explain to them that I had a stillbirth*
Mother 11*; the recommendation that I can give is, sin at Wilkins is the money charged is too much compared to Hospital, which charges thirty dollars, if they can reduce the charges for someone who has lost the baby*
Mother 5*; my advice is that nurses must sit down with bereaved mothers and explain to her in a manner that she will understand*
Mother 7*; I think if they can take their time talking to you then just write your book. If they can write the book, then explain to you or offer to counseling*
Mother 9*; my recommendation that they must treat clients well taking into consideration the loss. They must not be rough to one who has experienced a loss.*

SUMMARY DISCUSSION IMPLICATIONS AND RECOMMENDATIONS

This section focused on the discussion of the findings and analysis in relation to literature, theoretical framework to address the objective of the study, which was the perceptions of postnatal mothers regarding management following perinatal loss. Throughout the study, theoretical framework which is a holistic nursing theory which focuses on healing the person in totality was integrated. It further identified recommendations for the provision of quality care to postnatal mothers who have experienced perinatal loss

Purpose of the study

The aim of the study was to explore the perceptions of postnatal mothers regarding management following the perinatal loss with regards to the quality of care rendered to them, so as to have an in-depth understanding on how they perceived the care in an effort of improving care.

DISCUSSION OF FINDINGS

Demographic Characteristic

Twelve in-depth interviews were conducted with mothers who experienced perinatal loss and one key informant so as to get information on the phenomena of how the mothers perceived the care rendered to them by health workers. The key informant was a Midwife working in one of the selected Council clinics.

The study demographics included age, which ranged from twenty-one to thirty-seven years with the majority of them being under thirty years. In the study, it was noted that young mothers especially the first-timers were most affected by the loss as all hopes of holding a baby was lost and more so immature to understand the impact of loss. The parity of the participants ranged from zero to four children per participant with the majority of them having two children and above. Almost all participants in the study were unemployed with the majority of them facing challenges to meet hospital expenses. In the study, it was revealed that the majority of the participants were married according to the customary law of Zimbabwe with only one participant who was a divorcee. It was noted that the majority of women got social support from the husband and relatives hence the impact of the loss was less marked as the women had someone to share her problems with. The findings concur with the literature found by (Sutan et al., 2010) in the study on the psychosocial impact of mothers with perinatal loss and its contributing factors which revealed that having good emotional support after the stillbirth may protect the woman from post-traumatic disorders. From my own point of view, it is important that following perinatal loss

the women must be provided with social support as this helps the woman to cope with the stress. The researcher noted that it is important that health workers be trained in bereavement counseling to enable them to provide social support to bereaved mothers to combat psychological problems.

The majority of the mothers in the study were Christians with one participant who was a non-Christian. Christianity has been found to help mothers relocate the baby to God where there is eternal life and Christians have the belief that one day they will reunite with the baby. Religious beliefs allowed the women to metaphysically relocate the babies to other realms like Paradise or God's hands (Tseng et al., 2014). Because of Christianity, some bereaved mothers believed that their babies not only existed in another way but also were being cared for in the spiritual world Data analysis highlighted two major themes, several subthemes and recommendations from the postnatal mothers interviewed. The first theme was facilitating factors which were found to enhance the provision of quality care to postnatal mothers following perinatal loss with its sub-themes, positive attitude of nurses and support systems. The second theme was of barriers in the management of perinatal loss management with its three subthemes negative attitudes from the nurse, unfavorable health facilities and economic factors. Lastly, recommendations made by the postnatal mothers who experienced perinatal loss.

Facilitating Factors

Facilitating factors were some of the major factors which emanated from the study. The theme came from the objective of the study, which was to explore the perceptions of postnatal mothers regarding management following perinatal loss. Under facilitating factors sub themes identified were, positive attitude of nurses and support systems for the family and others. The study revealed that following perinatal loss mothers recalled in detail the events and experiences the woman went through after the loss leading to one of the themes of facilitating factors in the management of perinatal loss by health workers.

