

EXPLORING MIDWIVES' EXPERIENCES OF
MANAGING PATIENTS' PERINATAL LOSS AT A
MATERNITY HOSPITAL IN THE WESTERN
CAPE, SOUTH AFRICA

MELISSA GRACE WILLIAMSON

Student number: 2445955



A mini-thesis submitted in partial fulfilment of the requirements for the degree of Magister Curationis in the Faculty of Community and Health Sciences, School of Nursing, University of the Western Cape.

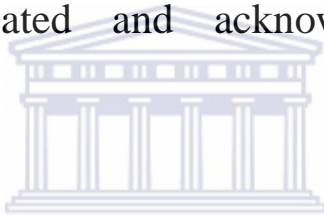
Supervisor: Prof H. Julie

Co-Supervisor: Ms. E. Kearns

May 2016

DECLARATION

I declare that Exploring Midwives' Experiences Managing Patients' Perinatal Loss at a Maternity Hospital in the Western Cape, South Africa is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources I have used and quoted have been indicated and acknowledged as complete references.



Melissa Williamson UNIVERSITY of the
WESTERN CAPE

Signed.....

May 2016

EXPLORING MIDWIVES' EXPERIENCES OF MANAGING PATIENTS' PERINATAL LOSS AT A MATERNITY HOSPITAL IN THE WESTERN CAPE, SOUTH AFRICA

Melissa Grace Williamson

KEYWORDS

- Bereavement
- Maternity hospital
- Midwife
- Neonatal death
- Perinatal loss
- Phenomenology
- Pregnancy
- Stillbirth
- Qualitative research



DEFINITION OF CONCEPTS

Bereavement

“Bereavement describes the entire experience of family members and friends in the anticipation of death and subsequent adjustment to living following the death of a loved one” (Christ et al. 2003: 554).

Maternity hospital

A hospital that provides help and medical care to women when they are pregnant and when they give birth (www.collinsdictionary.com).

Midwife

A person qualified to practice midwifery, having received specialised training in obstetrics and childcare (Forlex Partner Medical Dictionary 2012).

Neonatal death

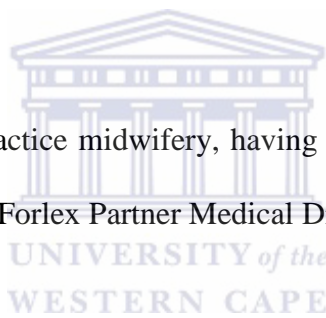
Loss occurring from time of birth to 28 days of life (Kelly & Lopez 2012).

Perinatal loss

The non-voluntary end of a pregnancy from conception, during pregnancy, and up to twenty-eight days of the newborn’s life (Kelly & Lopez 2012).

Pregnancy

The nine months or so for which a woman carries a developing embryo and fetus in her womb – is for most women a time of great happiness and fulfillment (WHO 2016).



Phenomenology

A philosophic attitude and research approach. Its primary position is that the most basic human truths are accessible only through inner subjectivity, and that the person is integral to the environment (Flood 2010).

Stillbirth

Late pregnancy loss that occurs after more than 20 weeks' gestation (Kelly & Lopez 2012).

Qualitative research

Methods such as participant observation or case studies, which result in a narrative, descriptive account of a setting or practice. (Parkinson & Drislane 2011).



DEDICATION

This study is dedicated to my wonderful husband, Robin, and our beautiful daughter Isabella Williamson and my mother Johanna Kloppers whom experienced two perinatal losses. All that I am, all that I have accomplished is because of your trust and support.



ACKNOWLEDGEMENTS

To the Almighty whom I serve, thank you for installing in me a sense of faith that I would achieve this completion of my studies. It has been a long journey and I could not have done this if it was not for the blessings bestowed on me.

To my husband Robin Williamson, you have been my pillar of strength, thank you for always being there, there are no words that can express my appreciation. To my daughter, you are too young to know, but thank you for allowing mommy to be away from you to study.

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I would at this time also give a huge thank you to Prof Hester Julie for your excellent and professional guidance who continued to nurture me in the last few weeks of submission. You have been a Godsend because I believe God had sent you to help me at this point of my life where I thought all was lost. I cannot express what it meant to have you only a phone call away and always available, so I thank you.

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Thank you to Nicolette Johannes, the postgraduate administrator at the School of Nursing for always listening to my complaints, sorting out problems and just being extremely helpful.

ABSTRACT

Perinatal deaths are emotion-laden events not only for the mothers, but also for physicians and midwives. Hence, mothers experiencing the phenomenon need support to overcome the experience. If the loss occurs in a health institution, the responsibility of supporting the woman is borne by healthcare providers, particularly midwives. However, limited information exists on how midwives manage patients who experience perinatal loss in health institutions.

Consequently, this study on midwives' experiences of managing patients' perinatal loss at a maternity hospital in the Western Cape, South Africa was conducted. The aim of the study was to explore midwives' management of patients with perinatal loss. The study utilised a qualitative research design and employs a phenomenological approach. Purposive sampling was used to select eight registered midwives to participate in the study. Data was collected by means of in-depth unstructured interviews, which were audio-recorded. It was then analysed by utilising Colaizzi's (1978) steps of phenomenological data analysis.

Four themes emerged from the data, namely, knowledge of perinatal loss, challenges when managing patients, managing perinatal loss, and getting emotionally involved. Themes were informed by several subthemes. In addition, implication on practice indicates that improving support to mothers with pregnancy loss requires a multi-disciplinary approach or teamwork from various professionals in order to enhance mutual collaboration between families and healthcare workers.

The study concludes that nursing education programmes should be reviewed to ensure that they include midwives' needs in the area of managing clients

experiencing a perinatal loss. Hence, student midwives should be given more clinical experience of caring for bereaved couples under supervision, as well as compassionate support, which would assist them to develop these skills before they graduate.

May 2016



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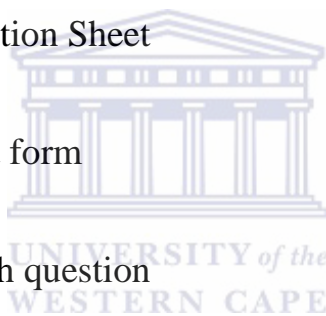
Appendix B: Consent form

Appendix C: Research question

Appendix D: Letter for permission to conduct study

Appendix E: Ethics clearance letter

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1. INTRODUCTION

This chapter provides an overview of the study. Being a phenomenological study, motivation for conducting the study is presented. Background information on perinatal loss, a problem statement, purpose, as well as the objectives of the study are provided. Key concepts are defined, which is then followed by a layout of the chapters.

1.2 BACKGROUND TO THE STUDY

The image of motherhood is culturally advertised as a synonym for success. Hence, pregnancy is a very special time for many women (Maria 2011). However, in certain instances some pregnancies end in loss, resulting in the experience changing from a happy event to a sad occurrence. Throughout the 1980s, quantitative investigations conducted in United States of America, Canada, Great Britain, Sweden and Australia demonstrated that perinatal loss in the Western world was considered a major loss for family members, which led to intense grieving (WHO 1999). The parents may not understand what has happened and the mother may feel responsible for the tragedy.

Perinatal losses are sometimes unavoidable and could be ascribed to idiopathic causes. According to the World Health Organisation (WHO),

intra-uterine deaths occur in 1% of all pregnancies worldwide (2006). The perinatal health outcomes of South Africa are poor because 23,547 babies die annually before or shortly after birth in hospitals (Department of Health 2012). The reported stillbirth rate (SBR) is 18 per 1000 live births and the neonatal mortality rate (NMR), 21 per 1000 live births. This translates to 22,000 mothers experiencing perinatal loss annually (Department of Health 2012). However, a secondary maternity referral hospital in the Western Cape Metropole, reported an average of 180 perinatal deaths per year. The reported NMR at the same health facility was 78 per 1000 live births and the SBR was 167 per 1000 live births for the period 2009 to 2010 (Mowbray Maternity Hospital 2010).

Perinatal loss includes both stillbirths and early neonatal deaths (infants that are alive at birth but die within seven days after the delivery), according to the Department of Health (2012). Stillbirth or foetal death refers to the natural death of a foetus before the complete expulsion or extraction of products of human conception, irrespective of the duration of a pregnancy (Lindsey 2016). Death is indicated by the fact that the foetus does not breathe or show any other evidence of life such as a heartbeat, pulsation of the umbilical cord, or definite movement of voluntary muscles after expulsion or extraction. It should be noted that heartbeats are distinguished from transient cardiac contractions and respirations are distinguished from fleeting respiratory efforts or gasps (James 2012).

Parents, who experience a tragic event of perinatal loss, need extensive support from all health team members (Rowland 2008). In previous years,

the extended family fulfilled this supportive role to bereaved parents (Rowland 2009). However, the extended family support system is slowly vanishing in contemporary society and thus, grieving parents are looking to healthcare providers to provide the necessary support (Rowland 2009). Bereavement is the entire process of loss through death, experienced by an individual (Cholette & Gephard 2012).

Gold (2008) reported that in the past few decades, medical schools in the USA have significantly increased curricular content related to death and dying. However, despite medical training in the management of bereavement, students, residents and healthcare providers attending to grieving mothers, often still report being unprepared in bereavement care (Gold 2008). However, Miya (2008) asserts that both midwives and doctors lack the necessary knowledge to support mothers experiencing perinatal loss.

The events surrounding the perinatal loss may ignite unresolved grief issues within the midwives themselves (Begley 2003). Yet, they are expected to provide sensitive and supportive care to these vulnerable families while coping with their own emotional response to a perinatal loss. Consequently, it is essential that midwives be sensitised to the needs of their patients in order that the claim of providing holistic care can be realised. Cholette and Gephard (2012) agree that exploring ways of caring for bereaved families

following a perinatal loss will offer much needed guidance for midwives in caring for themselves and each other.

