ESTABLISHING HELP-SEEKING PATHWAYS BY MOTHERS BEREAVED THROUGH PERINATAL DEATH IN DR GEORGE MUKHARI HOSPITAL, GAUTENG PROVINCE

By

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RESEARCH THESIS

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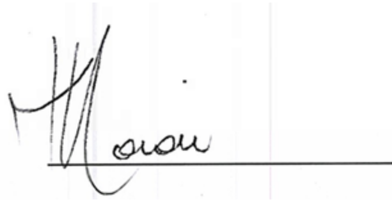
DECLARATION

I declare that this thesis **ESTABLISHING HELP-SEEKING PATHWAYS BY MOTHERS BEREAVED THROUGH PERINATAL DEATH IN DR GEORGE MUKHARI HOSPITAL, GAUTENG PROVINCE** hereby submitted to the University of Limpopo for a Doctoral Degree in Psychology has not been previously submitted by me for the degree at this or any other institution. It is my own work in design and in execution of all material contained herein is duly acknowledged.

Signed at Pretoria on the 21/01/2022



J.M. Moloisane-Ledwaba

DEDICATION

To God and my ancestors who have always carried me through the difficult times of my life. My children, Jeje, Lesego and Reabetswe, this is for you!!!

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ABSTRACT

The psychological impact of perinatal death in the form of bereavement has been widely researched especially from the western perspective. The aim of this study was to establish the help-seeking pathways by mothers bereaved through perinatal death from the African perspective.

The qualitative research paradigm in particular the phenomenological approach was adopted for the study. Phenomenology is described as an approach that focuses on the study of the lived experiences of individuals within their world. The application of this approach included personal interviews of 20 mothers who have experienced perinatal death at Doctor George Mukhari hospital in Gauteng province. The aim was to establish the help-seeking pathways they adopted to relief their distress, in terms of how they managed their bereavement and the help that they sought to relief their emotional distress.

The findings of the study indicated that mothers lacked knowledge about what precipitated the onset of sudden symptoms such as early rupture of membrane, bleeding, lack of foetal movement which finally led to perinatal death. This lack of knowledge led mothers to attribute the cause of perinatal death to various reasons and conclusions such as distance decay, bad roads that delayed their arrival timeously at the hospital for their babies to be saved. Some cited lack of sense of urgency from the medical personnel and shortage of staff, especially doctors. However, they perceived positive social support from their families, spouses and medical professionals as one of the factors that contributed to their level of calmness and ability to bear the pain of loss.

However, participants sought alternative help to facilitate clear understanding about what could have caused their babies to die, also how to manage their grief and how to deal with their subsequent pregnancies. Most of the participants benefited from the various healing pathways they chose. There is a need for healthcare system and community support to be more responsive to the plight of bereaved mothers, in reducing the stigma and the self-blame by bereaved mothers by offering support through counseling center. The findings reaffirm that despite the great studies taken in reducing perinatal deaths, there is a need for collaboration between the modern healthcare system and the traditional healthcare practitioners. Furthermore, emphasis

is needed on the preventative measures and training of healthcare practitioners within the maternal and child healthcare system to further reduce the alarming increase of prenatal deaths.

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ACRONYMS AND ABBREVIATIONS

HBM	Health Belief Model
ICD	International Classification of Diseases
IPA	Interpretative phenomenological analysis
MaNHEP	Maternal and newborn health in Ethiopia partnership
MDG	Millennium Development Goals
PTSD	Post-Traumatic Stress Syndrome
SMU	Sefako Makgatho Health Sciences University
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ZCC	Zionist Christian Church

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The purpose of this study was to investigate the help-seeking pathways adopted by women who experienced perinatal bereavement. One of the main objectives was to determine the meaning that they attach to the loss of their babies in terms of what they believe might have been the cause of their death. The study furthermore sought to understand the different help-seeking pathways they adopt in coping with and alleviating their emotional distress. In this chapter, the researcher provides a brief background of the general reaction of individuals and parents who have experienced the loss of children at birth or in utero.

1.2 BACKGROUND

Perinatal period commences with the completion of 22 weeks of pregnancy and ends seven days after birth. Perinatal mortality is the combination of stillbirths and early neonatal deaths (death within the first week of life). The number of stillbirths and neonatal in the first week of life per 1 000 births is known as perinatal mortality rate (P.M.R.). Globally, perinatal mortality rate is estimated as 53/1000 (7.5 million annually). Despite the substantial progress made globally to reduce the unprecedented increase of perinatal deaths, babies still die daily amounting to 47% of all children under 5 years. Globally the quality of care has emerged as a clear indicator and parameter for the assessment of the quality of life (Hassan, Mathew, Khanna and Das, 2017).

The United Nations with the collaboration of the African Union, formulated United Nation Interagency Group for Child Mortality Estimation (UNIGME) to determine the level and trends in the under 5 mortality in 195 countries between 1990 and 1995 and, at the same time to determine progress made towards reaching MDG4. It also aimed at the estimation of the impact of post 2015 towards the survival of children under 5 between 2016 and 2030 (Danzhen, Hug & Edermyn, 2015).

Most of these deaths occur in the under-developed countries such as Southern Asia which has 24/1 000 per live births and sub-Saharan Africa which has 27/1 000 live

births. A child born in Sub-Saharan African is 10 times more likely to die in the first month of life than children born in high-income countries. India failed to achieve Millennium Development Goal (MDG4) and the targeted maternal mortality rate (M.M.R.)

As a result, the new target for Sustainable Development Goal (SDG) was set at 12/1 000 live births by 2030 (Hassan et al., 2017; WHO, 2020). Most perinatal deaths occur due to preterm birth, intrapartum-related complications such as asphyxia and birth defects. Most of the neonates succumb to complications of pneumonia, diarrhea, malaria and malnutrition (WHO, 2020). Most of deaths are caused by maternal complications. As a result, the African Union collaborated with WHO and formulated the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) in 2009. South Africa is expected to accelerate progress in the reduction of perinatal death and maternal deaths especially those deaths that were preventable from 2018-2030 (Hug, Lancet, 2019).

In South Africa, perinatal deaths are about 18/1 000 per live birth. The main causes of this deaths are diarrhea, lower respiratory tract infections, HIV and AIDS infections, malnutrition which is associated with poor quality of care and poverty. However, South Africa was found to have an abnormal or an unusual trend of perinatal death based on the MDG4 & 5 although it has made significant progress towards the reduction of maternal and neonatal mortality rate in the last decade (Mabaso, Ndaba, Mkhize, & Kwitshana, 2014; Malinga, Dupreez, & Rabie, 2020).

However, the discrepancies in the maternal and child mortality rate estimation in South Africa were found to be due to lack of a reliable measuring tool in tracking progress and monitoring the SDG and the goals for healthcare for all in 2030 (Damian et al., 2019). The perinatal deaths may just be statistics to the country for future prevention and management of perinatal mortality rate, but to the families, these losses are real and personal. The pain of loss is very deep and lingers for a long time.

The death of a child is an overwhelming and a traumatic experience which is regarded as unnatural, as it tends to subvert the conventional order of life. The death of a child throws the family into a crisis that triggers emotional disequilibrium (Arnold, Woods, & Hawryluk, 2007; Freud, 1961; Wortman & Boerner, 2011). For example, a study by Grinyer (2002) found that parents find it difficult to find words to describe their

experiences with the loss of a child. Knapp (2005) described this as a lack of vocabulary in describing feelings of loss such as emotional instability.

Parents who have lost a child not only lose the child, but they also lose all that the child represented such as the future and descendants. The life that they had planned for the child ends when the child dies, changing their status to that of bereaved parents. Parents remain inconsolable and may never find a substitute to replace their lost child. The lost child remains an integral part of the family. Death rips the child from the family tapestry, thus changing the overall outlook of the family (Boyd, 2018; Murphy & Cacciatore, 2017).

The painful experience of the loss of a child tends to prompt bereaved mothers to embark on help-seeking pathways so as to alleviate this emotional trauma. A few studies have suggested that the help-seeking pathways followed by individuals are influenced by a number of factors that include cultural factors, belief systems, socioeconomic status and social networks (Fridgen, Aston, Gschwandtner, Pflueger, Zimmermann, Studerus, Stieglitz, & Riecher-Rössler, 2013; Zondo, 2010). In terms of cultural practices, the individual's perception of illnesses, in this case what could have caused the death of child, the explanation and their expression of the symptoms, and how and when they seek help are greatly influenced by the individual's cultural background (Galdas, Cheater & Marshall, 2005; Papen, 2008; Shaik & Hatcher, 2004). For example, in some African communities, pregnant women have been reported to consult traditional healers in the first trimester of their pregnancies as they believe that such actions will protect them against evil spirits. Consulting a traditional healer, in this instance, is believed to increase the likelihood of a successful pregnancy (Ngomane & Mulaudzi, 2010; Van der Kooi & Theobald, 2006).

This behaviour often results in delayed antenatal treatment and, in some cases, delivery of their babies at home thus predisposing the mother and the baby to birth complications such infections that may result in the death of both mother-child (Maimbolwa, Yamba, Diwan, Ransjö-Arvidson, 2003). During the process of labour and delivery, pregnant women of the Anyi-Ndenye tribe in Cote d'Ivoire despite the advanced modern ante natal healthcare system, still prefer to use traditional herbs to ensure the smooth foetus development and uncomplicated labour and deliveries (Neffatti, Najjaa & M'ath'e,2017).

The trend of using traditional herbs during pregnancy, labour and deliveries have been noted among the South African women in Mogwase community in Rustenburg district, who are using a medicinal plant call kgaba and crushed ostrich eggshells to speed up the process of labour and delivery as it relaxes the muscles during childbirth (Van der Kooi & Theobald 2006). In the instances where pregnancy does result in a successful childbirth, mothers engage in different help-seeking pathways looking for answers of what could have caused the death of their babies, at the same times seeking help to alleviate their distress. Pitman, Rantell, Marston, King and Osborn (2017) found that mothers who have lost their children perinatally reach out for support from family, compassionate friends and appropriate counselling agencies. These findings are further supported by Grace, Christ, Bonano, Malkinson and Rubin (2003) who revealed that social support systems are used as a buffer in the prevention of any long-term negative impact on the mothers such as depression, suicidal thoughts and anxiety. The pathways adopted are often not linear but recursive and complex (Mbatha, Street, Ngcobo, & Gqaleni, 2012).

The type of help-seeking pathways that mothers adopt are influenced by their subsequent attitudes, values and belief systems towards the cause of the loss of babies and these vary from one individual to another. Wong-Kim, Sun, and Demattos (2003), Li, Hsu, Chen and Shu (2017); and Rakhkovskaya and Holland (2017) stated that the beliefs that people have play an important role in their understanding of their health condition. These include beliefs that people have in understanding and explanation of their sickness; beliefs of what caused their sickness which then determine the type of treatment to be sought; which significantly influence their expectations and hope regarding the possible healing outcome (Oji, Hung, Abbasgholizadeh, Terrell Hamilton, Essien & Nwulia, 2017; Podolecka, 2016).

1.3 RESEARCH PROBLEM

The loss of a child in vitro or after birth is a traumatic experience for bereaved mothers. In an effort to restore their health, several help-seeking pathways may be adopted which are influenced by the individual's perception of the cause of the illness and are culturally influenced in terms of the manner in which the symptoms are expressed (Fridgen et al., 2013; Pandalangat, 2011; Shai, 2012). These perceptions influence the treatment modalities adopted in the management of the identified health

conditions. In this current study, this was mothers bereaved by perinatal death. For example, in some African countries, people use the services of traditional healers as the first point of contact, if not as their only source of healthcare (Shai & Sodi, 2015).

Traditional health practitioners' practices are the major source of healthcare in some parts of Africa because of the socio-cultural understanding of their illness and their accessibility to the communities (Lesolang, 2010; Pitje, 2004; Shirinda & Nyazema, 2005). Consequently, the prenatal care of pregnant women is at times done by traditional healers (Malan & Neuba, 2011). Ngomane and Mulaudzi (2010) found that pregnant women in Bohlabelo Community in Mpumalanga Province use the services of traditional healers in their first trimester, before proceeding to use antenatal care services in their second and at times in their last trimester. Whatever pathway is followed, mothers bereaved through perinatal death are impacted negatively, often resulting in conditions such as post-traumatic stress disorder and subsequent depression and anxiety (Geller, Bonacquisti, & Patterson, 2018; Gold, Leon, Boggs & Sen, 2016).

Despite all the help-seeking efforts taken by pregnant mothers to preserve their pregnancies and expect a smooth labour and deliveries, babies still die perinatally, leaving emotional scars on mothers who leave the hospital empty-handed and in distress. While there is ample literature on the phenomenon of perinatal deaths, these studies have often tended to focus on areas such as the causes (Statistics South Africa [StatsSA], 2013; World Health Organisation [WHO], 2006); risk factors (Lawn, Cousens, Zupan, Lancet Neonatal Survival Steering Team, 2005; WHO, 2005); psychological impact on the mothers (Burden, Bradley, Storey, Ellis, Heazell, Downe, Cacciatore, Siassakos, 2016; Cacciatore, 2013) and the training of midwives and medical practitioners dealing with perinatal deaths (WHO, 2002). The researcher is not aware of any studies that have investigated the help-seeking behaviour and pathways followed by African mothers who are bereaved through perinatal death.

Therefore, the researcher in the present study sought to address the gap by investigating the help-seeking pathways adopted by black mothers bereaved through perinatal deaths. The study of this nature sheds light on the understanding of the bereavement process, the psychological impact, the coping strategies, and the different help-seeking pathways adopted by African mothers perinatally. This is

particularly important as most of the studies around the bereavement of mothers due to child loss whether in utero or later in life has been conducted mostly with Caucasian mothers. Little is known about the bereavement processes of African mothers and the help-seeking pathways that they adopt, having experienced perinatal death.

1.4 SIGNIFICANCE OF THE STUDY

The current study could potentially achieve the following outcomes:

- Knowledge of the pathways followed by mothers bereaved through perinatal deaths may improve maternal and child healthcare services, thus limiting the long-term psychological impact on the bereaved mothers.
- In addition to the existing literature may improve the training of health professionals especially those who are managing pregnant women.
- The knowledge of the pathways followed by bereaved mothers may highlight some of the gaps in the western approach adopted towards the management of bereaved African mothers perinatally and may provide a new cultural dimension in the care provided to bereaved mothers.
- This may also open an avenue for a debate regarding the possible collaboration between traditional healers and western-trained healthcare practitioners in the formulation of policies pertaining to the management of bereaved mothers following perinatal death.

1.5 PURPOSE OF THE STUDY

1.5.1 Aim of the Study

The aim of the study was to explore the lived experiences of mothers bereaved through perinatal deaths and to establish the help-seeking pathways they adopt in alleviating their distress.

1.5.2 Objectives of the Study

- To investigate the experiences of the bereaved mother by prenatal deaths
- To determine the understanding and meaning of the causes of prenatal death from bereaved mother.
- To investigate the help-seekin

- To present the psychological meanings distilled from the experiences of the bereaved mothers

1.6 DEFINITION OF CONCEPTS

- **Anticipated bereavement:** This is a grief reaction that occurs in anticipation of an impending loss. The term anticipation grief is used when families discuss the impending death of a person, although dying individuals themselves can experience anticipatory grief. Anticipatory grief includes many of the symptoms of grief after a loss. Often, it is defined as a total set of cognitive, affective, cultural and social reactions to expected death felt by the parents and the family. Anticipated grief is the grief experienced by families who are informed that their unborn child may not survive in utero or during or after delivery. The researcher in this study adopted this definition of anticipating grief (Bennet, Dutcher, & Snyders, 2011).
- **Bereavement:** Bereavement is the state of having lost a loved one. This is expressed through grief which is the feeling of loss. The feeling of loss is expressed as mourning according to cultural norms (Markin & Zilcha-Mano, 2018). In the present study, the same meaning of bereavement was adopted.
- **Help-seeking pathways:** These are viewed as routes taken or followed by individuals to achieve a specific outcome. Pathways are referred to as remedial actions taken with regard to an identified disease (Zondo, 2010). In the context of the present study, the same meaning of help-seeking pathways was adopted. These different pathways are influenced by the lived experiences of different individuals seeking help.
- **Lived experience:** These are the thick descriptions that record more than what the person is doing. It goes beyond the mere fact and surface appearances of the individual, and presents detail, context, emotions and the ramifications of social relationships that joins a person to each other. They evoke emotionality and self - feelings. These thick descriptions insert history into experience, where the voices, feelings, actions and the meanings of the interacting individuals are heard (Mouton, 2001).
- **Perinatal death:** According to the WHO (2011), perinatal deaths are a combination of foetal deaths, commonly called stillbirth, and infants that die within the first 28

days of life. This includes early neonatal death, that is, infants dying within the first week of a live birth. For the present study, perinatal death means babies who died during delivery or were stillborn.

1.7 OUTLINE OF THE THESIS

The thesis is organised into eight chapters.

Chapter 1 is comprised of the introduction, background to the study, the research problem, purpose and objectives of the study and the significance of the study.