The Positive Attitude Of Nurses

From the study, it was discovered that positive descriptions were given of individual nurses who displayed positive attitudes towards the mothers who had experienced perinatal loss. The study highlighted that nurses reassured the mothers and managed to provide counseling services to the family. The sensitivity and support of the nursing staff were frequently mentioned in the study. The findings agree with the study conducted by (Sanchez, 2001) in major hospitals where several positive accounts were given to individual nurses completing nurturing tasks in a major hospital. Nurses were described in the study as people who were very caring, sensitivity, understanding and apologetic thereby expediting their recovery process. This was supported by Red shaw & Henderson , (2018) who noted in the study that mothers reported that nurse wer kind and respectful. This has been noted to facilitate grieving process and help the mother to cope with stress positivelt.

The above findings also concur with a study that was conducted by (Sereshti et al., 2016b) on mother's perceptions of quality of services from health centers after perinatal loss where some participants expressed satisfaction with regards to their dignity where the health workers' attitude was noted to be good as they managed to calmly break the news of loss in privacy.

The researchers point of view is that despite perinatal having devastating effects to the mother, it has been noted when the mother is provided with quality care, that

can help the mother cope with the stress well and recover quickly. The health workers were implored to have a sensitivity approach in the way they render care to women who have experienced perinatal loss so as to minimize the trauma of perinatal loss.

Health workers generally are considered as a professional who should be offering passionate care to mothers who have experienced perinatal loss. In this study, the mothers mentioned some positive comments regarding physical care aspects where some mothers narrated that they were given tablets for pain relief by health workers and frequently checked their condition when they were still admitted in the ward. These findings are similar with what (Richards et al., 2015) revealed in his study of mothers perceptions on the perinatal loss of co-twin where mothers placed a high value on their relationship with those staff members who offered emotional support and the relationship had a major impact on their experience in the hospital.

Supporting systems

The impact of support systems was highlighted in the study as it forms an integral part of the management of women after experiencing perinatal loss to prevent the occurrence of psychological problems. The study established that some participants indicated that they were satisfied with the emotional support they received from the health workers. Some few mothers narrated that health workers managed provide to psychological support to the family as they managed to explain what had happened to the husband and the family. Under this subtheme, the women expressed lots of issues which included the provision of counseling services despite the nurse's workload some health workers managed to provide counseling services to the bereaved mothers These study findings concur with a systematic review of parents' experiences with health providers conducted by (Gold, 2007). The study revealed that nurses were generally perceived as the care provider most likely to provide emotional support and parents had a chance to discuss their feelings with the nurses which were helpful. From the researcher of point, social support system has been found to add value to the grieving mother as it allows the mother to verbalize her concerns thereby reducing the time taken by the mother to come to terms with the loss.

The study findings also highlighted that bereaved mother's sort of support from Pastors and church mates. It was indicated in the study that religious societies were perceived as support centers with rich social support and participation in these societies were noted to help mothers process and and accept their loss and ultimate view of life. Tseng et al., (2014) noted that religious beliefs allowed the women to metaphysically move the babies to other kingdoms like Paradise or God's hands where the baby was kept safe and one day would reunite with the mother. The researcher believes that health workers should incorporate and respect the spiritual aspect of the mother who has experienced perinatal loss as this was found to be vital in the management of bereaved mother.

In the study it was reported that some mothers expressed satisfaction with the hospital facilities with regards to where they were admitted following perinatal loss. Some mothers appreciated being admitted in a separate ward where they were not seeing mothers breastfeeding their babies. Similar findings were noted by Ellis et al., (2016) from a study of the findings of systematic review to understand and improve care after stillbirth, the study revealed that some parents appreciated the availability of private rooms that were situated away

from the main maternity where mothers could not hear the voices of babies crying or see mothers breastfeeding their babies. However, this researcher noted that some mothers preferred to be admitted in the same ward with the mothers who had live babies as they cited that being alone in a room deepened their grief.

BARRIERS TO PERINATAL LOSS MANAGEMENT

The second theme derived from data analysis was that of barriers to perinatal loss management. Three sub-themes identified under this theme were negative attitudes of nurses, unfavorable health facilities and economic factors. Participants were posed questions that asked them how they perceived the care rendered following the perinatal loss

The Negative Attitude Of The Nurses

Healthcare providers are at the forefront of supporting bereaved mothers following perinatal loss. It has been noted that proper management, good communication and being sensitive to the bereaved mothers concerns after perinatal loss is crucial, as it helps to reduce the risk of psychological problems.