According to a report on bereavement and grief research by the Center for the Advancement of Health; “Many healthcare providers experience sometimes profound grief when a patient dies” (Genevro, Marshall, Miller & Center for the Advancement of Health, 2004: 550). However, little is known about how perinatal loss affects health workers, specifically midwives. Two local studies (Lebese 2009; Kheswa 2014) have reported on experiences of nurses who assisted with the termination of a pregnancy, which is considered a planned intervention. Perinatal loss is often, sudden and thus, comes as a shock to both the mother and the midwife. The reaction from staff could also affect the grieving parent negatively or positively.

Stillbirths and infant deaths are often emotional events for both parents and the health professionals. The unexpected nature of a perinatal loss may lead to prolonged or complicated grief and mental health challenges (Gold 2008). This study therefore, attempts to explore midwives’ experiences in the management of mothers experiencing perinatal loss.

1.3 RATIONALE FOR CONDUCTING THE STUDY

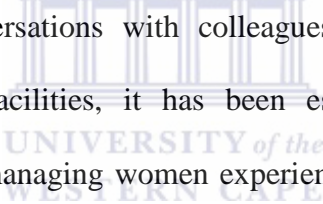
The idea for conducting this study was conceptualised when the researcher assisted with a stillbirth delivery. The knowledge that it was an intra-uterine death did not impact on the researcher at the time because she lacked a deep understanding of the phenomenon of perinatal loss. New to the midwifery profession, she had very little insight and could only offer

minimal support to the mother. Later on in her practice, the researcher began encountering numerous mothers with perinatal loss, and despite repeated exposure, she experienced every event as different and more complicated. She became concerned about the treatment of midwives and doctors treated mothers who had suffered a perinatal loss. Many times these mothers were left alone in their grief and nursed as if all was well.

The following example illustrates how healthcare professionals treated a patient with perinatal loss: A young couple had just found out that the fetus the woman was carrying was no longer alive. The news was devastating to the parents and they requested that the husband be allowed to stay with his wife in order to support her. However, the hospital policies were very strict in terms of permitting the spouses of delivering mothers in the first stage delivery room. The latter was an area where inductions were done and unstable problematic deliveries were catered for. The admissions midwife, the researcher, tried to accede to their request by moving the couple to a separate room in the labour ward. This intervention was overturned by the manager. Hence, the husband had to leave his devastated spouse and was only permitted back when his partner was about to give birth to their dead infant. Shortages of staff can be considered a contributory factor that eventually leads to unrealistic practitioner workload. Consequently, a grieving mother could be left in the care of an overworked and tired midwife who fails to render appropriate support for perinatal loss.

1.4 PROBLEM STATEMENT

While literature confirms that nurses grieve the loss of their patients (Wilson & Kirshbaum 2011; Gerow *et al.* 2009), it does not specifically address how healthcare workers, who care for families who experience perinatal loss, integrate their experience into practice. Grieving the loss of a patient is most often researched with respect to nursing practice in oncology, palliative care, and critical care (Wilson & Kirshbaum 2011). Midwives caring for families who experience perinatal death may also grieve and thus, it is important to explore their experience of grief in this context.



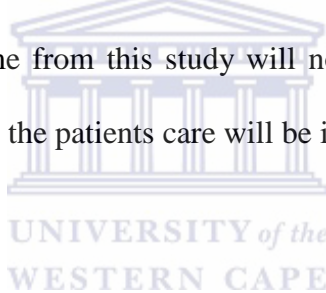
Through personal conversations with colleagues, midwives working in Western Cape health facilities, it has been established that they are continually exposed to managing women experiencing perinatal loss. They have voiced their concerns about being unsure of how to care for these patients. Hence, when managing a woman who experiences a perinatal death, there is limited information on how midwives experience the phenomenon. By receiving proper training this gap in caring for women who experiences perinatal loss might be narrowed. Midwives might feel more confident in caring for these women and also contribute to patient care.

1.5 SIGNIFICANCE OF THE STUDY

The findings of this study could stimulate further research with regard to formulating guidelines for the practice of midwifery staff in managing mothers who experience perinatal loss.

1.6 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the lived experiences of midwives' in the management of patients who experienced perinatal loss in order to provide improved understanding to policy makers, midwifery educators and managers on how midwives deal with the phenomenon. The knowledge that will come from this study will not only benefit the future midwives but in so doing the patients care will be improved.



1.7 OBJECTIVE

To explore the experiences of midwives working in a hospital in Western Cape in relation to their management of mothers who experienced a perinatal loss.

1.8 RESEARCH DESIGN

A qualitative descriptive, phenomenological study design was used to explore midwives' experiences of caring for patients who are experiencing a perinatal loss. Qualitative research applies methods, which result in a

narrative, descriptive account of a setting or practice (Parkinson & Drislane 2011).

According to Christensen, Johnson, and Turner (2012) the primary objective of phenomenological study is to explore the meaning, structure and essence of the lived experiences of a person, or a group of people, around a specific phenomenon. As defined by Creswell (2009), phenomenology is a research strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants.

1.9 OUTLINE OF THE STUDY

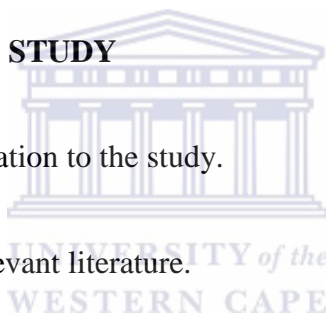
Chapter 1 provides orientation to the study.

Chapter 2 reviews all relevant literature.

Chapter 3 details the research methodology and methods utilised.

Chapter 4 provides the findings of the study and a discussion of the results.

Chapter 5 presents the conclusion and recommendations of the investigation.



CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter covers the literature that was reviewed. The review shares results of studies closely related to the phenomenon under investigation and identifies gaps in the existing literature, thereby highlighting knowledge on ongoing dialogue about the topic. Finally, it provides a framework that establishes the importance of conducting the study. The consequence of research on the subject of bereavement has led to a deeper social and cultural understanding of the grieving process, particularly in relation to perinatal loss (Stolberg 2011). "Perinatal grief is a unique grief. It is a prospective mourning, relinquishing hopes, dreams and fantasies about the baby that never was" (Leon, 1990: 4). Emotionally, grief is a singular journey and any bereavement is individual to the bereaved. The literature reviewed is divided as follows: Care of bereaved mothers, nature and quality of perinatal bereavement, effects of grief on care provision, grieving process, and midwives' management of mothers who experience perinatal loss, mourning the loss of an infant and international organisation in support of parents who have suffered perinatal loss.

2.2 CARE OF BEREAVED MOTHERS

"Bereaved parents never forget the understanding, respect, and genuine warmth they received from caregivers, which can become as lasting and important as any other memories of their lost pregnancy or their baby's brief

life” (Canadian Paediatric Society, 2015 469–477). Radestad, (2009) suggests that the grieving process begins when a mother embraces her infant after a delivery. Since the 1970s a lot has changed in terms of how hospitals manage perinatal loss. Back then, mothers were not allowed to see their babies (Blood & Cacciatore 2014). Parents who have experienced a perinatal loss are currently being prioritised, and research is now focusing on how hospital care can impact on parents’ psychological outcomes (Blood & Cacciatore 2014). Hospital protocols have also changed, and are more sympathetic towards patients who have experienced perinatal losses (Lang et al. 2011).

There is currently very little research on midwives managing patients who suffered a perinatal loss (Fenwick et al, 2007: 153-160). A programme in South Africa called Perinatal Problem Identification Programme provides statistics on perinatal deaths, as well as for its causes and preventable measures (Rhoda, 2014:162). However, his programme does not provide reasons for the training of midwives in this regard. There is currently no training for midwives in South Africa to equip them for perinatal loss. In addition, South African hospitals do not have perinatal programmes that help families deal with loss and does not provide any support after the loss. There is a great need to educate midwives and other healthcare providers that care for these patients and families.

According to Jonas-Simpson (2013), no midwife is prepared for this experience, and her prior training has not prepared her to deal with such an event. Consequently, she relies on support from her fellow colleagues and

other means of education. Midwives should be creating an environment, which promotes empathy, mindfulness and care in order to promote a healthy start to the grieving process (Hannebaum, 2014:26). It is suggested by Williams (2013:51) that communication between the midwife and mother should be a priority. Patients often want to communicate and have someone who listens to them, and midwives are in the perfect position to provide this (Williams, 2013:51).

2.3 NATURE AND QUALITY OF PERINATAL BEREAVEMENT

Perinatal services rendered by facilities differ from one hospital to the next pertaining to the environment and value (Kelly and Trinidad 2012). Healthcare environments are still being portrayed as a low quality and marginalised in some research studies (Frøen et al 2011). It is important for parents to practice their rituals and morals after a perinatal loss occurrence. (Hughes & Goodall 2013). A family's current distress levels are heightened if they are not supported emotionally and spiritually or if their basic needs are not being met (Lang et al. 2011).

In order to ensure privacy for the parents the midwife should offer a private room. (Williams, 2013: 27). A calm environment with the mother able to spend as much time as she wants with her newborn child is beneficial, as are tokens of remembrance of the child. Radestad (2009) recommends that instead of enforcing mourning rituals; flexibility should be shown towards the mother's own needs. Cacciatore (2008) clarifies that the grieving process

starts on a healthier note when mothers actually hold and view their stillborn infants. Midwives are also encouraged to engage with their patients.