Chapter 2 is the literature review. It comprises of the following: Introduction, classification of perinatal deaths; prevalence and risk factors towards perinatal death; psychological impact of perinatal death on bereaved mothers; introduction to barrenness; definition of barrenness; causes of barrenness; Western perspectives on the causes of barrenness; African perspectives on the causes of barrenness; management of barrenness within the African context; and motherhood.

Chapter 3 provides a theoretical perspective of grief. It comprises the following: the classical psychoanalytic theory of grief; the Kubler-Ross model of grief; the dual process model of grief; and Bowlby's attachment model.

Chapter 4 addresses the conceptual frameworks. It covers the role of theory; the pathway model which involves the role of social support model of bereavement; the process of help-seeking within the social support model; decision to seek help; selection of a help provider; feedback loop between the help-seeking stages; limitations of social support model; advantages of social support network; health belief model; health belief model framework; socio-demographic factors; psychological barriers; demographic variable and barriers; the Afrocentric perspective which addresses the conceptualisation of the Afrocentric paradigm; the theoretical principles of the Afrocentric paradigm; and the criticisms of Afrocentricity.

Chapters 5 is the presentation of the methodology for the study, followed by the research design, data analysis and the issues about the quality pertaining to the study, lastly the presentation of the ethical issues adopted in conducting the study.

Chapter 6 is the presentation of findings which comprises of the phenomenological themes as revealed by the participants' lived experiences of the bereaved mothers as

caused by the perinatal death and the help-seeking pathways adopted to alleviate the distress.

Chapter 7 presents an analysis of the shared experiences and the interpretation of the participants' answers and then aligns this with van Manen's existential dimensions which is used as the theoretical framework for the study.

Chapter 8 is the final chapter of the study, which comprises of the summary, conclusions and the recommendations of the study. The limitations are also outlined followed by the implications of the study in terms of the theory, practice, training outlined by the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is divided into three parts: the first part focuses on the obstetrical classification of the child mortality rate and classification of child diagnosis according to the international coding system, followed by the prevalence and risk factors of perinatal deaths, and finally the discussion on the psychological impact of perinatal death on bereaved mothers.

Obstetrically there are two types of child mortality, namely, infant mortality and perinatal mortality. Infant mortality refers to all the deaths of children younger than 12 months, while perinatal mortality accounts for deaths of all the children dying pre-birth or immediately after birth (stillborn), and those dying within the first 28 days of life. Perinatal deaths are classified by the WHO so as to achieve better diagnosis and management of the condition. Infant mortality is a serious problem globally. For example, statistics by the WHO (2011) show that, globally, an estimated 7.6 million children are reported to die within their first five years of life.

Measures have been taken by the United Nations towards the reduction of infant mortality rate by adopting the global Millennium Development Goals (MDGs) 4 and 5 in 2015. Sub-Saharan countries (including South Africa) account for most of the infant mortality rate. In 2017, WHO and UNICEF developed a strategy adopted by 51 countries that would contribute towards the reduction of the infant mortality. The strategy was the use of a tracking tool to provide evidence that would support an action plan for the prevention of new-born deaths and still births (StatsSA, 2013; WHO, 2017). Unfortunately, these measures are hampered by poor record-keeping, and this has resulted in an incomplete international classification coding system of birth, death and the possible causes of those deaths.

The global mortality rate has declined significantly according to the United Nations to 90.6 deaths per 1 000 live births in 2015 as determined by MDG4. However, certain countries especially in the sub-Saharan countries, South Africa included, failed to achieve the MDG4 goals. There is a clear indication that 2/3 of sub-Saharan countries

need to accelerate progress so as to achieve the determined target (You, Hug & Ejdemyr, 2015).

Despite the significant drop in the decline of the under-5 infant mortality rate, there is a great need for all countries to strive towards avoiding preventable deaths, so as to achieve sustainable development goals of the under-5 mortality rate of 25 or fewer deaths per 1 000 live births as projected by the United Nations in 2030 (Hill, You, Inoue & Oestergaard, 2012).

2.2 CLASSIFICATION OF PERINATAL DEATHS

There has been little progress in the prevention of perinatal deaths. Many classification systems have been adopted to identify the causes of perinatal deaths. The WHO took it upon itself to develop a system that enable comparison within and between diversities that is the low-middle-high income countries. This was designed for the purpose of benchmarking and identifying the trends, the gaps modifiable factors and the type of intervention needed towards prevention globally and locally. Most of the countries with the highest mortality rates have limited or non-existent birth and death registration processes and have inadequate medical records. Hence, it is vital that in addressing high perinatal mortality rate, the causes of those deaths should be accurately captured and classified (Lavin, Preen & Pattinson, 2016). WHO, in collaboration with its partners, has designed a global system of classification to identify the causes of perinatal death. This classification was achieved by using the International Classification of Diseases (ICD) and related health problems, using the ICD coding rules of the 10th revision (ICD 10) called perinatal mortality (ICD-PM).

The ICD-PM has distinct features. First, it captures the time of death of the baby whether it was antepartum (before birth), intrapartum (during labour) or postpartum, that is, during the neonatal period (WHO, 2012). Secondly, ICD-PM adopts a multi-layered approach in classifying the causes of death, using information given, assessing the clinical conditions that may have led to the death and linking it to the ICD code for proper diagnosis. Thirdly, ICD-PM links the contributing maternal factors with the death (Allanson, Tunçalp, Gardosi, Pattinson, Francis, Vogel, Erwich, Flenady, Frøen, Neilson, Quach, Mathai, Say & Gülmezoglu, 2016). This knowledge and the link of the maternal factors and foetal factors can contribute positively towards

the prevention and therapeutic intervention of mother-child health programmes, thus reducing both maternal and child deaths, especially perinatal deaths.

Obstetrically, perinatal deaths are further classified as ante-partum where the baby dies after 37 weeks of the gestational period before the onset of labour; and intra-partum where death occurs after the onset of labour but before birth (Blencowe et al., 2016). The use of the ICD-PM in providing the diagnosis, time of death and what could have been the cause of death, seem to have not prevented the death of babies as desired by clinicians, as perinatal deaths remain high globally. Most of the researchers found that that there are extraneous factors that are beyond the mother and child, that predisposes both the pregnant mothers and the unborn baby to maternal and child mortality rate. This are known as the risks and prevalent factors (Ajao & Adeoye, 2019; Ghorat, Ghafarzadeh & Jafarzadeh Esfehani, 2016; Vogel, Souza, Mori, Morisaki, Lumbiganon, Ortiz-Panozo, Hernandez, Pérez-Cuevas, Roy, Mittal, Cecatti, Tunçalp, Gülmezoglu & WHO, 2014).

2.3 PREVALENCE AND RISK FACTORS TOWARDS PERINATAL DEATHS

A number of risk factors have been found to predispose mothers to perinatal deaths. These, among others, are the age of the mother (Oji, 2008; StatsSA, 2011); socioeconomic factors (Mmusi-Phetoe, 2016); and a lack of education (Fischetti, 2011).

2.3.1 Maternal Age

Studies conducted by Dietl, Cupisti, Beckmann, Schwab and Zollner (2015) revealed that mothers who were 40 years or older at conception have more risk of perinatal deaths than younger women. These findings are also supported by Walker, Bugg, Macpherson, McCormick, Grace, Wildsmith, Bradshaw, Smith, Thornton and the 35/39 Trial Group (2016) who also revealed that women who conceived over the age of 35 years had a higher risk of perinatal death. This was also evident in women who were 17 years or younger (Timur, Kokanalı, Topçu,, Topçu, Erkılınç, Uygur & Yakut, 2016). Ribeiro, Ferrari, Sant'Anna, Dalmas and Girotto (2014) revealed that maternal age is considered to be one of the determinants of gestational risk as young mothers aged below 15 years have a comparatively higher risk of perinatal death due to lack of child-rearing skills and an increased need for medical attention.

2.3.2 Maternal Education

Several studies have demonstrated that maternal education has a significant relationship with perinatal deaths in both developed and developing countries. Karlsen, Say, Souza, Hogue, Calles, Gülmezoglu and Raine (2011) observed that, compared to those with higher levels of education, young mothers with low levels of education are unable to make optimal decisions with regard to antenatal care, basic hygiene and nutrition which are essential elements in the reduction of perinatal mortality. This is supported by the findings of a study by Chomba, McClure, Wright, Carlo, Chakraborty and Harris (2008) who suggested that women with less than a secondary education had a relatively higher chance of a perinatal death compared to women with higher levels of education. This was partly attributed to lack of access by women with low levels of education to information and understanding of the importance of services such as antenatal care (Jones, Lattoff, & Coast, 2017; Ngomane & Mulaudzi, 2010; Oji, 2008).

In Japan, Sugai, Gilmour, Ota and Shibuya (2017) conducted a study among the women who were attending family planning services, in which the findings revealed that higher maternal educational status played a significant role in the reduction of perinatal death. These findings were further supported by a study conducted in Belgium by Zeitlin, Manktelow, Piedvache, Cuttini, Boyle, Van Heijst and Schmidt (2016) to measure the role of social inequalities in perinatal mortality. The researchers concluded that perinatal death was strongly correlated with the level of education of the mother.

In African countries, Sami, Amsalu, Dimiti, Jackson, Kenyi, Meyers, Mullany, Scudder, Tomczyk andd Kerber (2018) conducted a study within the community of Sudan and found that perinatal mortality rate decreased as the number of years of full-time studies increased among women. Even in Nigeria, Chomba, Carlo, Goudar, Jehan, Tshefu, Garces, Parida, Althabe, McClure, Derman and Goldenberg (2017) showed that perinatal mortality rate was higher among mothers with no formal education than those with higher educational levels.

2.3.3. Socioeconomic Status

In terms of socioeconomic status, studies revealed a higher risk of perinatal deaths among women of lower socioeconomic status than those of higher socioeconomic status (Oji, 2008). Socioeconomic status is influenced by employment of the mother or the spouse, which will indirectly influence the accessibility of the pregnant woman to better healthcare services, proper water, sanitation and good nutrition. Lack of proper prenatal nutrition to pregnant mothers has been found to be closely associated with babies born with low birth weight. Poor maternal nutrition results in poor neurocognitive development of the foetus in utero, preterm birth and infant macrosomia leading to perinatal death (Steegers, Barker, Theunissen & Williams, 2016).

2.3.4 Smoking and alcohol

Smoking has been found to be one of the risk factors of perinatal death. The harmful effect of nicotine enters the fetal circulation, resulting in multiple organs failure such as lungs, adrenal glands, cerebral cortex, eventually resulting in respiratory failure and death of intrauterine and neonatal death (Bednarczuk, Milner, & Grenough, 2020).

Similarly, Lawder et al. (2018) also revealed that smoking during pregnancy leads to babies with low birth weight, often prematurity with respiratory infections such as Asthma, Bronchitis, with negative birth outcome.

Smoking was also found to play a negative role in perinatal deaths. This has been a challenge as far back as the 1950s. Various studies have revealed that the risk of perinatal death increased by 28% among mothers who smoked during pregnancy. Smoking increases vasoconstriction resulting in poor uterine growth of the foetus, finally causing pathophysiological changes which ultimately lead to perinatal death (Faber et al., 2017; Oji, 2008).

2.3.5 Parity

Various studies have demonstrated a close association between parity and perinatal death. According to Devabhaktuni et al. (2019) and Mayo et al. (2019), both ends of parity, namely the first-time pregnant women (nulliparous) and those with more than three pregnancies (multiparous) were associated with significant increase in perinatal

deaths. This is attributed to increased rate of foetal malpresentation, meconium-stained liquor and placenta previa with low foetal Apgar scores in multiparous women compared to the nulliparous women or those with lower parity (Mgaya et al., 2013).

Nulliparous women were found to have higher risk of perinatal deaths due to obstructed labour necessitating assisted deliveries such as forceps and vacuum extraction (Kozuki et al., 2013). This is supported by Başer et al. (2013) in their study with Turkish pregnant women which revealed that there was higher rate of preterm delivery, with low Apgar scores, which resulted in intensive care unit admission and perinatal deaths among nulliparous women, while multiparous women were found to be more prone to preeclampsia or abruptio placenta with increased foetal demise.

2.3.6 Place of Residence

Mothers residing in rural settings were found have a higher risk of perinatal mortality compared to those in urban settings. This may be attributed to cultural practices or taboos that were found to be practised more by rural mothers during pregnancy and after birth (Withers, Kharazmi, & Lim, 2018). Rural settings were also associated with poor service delivery such as lack of proper water and sanitation, well-trained health professionals and lack or accessible health facilities (Lisonkova et al., 2016).

2.3.7 Place of Delivery and Delivery Assistants

Delivery of babies at home by birth attendants have been found to have the lowest perinatal deaths, compared to medically trained professionals. This could be attributed to mothers being referred to hospital at a late stage of their labour or delivery by which time not much can be done by the doctors to save the babies (Oji, 2008).

However, some of the foetal factors that contributes to perinatal deaths were revealed by various researchers as foetal growth restriction due to abnormal doppler velocimetry, which leads to abnormal umbilical and uterine artery functioning, eventually resulting to foetal growth retardation with a low birth weight and prematurity and foetal death (Demirci et al., 2015). These findings were supported by Sharma et al. (2016) who revealed that foetal growth restriction predisposes the foetus to asphyxia, hypothermia, hypoglycaemia and polycythemia with negative outcomes such as congenital birth abnormalities presenting commonly as trisomy 13 Patau

syndrome which is a chromosomal condition associated with severe intellectual disability and physical abnormalities in many parts of the body).

Other conditions such as trisomy 18 (Edwards syndrome, it is a chromosomal condition associated with abnormalities in many parts of the body); whereas trisomy 21 (Down syndrome, a genetic disorder typically associated with physical growth delays, mild to moderate intellectual disability, and characteristic facial features); and metabolic disorders such as galactosemia leading have also been associated with the causes of perinatal deaths. According to StatsSA (2013) infections, such as viral disease, bacterial sepsis, haemorrhagic and haematologic disorder of the foetus were also found to be the contributing factors towards perinatal death. The impact of these symptoms and risks factors have resulted in increased perinatal statistics, with long-term psychological repercussions for the bereaved mothers (Gandino et al., 2019).

2.4 PSYCHOLOGICAL IMPACT OF PERINATAL DEATHS ON BEREAVED MOTHERS

Perinatal loss is an unexpected traumatic life-changing experience (Cacciatore, 2013, Gold et al. 2016). It is an experience that may change the belief system, values and spirituality of the mother and may be viewed as an existential dilemma (Jong et al., 2018). Mothers who experience perinatal death were found to have a higher risk of developing depressive symptomatology, which was found to be fourfold higher as compared to women with live birth, especially if the pregnancy loss occur in the longer gestational period beyond 20 weeks. These symptoms were found to be predisposing to bereaved mothers even nine months after a perinatal death experience, especially among young mothers with lower educational levels and a history of previous mental health condition (Bhat &Byatt, 2016).

Increased symptoms of phobia and anxiety were found especially in the first four months after the pregnancy loss, even after successful subsequent live birth were observed among the mothers compared to those with live babies. Further, feelings of obsessive-compulsive disorder, suicidal ideations, isolation and disconnectedness with their social environment, accompanied by overwhelming guilt and negative cognitive appraisal such as a sense of failure were also observed (Bhat & Byatt, 2016; Burden et al., 2016).

According to Boyle (2018), the psychosocial impact of perinatal deaths on mothers is massive, as it may cause major emotional problems in terms of adjustment to the bereavement period, such as unpreparedness to face the painful reality of loss. Others expressed the wish that people should acknowledge their loss and be sensitive to their pain of loss and give them a listening ear and support. One woman expressed her emotional pain after two stillbirths as being in "limbo", a state that she and her husband felt powerless to escape, living in some place between heaven and hell, struggling to make sense of the birth and the death of their child (Layne, 1990). Some felt that that their grief is being 'disenfranchised' as it is less acknowledged or socially unsupported (Bhat & Byatt, 2016). Whereas some women view their pregnancy loss as a complete failure as the birth failed to bring forth life, and that their bodies have failed to reproduce itself (De Montingny, Verdon, & McGrath, 2015).

Faleschini et al. (2020) revealed that death impacts negatively on the marital relationship of parents of the stillborn babies, with serious long-term consequences on their health and their subsequent children. These findings were supported by Meaney (2015) who stated that mothers bereaved through perinatal deaths expressed a high level of anger and distress towards the hospital for their unsafe maternity unit, simultaneously harbouring feelings of self-blame and fear of the repetition of the perinatal loss with their subsequent pregnancies.

Some research studies revealed a high suicidal tendency among the bereaved mothers as compared to the women of the same reproductive age. The psychological impact of perinatal death among the fathers have been found to be higher within the first month post the perinatal death although in the lower rate compared to the bereaved mothers (Bhat & Byatt, 2016). However, fathers' experiences are also a key factor of concern for health professionals managing the challenges pertaining to maternal and child issues especially perinatal deaths.