The study findings indicated that some participants were not content with the attitude displayed by the health workers when they experienced perinatal loss. Some participants noted that, some health workers were not paying attention to their concerns as they ignored them when they were calling for assistance during labor. Some narrated that the health workers were rough and shouting at them and there was no provision of counseling services to the clients after the loss. These findings are similar to those found by Sutan et al., (2010) who indicated the majority of the mothers received emotional support from the parents , friends and siblings which came through encouragement and counseling.

These findings are similar to those found by (Meaney et al., 2017). The study discovered that the experience of miscarriage had a huge effect on men and women hence the need to also involve the man in the management of the women following perinatal loss. This study went on to include men which was found to be good as the researcher was able to assess the impact of loss from both parents unlike in this study where the researcher collected data from the mothers only. The researcher believes there is need for training of health workers on good customer care to improve the quality of care rendered to the women following perinatal loss.

In this study, it was discovered that mothers had no access to a social worker, psychologist or bereavement counselor due to a lack of these personnel in most clinics with only a small number of participants receiving counseling services from the health workers. These study findings concur with what (Kersting & Wagner, 2012) revealed in their study that only a small number of the women received routine counseling and routine follow up following perinatal loss. In view of this, the researcher trust if health workers are trained in bereavement counseling that will go a long way in helping the mother, as City Council clinics do not employ psychologist or social workers who provide these services.

Evidence suggests that such an experience can make the women negatively perceive the management rendered as poor. Similar sentiments were echoed by a study that was carried by Siassakos, (2018) on all bereaved parents who are entitled to good care after stillbirths. The study revealed that the care rendered to the bereaved woman was poor as there was no good communication between bereaved parents and staff.

Unfavorable health facilities

Some participants expressed dissatisfaction with the care rendered to

them following perinatal loss regarding unfavorable health facilities. Important negative findings as regards to the unfavorable health facilities indicated in the study involved among other things long waiting time to be informed about the loss or waiting for a long time before getting treatment especially to those who had experienced abortion.

These findings are similar to those found by Siassakos, (2017) in his study on all bereaved parents who are entitled to good care after stillbirths that there was no standard approach to how care was given. Sometimes there were long delays before the death of the baby was confirmed. After it had been confirmed that the baby had died, it was noted the staff focused on the mothers' needs, but the parents' priorities were still with their baby. In such instances health workers were blamed for the delay, but at times it is not her fault. The researcher noted that nurse patient ratio was not adequate as all clinics were understaffed.

Study findings revealed that all participants indicated that no follow-up visits were conducted after experiencing perinatal loss because of rigid systems of the health facilities. Mothers indicated that they expected the health workers to visit them at home to check on how they were coping after the loss because most of them had some issues which wanted to be addressed by health workers. Issues like the method of family planning to use, when to get pregnant after the loss and what might have caused the loss were some of the issues mothers expected to be addressed by health workers. The findings are similar to those found by (Sereshti et al., 2016b) in a study of mothers' perceptions of quality of service from health centers after perinatal loss.

The researcher indicated in the study that the participants were dissatisfied with the care provided after the loss as they were no follow up visits that were conducted after the loss. The researcher believes that follow up visits are very vital part of the management of the women following perinatal loss as most mothers had indicated in the study that during the conduct they can express their concerns and ask some questions they were unable to ask soon after losing the pregnancy.

The researcher established that some mothers were dissatisfied with inadequate resources at the clinics pertaining to the infrastructure. The study findings indicated that mothers narrated that in some instances they were mixed with mothers who had delivered live babies, which was very traumatic to them as they kept on asking themselves as to why they had experienced perinatal loss. (Sereshti et al., 2016b) found out that most participants were dissatisfied with the setup of some hospital wards as voices of the newborn babies crying could hear and happiness of families who had healthy babies affecting the mother who had experienced perinatal loss.