2.4 EFFECTS OF GRIEF ON THE CARE PROVIDER

A midwives' sole purpose is to offer support, care, advice and education to pregnant women throughout the range of pregnancy, labour, birth and the postnatal period (Williams, 2013:51). When perinatal loss occurs women are often in the process of adjusting to motherhood (Leyland 2013). Few share the memory of a baby's delivery and passing; only the parents and the midwife share this event. As a result, it is important that the midwife is an active participant during this time (Stolberg 2011). The parents may experience relief or frustration at the quality of care that is given during this time (Kohner & Henley 2006). A study by Caelli et al (2002) mentions that a midwife's most important role is to offer good listening skills, understand what the parents are going through and to sympathise with them. This implies that the midwife should become part of the parents' story in relation to their baby's death.

Healthcare providers are also encouraged to be more sympathetic (Cacciatore 2010). Delicate verbal and non-verbal communication with the bereaved mother provides memories, which aid her, start the mourning and facilitate the grieving process (Cacciatore 2010). A critical component in this regard is how the message is relayed to the mother that has just heard about her baby's death, since it stays with her for a long time (Schott et al

2007). An exploratory study by McGuinness (2013) found that health professionals were attuned to the bereaved mothers' emotional state providing warmth, friendliness and sensitivity. With this in mind, the development of an empathic relationship based on mutual respect and genuineness (Stolberg 2011; Nursing Midwifery Council 2010) provides direction to the grief process.

2.5 THE GRIEVING PROCESS

Grief is described as a natural reaction to separation, bereavement or loss of a loved one (Glaser 2010). Dr Elizabeth Kubler-Ross (1969) identified the five stages of grief. Kubler-Ross suggests that anger could be the next possible stage in the grief response. The question that many parents ask themselves is 'why me?' and they feel angry with themselves (Kubler-Ross 1969), which is the common stage midwives observed among patients. The other stages of grief are denial, bargaining, depression and acceptance.

However, the grieving process is a personal experience and hence different for every mother. Although there is no standardised grieving process (Takeuchi 2016), midwives can make the event more bearable. Research has also concluded that the level of involvement of midwives in helping parents reach decisions with regard to mode of delivery, encouraging parents to hold the baby, providing memorabilia, could aid the parents and facilitate a better grieving process (Rowland 2009).

2.6 MIDWIVES' MANAGEMENT OF MOTHERS WHO HAVE EXPERIENCED PERINATAL LOSS

Stillbirths and neonate deaths are significant events in women's lives, and midwives are usually at the forefront of the experience and provide care. Midwives are often relied on to care for bereaved parents and families affected by these traumatic events, which are stressful for all involved (Black & Tufnell 2006). The loss of a baby has a great effect on the parent, and it is important for the midwife to interact with parents (Gold 2007). A nurse's willingness to sit quietly and observe, to remain open and nonjudgmental, and to explore what might be helpful are all useful strategies to bridge cultural differences (Rawort, 2012). They are therefore expected to interact with the bereaved in a supportive manner, regardless of whether they feel adequately prepared or not (Cox & Briggs 2004).



According to Gardner (1999), perinatal death has been described as a life crisis for both parents and professionals. Students expressed their own concerns about dealing and coping with such a delivery (Mitchell, 2004). It has been said that showing emotions in the presence of a patient demonstrates unprofessionalism (McCreight 2005). Staff describe 'feeling awful' because they cried with the patient (Raeside 2000). Expressing one's emotions was considered unsuitable as senior nursing staff stated (Begley 2003). A discussion around stillborn and neonatal death pertaining to care rendered, is a topic that is not spoken about frequently (Thompson 2008). Pregnancy embodies a happy time, and midwives and other healthcare

providers are not equip to deal with events of a sad nature (Fenwick et al 2007). Thompson (2008) argues that this topic presents a challenge to contemporary society because of concepts of perfect reproduction permeating in conjunction with availability of prenatal screening and mothers' responsibilities to produce normal babies. Gardner (1999) suggests that, from the identified experiences of mothers with pregnancy loss, midwives and doctors who care for these mothers should improve their communication skills by providing information, time, choices and recognition of their loss. The significant needs and acknowledgement of midwives should be considered when managing patients with perinatal loss event (McCreight 2005).

Midwifery has been described as being emotion work (Hunter 2004). Caring for bereaved families is regarded as being stressful for midwives who also have to deal with their own grief simultaneously. They may have limited experience in working with bereaved parents, limited knowledge about the grief process, lack appropriate communication skills or do not receive necessary support from their colleagues (Gardner1999). Hence, many may experience difficulties with this area of practice (Mitchell 2005). Nurturance was a strong theme that emerged from a qualitative study carried out by Sanchez (2001). The mothers in Sanchez's study spoke positively about individual nurses completing nurturing tasks such as holding the mothers hand, brushing her hair and casually conversing. Participants' language used to describe the nurses reflected nurturance. Words such as 'gentle', 'sweet' and 'understanding' nurse were used. More recently, health professionals

played prominent roles in a study by Lathrop and VandeVusse (2011) in which many mothers expressed appreciation for the way nurses treated their babies; calling their baby by their name and treating their deceased baby with affection and respect. However, Nordlund et al (2012: 782) “found that mothers often experience negative emotional responses with health professionals following stillbirth, particularly in relation to bonding time, when they felt “hurried” in their final moments of goodbye”.

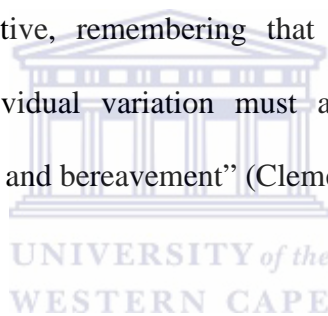
2.7 MOURNING THE LOSS OF AN INFANT

A baby’s death, whenever or however it occurs, is a profound loss. Unfortunately, society in general, friends, and relatives in particular often do not acknowledge that this wished-for child, regardless of gestational age, was a unique individual and an important part of an individual’s future. According to Callister (2006), perinatal loss engenders a unique kind of mourning since the child is very much a part of the parent’s identity. Societal expectations for mourning associated with perinatal loss are noticeably absent. Gender differences in response to such loss, as well as sibling and grandparent grief have been identified in the literature (Pediatric Child Health 2001). Nursing interventions in perinatal loss have been refined over the past two decades because of research studies. These include helping to create meaning through the sharing of the story of parental loss, facilitation of sociocultural rituals associated with loss, provision of tangible mementos, sensitive presence, and the validation of the loss.

Patients are in shock when they are given the bad news of their infant's death. Avoidance or protest cover the period during which the news of death is initially received and the time briefly thereafter. Anger and hostility are frequently present during the initial phase of mourning, and may be directed at healthcare workers or towards the self, specifically for having failed to do something to avert the loss (Pediatric Child Health 2001). Researchers and parents agree that perinatal bereavement interventions should validate the baby's worth and existence, support parents' expression of grief and mourning, assist in meaning-making, and improve parents' ability to cope with the death (Blood & Cacciatore 2014). Though research has highlighted the value of bereavement photographs for these tasks (Blood and Cacciatore 2014), often in perinatal death the only opportunities to capture the baby's visage occur during postmortem. A vast majority of USA and European parents participating in research reports gratitude for postmortem photographs of their newborn. Conversely, most express regret if they do not have such photographs (Blood & Cacciatore 2014). Studies have identified postmortem bereavement photography as "one of the most helpful services" during the crisis of a newborn's death (Gold et al. 2007:1160).

Since the 20th century, healthcare professionals are offering parents photographs of their babies (Hilliker 2006). Though a wide variety of cultures, past and present, have embraced postmortem photos as an aid to memory, mourning, narrative, and therapeutic grief ritual, some in the public and in healthcare still perceive these practices as strange or morbid

(Cacciatore & Flint 2012). Additionally, some cultural traditions do not endorse memento-making practices (Chichester 2005). “Parents from some cultures or religious traditions might not want or be permitted to take photographs of their dead children. Some Native American tribes, The Church of the Latter-Day Saints, Old Order Amish, and Orthodox Jewish traditions have proscriptions against postmortem photography, contact with dead bodies, or both” (Blood & Cacciatore, 2014:226). Muslim families, also, may not want postmortem photography or memory boxes since their belief is everything that comes from God must return to God, meaning that everything should be buried (Lundquist et al. 2003). “Cultural sensitivity by providers is an imperative, remembering that cultural groups are not homogeneous, and individual variation must always be considered in situations of death, grief, and bereavement” (Clements et al, 2003:19).



2.8 INTERNATIONAL SUPPORT

Three Chicago mothers who experienced stillbirths came together in 2002 to create an organisation that would combine the knowledge of healthcare professionals with the passion of families in order to advance stillbirth research, medical care, and bereavement services. Thus the International Stillbirth Alliance (ISA) was founded. Today, ISA utilises the experience and international reach of its partner organisations to continue the mission of understanding the causes and prevention of stillbirth (Gold 2007). There are other organisations such as the Open to Hope and Miss Foundations that support families who have gone through perinatal loss.

2.9 CONCLUSION

This chapter reviewed literature, which suggests that midwives are at the forefront of perinatal loss support to patients. It highlights that trained and educated midwives could produce quality care to those patients who experience perinatal loss, in the sense that they become aware of the impact of the loss; not only on the patients but also on themselves.




CHAPTER THREE: METHODOLOGY AND METHODS

3.1 INTRODUCTION

Research methodology describes systematically what the researcher has done to solve a research problem. The reasons for using a particular research approach and design are provided so that others (Gupta & Gupta 2011) can appraise research findings. This chapter gives an account of the research approach and design, the study setting, study population, inclusion and exclusion criteria, data collection, as well as data analysis. Ethics and issues of trustworthiness are also discussed.