2.4.1 Impact on Fathers

The grief of fathers perinatally is less documented than that of the mothers, as pregnancy is arguably still considered to be primarily a women's issue. As a result, fewer studies have been conducted in relation to the impact of perinatal loss on the wellbeing of fathers (Due, Chiarolli, & Riggs, 2017), and perinatal death although at a lower rate (Bhat & Byatt, 2016). Fathers were found to be grieving differently, that is,

preferring to talk less with feelings of powerlessness, irritability, anger with aggressive tendencies, accompanied by compensatory behaviours such as heavier alcohol consumption and another drug use (Due et al., 2017; Bhat & Byatt, 2016). Some research studies found that medical practitioners and family members were finding it difficult to understand the pain of fathers as they are less expressive as compared to their spouses (Dubeau, Coutu, & Lavigueur 2013, Tseng et al., 2017).

In most societies, pregnancy is viewed as a rite of passage even for fathers (Jacinto et al., 2019). Ethnographic research revealed evidence that men avoided certain food as taboos and secluded themselves during their wife's pregnancy and during childbirth. The rite of passage framework clearly stipulates the pregnancy as a social process that involves both men and women although differently. The grief for the stillborn baby is sometimes viewed as a "forgotten" form of grief, whereby even fathers perceive themselves as forgotten mourners as they feel ignored in the whole process of perinatal death (Elmir & Schmied, 2016).

After being informed about the loss of their child, fathers experience feeling of frustration and helplessness during and after the delivery. Most men find meaning and relief from the trauma of losing their babies by supporting their partners, instead of dealing with their own loss. Some fathers found relief from a close relationship with their partners and some even stated that, in this difficult time, they missed having another man around them to share their pain with, as they were unable to share their pain with their spouses, for fear of aggravating their spouse's emotional trauma (Obst & Due, 2019).

Albuquerque, Pereira and Narciso (2016) and Hagen, Iversen, and Svindseth (2016) revealed that there are gender differences in coping following the birth of the stillborn babies between parents. Fathers were found to be trying hard to be the strong partner in their relationship, more concerned about the mother, while the mothers were found to be more concerned about the baby and more receptive of the health professional support. This was identified as a major challenge for parents in terms of dealing with the pain of loss.

Men were found to be more worried about the social support and ignoring the situation, whereas women were found to be seeking comfort from the spiritual world to reduce tension and support from others who have experienced the same loss. The death of a

child perinatally is an overwhelming experience also to the fathers, as most fathers expressed feelings of being marginalised and unacknowledged by the healthcare professionals, family and society as grieving parents. What was more hurtful for parents was when their baby was referred to as less than a person but as something that could be easily replaced and not to be remembered or mourned for (Burden et al., 2016).

The impact of loss is also felt by the siblings as they would have been expecting to meet a new baby, then the loss comes as a great shock to them. Although Alenius et al. (2018) revealed that the impact of perinatal death on surviving siblings has virtually been unexplored, after reviewing the impact of perinatal death on parents, he reported that the reactions, distortions of information about the death of the baby and the communication between the parents have a direct influence on how the siblings will respond to the loss.

2.4.2 Impact on Siblings

Perinatal bereavement has negative repercussions on children born earlier or even after the stillborn babies (De Montigny & Verdon, 2012). The communication between parents and children, whether verbal or non-verbal seems to be altered by the sensitivity to the emotional changes of the bereaved parents, resulting in the children reacting or behaving differently as influenced by their own developmental stages. Some children seek more attention from their parents becoming clingy and more temperamental, while others may experience psychomotor retardation (De Montigny, Verdon, & McGrath, 2015). Providing information to the children about the changes that are taking place within their home tended to reduce the negative reactions of the other siblings and being caught up in the silence and taboos around perinatal death. Including them in the rituals around the burial, picture-taking and funeral processes helped to reduce the impact of the trauma on the older siblings (Mason, 2010).

Jonas-Simpson et al. (2015) stated that siblings suffered from two losses in the bereaved family: first, the loss of the new sibling they were expecting, and second, the loss of their parents as they knew them before the loss. Their grieving parents become unavailable as they become absorbed in their own emotional loss. The feeling of disequilibrium of the family becomes intense as they live with parents whose behaviours are altered by the intensity of the grief.

The grief of the siblings remains for a long time due to the disappointment and sadness leading to feelings of helplessness (Morris et al., 2016). Most grieving parents spend considerable time stuck in their own emotional pain of loss and do not know how to support the remaining siblings. As a result, older siblings feel disenfranchised, unrecognised and unimportant. The grief of siblings after the loss of a brother or a sister should be recognised. Parents should let the siblings experience their stillborn brother or sisters by allowing them to participate in the chains of events following the death of a child. This can be achieved by allowing older siblings to see, hold and touch the baby. This will enable them to understand what happened to the family and possibly facilitate the process of finding closure for them (Morris et al., 2016)

2.5 PREGNANCY, BIRTH, AND PERINATAL DEATH-THE RITE OF PASSAGE FOR THE WOMAN

The intensity and the duration of the psychological impact of bereavement on mothers who have experienced perinatal death are influenced by various factors such as attitudes and perceptions that are culturally entrenched. Culture shapes people in terms of perceptions and expectations around barrenness, childbirth, motherhood and pregnancy loss. These concepts mirror the societal expectations and the role of woman in general (Glenn, Chang, & Forcey, 2016). Pregnancy in many cultures is viewed as a rite of passage, especially if it is the first pregnancy. Some cultures even go the extent of believing that a woman is not 'complete' 'or a 'real' woman until she has given birth to her first child (Reed, Barnes, & Rowe, 2016).

Scholars such as Van Gennep (1960) and Turner (1969) discussed the theory of liminality, whereby the mother to be is separated from the community into the unknown world called the liminal space. In the cultural community of the Bemba, this state is called the *balipakati* meaning that the woman is in midlife position of being between life and death, or as being in limbo that is between the past and the future state of life (Siwila, 2015). These scholars concluded that liminal space when discussed within the rites of passage may have both a positive and a negative implication for the pregnant woman. The negativity of the liminal process may predispose the pregnant woman to considerable harm and risk as it is charged with power and a high degree of vulnerability, whereas the positive effect may be that the woman experiences support

and attention from those who are accompanying her on the birthing journey (Siwila, 2015).

Van Gennep (1960) concluded that there are three important roles of the rite of passage:

- Separation, which excuses the person from normal social roles and status. In communities such as Zambia, the pregnant woman is separated from the rest of the community as a way of protecting her and her unborn baby. The woman is said to be handed over to the ancestors, who are believed to be the custodian of the pregnancy even before it is revealed to the people. This is done through a ritual ceremony called *kwaanga da* where the pregnancy is officially announced to the living and the dead community;
- Transition is the process in which the person adapts to a new role. Some scholars have noted the transitional character of the pregnancy which sets off the pregnant woman from the daily routines such as taboos of eating certain foods; carrying out certain duties that demand physical exertion; avoiding social activities that may traumatise her emotionally such as being around the sick and grossly deformed individuals; and even avoidance of evil thoughts (Kariuki et al., 2017; Sennott & Mojola, 2017);
- Incorporation is the process of integration of the new role into the self that is living the new person which happens after the birthing process;
- After the process of birthing, the pregnant woman is integrated into the new role of motherhood and back into the community with the new status and the new role as a mother through the rite of reincorporation (Kanu, 2017) which is characterised by lifting of the taboos and being addressed as ‘Mom’ (Radcliffe-Browne & Forde, 2015). However, failure to deliver a live baby, as a result of the miscarriage or perinatal death, halts the process of the rite of reincorporation of the woman into her normal role. This stage is referred to as the “rite of return” (Layne, 1990) whereby the woman returns to her pre-pregnancy status rather than progressing to the new or renewed status of motherhood despite having gone through all the rituals and the processes of pregnancy. The rite of return robs the woman of fulfilling the personal and the societal expectations of motherhood and she has to endure the bereavement for the “would-have-been” child and the loss of

parenthood. The bereavement of those women who have children and still have a chance of bearing more children is not as intense as those with multiple miscarriages or stillbirth ending in childlessness (Adebayo, Liu, & Cheah, 2019).

It is appropriate for the researcher to briefly discuss the two concepts of motherhood as it is closely related to the narratives that inform the debate around perinatal deaths in terms of the causes and the psychological impact on the mothers or parents who are dealing with the deafening silence around miscarriages, stillbirth and perinatal deaths.

2.6 FACTORS AGGRAVATING THE PSYCHOLOGICAL TRAUMA OF PERINATAL DEATH OF BEREAVED MOTHERS

Mothers have been discouraged from mourning the loss of their babies as it is viewed as impeding the process of recovery (Furtado-Eraso et al., 2020). In most instances, they are encouraged to 'let go' of the pain of pregnancy loss and to move on and replace the dead baby by getting pregnant again as soon as possible. This 'replacement child syndrome' seems to affect the process of grieving for the lost baby negatively and has been found to increase the anxiety levels of the women in subsequent pregnancies, resulting in some of the mothers postponing subsequent pregnancies (Boyle, 2018). The loss of pregnancy to stillbirth results in the bereaved mothers regressing to the emotional state of childlessness and perceived barrenness by the community around them, especially to those who were expecting their first babies. It is appropriate, at this stage, for the researcher to discuss the phenomenon of barrenness briefly as it closely relates to the narratives around perinatal deaths.

The following factors have been found to be aggravating the trauma of perinatal deaths experienced by mothers

2.6.1 Advanced gestational period

Perinatal loss especially at an advantaged or when the pregnancy is already showing is often associated with a lot of emotional trauma especially when the pregnancy was beyond 20/40 weeks to term. Most of the mothers presented with depressive symptoms, anxiety and post- traumatic stress disorder.

2.6.2 Pre-existing Marital Relationship Conflicts

Research studies revealed that mothers who were exposed to violence before perinatal deaths presented with high level of anxiety and depression after the loss of their babies perinatally. Reduced exposure to conflicts and violence during pregnancy has been associated with the reduction in perinatal deaths (Buitrago & Moreno-Serra, 2021)

Perinatal deaths may lead to the dissolution of marriage. If the relationship was good before the perinatal deaths, it would not matter whether the woman had more than one stillbirth or whether the man's family has influenced him negatively to divorce or separate from bereaved mother.

2.6.3 Termination of Pregnancy

Ambivalent attitudes towards termination of pregnancy were found to lead towards a heightened emotional trauma for bereaved mothers. Loss of an unplanned pregnancy was found to be the source of guilt and self-blame. However, those that were interested in the pregnancy, even thought of names or bought clothes and prepared nurseries showed intense guilt as they yearned for the lost baby (Kersting, 2012). Mothers who had to terminate their pregnancy due to abnormal fetus development such a chromosomal defect were also found to have high levels of anxiety and low self-efficacy with self-doubt in decision-making (Scheidt, 2015). Even those mothers who had experienced fetal movements and suffered a pregnancy loss prenatally, suffered increased emotional trauma such as anxiety and depression.

2.6.4 Delay in Communicating the Course of Perinatal Death by Medical Team

Delay in the provision of what would have caused the baby to die was found to have heighten the level anxiety and post traumatic flash backs. Often the cause of death was described and explained to bereaved mothers in biomedical terms or mothers were given inaccurate information too late accompanied by inappropriate comments and harsh treatment by healthcare professionals. This has resulted in mothers advancing their own understanding and factors that could have caused their babies to die such as witchcraft, heat in the womb, the baby becoming tired or having a weak uterus (Daka, 2006; Kiguli et al., 2015)

2.6.5. Contact with the Stillborn Baby

Studies revealed that presenting the baby to the mother or parent gave the mother an opportunity to say goodbye to the baby and find closure. Some mothers would have taken photographs of the baby. This action has been found to lower the level of anxiety and depression of mothers significantly (Kersting & Wagner, 2012). However, some studies revealed that holding the deceased body of the baby by the mother may result in high levels of anxiety, depression and post-traumatic stress disorder, compared to those mothers who did not have the opportunity to hold their babies (Camacho-Avila, Fernandes, & Hernandez-Padilla, 2019). Some mothers described the feeling of dissociation and explained that it was like a dream. The mothers felt disconnected from reality; to some the experience of holding a stillborn baby was heart-breaking, they were distraught and felt helpless. However, some mothers felt that it was surreal; this helped them to accept and cope better with the pain or loss and helped mothers to build lasting memories.(Renick et al., 2014)

2.6.6 Absence of Older Siblings

Studies revealed that the presence of living children has been found to be a buffer or an important predictor of the intensity of the grief reaction of the mother to the loss. Childless women who have suffered prenatal deaths have been found to have a significantly high level of psychological disorders such as depression, anxiety than those mothers who had older children (Hinesburg & Kesting, 2015). However, the grief for the lost child was still found in the most mothers years later (Davies, 2004).

2.7 THE CONCEPT OF MOTHERHOOD AND PERINATAL DEATH

Motherhood is viewed as a sacred status within the family and community in which the woman lives and it is celebrated. The woman who gives birth is viewed as someone who has increased the family lineage; as a result, she is held in high regard and enjoys special treatment. This ideology is supported by narratives like "the woman's glory is crowned in childbirth" a Sotho Idiom "*Mosadi ga hlaletsa ngwana bolwetsi bo a fola*". [When the mother plays with the child, her sickness gets healed]. This implies that motherhood reduces her problems. Even if problems arise, she will be able to cope because the biggest problems of African women are perceived to be solved by child-bearing (Chimbatata & Malimba, 2016).

Mbiti (1988) views the birth of a child as a joyful period within the family. As a result, the woman deserves to be treated with greater respect than before. Child-bearing is viewed as an integral part of marriage and adulthood. Often women tend to conform to social pressure of parenthood at an early age even before marriage, so as to avoid stigmatisation associated with barrenness or childlessness. In Sesotho words like "*Moopa*", the "one who ate her baby's placenta", the "one whose basket leaks" are some of the harsh negative words used to describe a woman who is viewed as a barren. In African culture, a childless woman is excluded from the child rituals such as naming of the child, because names are only chosen by women who have children. Mathekga (2001) commented during a televised report on SABC2 on the marriage of King Letsie III of Lesotho, that his new wife would not be given a royal name until she had given birth. This shows that motherhood cannot be separated from marriage within the African context (Ntshongwana et al., 2015).

Research has revealed different reactions amongst bereaved mothers. Multiparous mothers found more solace in looking after their other children but could also be less attentive and unable to respond to the sensitivity of these children's needs, whereas the primiparous mother after death of their babies may start questioning their status of identifying themselves as mothers. They may choose to refer themselves as the mothers of the deceased babies, even avoiding to mention that they had a stillborn baby (De Montigny et al., 2015). Mothers must also deal with psychological and hormonal changes after still birth delivery. Among these changes are postpartum lactation which to some mothers may be a symbolism that the birth was indeed "real" while to others, it may be a symbol of the harsh reality that they will not experience the process of breast-feeding their babies (De Montigny et al., 2015).

With the loss of pregnancy prenatally bereaved mothers often embark on the help seeking pathway. Most of the mothers would consult traditional health practitioners and spiritual intervention as an alternative pathway adopted by bereaved mothers.

The World Health Organization (WHO 2014) states that 60% of the global population, uses traditional medicine to management their various ailment, the majority being African people that use traditional medicine to meet their daily needs (Mawoza, Nhanchi, & Magwaza, 2019). Research conducted revealed that 70% - 84% of South African population consult traditional health practitioners for various ailments (Zingela,

Van Wyk, & Pietersen, 2018). Most of the South Africans use the service of the traditional health practitioners as their first contact person, or as their main source of healthcare (WHO, 2012). In most instances, it is the belief system, the perception, and experiences of the health condition that may be aggravated by the cultural differences between the patient and the service provider (Putsch & Joyce, 1990).

Patients may therefore feel comfortable in using the service of traditional health practitioner, as they are viewed as reliable as they are part of the community and that they are accessible and affordable (Sodi et al., 2011). There are two types of traditional healthcare practitioners: that those that uses divination, commonly known as Sangoma; and spiritual healers who use the religious approach to diagnose and manage ailments presented (Zuma et al., 2016). However, African woman have been found to be using the services of traditional healer in assisting them on conception, labour, delivery and for protection and lactation process, African states such Ethiopia, Kenya, Zimbabwe and Uganda have been found have a high rate of women using traditional medicine in pregnancy, labour and delivery processes (Malan & Neuba, 2011).

CHAPTER 3

EVOLUTION OF GRIEF THEORIES

3.1 INTRODUCTION

Different theories present the variables that are at play around the grief process, such as why some women react with intense emotions and take longer to bounce back and regain their pre-morbid selves than others. A factor that was found to influence the aftermath was the coping abilities of bereaved individuals, resulting in their failure to regain the pre-morbid state of their health while others went through their loss unscathed and even came out stronger (Wortman & Boerner, 2011). However, grief has always been viewed from the western perspective, which as discussed later, can be problematic in the African context.

The grief theories evolved since the early twentieth century. It started with the publication of Sigmund Freud's *Mourning and Melancholia* in 1917 and a later edition in 1957. In this publication, Freud attempted to explain the processes of mourning in relation to his ego developmental theories. This is grounded in the psychoanalytical perspective (Denhup, 2014; Scott et al. 2019).