The researcher noted with concern that health workers have to be sensitive, accommodating as well as the aspect of involving the family in the management of the mother who has experienced perinatal loss as they are also equally affected by the loss In view of the spiritual aspect of the bereaved mothers, it was noted in the study that the majority of the participants wished their pastors were summoned to come and pray for them and the body before taken to the mortuary. Religious individuals tend to feel more satisfied with life and experience lower levels of depression and have a more positive perception about life and in particular support services offered by others to them.

ECONOMIC FACTORS

The study established that due to economic

hardships faced by participants, some of them failed to get money to meet hospital expenses. One participant had to book her pregnancy at Harare Hospital because it's free leaving the nearest clinic which was demanding twenty-five dollars to book the pregnancy. In a study that was conducted in Zimbabwe in 2016 on the severity and management of post-abortion complications among women, it was noted that Post Abortal Services were not offered in most primary health centers which are more accessible to most urban and rural women. The higher level facilities where it was found the cost of the service was high. (Madziyire et al., 2016).

The study also established that mothers were concerned with high charges demanded at Wilkins where babies are sent in preparation for incineration. They indicated that the charges were too exorbitant and beyond the reach of many. Some mothers had to ask their relatives to make some contribution to raising the money needed for the hospital expense at the same time mourning the loss of their baby

IMPLICATIONS

Implications To Midwifery Practice

The study findings in this research indicated that midwives' negative attitude towards the mothers who had experienced perinatal loss impacted negatively psychologically to the mothers. The study revealed that health workers need to be sensitive to the bereaved mother's plight, provide counseling services and involve their families in the management and conduct follow up visits to mothers who had experienced perinatal loss

Implications for Midwifery Education

The study is going to inform the educators about the value of research so as to enable them to assist the students and also to assess the students on exposure to research. It will inform the nurse educators in helping the student to view the patient in her totality incorporating the four central concepts of person, nursing, environment, and health. Nursing education should emphasize on the totality of the patient, hence must not be treated in isolation. The mother who has suffered a perinatal loss has to be viewed in terms of psychological wellbeing, physical well-being, social and spiritual well-being.

The implication to Midwifery Administration

This study is going to inform the administration in relation to providing human resources to address the problems of shortage of staff in the clinics to enable the staff to provide quality care as most mothers indicated that some delays were being caused by a shortage of staff. It is going to inform the administration in terms of procuring material resources like pregnancy test kits as the mothers were being asked to go and buy the pregnancy kits to confirm the presence of the pregnancy. In terms of the infrastructure, the study is going to inform the administration to build infrastructure which can accommodate the bereaved mothers as some of them complained that they were admitted in the same ward with mothers who had live babies which found to be very traumatic. The study is also going to inform the midwifery administrators to consistently supervise or monitor the quality of care rendered to mothers after the perinatal loss and to quickly identify and address the problems being faced by mothers who have experienced perinatal loss. On job training and refresher courses on good customer care to health workers will ensure provision of quality care. The study is going to inform the midwifery administration to avail care protocols to the midwives to enable them to provide comprehensive management to mothers who have experienced perinatal loss and the care to be uniform in all council

hospitals and hospitals.

The implication to Midwifery Research

The study is going to inform the administrators the value of research in the clinical area in terms of generating new information that could be utilized by the health workers on the management of mothers who have experienced perinatal loss in terms of psychological aspect, social aspect, spiritual aspect, and physical aspect. The research will serve as a base for coming up with interventions for women who have experienced perinatal loss. The study implies a need for more researches to be done on perinatal loss on how it affects the health worker when the mother loses a baby so as to improve the management offered to bereaved mothers.

Policymakers

The study outlined some vital information that needs to be included in the policies concerned with the provision of quality care to mothers who have experienced perinatal loss. There is a need to formulate guidelines on how to provide care of mothers who have experienced perinatal loss to enable health workers to provide comprehensive care to bereaved mothers. In the policy, emphasis should place the involvement of the family, counseling sessions for bereaved mothers and, follow up visits to check on how the mothers are coping at home. This will go a long way in reducing stress-related problems encountered by the mothers following perinatal loss.