3.2 RESEARCH APPROACH AND DESIGN

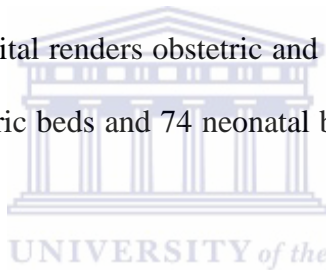


An exploratory qualitative research design and descriptive phenomenological approach were utilised in this study. The qualitative design was found appropriate since the focus of the study is to describe the lived experiences of midwives who nurse patients who have experienced perinatal loss. In comparison to quantitative research, qualitative inquiry emphasises the qualities of entities, processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency (Denzin & Lincoln 2000). In other words, qualitative research focuses on the meanings, concepts, definitions, characteristics, metaphors, symbols and description of things (Berg 2007). It also refers to a object essence and ambience the what, how, when and where of it (Denzin & Lincoln 2011; Creswell 2009). According to Christensen, Johnson, and

Turner (2012), the primary objective of phenomenological study is to explore the meaning, structure and essence of the lived experiences of a person, or a group of people, around a specific phenomenon.

3.3 STUDY SETTING

The study was conducted at Mowbray Maternity Hospital, which is a secondary maternity hospital in Cape Town. The setting is a specialised maternity hospital in the Western Cape and is categorised as a regional hospital serving the surrounding community of the southern suburbs and its drainage areas. The hospital renders obstetric and neonatal services to these areas and has 106 obstetric beds and 74 neonatal beds (Mowbray Maternity Hospital 2014).



The setting was purposively sampled based on the fact that the majority of stillbirths and neonatal deaths in comparison to any other facility in the catchment area, and due to its status. Hence, the midwives working in the facility are often exposed to women experiencing perinatal loss. Midwives who work at the facility are placed in the labour ward after first rotating throughout the facility to gain experience. Midwives together with a range of health professionals such as doctors, radiographers, psychologists, social workers and pharmacists play a part in managing patients.

3.4 STUDY POPULATION

Brynard and Hanekom (2005:43) explain that in research, ‘population’ does not refer to the population of a country, but rather to the objects, subjects, phenomena, cases, events or activities specified for the purpose of sampling. The study population includes all midwives working at the maternity hospital, who had cared for patients who had a stillbirth or neonatal death over the data collection period. The target population is midwives working in the labour ward.

3.5 PARTICIPANTS

According to O’Leary (2004:103), sampling is a process that is always strategic and sometimes mathematical, which involves using the most practical procedures possible for gathering a sample that best ‘represents’ a larger population. Kumar (2005:179) motivates that purposive sampling is extremely useful when constructing a historical reality, describing a phenomenon or developing something about which very little is known. Purposive sampling was utilised to select eight midwives who participated in the study. In purposive sampling, the researcher seeks to include people who represent the widest variety of perspectives possible within the range specified by their purpose (Higginbottom, 2004:7). The number of participants was also dependent on the resources and time available, as well as the study’s objectives. There were only four midwives on either night duty or day duty each day.

3.5.1 INCLUSION CRITERIA

Midwives who had been working in the labour ward for at least one year.

Midwives who had personally delivered women who had a perinatal loss in the last six months.

3.5.2 EXCLUSION CRITERIA

Midwives were excluded from participating if they had: Worked in the labour ward for less than one year. Not attended to a woman who experienced a perinatal loss in the last six months.

3.6 DATA COLLECTION

After ethics approval (Appendix A) was granted by the University of the Western Cape, a copy was given to the Chief Executive officer (CEO) of the study setting. The purpose of the study was explained with the view to get permission to collect data.

After permission was granted, appointments were made with individual midwives on duty. The purpose of the study was explained to midwives who met the inclusion criteria. An information sheet (Appendix B) was given to each potential participant. They were assured of anonymity and nobody was coerced to participate. Participants agreeable to the study were then recruited.

Written informed consents (Appendix C) were obtained before conducting

the interviews. Appointments were made and interview dates and times were arranged. During the participants' lunch breaks the interviews were conducted in a private room in the labour ward.

The core question for the interviews was: "Could you tell me how you experience managing women experiencing a perinatal loss?"

Before commencement of each interview, the researcher greeted the participant and involved her in informal conversation in order to allay any anxiety. After the participant was at ease, the purpose of the study was briefly explained to ensure that participants are well-acquainted with the process. Participants were asked if they still wanted to proceed. When they agreed they were told that the interview would be audio recorded in order to enable the researcher to transcribe and later analyse the data. Each participant was thanked for agreeing to participate.

Data collection took place between June and July 2014. According to Raworth (2012), unstructured interviews are often the best way to elicit information about motivations behind people's choices and behaviour, their attitudes and beliefs, and the impacts of specific policies or events on their lives. Interviews lasted 30-45 minutes approximately, depending on the information provided by each participant. In order to obtain as much information as possible, probes such as; 'could you clarify what you mean by that?', 'how did it make you feel?' were posed. Privacy was ensured

during each interview. The interviews were conducted in English and the researcher had no assistance from an interpreter.

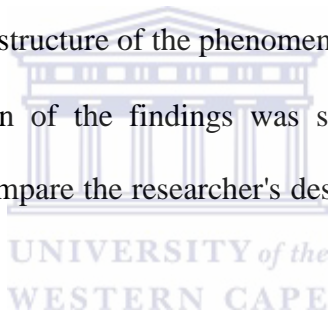
3.7 DATA ANALYSIS

In qualitative research, data analysis goes hand in hand with data collection. It constitutes extensive work with an objective to give meaning to the verbatim transcripts in order to draw conclusions about the phenomenon (Helen & Dona 2007).

In phenomenology, data analysis has to respect and retain the originality of the experience as lived by the participant while giving a proper understanding of the phenomena under investigation (Sales, 2013:35). To ensure this, Colaizzi's (1978) steps of phenomenological data analysis in De Vos et al. (2007) were used, namely

- Each interview was conducted and audio-recorded. Using field notes and the transcriptions, the researcher was guided when conducting the next interview.
- Recorded data were transcribed verbatim. The researcher listened to the recordings again to verify the accuracy of the transcripts and to make minor corrections if necessary. Transcribed copies were given to the relevant participants for verification.

- Each transcript was read and re-read in order to obtain a general sense about the whole content
- For each transcript, significant statements that pertained to the phenomenon under study were extracted. The statements were recorded on a separate sheet noting their pages and lines numbers.
- Meanings were formulated from the significant statements.
- The formulated meanings were sorted into categories, subthemes and themes.
- The findings of the study were integrated into an exhaustive description of the phenomenon under investigation.
- The fundamental structure of the phenomenon was described.
- Finally, validation of the findings was sought from the research participants to compare the researcher's descriptive results with their experiences.



3.8 ETHICAL CONSIDERATIONS

Ethical clearance to conduct the study was obtained from The University of the Western Cape, Higher Degrees Committee. The clearance was used to obtain permission from the CEO of the Maternity Hospital to conduct the study at the facility. Participants were informed of the nature and intention of the study in their language of choice. They were informed of their right to withdraw from the process at any stage of the project. After participants agreed to participate in the study, they signed a consent form. Participants

were assured of confidentiality and anonymity. If a name was mentioned during the interview, it was not transcribed. Pseudonyms were used to protect participants' identities when transcribing and analysing the data. To maintain the confidentiality, each recording was allocated a number. The transcripts were kept in a locked drawer at the researcher's home and only the researcher had access to them.

3.9 TRUSTWORTHINESS

In qualitative research, trustworthiness rather than validity or reliability is used to establish rigor. In their definitive work, the book "Naturalistic Inquiry", Lincoln and Guba (1985), as cited in Pilot and Beck (2012: 583), stated that the aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are "worthy paying attention to." This is quite different from the conventional experimental precedent of attempting to show validity, soundness, and significance.

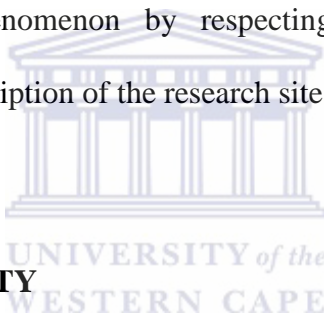
3.9.1 CREDIBILITY

To ensure credibility the researcher kept a journal of her own reflection during the data analysis process to minimise her own biases. Motivation for conducting the study is presented in the first chapter. A recording device was used during the interview and all the interviews were transcribed by the researcher. Transcripts were given to the relevant participants to check whether they reflected their experiences. No changes were made by the

participants. Coding of the data was done by the researcher and validated by the supervisor. Consensus was reached with relation to the naming of the themes.

3.9.2 TRANSFERABILITY

As an aspect of trustworthiness, transferability refers to the applicability of the study to other similar contexts outside the study situation (Lincoln & Guba 1985). Qualitative research findings may not necessarily be applicable to similar contexts (De Vos et al. 2007). The researcher ensured a thick description of the phenomenon by respecting the phenomenological research method. A description of the research site was validated.



3.9.3 DEPENDABILITY

For a study to be accurate Lincoln & Guba (1985) suggests that an audit trail should be kept. In this study the co-coding of data from the transcripts was done by the researcher and her supervisor to minimise bias during the data analysis process. An audit trail was maintained throughout the study by keeping all the raw data and providing a detailed description of the data analysis process.