According to Freud (1917), grief is based on the working through process, which is the gradual surrender of the psychological attachment from the loved object. He views it as internal and a painful emotional struggle to relinquish the deceased through a process of grief. This process happens in three phases, that is: 1) freeing of the bereaved from the bondages of the deceased; 2) readjustment of the bereaved to the new life without the deceased; and 3) building relationships. This separation process involves energy of acknowledging and expressing the painful emotions such as guilt and anger. This psychological process is referred to as cathexis, whereby there is a process of withdrawal of the emotional energy from the deceased, and detachment of the individual which is decathexis.

Once this process has taken place, the individual has worked through the grief (Wortman & Boerner, 2011). Failure to do this will increase the risk of mental and physical illness, thus compromising the bereaved person's process of recovery (Brinkman, 2018). In his own private capacity as a bereaved father, he was aware of the long-term effects of grief and the ongoing attachment bond between the parent

and deceased child (Brinkmann, 2018). According to Worden (2018), the grieving process fails to differentiate clearly between the processes of rumination, confrontation, coping and the expression of emotions.

According to Freud, mourning ends with detachment or relinquishing of the attachment bond from the lost object. He further hypothesised that failure to detach oneself results in psychological conditions such as depression and maladies (Freud, 1917). In his theory, Freud coined words like grief work which has influenced most of the work of several theorists who are his successors in terms of bereavement theories (Stroebe et al., 2001). He further believed that grief must be worked through and that failure to work through the grief may result in grief complications (Bonanno & Kaltman, 1999). Detachment from the deceased was the desired goal of the bereavement; however, Davies (2004) found that Freud's advocacy for absolute process of attachment from his own personal experience, after the loss of his daughter, Sophia, was far from being attained.

This was evident in the letter that he wrote to his friend whose own child had died nine years after Sophia's death. He stated that "although we know that after such loss the acute stage of mourning will subside, we also know that we shall remain inconsolable and we will never find a substitute... Actually, this is how it should be. It is the only way of perpetuating that love which we do not wish to relinquish" (Freud, 1929, cited in Davies, 2004, pp. 507–508). Freud's personal experience with the death of his child is a direct contradiction of his theory that detachment from the deceased disconnected the bond between the deceased and the bereaved. Unfortunately, this theoretical paradox is still upheld as the centre of subsequent bereavement stage models of the grief process.

3.2 THE STAGE THEORIES OF BEREAVEMENT

Lindemann (1944) became the first researcher to name the grief process as the stage grief model. He formulated the stage theory which was influenced greatly by Freud's theory. He based his theory on psychoanalytical theory which included shock and disbelief as the acute phase of mourning and resolution (Lindemann, 1944). Lindemann's grief stage model influenced researchers such as Kubler-Ross in 1969 to write a book on death and dying. Her model of grief involves five stages, namely, numbness, denial, anger, blame and acceptance stage (Kubler-Ross, 2003).

Ironically, her grief stage was derived from studying people in the acute phase of their dying process. Unfortunately, it is applied even to individuals who are going through the process of grieving.

The stage theory of grief was formulated by Kubler-Ross in 1969 in which she believed that bereavement follows a linear progression of sequential stages, which results in the final process of recovery from the loss, and the reorganisation of one's life, by going back to the normal life with the acceptance of their loved object's death (Kubler-Ross, 2003). Kubler-Ross's grief stage model is often applied to grieving individuals, but it has been labelled as the best known, least understood and most misused theory about grieving (MacWilliams et al., 2003). Even though her model was never intended to be linear, sequential, and orderly, the model is, in most instances, presented as a sequential grief model, with the stages that all grieving people should go through (MacWilliams et al., 2003).

Several research studies revealed that there is a major shift in the theoretical findings underpinning the bereavement of individuals. Instead of individual following the linear progressive model of bereavement, studies revealed that detachment and closure does not happen in such a fashion, but rather the continued bonds with the deceased continues throughout the bereaved life span without achieving total completion and closure of the bereavement experiences (Scott et al., 2019). These findings are supported by Gold, Sen, and Leon (2018) who revealed that bereaved mothers experience intense bereavement and relive their traumatic experiences throughout their lives.

Kubler-Ross's grief model is popularly used and entrenched among the healthcare professionals, and extensively used by grieving persons and their families, thus leading to the common understanding of grief within societies. The progression of research studies around the death and dying theory resulted in most researchers giving little support to the systematic stages of grief model (Wortman & Boerner, 2011). This model of grief was mainly based on the anticipatory grief reactions, namely, how the individual would normally respond to a terminal condition but was later applied to the bereavement process and many other processes of change. The Kubler-Ross model has been widely criticised for suggesting that, during bereavement, individuals have to move through stages as there are no empirical findings supporting this.

Hall (2014) viewed the five stages of grief theories as having a "seductive appeal" and having a sense of conceptual order to a more complex process leading to the emotional "promised land of recovery and closure" (p. 8). However, the stage model does not address the deep-seated complexity especially around the spiritual, psychological and social experiences of the bereaved families and other broader social network around them. Nevertheless, this model of bereavement has been widely used as part of the curriculum in the medical professions.

Attig (1996) and Archer (1999) stated that the reaction to loss varies from individual to individual, and that not all people pass through the stages of grief in the same way. A major flaw of the stage model was its failure to explain the variations of the bereaved in responding to the loss. Secondly, it placed the bereaved in a passive role and failed to consider the cultural and social aspects that influence the process of bereavement (Neimeyer, 1998).

The stage model of grief was also found to pathologise people who are unable to complete the stages of grief. As a result, failure to reach the final stages of acceptance may be perceived as failure of the individual to deal appropriately with the grief. Lack of empirical support for the model and the above-mentioned factors led to most researchers not supporting the fixed sequence of the stages of grief (Neimeyer, 1998; Stroebe, Schut, & Stroebe, 2005).

3.3 THE DUAL PROCESS MODEL OF GRIEF

In the mid-1990s, Stroebe and Schut (1999) formulated a model of grief called a dual process model of grief. This model suggested that during the period of grief, the bereaved operated in two ways, switching back and forth between them. The dual process of grief does not support processes such as 'working through' but rather encourages the process of ignoring one's emotions, by creating a distraction from the process of grief, as a natural way of coping with the loss. The theory postulates that as one grieves, one switches or oscillates between two different modes of being. Hence, the model is called the dual process model.

This model is viewed as being more comprehensive as it not only focuses specifically on the bereavement process but attempts to integrate the diverse elements of theoretical approaches into a comprehensive grief process model. Within the dual

process model of grief, the individual having lost a loved one oscillates between two coping mechanisms, that is the loss-orientated coping where the bereaved individual focuses primarily on the attempt to conceptualise and resolve some of the emotions of loss, or restoration-orientated coping where the individual strives towards the adaptation and mastering of the life challenges that may have occurred due to the loss of life (Wortman & Boerner, 2011). Wortman and Boerner (2011) further pointed out that in the beginning of the grief process, the individual adopts loss-orientated coping strategies, namely, dealing with the overwhelming emotional challenges of grief such as shock, anger, aloneness and sadness, and later shifts towards the restoration-orientated coping mechanism.

This model provides a way of determining how different individuals cope with grief and the aftermath of the loss, such as financial challenges, burdens of responsibility in terms of caring for their children, or possible relocation. Women have been found to be more loss-orientated than men, and their grief-coping mechanisms are more predictable in terms of coping with stressful life events such as death (Stroebe & Schut, 1999). The grief work is characterised by the process of loss orientation, whereas the restoration orientation deals with the secondary losses that occur as the aftermath of the death (Dent, 2005).

Although some researchers view the dual process model as an over-simplification of the grief process, the process of focusing on the death itself (restoration) is viewed as avoidance behaviour of not confronting the issues around the death but shifting one's focus to the aftermath of the death. This may be perceived by some as an avoidant grief style, thus predisposing the bereaved to higher levels of somatic complaints sometime after the loss (Worden, 2018). Those who confronted the challenges around the loss of the person instead of adopting avoidance behaviour were found to have positive morale shortly after the death but later experienced signs of depression (Stroebe & Schut, 2016).

One can conclude that confronting the issues around the loss of a loved one by adopting the avoidant grief pattern, impacts equally negatively on the bereaved, but the positive aspect of the dual model of grief is that the bereaved has more control over the process of grief in terms of what to focus on during the acute phase of bereavement and when to do so. Since the model does not adopt a linear process in

dealing with grief, it allows people to experience their grief from their own perspective and not adopt a uniform way of following stages and tasks. The dual model of grief allows one the opportunity to reconstruct one's life without feeling guilty about the deceased and affords the bereaved the opportunity to revert to the grief process as and when the need arises.

3.4 BOWLBY ATTACHMENT MODEL

In the 1960s, John Bowlby conducted research on childhood bereavement with children between 1 and 3 years of age, who were separated from their parents over a prolonged period. His findings were that their reactions resembled those of bereaved adults (Christ, 2000). He formulated a hypothesis from these findings that children's bereavement processes originate from attachment bonds formed between parents and their children. This led to his attachment model of bereavement. Bowlby (1980) believed that attachment is influenced by the following three functions: 1) proximity to the attachment figure provides the child with a safe haven; 2) accessibility of the attachment figure provides the child with a secure base from which the child can confront challenges; and 3) separation from the attachment figure may trigger separation anxieties which is a distress emotional state, where the child's energy may be directed to the attachment figure. From these three attachment functions, Bowlby (1980, cited in Denhup, 2014) described how the loss of parents in childhood can result in possible emotional reactions in children.

The attachment model is based on the developmental stages of children and how individuals deal with mourning. According to Bowlby (1980), during the normal development process, children and parents instinctively form attachment bonds or affectionate bonds, which are later formed between adults. He further suggested that the type of affectionate bonds formed between the child and the parent tend to influence how one will deal with separation or bereavement later in life. Any threat to the affectional bond results in the activation of powerful emotions such as crying or angry protest, with the longing for reunion with the departed loved ones, but in the case of permanent loss, proximity with the attachment figures is viewed as pathological.

Unlike Freud, Bowlby (1973) posited that bereavement does not withdraw the deceased from the bereaved; rather, the process of reunion takes place through the

opposing forces of the activation of the attachment behaviours and dealing with the reality that the loved one is permanently gone. In order for one to deal with these opposing forces, the bereaved goes through four stages. These stages are numbness, disbelief or shock, yearning or searching for the lost object, despair and disorganisation as the bereaved gives up the search for the lost object, and feelings of depression and hopelessness (Wortman & Boerner, 2011).

Through the theory of attachment, Bowlby (1973) was the first to explain the relationship between individuals and the attachment history as to how an individual will react to the loss of a loved one. For example, children who experience separation from their parents may become anxious and highly dependent adults, resulting in an intense and prolonged grief when they lose their parents or spouse in the future (Stroebe et al., 2005). Thus, the effect of parental loss increases the likelihood and vulnerability to future adversity among children (Bowlby, 1982). Similarly, Furman (1974) hypothesised that children who experience the death of a parent would experience problems later in life. However, he further concurred with Bowlby (1980) that the child will resume his life and move on, which will be the final task stage of the child's grieving process, which according to Scott et al. (2019), will be considered to be the child's completion of the grief process.

In 1978, Leshan concluded that the mourning of children never ends, but rather a process of "resurgence" of mourning may take place throughout the life of the child. This may be triggered by significant events such as birthdays, graduations and weddings that may constantly remind the child of the absent parent (Leshan, 1978). However, researchers have criticised the attachment model for not identifying the factors and the processes involved in life-changing experiences of individuals, "that is reaching a point of becoming a (transformational) turning point" (Wertlieb, 1997, p. 189).

Similarly, Oltjenbruns (2001) found that even after several studies were conducted on bereavement of children, "there is no clear understanding of how a child grieves" (p. 181). This resulted in most theories around the grief process of children being viewed as inconclusive and contradictory, as they failed to distinguish how the symptoms of bereavement in children differ from childhood psychiatric disorder (Scott et al. 2019). This view is supported by Stroebe and Schut (1999) and Attig (1996), who concurred

that lack of specification of the grief process of children fails to account for the emotional, behavioural, physical, and intellectual consequences that children experience as a result of grief. Despite all these limitations, the attachment model of grief of children has influenced the understanding of bereavement of children immensely.

CHAPTER 4

CONCEPTUAL FRAMEWORK

4.1 INTRODUCTION

In this chapter, the researcher discusses the theoretical framework underpinning the study. The researcher looks at the role of theory in determining an effective healthcare model that is comprehensive and holistic in addressing the body, mind and spirit of individuals, and the pathway model that facilitates the process of social support in terms of coping with the stressful situation. The health belief model and its relevance to bereavement of African mothers and the adoption of the Afrocentric model for the current study is also considered.

4.2 THE ROLE OF THEORY

The comprehensive care of the soul does not provide a clear distinction between the person, body and the spirit, but rather views this aspect of care as a totality that is characterised by mutual and reciprocal influence. Unfortunately, there is a lack of a well-articulated, comprehensive clinical models to capture the essence of the care of people within the broad multi-faceted healthcare system. This results in practitioners adopting the psycho-spiritual approach towards all issues of care of individuals, which results in the somato-psychospiritual care of the person (Sturmberg, 2018). This means that there is a need for a model of care that will emphasise the interconnectedness of all dimensions of aspect of care that is physical, social, spiritual and cultural, thus, preventing the general reductionism and compartmentalisation of healthcare systems.

In the absence of comprehensive models of care that provide guidance on care of the person in totality, practitioners are “stuck” in operating within the frameworks that they know. This reality calls to mind the old story of the blind man and the elephant, whereby each one thought that the part that they touched represented the whole. This provides a challenge to practitioners who adopt various care models to acknowledge the risk of errors with greater humility; that within our various disciplines, we see only one aspect of the whole. There is thus a need for researchers to forge ahead in articulating comprehensive models that will reflect the true care of the soul (Benner, 1998).

4.3 THE PATHWAY MODEL

According to Schriver, Van Hoorn, and Huiskes (2012), the pathway model involves complex interventions for the mutual decision-making and organisation of healthcare processes for individuals. The model puts emphasis on the role that significant others play as decision-makers (Good, 1987). These decision-makers may be extended family members who form support systems in the management of the illness. These support systems are dynamic and may change the treatment regime and the pathway adopted (Janzen & Arkinstall, 1978). Based on the pathway model as elucidated by Schrijvers et al. (2012), it can be argued that mothers who have been bereaved through perinatal death will tend to choose various pathways so as to reach out to significant others for emotional support during their bereavement. In this regard, Jaffe (2014) suggested that these bereaved mothers will be supported in their help-seeking behaviour by significant others. Similarly, the researcher in the present study argues that mothers bereaved through perinatal deaths will follow some logical sequence that will be punctuated by the support of significant others when they seek help.

4.4 THE ROLE OF SOCIAL SUPPORT MODEL OF BEREAVEMENT

Social support systems whether informal or formal have been shown to improve women's mental health in terms of their willingness and ability to seek help from the formal support systems, leading to their subsequent capacity to overcome their pain and loss. Mostly families and friends were found to be providing women with informal support during the period of distress (Goodman, Tummala-Narra, & Weintraub, 2005; Horton & Johnson, 1993), in the form of advice, encouragement or affirmation or even babysitting in case of other, older siblings (Goodkind et al., 2003). Formal support often come from the institutions such as health professionals, mental health professionals and spiritual groups.

According White et al. (1992), the size of one's informal social network and the level of perceived supportiveness of the close family members and friends predicts one's psychological wellbeing towards traumatic experience, although there is dearth of documented studies about social support for women who have experienced traumatic incidents, including bereavement. However, traumatised women were found to be reluctant to access existing support networks whether formal or informal (Dunham & Senn, 2000). This behaviour is quite significant as informal social support such as

friends and family members are viewed as key protective factors and the buffer in minimising mental health complications (Astin, Lawrence, & Foy 1993; Carlson et al., 2002; Kemp, Rawlings, & Green, 1991).

This indicates that emotionally traumatised women who receive tangible support may be less susceptible to the deleterious psychological impact of perinatal death, such as anxiety, depression, suicidal thoughts or post-traumatic stress syndrome (PTSD) (Wang et al., 2005). In the next section, the researcher briefly discusses different stages of the social support model as one of the help-seeking pathways adopted by women in distress, followed by the HBM.

4.4.1 The Process of Help-Seeking within the Social Support Model

Several studies have examined the nature and extent of help-seeking behaviour among mothers who have been emotionally traumatised by perinatal deaths. However, a theory of help-seeking that provides a framework for such findings has yet to be developed. In the current study, the researcher will draw from the general model of help-seeking towards change as discussed by (Liang et al., 2005) to elucidate the process of help-seeking by distressed mothers.

The model (Figure 4.1) tends to focus on the individual help-seeker's internal cognitive processes, namely, problem recognition and definition; the decision to seek help; and the selection of a help provider. These three stages are influenced by factors such as the individual's own perceptions, interpersonal factors around the individual and the socio-cultural factors within which she lives.