The strength of the study

The strength of this study was that it focused on an in-depth way on the impact of perinatal loss for bereaved mothers using qualitative methodology to reveal the perceptions of the postnatal mother regarding management following perinatal loss. These findings have weight beyond the samples studied and can contribute priceless insight for clinicians caring for parents who experienced perinatal loss.

Limitations of the study

The study was carried out in three City Clinics, although they experience high rates of perinatal loss, this may make generalization of results to other clinics and hospitals in Zimbabwe difficult. The data were based on the narration of sensitive issues through face to face interviews. The time to conduct the research was limited and the researcher faced financial problems.

RECOMMENDATIONS

Based on the research findings and conclusion the researcher made the following recommendation The provision of appropriate information on what might have caused the perinatal loss in a manner that the bereaved mother would understand.

The researcher recommends the involvement of the family in the management of the mother following the perinatal loss, as the loss has the potential to have a large negative impact on the family as well as.

City of Harare Directorate to reconsider its midwives establishment in the maternity department and health centers to match with the growing population in need of maternity services in its clinics to enable them to efficiently provide comprehensive management.

In-service training of midwives or refresher courses on current topics pertinent to midwifery issues, especially in customer care and bereavement counseling in order to improve the care rendered to mothers following perinatal loss.

Large scale research using qualitative methods involving major hospitals to try and understand how mothers perceive the management rendered following a perinatal loss when they are admitted in

the central hospitals City of Harare to provide the appropriate infrastructure that can accommodate bereaved mother in terms of privacy issues and to make a provision for the church Pastor in the event that the woman may wish her pastor to come and pray for her The recommendations will go a long way in assisting the health workers in the provision of comprehensive care to mothers who have experienced perinatal loss.

CONCLUSION

A conclusion made from the study, limitations, and implications of the study to midwifery practice, research, midwifery administration, and midwifery education. From the research findings, two major themes, several subthemes were identified from the study and recommendations from bereaved mothers. The first theme identified was facilitating factors that enhance the management of postnatal mothers following the perinatal loss with its sub-themes, positive attitude of nurses and support systems from the family and others. Under the theme facilitating factors positive attitudes, several positive accounts were highlighted of individual nurses who displayed positive attitudes as bereaved mothers expressed satisfaction with the treatment they received from the health workers. The study highlighted that nurses provided emotional support to mothers and managed to provide counseling services to the family. Sensitivity and support of the nursing staff were frequently mentioned The second theme was of barriers in the management of perinatal loss management with its three subthemes negative attitudes from the nurse, unfavorable health facilities and economic factors. Study findings indicated that some participants were not content with the attitude displayed by the health workers when they experienced perinatal loss as they were noted to be insensitive and not paying attention to their concerns. The study findings indicated that only a small number of participants received counseling and health workers did not manage to involve the family in the management of the mother following perinatal loss. The health facilities were noted to have no provision to accommodate the Pastor to come and pray for the bereaved mothers and no follow up visits were conducted to check on how the mothers were coping at home after being discharged

ACKNOWLEDGMENT

I would like to give glory to God for guiding me till the completion of this study. My gratitude goes to the study participants who, despite experiencing perinatal loss and in their grief were free to make meaningful contributions to this study. Their cooperation is indeed greatly appreciated. My sincere gratitude goes to Mrs. Nyamakura the Chairperson of the Nursing Department and all the lecturers at the University of Zimbabwe, Department of Nursing Science for their constant guidance and encouragement. I am greatly indebted to Sister Gladys Vincent Mugadza, my supervisor for her unwavering support, patience, and guidance. She accommodated me despite her very busy schedule at her workplace. May God continue to give her more strength and wisdom.

I would also like to acknowledge and register my sincere thanks to the Director of Health Services Dr. Chonzi and my Nursing Manager, Mrs. Chitando for granting me a study leave to pursue my Master's degree and giving me the permission to carry out my study in the three selected City of Harare Clinics. May God richly bless them Special thanks go to the Joint Research Ethics Committee (JREC) and the Medical Research Council of Zimbabwe (MRCZ) for approving my research proposal. To my friends Abygail Mudege, Ester Jaravaza and Barbra Bikwa I just want to say thank you for the support and encouragement.