3.9.4 BRACKETING

Drew (2004) suggests bracketing is the researcher's own evidences in discovering their phenomenon experience. Gearing (2004) define bracketing

as a scientific process in which a researcher holds in abeyance his or her beliefs, prejudices, expectations, ideas, or past experiences to observe and describe the phenomenon. Starks and Trinidad (2007) also advise researchers to stay true to their own beliefs; be honest and maintain vigilance throughout the process; engage in a self-reflecting process in order to develop an insightful hypothesis.

Personal reflection

I rotated throughout the hospital for the year I worked as a community service nurse, under the supervision of a registered professional nurse. Part of the rotation included working in the labour ward. This is where I wanted to be and where all the magic happened for me.

I was oriented to the unit and then the head nurse spoke of room 8. I did not know what she was talking about and then she said something about a fridge. I didn't take much note of what she had said because I was just too excited to be in labour ward. The next day I went to the allocation book, to determine my duties for the day. Next to my name was number 8 and fridge, and I asked the head nurse what it meant, she smiled and said: 'I will take you'. Room 8 was the ward allocated to mothers who had a miscarriage or delivered a stillborn baby. The fridge was where the bodies of the stillborn babies were kept until it was disposed. I tried to keep my composure but I could not help feeling ill: deceased baby bodies in a kitchen fridge? This fridge was kept in a utility room where the midwives cleaned their equipment with open access to the cleaners. Is this the environment that I was expected to work in? These disturbing thoughts were racing through my

mind. It also reminded me of the first time I saw a deceased body in my 2nd year of training and the feelings of extreme helplessness I experienced.

However, this time the feelings were different because the babies looked normal and even healthy. I kept it together (my emotions) during my first stillborn delivery and after a while I was getting used to delivering stillborn babies. I perceived this to be a problem and spoke to other midwives and was told that 'we do become numb'. I felt a sense of uneasiness, especially because the midwives had to a tendency to scatter and leave you alone to manage a patient who has experienced a perinatal loss. The reasons for these were twofold. The feelings that accompany a perinatal loss was so tangible that, no one wanted to deliver these babies. The second reason was linked to the amount of paper work that was required for a perinatal loss.

This was difficult for me because we were failing the patients and their families. There was clearly a gap in nursing care and this started my interest.

3.10 CONCLUSION

This chapter presented the methodology and methods utilised to conduct this study.

CHAPTER FOUR: FINDINGS AND DISCUSSION

4.1 INTRODUCTION

The chapter presents the participants' characteristics in order to give an overview of their demographic profiles. The study findings and a discussion of it in relation to wider literature are also presented with the purpose of indicating how these findings fit into what is already known about the phenomena. It does not seek to confirm or argue existing findings (Helen and Dona 2007).

4.2 CHARACTERISTICS OF PARTICIPANTS

Table 4.1 Demographic profile of participants below provides a summary of the demographic information of the participants.

Number	Age	Gender	Nationality	Language	Years of work experience
A	30	Female	South African	English	7
B	32	Female	South African	English	7
C	27	Female	South African	IsiXhosa	4
D	45	Female	South African	IsiXhosa	17
E	25	Female	South African	IsiXhosa	2
F	26	Female	South African	IsiXhosa	3
G	26	Female	South African	IsiXhosa	3
H	27	Female	South African	English	4

4.3 PRESENTATION OF RESEARCH FINDINGS

Four themes, namely midwives' knowledge of perinatal loss, challenges when managing patients, managing perinatal loss, and being emotionally involved, emerged from the data. These themes were informed by several subthemes as presented in Table 4.2 below.

Table 4.2 Summary of themes and subthemes

Themes	Subthemes
Midwives' knowledge of perinatal loss	
Challenges when managing patients	<ul style="list-style-type: none"><input type="checkbox"/> Staff shortage<input type="checkbox"/> Time constraints<input type="checkbox"/> Impact of experience<input type="checkbox"/> Unaware of hospital policy pertaining to perinatal loss
Managing perinatal loss	<ul style="list-style-type: none"><input type="checkbox"/> Providing choice to patients<input type="checkbox"/> Support from hospital management
Getting emotionally involved	<ul style="list-style-type: none"><input type="checkbox"/> Feeling sad<input type="checkbox"/> Leaving patients to cope on their own<input type="checkbox"/> Holding on to memories of the event<input type="checkbox"/> Failing to handle the loss

4.3.1 MIDWIVES' KNOWLEDGE OF PERINATAL LOSS

The first theme highlighted the participants' knowledge of perinatal loss. Their knowledge and definition of perinatal loss varied. The following definitions were provided:

‘A miscarriage is less than 26 weeks according to the Act...only a baby born, whether he is dead or alive is viable only after 26weeks and more...’ (Participant D).

‘According to here Mowbray, everything that is not viable is a miscarriage. So anything that is viable is a stillborn. But there’s also a weight difference. I don’t know how much weight. I don’t know if its 500g at stillbirth or less than 500g then its miscarriage’ (Participant G).

When asked to explain the difference between a miscarriage and stillbirth, responses also varied. For instance, participant B responded:

‘Yes a stillbirth is when the baby is viable and a miscarriage would be when the baby is not viable and obviously, it varies according to institutions, registration and weight’ (Participant B).

‘A misscariage- a patient comes in bleeding and a stillborn is when the baby is born and the baby is dead’ (Participant H).

Gardner (1999) emphasised common needs of caregivers for increased knowledge, mentored experience and personal support to confidently provide sensitive care to families, in this instance, after a perinatal loss.

As stated by Andrews (1997), inadequate knowledge on certain pertinent topics must be established whether it arises from a lack of training or not in order to assist with putting programmes in place that are relevant to existing needs. In the case of this study, participants’ responses pointed to the fact that because caregivers lacked the skills and knowledge to care for mothers with pregnancy loss, they were working under stressful conditions. In a

study conducted in Hong Kong it was suggested that midwives required increased knowledge and greater hospital and team member support on bereavement care experience in order to improve their communication skills and management of clients (Chan 2008).

The study findings highlighted the universality of grief for a lost baby, irrespective of cultural differences. Study findings were used to improve support of midwives to ensure sensitive bereavement care in perinatal settings and to reflect training needs in the midwifery education curricula (Chan 2008).



4.3.2 CHALLENGES WHEN MANAGING PATIENTS

This second theme entailed challenges that were regarded as barriers in caring for patients. It was supported by the following subthemes: ‘staff shortage’, ‘time constraints’, ‘feeling inadequate to assist in stillborn deliveries’ and ‘unaware of hospital policy pertaining to perinatal loss’.

4.3.2.1 STAFF SHORTAGE

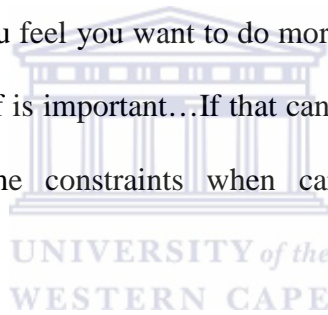
Most participants mentioned shortage of staff during their interviews. They stated that the ever-growing workload deterred them from rendering quality nursing care that patients going through a perinatal loss deserved. For instance, some participants said:

‘shortage of staff and obviously your topic- stillbirths. Having to deal with patients’ losses and being so intimately involved with peoples birthing experience’ (Participant B).

‘Difficult patients that we are dealing with. Different patients we are dealing with. Sometimes more short staff and patient as well’ (Participant F).

‘I think shortage of staff because you cannot give whole quality care to a patient who just had a miscarriage...out of the room and put another on at that same time...and before you are even finish with her...I would say that is number one’ (Participant G).

‘...staffing, kills me. You feel you want to do more for the patient. At times you can’t even... so staff is important...If that can be sorted out...It is a big challenge for me...Time constraints when caring for these patients’ (Participant C).



The Canadian Health Services Research Foundation (2006) on Teamwork says that an effective way of improving the quality of care and patient safety is by reducing staff shortages, stress and burnout among professionals. In the case of this study, participants expressed that the turnover of patients was so fast that midwives were often exhausted because the demand for care was very high. Staff shortage was something that midwives experienced almost daily. However, literature indicates that structured support and education for midwives could assist in resolution of grief, and is significantly associated with decreased burnout (Feldstein & Gemma 1995; Fisher 1992) but was not evident in interviews conducted. Time constraint

was another challenge that participants faced in their management of patients going through a perinatal loss.

4.3.2.2 TIME CONSTRAINTS

Some participants expressed that even though they were short- staffed, they were interested in spending more time with their patients. However, they claimed that because of the high turn-over of patients this was proving to be impossible. One participant said:

‘...yes, there is no time for us to connect with our patients emotionally...’
(Participant H).

Another participant mentioned that it was as though patients were on ‘conveyer belts’ because there was no time to give them care during their short hospital stay after the loss.

‘... she’s (woman who has experienced a perinatal loss) not given enough time after experiencing the loss...and then one, two, and three she’s induced and then she’s having this baby and then she’s discharged...and then she is lost it’ (Participant A).

Midwives have the responsibility of looking after mothers who experience perinatal loss, as well as those who give birth to live babies. Due to the high turnover of patients, they have less time to focus and support mothers going through a loss. In the absence of time constraints, midwives would have

ample time to support mothers with prenatal loss without rushing to care for other mothers.

4.3.2.3 IMPACT OF EXPERIENCE

Some statements reflected a feeling of inadequacy by midwives when dealing with patients giving birth to a stillborn infant or having a miscarriage. The feeling of inadequacy was associated to the years of experience of working in the labour ward. A participant who had 17 years of experience in the nursing profession as a midwife said:

Because I do it so much I don't really ... I don't say that I don't feel anything. But it is almost like part of my work. It's not that I haven't got sympathy for them. Definitely, I have sympathy for them. As I said, I will always ask the patient do you want to view the baby. Do you want to hold the baby? Identify, even if it's a miscarriage. It doesn't matter how big the baby is. For that mom it is very important because she lost a part of herself. So I will act according the mom's feeling and the mom's question. If she doesn't want to view the baby I respect her and take the baby away
(Participant D).