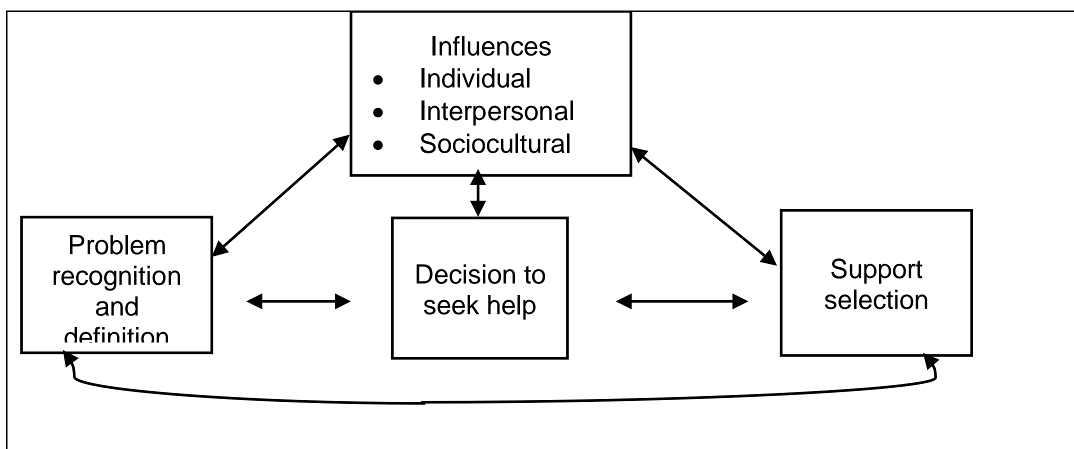

Figure 1: Adapted model of help-seeking and change

Source: (Liang et al., 2005)

4.4.2 Process of Help-Seeking

According to the model, the individual's definition of the problem, and the decision on whether to seek help and choose support are provided as distinct stages that are not linear. The bereaved woman's appraisal or definition of her situation determines her help-seeking pathways and from whom the help is sought. The helper that she chooses also influences her definition of the problem and whether she will choose to seek help again. The stages are dialectical and inform the others in an ongoing feedback loop. The double-headed arrows are placed in between the stages to capture the complexity of this interactive process.

According to Saami et al. (2007), the help-seeking pathways of traumatised women are primarily described in terms of cognitive processes, but emotions are closely linked to cognitive and intentional actions. For example, feelings of guilt, shame or stigma that may result from a decision to seek help may be a barrier to acting upon the decision to seek help. These internal processes are influenced by interpersonal and socio-cultural factors such as the economic and cultural factors in which her life experiences are entrenched, coupled with her individual and previous history.

4.4.3 Problem Definition and Appraisal

Individuals respond to problems differently, depending on how they define the problems and how they evaluate the severity of the problem; e.g., a therapist who defines the problem of a client as depression will treat and approach the problem accordingly, but this intervention will make less sense to the client who defines the same problem as caused by a spiritual crisis. Most of the literature on help-seeking behaviour views problems as a trigger point for the help-seeking behaviour assuming that their definition of the problem is universal. The literature on help-seeking behaviour puts emphasis on defining the problem from the perspective of the individual in need, in this case, a bereaved woman, thus moving away from the definition of the problem from the professional perspective (Broadhurst et al., 2008). Women who have experienced emotional distress interpret the situations as influenced by overlapping multiple factors such as individual, interpersonal relationships and socio-cultural factors when it comes to their problem definition.

According to Lempert (1997), most of the help-seeking behaviours of emotionally traumatised women are derived from formal institutions and this has actually limited people's understanding of the process of problem definition and may hamper or enhance the help-seeking behaviour. Most researchers have focused on what distressed women do instead of how they interpret their emotional experiences. These interpretations of their experiences influence the help-seeking behaviour (Wang et al., 2005). The definition of one's emotional trauma influences the type of intervention one will adopt in relieving one's distress.

4.4.4 Individual Influence on Defining Emotional Trauma

The perception of the emotional trauma by women influences their preventative strategies in managing the distress. So too, their readiness to adopt certain strategies is influenced by their own individual approaches; that is, the individual's definition of emotional trauma shifts over a period of time depending on their level of readiness to change their lives. For example, according to the trans-theoretical model, a bereaved woman who is experiencing a perinatal death for the first time will differ from those who have experienced multiple miscarriages (Haggerty & Goodman, 2003).

Bereaved women spend time in the pre-contemplation phase as they accept the problem as minimal as defined by those around them. At times, they regard their problem as their fault, resulting in reluctance to take action in seeking help and advice from others. Gradually, when they start realising the emotional intensity of the problem and start weighing the pros and cons of seeking help, it is then that they start thinking about the problem: this is called the preparation phase. They start moving towards taking action by seeking help and going through the phase of reconceptualisation of their situation, as they start to act on their distress (Liang et al., 2005). People around the bereaved woman also influence their definition of their emotional problems and their help-seeking pathways.

4.4.5 Interpersonal Influences on the Definition of Emotional Trauma

People around the emotionally traumatised woman play a significant role in facilitating her definition of the trauma, especially a partner, spouse, other family members or friends. The nature of this interaction may aggravate the intensity of the distress especially where there is distortion and dissonance among her social network in terms

of the definition of the problem; for example, in response to verbal abuse about the pregnancy loss from their partners or their social networks, women may doubt and blame themselves and reconstruct the meaning and redefine their loss (Lempert, 1997).

4.3.6 Socio-Cultural Influences on the Definition of Emotional Trauma

The individual's definition of emotional trauma is also influenced by the social context in which they live. This is further shaped by the interacting dimensions of class and culture. There are some cultural or religions institution that reinforce power inequities and are very oppressive towards women (Michau et al., 2015). For example, in certain cultures, a husband is allowed to bring other women to bear him children when the wife does not conceive or has multiple miscarriages, and they may even be subject to beatings (Baloyi, 2017; Phoofolo, 2007). Class and socioeconomic status play a significant role in understanding the emotional trauma of the women who have experienced perinatal deaths. Women with more resources may have more options for taking action in seeking help than those in poor socioeconomic classes (Liang et al., 2005). The definition of the problem by the woman facilitates the decision-making process to seek help to relief her distress.

4.4.7 Decision to Seek Help

The decision of the emotionally traumatised woman to seek help depends on her problem definition, the continuous cognitive appraisal of her situation and external circumstances around her (Liang et al., 2005). According to Cauce et al. (2002), there are two internal factors that are fundamental in seeking support:

- Recognising the problem as undesirable; and
- Seeing the problem as unlikely to go away without help from others.

Research findings around these two factors reveal a correlation between the severity of the emotional distress and help-seeking behaviour, which result in the gradual move from dealing with the distress privately to even choosing to speak about the trauma publicly (Haggerty & Goodman, 2003).

According to Lempert (1997), emotionally traumatised women tend to seek help only when their resources are depleted and when they have lost hope in their own ability

to deal with the trauma themselves. Rose, Campbell, and Kub (2000) identified two common factors that prevent women from seeking support: 1) A fear of isolation; 2) A cautious relationship with others. This means that an emotionally traumatised woman may chose not to seek support because of fear of insecurity, ambivalent feelings of reaching out to others; they rather chose to 'close-up' around people and push themselves to endure their grief alone, thus blocking all the mechanisms of reaching out to others for help.

Cultural factors, class and gender play a significant role in helping the traumatised woman to seek help; for example, family privacy or gender dominance where a man is viewed as superior in their social setting and has to give permission to the woman to seek help outside the family circle, and fear of divorce and stigmatisation and isolation may paralyse many women from seeking help, even when they have defined their distress as problematic (Liang et al., 2005).

Their decision to seek help may also be influenced by their prior interpersonal relationships with their friends, family members and formal services such as nurses, therapist or doctors, who lacked sensitivity and downplayed their traumas (Liang et al., 2005). Cultural sensitivity towards childlessness due to barrenness or failed motherhood due to miscarriages may hinder bereaved mothers from seeking help. These women may fear being stigmatised, misunderstood and marginalised by those who are expected to provide them with care. Poor access to decent health services due to socioeconomic factors, class or cultural barriers may also hamper the process of distressed women to seek help, some women may ask themselves questions such 'will I be the only black woman, if I go out to seek help outside my own community' (Nelson et al., 2020).

Inability to access better healthcare services due to socio-cultural barriers such as language barriers in case of migrant women, may result in cultural isolation and failure to access financial and emotional support from those that they have left behind in their country of origin. In most instances, they may not even be aware of the available help due to low levels of education or inability to communicate their need for help to the available service providers and fear of being discriminated against (Mehta & Gagnon, 2016; Swamy et al., 2018). Many women in rural communities are unable to access good health facilities because of poverty, unemployment or low levels of education

and lack of health insurance (Bohren et al., 2015; Krishnan, Hilbert, & Vanleeuwen, 2001).

4.4.8 Selection of a Help Provider

Having identified the problem and deciding to seek help, the individual moves towards identifying a source of support, whether informal or formal. This process is not likely to be linear, as it will involve multiple, interactive, cognitive, and affective processes that are also influenced by the individual, interpersonal, and socio-cultural factors (Saint Arnault et al., 2018)

Research findings revealed that social support will act as a buffer to emotional distress only if the type of social support that is provided equates to the trauma experienced by the individual in terms of the coping needs and the situation (Biaggi et al., 2016). Furthermore, women in distress are unlikely to use the services of the healthcare provider who fails to acknowledge their emotional distress (Bohren et al., 2015).

4.4.8.1 Individual influence on choice of a source of support

A woman's own appraisal of the emotional distress as a personal psychological problem may prompt her to seek emotional solace and comfort from a trusted friend or psychotherapist, and spiritual challenges may lead to seeking help from a spiritual leader. The type of support that a woman chooses will also be influenced by problem-focused coping strategies and styles and the cost-benefit analysis. According to Lazarus and Folkmans (1984), women who perceive their distress from a problem-focused coping strategy will actively seek a solution to manage their distress; e.g., escaping their distress by moving back home to families or friends or even being hospitalised. Those women with an emotionally-focused coping style may seek social support services of a religious leader or a therapist to assist them with their distress (Gupta, Agasthiya, & Nageshwer, 2017).

The woman's ability to form strong or weak relationships with others also influences the type of support she chooses. Guerrero et al. (2017) indicated that if the distressed woman perceives a friend as someone that she feels comfortable with and worthy to seek help from, she will choose her as a source of support. The sources of support that the women choose may be determined by the cognitive weighing of benefit and costs of each potential source of support (Raphael-Leff, 2018), their definition of the

problem and how they cope with it. One of the costs that distressed women consider, whether it is formal or informal support, is the cost of loss of their privacy and stigmatisation especially in case of multiple miscarriages or childless marriages (Shreffler et al., 2018). In cases where the woman perceives the distress as severe, and families and friends fail to reach out to her with support, she may decide that remaining silent or relying solely on informal support may outweigh the risks of seeking formal support; for example, when the perinatal death is perceived as due to negligence or omission by the health professional.

4.4.8.2 Interpersonal influence in choosing the source of support

Friends and families may influence the distressed woman to seek help from an informal or use formal support. Women seeking help from formal support; e.g., healthcare settings, may find this type of intervention emotionally draining as they have to "relive" their trauma by telling their stories numerous times to health professionals to get help, and, at times, may need to face the very doctors and nurses who were involved in the deliveries of their stillborn babies (Kraemer & Steinberg, 2016). Choosing this type of formal support may require emotional and financial support from the family and friends for the emotionally distressed women (Liang et al., 2005). The greater their access to informal social support, the greater the number of help-seeking efforts emotionally traumatised women are likely to adopt (Burrick, 2014).

4.4.8.3 Socio-cultural influences on choosing the source of support

The cultural aspects of individuals in distress play a significant role in choosing the source of social support. In a study conducted by Aroian et al. (2017), immigrants were found to be less able to use the services of the formal social support than non-immigrants; rather, they opted to approach their friends and families for support due to cultural differences, gender roles and, at times, patriarchy.

4.4.9 Feedback Loop between the Help-Seeking Stages

There is an ongoing interplay among various individuals, interpersonal and socio-cultural factors that influence the help-seeking behaviour of distressed women. It is worth noting that the ways that distressed women define their problem and seek help for their distress influence each other. Women who define their problems from the perspective of the mainstream conceptualisation are likely to choose sources of

support from informal or formal settings. At times, the negative or positive experiences of the settings may determine the woman's definition of her problem and how she handles it (e.g., whether to seek additional help or not); for instance, a woman may choose to talk to a friend about her distress who may in turn accompany her to a hospital or to a spiritual healer (Liang et al., 2005).

4.4.10 Limitations of Social Support Model

Numerous studies have found social support as a buffer in stressful life events, thus limiting the negative impact of stressors (Hornstein, 2017). However, other research studies revealed a negative effect of social support on stressful subjects, instead of a buffer effect, especially in a death-related situation (Bottomley et al., 2017). Nevertheless, some studies reveal that there are several limiting variables in seeking social support as discussed below:

4.4.10.1 Age

Young mothers were found to cope better with parenting challenges of chronically ill children, because of the family integration, cooperation and optimism instilled within them by friends, family and their social networks, whereas young fathers relied more on maintaining social support to help them with their self-esteem to cope with parenting challenges. Researchers found that as one gets older, social support networks shrink leading to a reduced social support network. Older males were found to be affected by the reduced size of the social networks. This reduction predisposes them to a higher mortality risk than their female counterparts (Walen & Lachman, 2000).

4.4.10.2 Gender

In case of a chronic medical condition of a child, mothers in particularly were found to be more instrumental in seeking emotional support. They were found to reach out to spiritual/religious support groups while fathers often opted to use alcohol to numb their pain as a coping mechanism (Schwab, 1990). Women were found to maintain a larger social network, and to be more active in providing and receiving social support compared to their male counterparts (Shye et al., 1995). As a result, the size of the social network of a woman was more significant in their health outcomes compared to their male counterparts who were heavily dependent on their spouse or partner.

Hajeck and König (2019) further revealed that the size of the social networks of women facilitates the adaptation process of living alone, especially upon losing their spouse, compared to their male counterparts. Men were found to struggle with the challenges of widowerhood, resulting in greater mortality at this stage of their life-cycle.

4.4.10.3 Resilience

Kaufman et al. (2018) revealed that resilience of the individual plays a significant role in helping people to adjust and adapt to stressors and disruptive life changes and crisis, especially those who are dealing with chronic health conditions such as cancer or disabilities, meaning that individuals with low levels of resilience may be unable to seek social support as a buffer for their stressors.

4.4.10.4 Education and socioeconomic factors

The level of one's education was found to play a significant role in one's ability to seek social support. Mothers with higher levels of education reported better coping abilities than those with lower educational levels. They were found to be ablers to engage with medical personnel and consult with different health professionals compared to mothers with lower levels of education (Leonard et al., 2017).

4.4.11 Advantages of Social Support Network

Davidson (2018) listed the following as some of the advantages of social support.

- Improvement of one's health and behavioural wellbeing, thus preventing onset of chronic conditions such as loneliness leading to depression.
- Social network limits the impact and consequences of emotional trauma such as PTSD.
- Social support increases one's level of motivation.

The factors discussed above are also supported by Stults-Kolehmainen and Sinha (2014) who revealed that active life engagement contributes to successful ageing and avoidance of chronic diseases, thus increasing cognitive and physical functioning. Bucholz (2014) concluded that low levels of social support may predispose one to a greater health risk factors leading to increased mortality from diseases. Social support networks were found to have a moderating effect on genetic and environmental vulnerability to mental illness which enhances the neurobiological risk factors

(McEwen, 2017). These findings were supported by Dikmen-Yildiz et al. (2018) who revealed that poor social support was associated with chronic conditions such as post-traumatic stress disorder (PTSD), and the absence of strong and good social support systems may result in a distressed woman seeking help from health institutions such as clinics or hospitals which base their support and care on the HBM.

4.4.12 The Health Belief Model

According to the HBM, individuals differ in how they perceive their vulnerability or susceptibility towards contracting an illness. Once the illness has been diagnosed, the individual moves towards acceptance of the diagnosis (Rawlett, 2011). This increases the likelihood of the individual to seek treatment.

4.4.12.1 Origin of the health belief model

The HBM was conceptualised by Rosenstock (1966) and based the model of the socio-cognitive perspective. The concept was initially developed by a group of social psychologists in the 1950s in an effort to explain why some individuals fail to use preventative health behaviour for early disease detection, patient response to treatment and their medical compliance with the treatment chosen (Janz & Becker, 1984; Kirscht, 1972; Rosenstock, 1974). According to the HBM, individuals are likely to engage in health-related behaviour provided that they perceive that:

- they could contract an illness (perceived susceptibility);
- the illness may have a long-standing consequence that may hamper their smooth daily functioning (perceived severity);
- the intervention or preventative cause of action taken may render effective arrest of the illness, thus reducing symptoms (perceived benefit); and
- there are few barriers in taking that particular action (perceived barriers).

These four variables are influenced by demographic variables, such as race, age, socioeconomic and educational factors, but over a period of time, a fifth variable was added, namely, the cue to action, which refers to incidents that serve as a reminder of the severity or threat of an illness, e.g. noting the change in a shape of a mole may trigger an individual to consider seeking help for early detection of skin cancer or coughing of blood may prompt an individual to seek help for early detection of

tuberculosis. Even a conversation with a physician about the danger of smoking may prompt one to seek help in stopping smoking. Furthermore, social scientists such as Rosenstock, Strecher and Becker (1988), applied the concept of social cognitive theory to HBM which states that one's perceptions or expectations about the ability to succeed influence the outcome (self-efficiency). For example, the belief that one is capable of quitting smoking (efficacy expectation) plays a crucial part in determining whether the person will actually quit especially when the individuals perceived susceptibility, severity, benefits and barriers are known.