REFERENCES

1. Abiola, A. O., Ajayi, A., Umeh, C. S., Adegbesan-Omilabu, M. O., Olufunlayo, T. F., &Akodu, B. A. (2013). Knowledge, prevalence and psychological effect of miscarriage among women of reproductive age group attending obstetrics and gynaecology Clinics of Lagos University *Teaching Hospital, Nigeria.The Nigerian postgraduate medical journal, 20(4), 319-324.*
2. Allahdadian, M., & Irajpour, A. (2015). The role of religious beliefs in pregnancy loss. *Journal of Education and Health Promotion*, *4*.M., Unkels, R., Mdegela, M., Utz, B., Adaji, S., & Van
3. Bakker, J. K & Paris. (2013) Bereavement and religion online stillbirths neonatal loss parental religiosty perspective *Journal for the scientific study of relgion Mothers perspectives on the perinatal loss of a co twin;* a qualitative study Judy Richards, Ruth Graham , Nicholas D Embleton Claire Campbell and Judith Rnakin BMC Prganacy and Childbirth 210515;14
4. Den Broek, N. (2014). Causes of and factors associated with stillbirth in low-and middle-income countries: a systematic literature review. *BJOG: An International Journal of Obstetrics & Gynaecology*, *121*, 141–153.
5. Cacciatore, J., Schnebly, S., & Froen, J. F. (2009). The effects of social support on maternal anxiety and depression after stillbirth. *Health & Social Care in the Community*, *17*(2), 167–176.
6. Centers for the disease control and prevention 2017*Facts about Stillbirth https://www.cdc.gov/ncbddd/stillbirth/facts.html*
7. Creswell, J. (2013) Qualitative inquiry and research appraisal , choosing among five approaches , Thousand Oaks,CA;Sage
8. Dellicour, S., Desai, M., Mason, L., Odidi, B., Aol, G., Phillips-Howard, P. A., … ter Kuile, F. O. (2013). Exploring risk perception and attitudes to miscarriage and congenital anomaly in rural Western Kenya. *PLoS One*, *8*(11), e80551.
9. Ezechi, O. C., & David, A. N. (2012). Overview of Global Perinatal Mortality. In *Perinatal Mortality*. InTech.
10. Flenady, V., Boyle, F., Koopmans, L., Wilson, T., Stones, W., & Cacciatore, J. (2014). Meeting the needs of parents after a stillbirth or neonatal death. *BJOG: An International Journal of Obstetrics & Gynaecology*, *121*, 137–140.
11. Gijzen, S., L'Hoir, M. P., Boere-Boonekamp, M. M., & Need, A. (2016). How do parents experience support after the death of their child? *BMC Pediatrics*, *16*(1), 204.
12. Gold, K. J., Dalton, V. K., & Schwenk, T. L. (2007). Hospital care for parents after perinatal death. *Obstetrics & Gynecology*, *109*(5), 1156–1166.
13. Heazell, A. E., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., … Gold, K. J. (2016). Stillbirths: economic and psychosocial consequences. *The Lancet*, *387*(10018), 604–616.
14. Wonch Hill, P., Cacciatore, J., Shreffler, K. M., & Pritchard, K. M. (2017). *The loss of self: The effect of miscarriage, stillbirth, and child death on maternal self-esteem. Death studies*, *41*(4), 226-235.
15. Human, M., Green, S., Groenewald, C., Goldstein, R. D., Kinney, H. C., & Odendaal, H. J. (2014*). Psychosocial implications of stillbirth for the mother and her family: A crisis-support approach. Social Work, 50(4), 563-580*
16. Johnson, B., & Christensen, L. (2008). *Educational research: Quantitative, qualitative, and mixed approaches*. Sage.