One participant admitted that she ran away from assisting in such deliveries during her early years of joining the nursing profession. She stated:

'During my Comserve I used to run away from still-borns...I used to run away up until one night when I was with two midwives in labour ward...I had two still-borns in one night. So one... I actually ran away. The doctor

kept on calling me saying, sister this patient is fully dilated. She just needs encouragement...Then I kept on doing other things just to be away...so that someone can pay attention...hoping that the midwife that I was working with could go there and assist...Up until I opened up and said I never delivered a stillborn and I'm scared' (Participant C).

4.3.2.4 UNAWARE OF HOSPITAL POLICY PERTAINING TO PERINATAL LOSS

Some participants could not explain in their own words what they understood about the hospital policy regarding perinatal loss. Some admitted that they were not aware of its existence. Some of the responses were:

'I don't know if there is any hospital policy (Participant E).

'...oh, I've never come across it...I don't want to lie' (Participant G).

A participant who thought she knew explained what she thought was the hospital policy relating perinatal loss:

'They need to be seen by a social worker; whether it's the hospital's social worker or the patient...Beforehand...no, no, no, it would be...the patient has...depends if there's a cause of stillbirth, patients have an option of being discharged and coming back at a date for induction that suits them. Other patients opt to being induced immediately. Well, that's if they are viable for induction. If they've had a Caesar the management changes a bit. Postnatal,

I know part of the placenta needs to be sent for a histology and the patient gets the option of whether the body should be sent for a post-mortem and they're followed up at the perinatal clinic in six weeks' time. Prior to being discharged they need to be seen by a social worker or if they have a private social worker or psychologist they are then seen' (Participant B).

In the case of this study, results showed that there was a minimal difference between experienced and inexperienced midwives in the management of women experiencing a perinatal loss. Some junior midwives, some who had worked only for a few months in the labour ward, overshadowed senior midwives' practices when dealing with patients with perinatal loss. They claimed to be comfortable during and after assisting in the delivery of a stillborn. Some participants mentioned utilising experiential learning, role models of colleagues and reflections to help them create a two-tier framework for professional practice; hence, developing their professional competency on one level and on the other, developing skill in self-care. This enabled them to improve both the care they gave and their own coping capacity.

Nevertheless, several participants expressed their sincere appreciation for observing and listening to senior midwifery colleagues as they carried out the statutory midwifery care of the mother and her stillborn child. The actions and words used were considered and analysed and those perceived to be positive were remembered and became a point of reference for future stillbirth deliveries. However, in stark contrast, three participants judged

other midwifery colleagues and doctors. They expressed their opinion that the words and actions of those colleagues at that time added further negativity to an already sad situation. For these midwives, their response to their colleagues' behaviour, whether positive or negative, remained strong even though the events had occurred several years previously. Some of the junior staff said that they had no choice to deliver a stillborn and that they felt obligated.

4.3.3 MANAGING PERINATAL LOSS

The third theme was 'positive ways of managing perinatal loss by the midwife'. Participants stated that there were many things that could be done to make the entire experience of loss more pleasant for the patient to aid her recovery. The theme was informed by the following subtheme: 'providing choice to patients'.

4.3.3.1 PROVIDING CHOICE TO PATIENTS

Some participants mentioned that some patients preferred to be left alone in a room to deal with their grief while others preferred to be amongst people. Some participants advocated giving patient's mementos. Nevertheless, most of the participants advocated for patients to be given a choice. This is what some participants said:

'I think patients should have options whether they want to be in a six bed ward, in a room surrounded by other pregnant women or whether they want to be on their own. Secondly, I think that there shouldn't be strict visiting

hours for that woman. She should have or her family should have access to come visit her whenever they wish...and similarly, after the delivery as well. We shouldn't be so strict about visiting time and who is going to support her in labour...So that, I think needs to change' (Participant B).

'Let them decide. Give them time to be with their families. Let them take a decision. So I think it's a big, big improvement that they've done. Like if the patient is confirmed today then they will let the family come in. Then they make a decision. Do you want to go home for a week and then come back? It depends on the patient's blood results and everything. But I think it's a huge improvement. If we can keep it like that and continue to involve the family and follow up on our patients' (Participant C).

'We ask the mothers if she wants footprints. We'll give footprints. If they want photos, whatsoever and we give them that' (Participant D).

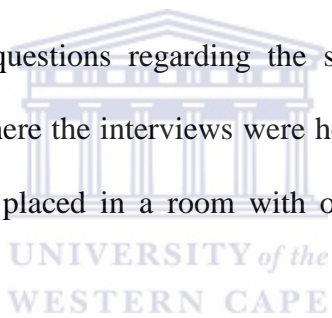
Regarding privacy, one participant commented:

'Sometime after the delivery of a stillborn baby, you would like to have a loved one around you all the time, to comfort you' (Participant A).

Some previous researches have mentioned that patients get comfort when they are offered mementos of their infants (Paediatrics & Child Health 2001), hence, the gesture helps with their grieving process and facilitates healing. When mothers are given the necessary privacy to grieve and time to make informed decisions, they have a better chance to say goodbye without any distractions. They should be provided with an environment where there is limited noise of non-stress test machines and babies crying, as well as

open time for visitation. It is also advised that no restriction should be placed on visitors. In a study by Gardner (1999), results demonstrated that bereaved parents acknowledged that unrestricted visiting hours for families, provision of privacy and time to grieve assisted in easing the grieving process. It is therefore, important for women who experience perinatal loss to be admitted in separate antenatal clinics, wards, gynaecological wards and side-wards of the labour wards.

Robinson and Thomson (1999) added that if the mother remains in the postpartum area, subtle signs such as a teddy bear or a flower outside the door can alert the staff that the family has experienced a loss, thereby, preventing inadvertent questions regarding the status or location of the infant. In the hospital where the interviews were held patients are not given any a choice. They are placed in a room with others mothers who have delivered a healthy baby.



4.3.3.2 SUPPORT FROM HOSPITAL MANAGEMENT

Participants mentioned that hospital management was not doing enough to assist midwives with caring for patients who experience a perinatal loss. They expressed that although they were eager to make changes, their lack of counseling rendered them incapable to do anything. One participant said:

‘...Because a loss is a loss regardless of gestation...And I just imagine how I would feel if I had to go through that. So I don’t think that the institution is

doing enough – no. And nurses as well – we’re not doing enough’ (Participant B).

Participants explained how the institution could assist midwives in making patients feel more comfortable and hence show more support to the patient and their families. One of the ways would be to allocate some rooms for patients experiencing perinatal loss instead of them sharing with other patients who might have crying babies. Although one participant said that one of the labour rooms had been converted to facilitate quality nursing care for patients that were about to deliver a stillborn or miscarriage, there was need for counselling before going through the experience. She said:

‘I think we renovated this room...it was one of the ideas to make patients more comfortable. You know I think they should go through the counselling before they have this social worker...before they give birth to the baby rather than afterwards... because...afterwards they just want to leave. They don’t want to stay here. They even sign the (inaudible)...saying that they don’t want to be here. And say it is over the weekend; the social worker doesn’t work over the weekend that means they must sit and wait for the social worker on Monday. They don’t want to be here once they’ve given birth” (Participant E).

Some participants expressed that training of midwives on how to manage patients experiencing perinatal loss was needed in order to broaden their knowledge:

‘I think many of us need to have training on how to deal with such patients and without judging them. Whatever they did, whatever they went through – it’s nothing. As long as we can really know how to...because sometimes when you get to that patient and somebody hands over to you...that person didn’t even show that patient that baby. That patient didn’t even hold that baby. But signatures are there. You ask but why did you sign if you didn’t see your baby? You can even see in the newspapers as well. Many times the people didn’t see their babies. So I think many of us really need training to...see...although I don’t feel maybe anything for that patient, but at least put yourself in that patient’s shoes and that is the way that you’re going to deal with that patient’ (Participant D).

‘I think both are needed...I think most definitely and I think previously the rate of stillborns and miscarriages was much lower. If you can remember when I started here I spent four months in the labour ward and there was nothing. I mean, now on a daily basis there is one or two’ (Participant A).

‘We do need training and counseling...I think it’s a need...I think it’s a need, especially as far as the emotions are concerned it is a need...Yes, I think we really need it’ (Participant C).

‘Yes, because there’s always different cases. It doesn’t happen the way you’ve delivered last time. So you never know what to expect. So everyone needs counselling, even if it is going to be debriefing or something but everyone I think needs it...There is always room for improvement. There is always like for example, for the people who are new, the CSPs, the people who have just started here, if they can offer some counseling for those

sessions after you delivered the miscarriage then you get someone to talk to, someone who is going to counsel you...Because sometimes it does affect you ' (Participant F).

'Yes, definitely there is need for training and counseling because everybody deals with death differently' (Participant H).

Although some participants had counseled patients who had experienced a perinatal loss before, they still felt there was a need for training and debriefing sessions to deal with issues pertaining to the experience:

'I managed to counsel the mother although I also needed the counselling. I think for all the first ladies, the midwives who deliver for the first time a stillbirth or a miscarriage; they need counseling or debriefing, especially the ESPs. I think I had another one in theatre where it was a fresh stillbirth – fresh, fresh, fresh. The patient came in the hospital without movement and then she was prepared quick, quick, quick. And then she was in theatre. But the time the operation happened the baby was already...the baby came out with no (inaudible)...but the baby looked like she was going to cry because she was pink' (Participant G).