4.4.12.2 Health belief model framework

The HBM is developed around three general approaches, namely:

- Increasing perception of the individual that is the susceptibility to illness and severity of symptoms;
- Decreasing the psychological or physical barriers to treatment; and
- Increasing the perceived benefits of the treatment.

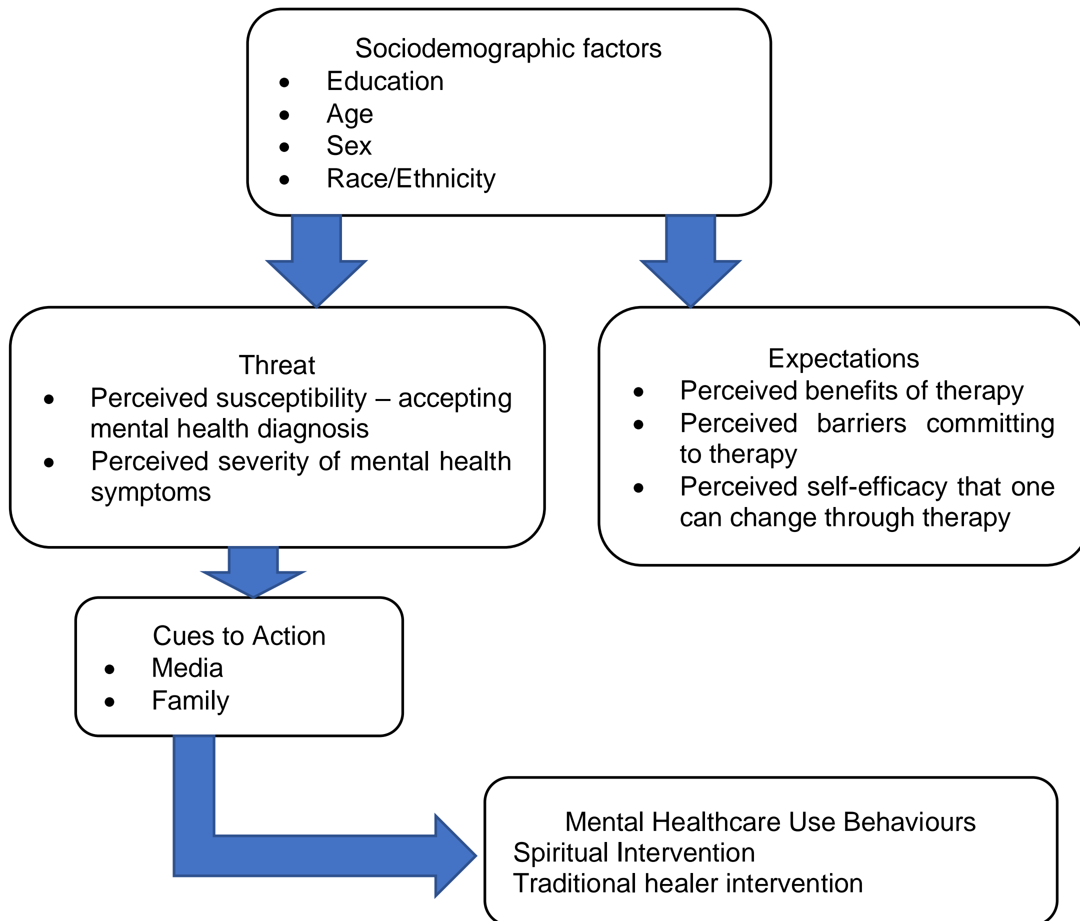

Figure 2: Conceptualized health belief model

Source: (Rosenstock et al., 1990, as adapted by Henshaw and Freedman-Doan (2009, p. 424)

4.4.12.3 Socio-demographic factors

- Education

Education has been proven to play a significant role in increasing public awareness of mental health issues, increase of support and resources towards mental health challenges; e.g., advocacy groups on maternal and child healthcare. Projects are suggested, such as national screening days for mental health issues or cancer awareness for individuals who may not have recognised symptoms as the signs of a particular illness that may warrant urgent intervention.

In most instances, the physician or general practitioner is the first contact person in providing healthcare. In the modern world, instead of the physician providing a

diagnosis and medication to the individual, it would help if the physician could provide information that will alert the patient that additional treatment is needed in the form of psychotherapy to facilitate early adjustment to a disorder, instead of waiting for the onset of a long-term mental health condition; e.g., for a bereaved mother, bereavement therapy or counselling may prevent long-term mental conditions such as depression (Henshaw & Freedman-Daon, 2009).

- Age

According to the HBM, older adults are likely to seek help for treatment when they perceive a strong need for it, although certain aspects of ageing may influence older adults not to seek help especially in a situation where symptoms may be perceived as a process of ageing, thus overlooking potential mental health symptoms (Clement et al., 2015).

- Gender

Women were found to seek help more often than their male counterparts. Women are more able to label their feelings as depression, compared to men who are experiencing similar symptoms of distress (Saint-Anault, Gang, & Woo, 2018). Women were also found to be more able to attribute neck and stomach pain to psychological distress compared to men who were more likely to indicate more significant causes for their somatic symptoms.

- Race/ Ethnicity

Research reveals that individuals from different ethnic backgrounds approach the severity of their illness differently; e.g., individuals from minority groups in America are more influenced by their cultural norms and values in perceiving their mental health problem than white Americans (Villatoro et al., 2018). It would be beneficial to clients if education about their symptoms could be provided in a culturally sensitive manner, so as to foster early detection of illness and compliance in treatment.

The above socio-demographic variables tend to influence the individual's perceptions of the threat posed by the illness which presents itself as the perceived susceptibility in accepting the diagnosis, in this case, the bereavement and that the perceived severity of the condition, if not treated, may lead to major depression. Once a diagnosis

is made, acceptance of the diagnosis is facilitated by the health professionals (Bonaari et al., 2004), thus increasing the likelihood of compliance with treatment regimes.

4.4.12.4 Expectations

According to Bishop et al. (2015), the socio-demographic variables may also influence the expectations such as:

- Perceived benefit therapy: Individuals are unlikely to seek treatment and use a service if they do not believe they will benefit from it. Thus, increasing the benefit of a professional service rendered is likely to increase the use of the service. This can be achieved by increasing public health programmes to inform consumers about available psychological services, hospitals and the value of such services.
- When awareness has been created about treatment and how the treatment can improve the individual's life, individuals are likely to be motivated to overcome their perceived barriers towards the treatment, especially those individuals who have never sought mental health treatment before. Describing the treatment in a reliable manner may assist them in making an informed decision about the treatment plan and enhancing their compliance in carrying it out.
- Perception of benefits to therapy are also influenced by the cultural demographics. The beliefs about the aetiology of mental illness and the individual's attitude towards using the professional services influence the use of the service and the perceived benefit of the treatment. In their comparative study between black and white respondents about the aetiology and attitude towards mental illness, Bishop et al. (2015) revealed that black respondents believed that the mental illness occurred as God's will or because of their bad character compared to their white counterparts who attributed mental illness to genetic conditions or poor family upbringing.
- These differences in belief systems about the causes of mental illness result in variable outcomes of mental health services. Older adults were found to be reluctant to seek psychological services, but Bishop et al. (2015) noted that older adults who had engaged in professional psychological treatment tended to see psychological help as more beneficial than those who had never sought treatment. It is not age but the changing cultural acceptance of mental illness over a period of time that is important.

- One of the factors found to be influencing the perceptions of individuals about treatment, benefits and compliance is the spiritual belief system. Those individuals who believe that mental illness or their psychological distress is caused by spiritual factors may prefer to see a religious leader rather than a mental health expert. This led to the development of a collaborative model between psychologists and religious organisations so as to allow community members more options to access healthcare services.
- Spiritual-psychological collaboration came about when the Catholic social services such as priests, religious schoolteachers and parishioners joined forces with other health professionals such as psychologists to provide a continuum of care from prevention to intervention. This allowed the community members to receive care through the sources that they considered more credible and available, thus increasing perceived treatment benefits and reducing barriers to care.
- One of the perceived expectations is addressing perceived barriers. Identifying salient barriers to healthcare and removing them and reducing their impact on decision-making for clients, results in increased use of mental healthcare services. Barriers towards treatment differ according to the type of treatment and the provider of the treatment.
- Formulation of public policy interventions is needed to reduce health barriers. Some organisations reduce barriers for treatment by minimising the costs of treatment, transportation problems and scheduling of treatment attempts by community leaders to reduce barriers involve providing services that are affordable and immediately available and owned by the community and reliable; for example, a few minutes' walk during family therapy sessions was developed as a solution. This approach was to allow individuals to access treatment at the time they felt ready to receive it, rather than making an appointment for several weeks in advance (Henshaw & Freedman-Daon, 2009). The walk-ins reduced financial barriers through a low commitment single session that was goal-specific.

The feedback given by the clients of a walk-in family therapy programme was satisfactory and studies showed a significant correlation with positive attitudes towards the reduction of treatment barriers and the integration of behavioural healthcare into primary care (Ramanuj, 2019). Although the majority of primary healthcare patients seeking mental health intervention prefer psychotherapy to medication (Alatawi et al.

2016), some preferred a combination of medication and psychotherapy. The integrated care model resulted in greater use of treatment centres and a higher mean number of mental healthcare visits (Adefolalu, 2018).

4.4.12.5 The integrated care model

The integrated care model further improved the use of mental healthcare services by black participants. This suggests that black participants sought treatment at a lower rate than white participants (Ayalon, Arean, Linkins, Lynch, & Estes, 2007). Collaborative treatment between physicians at primary care level with trained nursing staff was also found to have improved compliance with psychotherapy regimes for improving the clients' emotional responses and a reduction in relapse rates (Rost et al., 2002). Furthermore, research revealed that the enhanced care reduced absenteeism and increased productivity at the workplace (Rost et al., 2002).

The advantages of the collaborative or integrated care initiative were found to have reduced the stigmatisation of mental health patients as they were seen in a familiar location and the model was found to provide more structure in terms of treatment guidelines and services compared to treatment offered by the physician alone (Craven & Bland, 2006). The cost of psychotherapy was also found to be a barrier for mental health patients in using healthcare services. Whether patients have health insurance or not, many people indicated that they did not seek mental health treatment due to high costs as health insurance is divided to optimize profits by limiting use of resources, thus limiting the number of session's patients might need (Mojtabai, 2005).

4.4.12.6 Barriers to seeking help

- Psychological barriers

Psychological barriers such as fears about treatment and self-concealment were viewed as some of the psychological barriers in seeking treatment. These concepts increased the client's perceptions of psychotherapy as difficult or as painful endeavors, especially a disclosure of highly emotive situations (Komiya, Good, & Sherrod, 2000). Some patient's perceptions of unresponsive and coercive therapists, or what others might think about them, might result in reluctance to use mental health services (Kushner & Sher, 1989; Pipes et al., 1985). This was confirmed by Kelly and Achter (1995), who revealed that fear of emotional expression accompanied by lack of self-

disclosure to others and a reluctance to share negative personal experiences resulted in treatment avoidance and negative perceptions and attitudes towards the help-seeking process. Another aspect that was found to contribute towards treatment avoidance was beliefs about stigmatisation among those experiencing distress. There is a need for the adoption of intervention measures to reduce stigmatisation in order to enhance the use of mental healthcare services (Alvidrez, 1999; Henshaw & Freedman-Doan, 2009; Stefl & Prosperi, 1985). Large-scale mental health awareness campaigns are needed to address some of the stigma-related challenges (National Institute of Mental Health, 2016).

- Demographic variables and barriers

Underprivileged and marginalised groups who have been traditionally underserved in mental healthcare, due to lack of health insurance, rely almost solely on public health assistance and experience difficulties in seeking help (Wang et al., 2005). These barriers pose many challenges for developing effective intervention programmes. Some of the challenges cited by women in need of mental healthcare services were lack of finance or health insurance to access care; anxiety to access the treatment because of negative expectations and not knowing where to go for services; transportation; and childcare for those who had children without child-minders (Smith et al., 2019). Black participants were found have a mistrust of whites; this was a salient barrier to their seeking mental healthcare treatment. They viewed white counsellors as a less credible source of mental care treatment. Financial challenges and stigmatisation were also some of the identified cultural barriers (Swihart & Hughes, 2018).

4.4.12.7 Cues to action

This is the exposure of people towards prompt action that will lead to behavioural change. This involves people, events or things that may contribute to a change in behaviour. This cue to action may be internal or external; for example, illness of a family member, reading a medical report or an environmental event that creates awareness (Bishop et al., 2015).

4.4.12.8 Limitations of the health belief model

The HBM model has been found have shortcomings just like many other conceptual frameworks. It has been found to fail in identifying other factors that influence health behaviours such as habits and their impact on the general health of people (e.g., smoking). Secondly, the model has been found to be too broad in applying the theoretical constructs (Orji et al., 2012).

4.4.13 Afrocentric Perspective

The theory of Afrocentricity originates from the work of Molefi Asante (2007) who argued that there is a need for a paradigm shift that will relocate African people historically, economically, socially, politically and philosophically from being decentred, meaning that problems and experiences of African people should be understood and investigated from the African perspective, removing the chains of Eurocentric tradition. Asante's views were later expanded on by Owusu-Ansah and Mji (2013), who pointed out that Afrocentrism as an ideology is a research perspective that enables the researcher to view reality from within the context of the Africans themselves. The researcher, in the present study, deemed the Afrocentric perspective relevant because it gave African mothers, as the subjects of the study, a platform to tell their own stories in terms of their experiences following perinatal bereavement. In other words, by using the Afrocentric perspective, the researcher hopes to shed light on the various culturally-shaped pathways that mothers who are bereaved through perinatal deaths adopt to relieve their distress.

Like in other African communities, culture influences the perceptions of African people about illness and death (Mbiti, 1975). Disease management and health promotion within the African context are viewed as a collective phenomenon, not as an individual problem (Clancy & Hamber, 2008). The African perception of illness and wellness depends on the understanding of the root cause of the disease rather than the treatment. In other words, until the root cause of the disease is understood, treatment given maybe insufficient (Dlamini, 2006; Pellerin, 2012). Based on this understanding, individuals in many African communities tend to perform rituals in order to identify themselves culturally. Similarly, it can be suggested that women who are bereaved through perinatal death will be inclined to understand their condition as emanating from a particular root cause that is often culturally defined. Consequently, interventions

that are contemplated to deal with the perinatal death may involve the performance of rituals.

Africans tend to view ill health or misfortune as a conflict between the patient and other individuals, dead or alive (Peltzer et al., 2006; Sodi, 2009). Based on this perspective, the management of ill health and misfortune in the African context tends to be holistic, taking into account the values, the customs, habits and religion of the affected individuals (Asante, 2007; Mazama, 2003; Pellerin, 2012). Similarly, perinatal death is viewed as an event not only affecting mothers, but also the families and communities from which the mothers come from (Cacciatore, 2013; Jaffe, 2014).

4.4.13.1 Conceptualising the Afrocentric paradigm

The concept of Afrocentricity was defined by Africans as far back as 1980-1990. The first definition was coined by Molefi Asante whose definition contributed to many other definitions from other research scholars, such as Tshehloane Keto who defined Afrocentricity as the approach that centred Africa as the geographical and cultural starting point of studies involving African people while Maucana Korenga, defined Afrocentricity as thinking and practices firmly entrenched within the cultural identity and the human interest of African people and their descendants (Keto, 1989).

Noble (2006) views human behaviours as a connected whole. There is an interconnectedness and interdependence between behaviours of African people, meaning that there is no distinction between the spiritual or material aspects or substance and form – all natural phenomena are interdependent in terms of their functionality (Kambon & Bowen-Raid, 2010). The Afrocentric approach provides a holistic representation of African human behaviour as it represents and reflects the collective and spiritual characteristics of their being (Noble, 2006). This collectivism phenomenon is described by other research scholars who view the collective essence of African people as the means of survival (Long, 2017). However, Kambon and Bowen-Raid (2010) view the concept of Afrocentricity from the affective perspective that is more influenced by feelings than the power of reasoning, meaning that social interactions of people influence various life experiences whether positive or negative. As a result, emotions evoked by these experiences may influence the actions and decisions to be taken (Noble, 2006).

4.4.13.2 The theoretical principles of the Afrocentric paradigm

The Afrocentric paradigm puts emphasis on the assertion that the culture and behaviour of African people should be given precedence in any analysis of any of their problems, including mental healthcare (Mazama, 2003). According to Kershaw (1992) and Asante (1991), Afrocentricity is a framework of reference wherein phenomena are viewed from the perspective of the African person which centres on regarding people of African origin as being in control of their lives and attitudes about the world. As an intellectual theory, Afrocentricity is the study of the ideas and events from the standpoint of Africans as key role players rather than victims. This theory becomes, by virtue of an authentic relationship with the centrality of our reality, a fundamentally empirical project, whereby Africans assert themselves intellectually and psychologically, thus breaking the bonds of western domination in the mind as an analogy for breaking those bonds in every other field.