17. Kassar, S. B., Melo, A. M. C., Coutinho, S. B., Lima, M. C., & Lira, P. I. C. (2013). Determinants of neonatal death with emphasis on health care during pregnancy, childbirth and reproductive history. *Jornal de Pediatria*, *89*(3), 269–277. https://doi.org/10.1016/j.jped.2012.11.005
18. Kersting, A., & Wagner, B. (2012). Complicated grief after perinatal loss. *Dialogues in Clinical Neuroscience*, *14*(2), 187.
19. Kingdon, C., O'Donnell, E., Givens, J., & Turner, M. (2015). The Role of Healthcare Professionals in Encouraging Parents to See and Hold Their Stillborn Baby: A Meta-Synthesis of Qualitative Studies. *PLOS ONE*, *10*(7), e0130059. https://doi.org/10.1371/journal.pone.0130059
20. Leon, I. G. (2008). Helping families cope with perinatal loss. *The Global Library of Women's Medicine*.
21. Machado, C. J., & Hill, K. (2005). Maternal, neonatal and community factors influencing neonatal mortality in Brazil. *Journal of Biosocial Science*, *37*(2), 193–208.
22. MCHIP, (2017). *Assessment of Maternal and Perinatal Death Surveillance and Response Implementation in Zimbabwe*
23. Meaney, S., Everard, C. M., Gallagher, S., & O'donoghue, K. (2017). Parents' concerns about future pregnancy after stillbirth: a qualitative study. *Health Expectations*, *20*(4), 555–562.
24. Moule, P,.& Goodman, M. (2014).*Nursing Research*,2nd edition.Sage, Los Angeles :London
25. Mutiso, S. K., Murage, A., & Mukaindo, A. M. (2018). Prevalence of positive depression screen among post miscarriage women-A cross sectional study. *BMC Psychiatry*, *18*(1), Ncube, N., &Ticharwa, A. (2017). *"My Fruits Never Ripen": Risk Factors of Anxiety among Zimbabwean Married Childless Women with Recurrent Miscarriages. International Journal of Innovative Research and Development*,*6*(3).
26. Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description–the poor cousin of health research? *BMC Medical Research Methodology*, *9*(1), 52.
27. Ngwenya. S, (2018). Stillbirth rate and causes in low- resource setting, Mpilo Central Hospiatal. Bulawayo.Zimbabwehttp;//journals.sagepub.com/doi/abs/10.1177/0049475518789030?jounalCode=tdoa
28. Obi, S. N., Onah, H. E., & Okafor, I. I. (2009). Depression among Nigerian women following pregnancy loss. *International Journal of Gynecology & Obstetrics*, *105*(1), 60–62.
29. Owolabi, O. O., Cresswell, J. A., Vwalika, B., Osrin, D., & Filippi, V. (2017). Incidence of abortion-related near-miss complications in Zambia: cross-sectional study in Central, Copperbelt and Lusaka Provinces. *Contraception*, *95*(2), 167–174
30. Petiprin, Alice. (2016), *Holisticnursing.nursing-theory.org/theories-and-models/holistic-nursing*www.nursing-theory.org/theories-and-models/holistic-nursing.php
31. Polis, C. B., Mhango, C., Philbin, J., Chimwaza, W., Chipeta, E., & Msusa, A. (2017). Incidence of induced abortion in Malawi, 2015. *PLOS One*, *12*(4), e0173639.
32. Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence fornursing practice.* Wolters Kluwer/Lippincott/Williams Wilkins Health, Philadelphia, PA, USA,.
33. Polit, Denise F, & Beck, C. T. (2015). *Essentials of nursing research:*

appraising evidence for nursing practice.