It was evident that participants felt that dealing with patients who had experienced a perinatal loss had an impact on a healthcare provider because the experience was both emotional and tragic. Participants also felt that dealing with the experience was a subject that was not often spoken about. They felt that community service nurses who were new to the nursing profession needed a forum where they could vent out their emotions and

feelings. Participants explained that in a situation where it was their first time to deliver a stillborn, they were not prepared to counsel the patient, but management expected them to do so even though they had received no prior training. The participants went on to say that all midwives needed counseling and debriefing, irrespective of their length in practice, because every delivery was different.

Participants spoke about midwives being motivated to complete their Diploma in Advanced Midwifery to improve, among other, the care of patients experiencing a perinatal loss. A study on guidelines to supporting mothers with pregnancy loss conducted at a public hospital in South Africa revealed that both midwives and doctors could be used as implementers and evaluators of support programmes during practical training of students (Chan,2007). The result was reiterated by Gardner (1999) who stated that parents needed to be provided with feedback regarding nursing interventions. The suggestions for improving nursing care should be communicated to the nursing departments and incorporated into the curriculum. The study went further to say that schools of midwifery and nursing must include culturally sensitive care practices for bereaved families. By giving students this basic knowledge; having them consider their own feelings about death and rehearsing supportive communication techniques, students would be better prepared to support the bereaved.

Begley (2003) studied student midwives' responses to caring for women with perinatal loss. The following three themes were evident from the study:

'you do not know what to say''. This theme focused on the students' feelings of being unprepared and wanting not to cause further distress to the parents. 'They wrapped him in a blanket', referred to the positive physical care and supportive approaches of the experienced midwives. 'Crying like a fool', depicted the intense emotional responses of the students. Begley (2003) suggested that structured support during clinical experiences and more education about bereavement and communication were important to include in midwifery programmes.

Identification of lack of colleague support during stressful times was seen as a major variable in McVicar's (2003) literature review on workplace stress in nursing. More generally, colleague support was a major factor in whether midwives stayed in the midwifery profession or not (Kirkham, Morgan & Davies 2006; Ball, Curtis & Kirkham 2002).

Canine (1996) proposes that grief is a social process and, as such, is best dealt with in a social setting where individuals could support and encourage each other to experience and share the expression of their emotion. This corroborates the finding of this study that midwives reported faring better with professional bereavement when they were able to discuss issues around death with supportive colleagues. Spencer (1994) recommends support groups for staff and professional counseling if necessary as well as, post-event conferences and further education. Of particular importance is the need to educate staff and student midwives to care for themselves in order to reduce stress related to grief (Marino 1998) and to maintain a balance between engagement with, and detachment from bereaved couples

(Carmack 1997). Midwives and nurses, who do not care for themselves, find that their lives are diminished (Brown-Saltzman 1994), which eventually leads to a poorer standard of care.

4.4 GETTING EMOTIONALLY INVOLVED

This fourth theme was informed by the following subthemes: ‘feeling sad’, ‘leaving patients to cope on their own’, ‘Holding on to memories of the event’ and ‘Failing to handle the loss’.

4.4.1 FEELING SAD

Most participants expressed feelings of sadness and sympathy for the wellbeing of patients. In some instances, they were advised by colleagues to step back as professionals. This is how they expressed themselves:

‘I think that as a mentor of mine said. Sometimes I invest too much into deliveries and I become very emotional about people’s losses. And what she one day told me is that sometimes I need to take a step back because people aren’t that emotionally engaged as what I am about their own losses.’ (Participant C).

‘It’s sad because it is one of those things that you can’t go out and feel okay about it because when you deliver a baby you are (inaudible) ... the baby is okay. But if the baby is not alive that does really affect me...with me I kind of think about it even afterwards...but I try to forget about it.’ Participant E

‘You can never get comfortable delivering a stillborn. Because even if the mom accepted that the baby has died but the time when the baby comes out

the mother becomes more emotional and it becomes even more difficult for you because the mom is crying and you also want to cry. But you can't cry in front of her. You must be strong for her. So it is more difficult' (Participant F).

Participants mentioned that staff were always saddened by a perinatal loss and often felt that they had failed the patient. According to Hughes (2002), apart from family members, staff members are also shocked and upset when there is a stillbirth. Inexperienced staff might feel at a loss to know what to say or do. Nevertheless, if there are protocols that give them reassurance and guide them through processes of how to manage the situation, coping with the experience would not be very traumatic. However, when prenatal bereavement programmes are developed, caution should be taken against institutionalisation of bereavement (Backer & Nackerud, 1999). They reiterate that interventions should be sensitive to the individual differences of grieving families.

4.4.2 LEAVING PATIENTS TO COPE ON THEIR OWN

Some participants explained that there was a room allocated to patients that were giving birth to a stillborn or having a miscarriage. Consequently, since the room is located at the back of the ward, some patients were forgotten or the main ward would be so busy that patients were left to cope on their own. One participant stated:

‘I mean you find what happens and I also find it is quite frustrating. I mean nobody wants to deal with a mommy who had a stillborn baby; whether it is during pregnancy or whether she’s delivered. Nobody wants to deal with that. But somebody has to deal with that. And you find that she is in the labour ward...which is right at the back and you find that nobody monitors her. And I mean which makes it, I don’t know, I feel compelled that I now have to go there. It becomes frustrating because nobody enjoys it’ (Participant A).

As indicated in this study, if given a choice, midwives would rather spend more time attending to mothers with live babies.



4.4.3 HOLDING ON TO MEMORIES OF THE EVENT

Participants mentioned that after delivering a patient that had a miscarriage they found themselves thinking about the event afterwards. Some would go home thinking about the event and the patient.

‘Well, I mean it depends. If it’s something that’s confirmed already and the patient is like unemotional then you’re okay. I guess you just take your cue from the patient. But on the other hand if it is now maybe a patient that is unexpected and then of course you become a bit emotional. And when you’re off you still think about what could have been done differently’ (Participant A).

‘Because once you’ve delivered that SB, especially the undiagnosed one...when you get home that is the only thing that you talk about. And it

affects your family as well. Because it is the only thing...and you don't talk about it for one day. It is an ongoing thing and you'll keep on saying this happened and this happened' (Participant C).

Most of the participants said that they thought of the event afterwards and held onto the memory. Some expressed feelings of great sadness after the delivery. According to Pilkington (2006), the experience of grieving a loss is a significant human experience. Bolton (2000) carried out a qualitative study on nurses working in gynaecology in one of the facilities in North of England to determine how the introduction of new management of patients experiencing a perinatal loss affected nurses' work. The findings indicated that many nurses found that their emotional involvement in caring for patients caused them the most anxiety. Nurses also related how dealing with a miscarried baby caused them the most distress (Bolton 2000). Paradoxically, they also saw the emotional stresses of the job as bringing the greatest potential for job satisfaction (Bolton 2000). In contrast to the findings of this study, ambiguities surrounding miscarriage involved emotional dilemmas for participants who may have had little or no guidelines on hospital policy for dealing with what was sometimes termed as 'gynaecological scraps'.

4.4.4 FAILING TO HANDLE THE LOSS

Some participants said that assisting and dealing with the experience of a woman having a miscarriage left them with feelings of not being able to

handle the patient's loss. They felt that they first needed time to deal with their emotions on their own before dealing with the woman. One participant narrated that the first time she assisted a woman having a miscarriage; she had to leave immediately after the delivery because she felt that she needed to be alone.

'...because there was also a cord around the neck...it was three times around the neck. So I thought it was maybe the cause of the miscarriage...And then I couldn't wrap the baby. I went to the toilet. I delivered...finish. I delivered the placenta finish...all my things. And then I put the baby in a drain lappie and put it on the trolley and I left and I went to cry in the toilet. I couldn't take it' (Participant G).



Midwives are at the forefront when it comes to assisting and managing patients who experience a perinatal loss. Olesenand (1998) points out that because the expression of emotions is thought to be significantly embedded in the work of nursing care and a dimension of nurses' professional orientation, this trend creates the potential for tension between structural demands for efficiency and the expression of emotion. The psychosocial impact of perinatal loss has been studied extensively over the last 25 years.

Nonetheless, it must be emphasised that perinatal loss affects parents and those responsible for its management. The situations of perinatal loss produce a heavy emotional impact on health professionals, where, in most

cases, there is an evident lack of skills, strategies and resources to cope with these kinds of situations (Montero et al. 2007). According to Chan & Arthur (2009), many health professionals recognise their level of knowledge and understanding of grief counseling to being insufficient and few receive targeted training. Thus, the development of basic and advanced education would enable staff to better cope with their work (Laakso & Paunonen-Ilmonen 2001).

However, at times, instead of a solid education base, personal beliefs guide the actions of health professionals more so than evidence (Fernandez-de-Maya & Richard-Martinez 2010) or the parent's desires. There is also great ambiguity about the responsibilities among the different professionals involved, creating an obstacle to parents to acquire the appropriate information (Laakso & Paunonen-Ilmonen 2001). Worden (2003) describes the importance of sharing the emotional burden with other professional colleagues when supporting the bereaved, and in doing so, places great emphasis on the importance of considering the emotional health of carers. This was rarely the experience of the midwives who were interviewed; they spoke of a culture of neglect by management in this regard.

4.4 CONCLUSION

This chapter presented and described how midwives experienced the phenomenon of dealing with women going through a perinatal loss, as well as its emotional, physical and psychological impacts.