Karenga (1988) concurs with Asante and cogently defined Afrocentricity as "essentially a quality perspective or approach rooted in the cultural image and human interest of African people" (p. 404). This paradigm endorses a commitment to African values, morals, and beliefs, which leads to a positive self-persona and positive ethnic association. Looking at the study through an Afrocentric lens facilitates the incorporation of various strategies that are more in tune and consistent with distinct cultural styles, experiences, traditions, and interpretations of the African people, thus enhancing the effectiveness of healthcare services. Afrocentrism is a social science paradigm that is more reflective of the cultural and political reality of the African people. It is, therefore, the theory of choice in this study as it is grounded in African traditions and their philosophical assumptions. By way of confirmation, Mazama (2003) views Afrocentric research methodology as based on the following characteristics:

- People's worldview determines what constitutes a problem for them and how they solve problems. As a result, Afrocentric scholarship must reflect the ontology, cosmology, axiology, and aesthetics of African people.
- The essence of life and, therefore, of human beings is spiritual. Therefore, Afrocentric methods as well as Afrocentrically generated knowledge must reflect the primacy of the spiritual, the relationship between the physical and the spiritual,

as well as the interconnectedness of all things. The metaphysical concepts are also particularly important to Afrocentric subjectivity.

- The Afrocentric methodology must generate knowledge that will free and empower the African people.

Pellerin (2012) views Afrocentricity methodologies as designed and applied towards formulation and interpretation of research projects involving African people. These methodologies regard African people as self-willed agents instead of objects of investigations. It thus generates new research orientations for interpreting data that will yield fruitful and liberating research about African people.

Afrocentricity is a social science inquiry of the African cultural phenomena which rests on collecting data based on Afrocentric methodologies, that put emphasis on the Afrocentric orientation and interpretative framework. Pellerin (2012) supports this by concisely stating that:

> any deviation from what is African constitutes a shift in the interpretative framework and a shift in the understanding of African culture, life and experiences; thus, directly results in flawed research observations and thus becomes tainted research that cannot be used to assess African phenomena (p. 157).

This means that researchers using the Afrocentric paradigm need not simply describe the phenomenon under study but must provide a detailed cultural description and explanation of the phenomenon from the African perspective.

4.4.13.3 Criticism of Afrocentricity

Afrocentricity as a growing paradigm has attracted serious challenges and criticisms.

Firstly, those who criticise it tend to disagree with some of its centredness. The critics view the notion of ‘centredness’ as a cultural change that fails to acknowledge that ‘being African’ also means being partly European due to colonisation and westernisation (Asante, 2007). As a result, the critics view Afrocentricity as too restrictive and failing to grasp the dialectical complexity of African culture. Asante (2007), however, defends Afrocentricity as a liberating movement that will afford black people a place from which to challenge oppressive Eurocentrism.

Secondly, Afrocentricity has been viewed as failing to tackle gender issues that are mostly relevant to feminist approaches, in particular, those of African women.

Thirdly, Afrocentricity has also been criticised for making Egypt its main historical base, thus ignoring the rest of Africa and its African history. Thus, Afrocentrists have been viewed as having replaced white dominance with a black Egyptian approach (Adeleke, 2015).

Lastly, while Bernal has been hailed as the hero of Afrocentricity, Asante (2007) views him as only one of the people who significantly contributed towards the movement as there are other heroes like Cheikh Anta Diop, Maulana Karenga, Wade Nobles, Herbert Vilakazi and Herbert Ekwe-Ekwe among others, who have also contributed significantly towards the paradigm. However, he further provides a broad classification of the types of critics of Afrocentricity as follows:

- Capitulationists, as those who criticise Afrocentricity because they are uncomfortable with themselves and refuse to acknowledge that Africans should be viewed as agents, but rather as inferior to European people and not capable of conducting any research without tapping into European thought.
- Europeanised loyalists, as those who are in Europe but who look down upon the black people and believe that blacks can do no good on their own. They believe that good research theories can only come from European people. In other words, anything that is not European in origin has no validity.
- Maskers, as those Africans who are embarrassed about being African and hide their own identities behind the “white mask”. This group of people are loyal to and honour the “white master” and are embarrassed about being Afrocentrist. They pay homage to white supremacy and are afraid to come out boldly as African people out of fear of losing their jobs or retarding their career growth.

Thus, it was appropriate for the researcher in this current study to use both the pathway model and the Afrocentric perspective as theoretical frameworks, to understand the help-seeking pathways adopted by women bereaved through perinatal death. While the pathway model assists the researcher to understand the experiences of bereavement of the mothers from the conventional western psychological perspective, the Afrocentric perspective will assist the researcher to interpret these experiences within their African context, taking into consideration their cultural

realities. The combination of the two theoretical frameworks complement each other in the sense that HBM does not provide an account of cultural perspective or normative values (Rosenstock, 1974). This shortcoming in the current study was minimised by combining the two theoretical frameworks to understand pathways that bereaved African mothers undertake after experiencing perinatal deaths.

CHAPTER 5

RESEARCH METHODOLOGY

5.1 INTRODUCTION

In this chapter, the methodology adopted for the study is presented. It is divided into three parts. The first part of the discussion covers the definition of research methodology. An overview of the qualitative research paradigm is provided. The qualitative research paradigm was adopted for the current study with phenomenology as the research approach. Key concepts include the genesis of phenomenology, the rationale for its appropriateness for the study, aims of phenomenology and the shortcomings of the phenomenological approach. The researcher adopted a feminist social constructionist paradigm.

The second part covers the rationale for the adoption of the feminist social approach, followed by a discussion of feminist theory. In particular, the chapter addresses the first, second and the third wave of feminism, South African women and feminism, feminist psychology and feminist phenomenology.

The third part of the chapter covers the location, population, sampling procedures, data collection instruments, the pilot test and data analysis adopted for the study. Lastly the trustworthiness of the research study is addressed by discussing the core features of credibility, conformability, transferability and dependability. Ethical considerations such as researcher bias, permission to conduct the study and acquiring informed consent are outlined.

5.2 QUALITATIVE RESEARCH PARADIGM

The qualitative researcher starts by defining the general concepts which may change as the research progresses. This process is characterized by the researcher viewing the concepts of the investigation through a wide lens, searching for patterns and interrelationships between concepts. Qualitative researchers use themselves as the instrument of data collection in their own cultural settings to gain more insight into the study participants' social world. The researcher in this setting is more flexible, reflective and subjective in gathering the data.

According to McCracken (1988), the qualitative researcher "does not survey the terrain, but rather mines it" (p. 17). This means the qualitative researcher is more intensive than extensive, and more concerned with concepts and categories, not their incidence or frequencies. In other words, qualitative research is about the testing of theory and involves analytical induction rather than generalisation or inferences about findings.

5.2.1 Justification for the Use of the Qualitative Research Paradigm

The main objective of the study was to explore the experiences and the perceptions of mothers bereaved by perinatal death and the help-seeking pathways they adopt in alleviating their distress. This can only be achieved by investigating the phenomenon in detail.

The qualitative research worldview derives meaning from the experiences and the perceptions of the participants and insight into a given situation (Strauss & Corbin, 2008). It uses inductive reasoning, which is an emic approach to extract the meaning from the inquiry and provide a snapshot of people's perceptions within their natural settings that enable the researcher to be actively involved in exploring the experiences of participants (Choy, 2014; Creswell, 2009; Gentles et al., 2015). The researcher adopted a qualitative approach as the paradigm of choice because it uses words instead of numbers for the analysis of the lived experiences of the bereaved mothers. Their perceptions and experiences of perinatal deaths and the different pathways they adopt in alleviating their distress cannot be quantified.

Qualitative research as a paradigm is a social action that emphasises how people interpret and derive meaning from their experiences and how they understand their social realities. It makes use of different research methods such as interviews, journals, diaries, observations and questionnaires to obtain, analyse and interpret the data content obtained (Zohrabi, 2013). It is exploratory in nature as it seeks to explain the "how" and the "why" of a social phenomenon, with the aim of helping the researcher to understand the social world of the participants, and why things happen the way they do (Polkinghorne, 2005).

Qualitative research design has gained momentum in the social domain of educators, healthcare practitioners, sociologists, anthropologists, psychologists and business

practitioners (Denzin & Lincoln, 2005). The main paradigms within the qualitative research are the interpretivist and the critical feminist paradigms (Punch, 2013). There are different types of qualitative research designs such as:

- Case studies which are used in an in-depth study of people or group of people.
- Ethnographic studies which are "systemic processes of observation, detailing, and describing, documenting, analysis the lifeways or particular patterns of a culture (or subculture) in order to grasp the life ways or patterns of people in their familiar environment" (Langdridge, 2007, p. 35).
- Historical studies which involve the identification, location, evaluation and synthesis of data from the past events, which are normally contained in artefacts and documents.
- Narrative research studies which provide a unique, context-based insight into the intangible aspects of the participants' experiences. It tells a story about the participants where there is a plot, a sequence of events with the cause-and-effect, and a narrator (Constant & Roberts, 2017).
- Phenomenological studies involve the study of a phenomenon as it is experienced by individuals. It is the type of research design adopted in areas where there is little knowledge about a particular phenomenon (Creswell, 2009; Donalek, 2004; Munhall, 2007).

5.3 PHENOMENOLOGY AS RESEARCH DESIGN, THEORY AND PRAXIS

5.3.1 Phenomenology as the Research Design of the Current Study

In this study, the researcher used phenomenology as a lens through which she understood, interpreted and explained the experiences of mothers bereaved by perinatal deaths and the help-seeking pathways they adopted to relieve their distress; she aimed at finding the essence of their deep and rich experiences in terms of their thoughts, feelings and reflections as participants. It is, therefore, appropriate for the researcher to give a brief overview of phenomenology as an approach of choice that guides the current study.

Phenomenology is qualitative in nature and a discipline that is aimed at focusing on peoples' perceptions of their world and what it means to them as individuals, namely, their lived experiences (Langdridge, 2007; Merleau-Ponty, 1962; Munhall, 2007).

Phenomenology is the umbrella term that encompasses both the philosophical movement and an overarching perspective from which all qualitative research approaches are derived (Kafle, 2011; Maykut & Morehouse, 1994). This definition of phenomenology is supported by different researchers such as Carman (2008), who explained it as the beginning of things, and the existence of ourselves and the world around us.

Descartes was the first philosopher to float the idea of the unitary existence of the soul and the body through the principle of dualism, meaning that the body and soul cannot be separated (Kim, 2018). Husserl, through his school of phenomenology, believed that the experience of individuals has to be transcended to determine the reality. Husserl used the principle of reduction, which refers to the suspension of personal opinions or what he called 'bracketing' in attempting to reach the core or essence of the individual's experience through a state of pure consciousness (Scott et al. 2019).

Husserl believed that the basic focus of phenomenology is to discover and to describe the 'lived world' of individuals (Kafle, 2011). Husserl (1970) believed that the application of science to psychology fails to recognise that psychology is about human beings who develop perceptions of their own world as individuals. This was followed by Martin Heidegger's school of hermeneutic phenomenology.

Heidegger (1900-1901), a German philosopher, further explained phenomenology as "the things themselves" whereby the "things" are conceptualised as lived experiences (McConnell et al., 2009, p. 50). Heidegger (1962) defined it further as the "business of interpreting" (p. 62), believing that theories are needed for descriptions and interpretations so as to facilitate the understanding of the meaning of the lived experiences of individuals; in the current case, bereaved individuals.

The researcher considered descriptive phenomenology, reductive phenomenology, phenomenology of essence and constitutive phenomenology, which differ considerably in terms of their general approaches to a phenomenon and data analysis, and ultimately adopted a hermeneutic approach (Langridge, 2007). Through hermeneutic phenomenology, the researcher was able to focus mainly on the lived experiences of the participants and to illuminate the details and aspects that could be deemed trivial within these experiences or taken for granted by others. The focus of the current study was to extract and reveal a rich and deeper meaning of the

experiences of the bereaved mothers perinatally, and the various pathways they follow to relieve their distress.

5.3.2 The Rationale for Adopting Heideggerian Hermeneutic Phenomenology

Heidegger was a protégé of Husserl school of phenomenology as he accepted phenomenological inquiry as a method, although he disagreed with how Husserl explored the lived experiences of individuals (Laverty, 2003). Heidegger believed that the experiences of the individual exist within their own world rather than being epistemological (Laverty, 2003). By so doing, he rejected the idea of suspension of the researcher's personal opinions, called bracketing, and adopted the interpretive approach in narrating and describing human experiences (Kafle, 2011).

Heidegger adopted the ontological approach as he believed that ontology is about the reality that depends on the subjective knowledge of individuals of what they are going through on daily basis (Laverty, 2003). Individuals are the best narrative interpreters of these experiences as it is all that they have as a basis for their perceptions (Heidegger, 1962).

Heidegger believed that the phenomenon under study is influenced by the personal awareness thereof and it lies hidden within the individual under study (Laverty, 2003). As a result, he coined the term *Dasein* which refers to as the hermeneutic circle (Earle, 2010; Koch, 1995; McConnell-Henry et al., 2009). He also believed that the world of individuals is influenced by cultural and sociological settings which influence their own interpretations of their experiences (Laverty, 2003).

Heidegger (1962) believed that the understanding of a phenomenon depends on what he termed the fore-structure that pre-existed, meaning that it is difficult for one not to have a presupposition during the process of interpretation a phenomenon. This interpretation of process moves in a circular movement from the parts of the experiences of the individual to the whole of those experiences which is the hermeneutic cycle (Smith, 1999). There is no measurement of the behaviours nor does simulation in hermeneutics, but references are prompted by encounter, life-worlds and meaning-making provided by individuals (Van Manen, 1977).

Guidelines are provided in hermeneutic phenomenology to interpret the meanings of individuals about a phenomenon under study. As a result, bracketing and

presumptions are not set aside but they are rather embedded and kept, to be used in the process of interpretation (Laverty, 2003). In hermeneutic phenomenology, the researcher will be attempting to illuminate details, even those that could be considered as trivial in the experiences of bereaved mothers. These details are essential to the creation of meaning and understanding as they navigate their journeys after experiencing perinatal death and adopt various pathways to alleviate their distress.

Heidegger's hermeneutic phenomenology was viewed as the appropriate choice for the current study as it further allowed the researcher to immerse herself in the phenomenon. This made it possible to make what was implicit more explicit so as to facilitate the meaning-making process of these mother's experiences (Kafle, 2011). In conclusion, hermeneutic phenomenology is the approach of choice whenever there is a need to investigate individual experiences in situations that disrupt a person's normal life as an individual. Meaning-making is an ongoing process especially in conditions that are life-changing such as bereavement and perinatal death (Smith, 2011).

However, much as hermeneutic phenomenology has been found to play a relevant role in health psychology because of the gradual move from understanding a phenomenon from the biomedical model of disease and conditions such as bereavement, it has been found to be a difficult endeavour that requires commitment to engage in the philosophy underpinning the study design so as to move towards clarifying and understanding a phenomenon (Brocki & Wearden, 2006; Choy, 2014; Smith, 1999).

The researcher used hermeneutic interpretive phenomenology because the bias and the assumptions of the researcher are not bracketed or set aside but are rather embedded in the process of interpretative analysis (Heidegger, 1962; Laverty, 2003).

5.3.3 The Rationale for Selecting Interpretive Phenomenological Analysis

The current study was aimed at understanding how participants make sense of their own lived experiences. Interpretative phenomenological analysis (IPA) as a phenomenological approach is committed to clarifying and elucidating a phenomenon, event or a relationship, which in this current study is the help-seeking pathways adopted by bereaved mothers in alleviating their distress caused by perinatal deaths (Brocki & Wearden, 2006). IPA helps to avoid biasness and the preconceived ideas of

the researcher through the process of reduction of the data. This process leads the researcher to a clear elucidation of the lived experiences of the participants (Eatough, 2012).

Similarly, the current study is more about grasping the essence of the phenomenon which is the different help-seeking pathways of these bereaved mothers in alleviating their distress. IPA, arguably, seems to be the relevant analysis method compatible with the hermeneutic phenomenology, as it provides straightforward guidelines that are flexible and inductive in nature. As an inquiry method, it focuses on the uniqueness of the participants' experiences and the meaning they attach to their experiences, and how they present themselves within their own world as socio-cultural beings. Hence, the researcher adopted the IPA to access and gain deep and rich understanding of the participants' experiences within their personal space. The comprehensive guidelines to interpret and analyse the experience of the participants as stipulated by Smith (2004) were adopted for data analysis. However, much as phenomenology as a research approach is widely used in sectors such as health, business, economic and psychology, it has been found to be having its own shortcomings.