34. Richards, J., Graham, R., Embleton, N. D., Campbell, C., & Rankin, J. (2015). Mothers' perspectives on the perinatal loss of a co-twin: a qualitative study. *BMC Pregnancy and Childbirth*, *15*(1). https://doi.org/10.1186/s12884-015-0579-z
35. Sanchez, N. A. (2001). Mothers' Perceptions of Benefits of Perinatal Loss Support Offered at a Major University Hospital. *The Journal of Perinatal Education*, *10*(2), 23–30. https://doi.org/10.1624/105812401X88165
36. Sereshti, M., Nahidi, F., Simbar, M., Ahmadi, F., Bakhtiari, M., & Zayeri, F. (2016a). Mothers' perception of quality of services from health centers after perinatal loss. *Electronic Physician*, *8*(2), 2006.
37. Sereshti, M., Nahidi, F., Simbar, M., Ahmadi, F., Bakhtiari, M., & Zayeri, F. (2016b). Mothers' Perception of Quality of Services from Health Centers after Perinatal Loss. *Electronic Physician*, *8*(2), 2006–2017. https://doi.org/10.19082/2006
38. Siassakos, D., Jackson, S., Gleeson, K., Chebsey, C., Ellis, A., Storey, C., ..& Hillman, J. (2018*). All bereaved parents are entitled to good care after stillbirthBJOG: An International Journal of Obstetrics &Gynaecology, 125(2), 160-170*.
39. Simpson, C., Lee, P., & Lionel, J. (2015). *The effect of bereavement counseling on women with psychological problems associated with late pregnancy loss. Journal of Asian Midwives (JAM)*, *2*(2), 5-20.
40. Sully, E. A., Madziyire, M. G., Riley, T., Moore, A. M., Crowell, M., Nyandoro, M. T., … Chipato, T. (2018). Abortion in Zimbabwe: A national study of the incidence of induced abortion, unintended pregnancy and post-abortion care in 2016. *PloS One*, *13*(10), e0205239.
41. Sutan, R., Amin, R. M., Ariffin, K. B., Teng, T. Z., Kamal, M. F., & Rusli, R. Z. (2010). Psychosocial impact of mothers with perinatal loss and its contributing factors: an insight. *Journal of Zhejiang University SCIENCE B*, *11*(3), 209–217.
42. Tachiweyika, E., Gombe, N., Shambira, G., Chadambuka, A., Mufuta, T., & Zizhou, S. (2011). Determinants of perinatal mortality in Marondera district, Mashonaland East Province of Zimbabwe, 2009: a case control study. *The Pan African Medical Journal*, *8*, 7. Profile treehttps;//www.profiletree.com/what-is-content-analyisis/ 2017
43. Tommy's 2017*Physical effects of a stillbirth*https://www.tommys.org/pregnancy-information/.../stillbirth/physical-effects-stillbirth
44. Tseng, Y.-F., Chen, C.-H., & Wang, H.-H. (2014). Taiwanese women's process of recovery from stillbirth: a qualitative descriptive study. *Research in Nursing & Health*, *37*(3), 219–228.
45. Tulandi, T., & Al-Fozan, H. M. (2011). Spontaneous abortion: Risk factors, etiology, clinical manifestations, and diagnostic evaluation. *UpToDate*.
46. UNICEF, (2018) neonatal mortality *https://data.unicef.org/topic/child-survival/neonatal-mortality/*
47. Upadhyay, R. P., Dwivedi, P. R., Rai, S. K., Misra, P., Kalaivani, M., & Krishnan, A. (2012). Determinants of neonatal mortality in rural Haryana: a retrospective population based study. *Indian Pediatrics*, *49*(4), 291–294.
48. Usynina, A. A., Grjibovski, A. M., Krettek, A., Odland, J. Ø., Kudryavtsev, A. V., & Anda, E. E. (2017). Risk factors for perinatal mortality in Murmansk County, Russia: a registry-based study. *Global Health Action*, *10*(1), 1270536.
49. Wright, P. M. (2017). Perinatal Loss

and Spirituality: A Metasynthesis of Qualitative Research. *Illness, Crisis & Loss*, 105413731769866. https://doi.org/10.1177/1054137317698660

50. World Health Organisation, (2018), *Maternal, newborn, child and adolescent health http;//www.int/maternal child adolescent/epidermiology/stillbirths/en/*
51. World Health Organisation (2014), *Maternal, newborn child and adolescent health http;//www.int/maternal child adolescent/epidermiology/stillbirths/en/*
52. Zimbabwe 2015 Demographic and Health Survey Births and Individual https://dhsprogram.com/data/dataset/Zimbabwe_Standard-DHS_2015.cfm

Cite this Article as:
Shila Matsikwa. (2019). Perceptions Of Postnatal Mothers Regarding Perinatal Loss Management By Health Workers In The City Of Harare Zimbabwe. Journal of Nursing Research, Education and Management (e-issn: 2582-001X), 1(2), 19–56.
http://doi.org/10.5281/zenodo.3346242