CHAPTER 5: CONCLUSION

5.1 INTRODUCTION

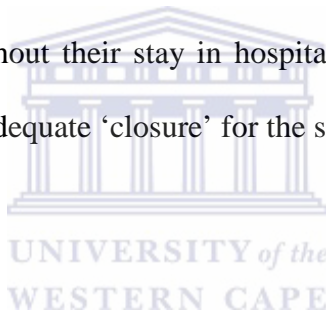
In this chapter conclusion of the study is presented together with implications for practice. In addition, recommendations and limitations are provided, as well as dissemination of the information.

5.2 IMPLICATIONS FOR PRACTICE

Improving support to the mothers with pregnancy loss needs a multi-disciplinary approach or teamwork. Teamwork is the collaboration of various professionals in a team on an equal basis to enhance mutual collaboration (Modlba 2008). The team should involve professionals who have a variety of skills and characteristics, with acknowledged membership and who have clear values that necessitate shared experience and co-operation (Collins 1984). According to Gardner (1999), multidisciplinary conferences targeting causes of prenatal death, effective interventions and care of the bereaved should be regularly scheduled. Collaboration strategies should be addressed at these meetings for purposes of improving the quality of care to the bereaved and providing support to the professionals. Prenatal nurses and midwives should be included in a physician's discussions with bereaved parents and the parents should participate in decision making regarding their care.

5.3 RECOMMENDATIONS OF THE STUDY

Based on the study findings, it is recommended that education programmes be reviewed to ensure that they include midwives' needs in the area of managing clients experiencing a perinatal loss. Student midwives should be given more clinical experience of caring for bereaved couples under supervision, as well as compassionate support, which would assist them to develop their skills before they graduate. Qualified midwives should endeavor to ensure that students working with them are debriefed following traumatic incidences and that further support is provided for those who require it. Students should also be encouraged to continue caring for bereaved parents throughout their stay in hospital, to ensure continuity of care for the couple and adequate 'closure' for the student.



5.4 LIMITATIONS OF THE STUDY

Due to the phenomenological approach utilised for this study, the results are context specific. However, this does by no means imply that the results would be inapplicable in other contexts.

5.5 DISSEMINATION OF STUDY RESULTS

A copy of this study will be placed in the library of the University of the Western Cape for other researchers to gain access. The results will also be published in peer-reviewed journals and presented at local and international conferences.

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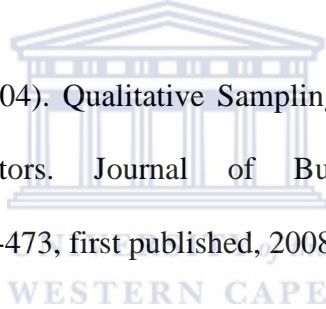
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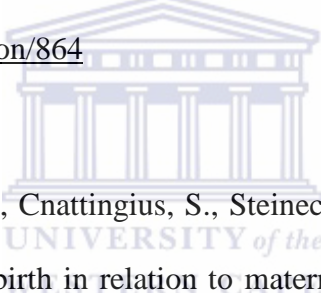
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APPENDIX A



UNIVERSITY OF THE WESTERN CAPE

SCHOOL OF NURSING PRIVATE BAG X17, BELLVILLE 7535

Tel: 021 959 3074 / 2271

Email address: njooste@uwc.ac.za

INFORMATION SHEET

Project Title: Exploring the lived experiences of midwives in managing patients' perinatal loss at a level two maternity hospital in the Western Cape, South Africa

What is this study about?

This is a research project being conducted by myself, Melissa Williamson, at the University of the Western Cape (Student number 2445955). I am inviting you to participate in this research project because you as a midwife may have nursed patients who have had such an experience as above. The purpose of this study is to explore and describe the lived experiences of midwives' in the management of patients who experienced perinatal loss in order to provide improved understanding to policy makers, midwifery educators and managers on how midwives deal with the phenomenon.

Permission for the study has been granted by the Senate Higher Degrees committee and Senate and Research Grants and Study leave Committee.

What will I be asked to do if I agree to participate?

You will be asked to participate in an in depth interview and talk about your experiences when managing patients who have had a perinatal loss. The study will be conducted at Mowbray Maternity hospital, in a private room allocated for the interviews. The interview will take about 30-45 minutes depending on the participants and their availability.

Would my participation in this study be kept confidential?

Your personal information will be kept confidential. To help protect your confidentiality, all transcripts will be kept in a locked drawer and only the researcher will have the key at all times. Your name will not be included on the transcripts and other collected data; a code will be placed on the transcript, and only the researcher will be able to link the transcript to the participant. The results of the study will not contain any reference of you as a participant in this research project; your identity will be protected to the maximum extent possible.

What are the risks of this research?

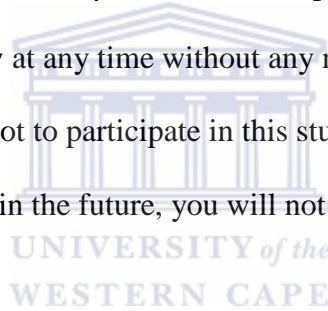
There are no known risks associated with participating in this research study. However, if you are afraid that talking about your experiences may come to the attention of higher authority, then you can rest assured that all information imparted to me will be held in confidence and will not be reported to management.

What are the benefits of this research?

There are no direct benefits to you currently, but the information gathered may assist future midwives to improve their management of patients who have had a perinatal loss and to submit to management a number of recommendations to assist midwives to manage their patients optimally.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary, so you may choose not to take part at all. If you do decide to participate in this research study, you may withdraw at any time without any negative consequences to yourself. If you decide not to participate in this study or if you stop participating at any time in the future, you will not be penalized for this.



Is any assistance available if I am negatively affected by participating in this study?

If sharing your experiences causes any negative feelings, you may be referred to the available counselling services at the institution.

What if I have questions?

This research is being conducted by, Melissa Williamson from the University of the Western Cape. If you have any questions about the research study itself, please contact me at: Tel: 0720396575, or email: melissawilliamson02@gmail.com

Should you have any questions regarding this study and your rights as a research participant, or if you wish to report any problems you have experienced related to the study, please contact either:

The Acting Head:

Prof K Jooste

School of Nursing

University of the Western Cape

Private Bag X17

Bellville 7535

Tel: 021 959 2274

Email: kjooste@uwc.ac.za

This research has been approved by the University of the Western Cape's

Senate Higher Degrees and Research Ethics Committee.



APPENDIX B



UNIVERSITY OF THE WESTERN CAPE
SCHOOL OF NURSING
PRIVATE BAG X17, BELLVILLE 7535
Tel: 021 959 3074 / 2271
Email address: njooste@uwc.ac.z

CONSENT FORM

Title of Research Project: Exploring the lived experiences of midwives in managing patients' perinatal loss at a level two maternity hospital in the Western Cape, South Africa

This study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered to my satisfaction. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not affect me negatively in any way.

Participant's name.....Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator details: Melissa Williamson

University of the Western Cape

Private Bag X17, Belville 7535

Cell: 0720396575 Fax: (021) 6582991 Email:

melissawilliamson02@gmail.com



APPENDIX C

Question for the interview

Please explain to me in detail your experiences of managing a patient who has had a perinatal loss. Start from the first time you had to deliver a stillbirth.



APPENDIX D

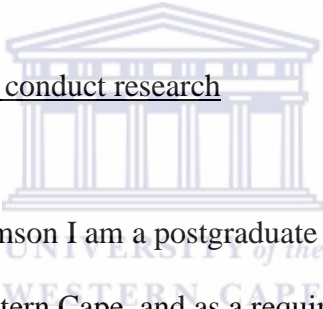


16th October 2013

Dear Research Committee

Mowbray Maternity Hospital

Requesting permission to conduct research

The logo of the University of the Western Cape, featuring a classical building with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.

My name Melissa Williamson I am a postgraduate student at the University of the Western Cape, and as a requirement of my Master's degree, will be submitting a thesis entitled "Exploring the lived experiences of midwives in managing patients' perinatal loss at a level two maternity hospital in the Western Cape, South Africa".

The aim of the study is to explore the experiences that midwives undergo while nursing patients that had a perinatal loss, and what effect it has on their management of such a patient. Your hospital has been identified because it is within the researcher's reach and the necessary working

relationships has been established the nursing staff in the labour ward.

The research proposal has already been approved by the University's Ethics Department, which has been included with my proposal. The findings will be published so that more knowledge can be obtained from this research.

Hoping that my request will be favourably considered.

Thank you in advance

Yours sincerely Melissa Williamson Email:

melissawilliamson02@gmail.com Cell no:0720396575



APPENDIX E



**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT**

10 September 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by Mrs M Williamson (School of Nursing)

Research Project:	Exploring the lived experiences of midwives in managing patients' perinatal loss at a level two maternity hospital in the Western Cape, South Africa.
Registration no:	13/7/5

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.


Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape



APPENDIX F

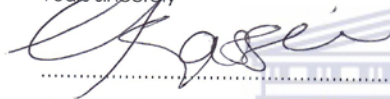
2 June 2016

TO WHOM IT MAY CONCERN

This is to certify that GAVA KASSIEM edited the thesis entitled
**Exploring Midwives' Experiences of Managing Patients' Perinatal Loss at a
Maternity Hospital in the Western Cape, South Africa** by Melissa Williamson.

The onus is however on the author to make the changes suggested and to attend to queries. The author requested that no formatting and reference checking be done.

Yours sincerely



Gava Kassiem

Independent Language Consultant

MA (Language Practice)

Email: gkassiem@gmail.com

Mobile: +27(0)82 4467400