5.3.4 Shortcomings of Phenomenology

One of the most influential contributions of phenomenology is that the body is considered to be at the existential null point from which our various engagements with the world, be they social, political, cultural or physical, are transcended. In this current study, women who were not pregnant did not have the experience of perinatal death until their physical engagement with pregnancy, labour and delivering stillborn babies (Csordas, 1999; Taylor, 2005). Furthermore, the body is not only an object that is available for scrutiny, but also a focus from which our experience of the world is displayed. It is a living entity through which we actively experience the world (Desjarlais, 1992). Some of the disadvantages of phenomenology are as follows:

- One of the most pressing critiques of phenomenology is that it is viewed as an approach that ignores the political and socioeconomic determinants of life and people's living conditions and has been described as the apotheosis of bourgeois individualism (Moran, 2000).
- Phenomenological approaches have been found by other research scholars not to address the issues of linguistic discursive or semiotic forces. As a result,

phenomenological approaches pertaining to language have been assigned to linguistic anthropologists (Crapanzano, 2004; Throop, 2010).

- Phenomenology can be viewed as an approach that risks missing the bigger picture in terms of anthropological insight. However, this mind-set arises because of a failure to tolerate the descriptive nature of phenomenology, which is detailed, dynamic and even complex with the intention of allowing greater access to the cultural, social, economic and political worldviews of individuals (Desjarlais & Throop, 2011).

5.3.5 The Feminist Social Constructionist Paradigm

Having adopted and discussed phenomenology as the research approach of choice to guide the study, the researcher applied the phenomenological approach within the feminist social constructionist paradigm as the most appropriate theoretical orientation to guide the current study. This approach afforded the researcher the opportunity to explore the bereaved mothers' issues in terms of the perception of their bereavement in relation to their subordination, resistance, resilience, rejection, isolation and stigmatisation as they navigated through their bereavement journeys and sought help to alleviate their emotional distress.

The main focus of feminist-informed research strategies is on comparative research studies conducted on the observation and evaluation of the characteristics and the abilities of women juxtaposed against their male counterparts, in terms of the norms and differences. This was found to be a deviant and inadequate strategy (de Villiers, 2011). These research findings prompted the researcher to embark on a strategy that will enhance the voices of women while exploring different alternative ways of understanding their world through their own feministic lens as women (Dukas, 2014; Harding, 1987).

It is therefore appropriate for the researcher to briefly discuss the development of feminism as a movement from European countries through Africa as a continent and now finds its place in South Africa. This includes a discussion of feministic perspective and the rationale for the adoption of feministic social approach.

5.4 A FEMINIST PERSPECTIVE

The term feminism became known in the 1980s and was a movement in support of ensuring that women had legal and political rights equal to those of men. Collin's English Dictionary (2020) defines feminism "as a doctrine or a movement that advocates equal rights for women". The term feminism is described as an intellectual and political movement committed to challenging the social and political ills that are entrenched within patriarchal societies that are oppressive and disempowering to women through the application of traditional practices and attitudes (Dukas, 2014). As a result, it is concerned with changing the patriarchal perceptions within such societies to those that are more egalitarian, and based on fair distribution of power, resources and mutual understanding (Evans et al., 2005).

In the current study, the researcher adopted the concept of feminism to explore the lived experiences of mothers bereaved by perinatal death. Regrettably, they are often seen as unequal and subordinate to their male partners in terms of their grieving process, and are stigmatized, ostracized, oppressed, blamed and sometimes killed by their partners for not bringing a live baby home. This extends to issues such as failed conception where men do not regard themselves as the potential source of the problem.

One could ask where the concept of feminism originates from. The general patriarchal notion that women are subservient to men has resulted in women being treated unequally to men within society which is crafted in such a way that it prioritises the needs and viewpoints of men. In response to this oppressive societal approach towards women, feminism emerged as a political movement to give a voice to women who are oppressed and to resist patriarchal dominance (Gavey, 1997; Makgoba, 2005). In the next section, the researcher briefly discusses the rationale for the adoption of feministic social approach.

5.4.1 The Rationale for Adoption of the Feminist Social Approach

The adoption of the feminist perspective allowed the researcher to seek a deep and rich understanding of bereavement as a phenomenon from the perspective of the mothers as opposed to the traditional medical or social model (Gergen, 2008). The researcher was prompted to adopt the feministic social constructionist paradigm as

the nature of the current study is about black South African mothers who had lost their babies perinatally.

The feminist phenomenology further looks into the bereavement process of mothers due to perinatal death, not from the individualistic biomedical approach as it tends to ignore and dismiss potentially trivial gaps in the knowledge base on the emotional challenges of the bereaved mothers, thus diminishing and simplifying the complex experiences of these mothers (Lafrance & Stoppard, 2006; Stoppard & McMullen, 2003).

Unfortunately, gender-based violence towards pregnant women exists in every country and society and has been found to have contributed to more deaths and disabilities than malaria, cancer, traffic accidents, and wars combined (Morrison & Orlando, 1999). Instead of pregnancy being a protected and celebratory time, domestic violence is a continuous risk for pregnant mothers (Ahmed, Koenig, & Stephenson, 2006). Due to societally entrenched gender inequality in terms of the cause and the treatment and management of perinatal deaths, women have been harshly treated and blamed for such deaths. In many instances, women who have failed to achieve the successful process of procreation are marginalised, stigmatised, humiliated and oppressed, and are blamed by their partners and society in which they live as the cause of the perinatal death, without any concrete or conclusive medical evidence (Dukas, 2014; White, 2002).

They are often beaten, verbally abused by their husbands, families and their communities. Some of these mothers may be taken back home to their families or the *lobola* that is paid for them may be reclaimed by their in-laws on the basis that they have failed to honour the spirit of the departed by increasing the family lineage or kept themselves into a state of immortality (Mbiti, 1969; Phoofolo, 2007). The husbands sometimes go to the extent of bringing other women related to their wives to bear children for them, or even resort to polygamous marriages.

In some instances, these women are killed or even considered to have committed a crime as they have disgraced the family. By doing this, men shift the focus from finding a solution and emotionally supporting their wives especially if the stillbirths were the first-born children within the marriage. In many instances, men may opt to impregnate another woman, thus, making these challenges of childlessness and barrenness the

problem of the woman (Baloyi, 2012; Chigudu, 2004; Kinoti, 2000; Oduyoye, 1995). They do not see that there might be problem with themselves in terms of infertility. A significant correlation between the physical and sexual violence of pregnant women by their intimate partners and child mortality rate including perinatal death, has been found (Rawlings & Siddique, 2018).

In some instances, men do not visit their wives after delivery of a stillbirth as they do not feel responsible for the death of the child or responsible for their wives, especially in cases of the first-time mothers, as the marriage is only 'confirmed' when the woman is pregnant and has successfully given birth to a live baby. Often men are ill-prepared to handle what they regard as the shame and the guilt of childlessness as they feel double demasculinisation in terms of their sexuality and authority over the women (Oduyoye, 1995; Runganga et al., 2001; Umeora et al., 2008). Whatever the situation, childlessness either due to barrenness or miscarriages including perinatal deaths is regarded as traumatic experience for women (Sobolik,, 2018).

However, much as phenomenology as a research approach has attracted a growing interest in the everyday experience in the domain of the public and the professional practice, including psychology, there is a paucity of phenomenological research studies in South African literature, particularly around maternal and child healthcare, in terms of how women narrate their own experiences after the death of their babies especially perinatally. This implies that the meaning and the experiences of bereavement from the standpoint of mothers has been largely neglected (Dukas, 2014; Ngcobo & Pillay, 2008). It is for this reason that the researcher adopted the feministic social constructionist approach for the current study, as it is a tool that serves the interests of those that are marginalised (Mies, 1993): in this current study, mothers bereaved due to perinatal death. By so doing they will be emancipating themselves from their bondages of oppression, stigmatisation, exploitation and humiliation (Makgoba 2005). With the feministic social constructionist approach, the researcher becomes part of the research process instead of being a distant, indifferent and disinterested observer (Harding, 1987).

5.5 POPULATION AND SAMPLING

The current study was conducted at Gauteng province within Tshwane Metro Municipality at Garankuwa Township at Dr. George Mukhari Hospital, where the population and the sample were identified.

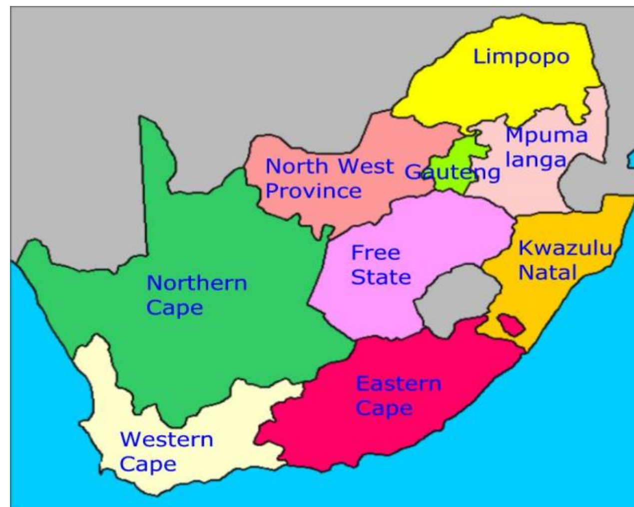

Figure 3: Provinces of South Africa map

Source: (South African Weather Services [Sawx], 2019)

5.5.1 Study Setting

The researcher chose the City of Tshwane in Gauteng Province as a site for this study (see Figure 4 below). Figure 4 shows where the City of Tshwane is on a map of Gauteng.

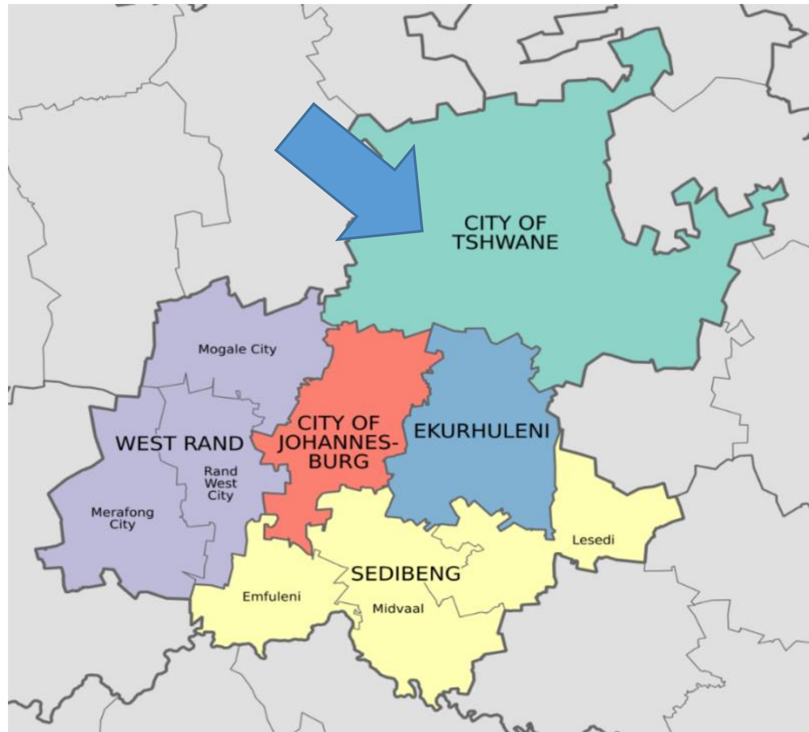

Figure 4: Metropolitan Municipalities of Gauteng Province map

Source: (Sawx, 2019)

Metropolitan Municipalities of Gauteng province is divided into three, namely:

- City of Ekurhuleni
- Tshwane Metropolitan Municipality
- City of Johannesburg

which are further divided into six local municipalities. The current study was conducted in the Garankuwa district of the Tshwane Metropolitan Municipality as shown in Figure 4.

Figure 5: City of Tshwane Metropolitan Municipality map

Source: www.municipality.co.za (2020)

Tshwane Metropolitan Municipality is the single largest Metropolitan Municipality in the country, comprising of seven regions which are made up of 107 wards represented by 210 councillors. It comprises of these regions: Themba, Akasia, Soshanguve, Hammanskraal, Pienaars River, Eersterust, Mamelodi, Pretoria, Laudium, Attridgeville, Crocodile River, Centurion, Tswaing, Winterveldt, Mabopane and Garankuwa.

Garankuwa Township is the location of Dr. George Mukhari Academic Hospital where the current study was conducted. The hospital was previously known as Garankuwa Hospital. It is a teaching facility for Sefako Makgatho Health Sciences University (SMU) formerly known as the Medical University of Southern Africa. Dr George Mukhari Hospital is a public hospital with 1 650 beds. The hospital is divided into different wards according to the various specialties: surgical, orthopaedic, paediatric, medical, oncology, burns unit, neonatal, intensive care unit and gynaecology and maternity.

The City of Tshwane is the centre of local government of the northern Gauteng province of South Africa. At its centre is the city of Pretoria with surrounding town and localities. It has a population of 2 921 million. It comprises of the following demographic makeup:

Table 5.1:

Demographic information

	2016	2011
Population	3 275 152	2 921 488
Age Structure		
Population under 15	25.7%	23.2%
Population 15 to 64	69.0%	71.9%
Population over 65	5.4%	4.9%
Dependency Ratio		
Per 100 (15-64)	45.0	39.0
Sex Ratio		
Males per 100 females	98.5	99.0
Population Growth		
Per annum	2.60%	n/a
Labour Market		
Unemployment rate (official)	n/a	24.2%
Youth unemployment rate (official) 15-34	n/a	32.6%
Education (aged 20 +)		
No schooling	4.5%	4.2%
Matric	38.5%	34.0%
Higher education	19.8%	23.4%

	2016	2011
Household Dynamics		
Households	1 136 877	911 536
Average household size	2.9	3.0
Female headed households	37.5%	35.8%
Formal dwellings	82.6%	80.7%
Housing owned	62.2%	52.0%
Household Services		
Flush toilet connected to sewerage	77.2%	76.6%
Weekly refuse removal	79.4%	80.7%
Piped water inside dwelling	62.1%	64.2%
Electricity for lighting	91.8%	However, birth rate in Dr George Mukhari Hospital in the period when the study was conducted had an average of 5 192 total births bi-annually with 3.8% of perinatal deaths

Source: www.municipality.co.za (2020)

5.5.2 Population

The population of the study comprised of mothers who had experienced a perinatal death at Dr George Mukhari Hospital between 2015 and 2019. The researcher selected the study population through the birth register in the maternity ward in the hospital. Unfortunately, there was no specific perinatal death register as all the births and the deaths were registered in one general register for a specific year. The researcher was given five registers from 2015 to 2019, as the current study focused on the five-year period that is from the date of the occurrence of the perinatal death to the year of data collection. All the perinatal deaths were highlighted in red pen in the column of the birth outcome on the birth register. The researcher compiled a list of all the perinatal deaths in a book which became the population of the study, from which a sample was selected.

5.5.3 The Sample

After obtaining gatekeeper permission from the Chief Executive Officer of Dr. George Mukhari Hospital (Appendix C), the researcher accessed the perinatal deaths register containing the names of all the mothers who had experienced perinatal deaths at the hospital. Their names were recorded in numerical order. 20–40 years of age mothers, who delivered their babies through a normal and caesarean section were recorded in numerical order. The researcher used purposive sampling to select 20 mothers to determine the sample for the study. This method gave all the members of the population a probable chance of being selected to be in the sample (Gravetter & Forzano, 2009).

The researcher chose a sample for the study guided by Robinson's (2014) four stages of sampling, namely:

- Determining the sampling universe, which involves the inclusion or exclusion criteria of the study;
- Selection of the sample size taking into consideration what is practical or ideal; and
- Clearly outlining the specific categories of individuals to be included in the sample;
- Recruiting the selected participants from the population.

The sample that was chosen had unique characteristics that qualified them to be included as participants for the study. The inclusion criteria for the current study were identified as follows:

- Black South African mothers;
- Between 20–40 years of age;
- With the gestational period of 20 weeks (early stillborn) or 28 weeks to 36 weeks (late stillborn);
- Who delivered their stillborn babies between 2015 and 2019 either by normal delivery or caesarean section at the Dr George Mukhari Hospital; and
- Who are able to communicate in at least one of the following languages: Setswana, Sesotho, Sepedi or English.

The exclusion criteria from the participation in the study were as follows:

- Those who met the inclusion criteria but were unwilling to participate;

- Those who had delivered either at home or on their way to the hospital;
- Those mothers who were already suffering from mental health problems, as the study might aggravate or precipitate a relapse;
- Those mothers who did not speak Setswana, Sesotho, Sepedi or English. The reason for these language criteria is that most of the people in the Tshwane municipality where Dr George Mukhari Hospital is situated speak Setswana, Sesotho or Sepedi.

Having identified the sample for the study, the researcher commenced with data collection which started with the negotiations to gain access to the homes of the participants.

5.6 ENTRY NEGOTIATION

The researcher requested an appointment with the participants and confirmed their availability before travelling to their homes. The homes of the participants were spread out in villages such as Sinoville (town), Fafung, Jericho, Legonyane, Madidi, Letlhabile, Winterveldt, Mmakau, Bapong-Brits, Soshanguve and Garankuwa Township.

Collection of data was the daunting exercise that made me think twice about the study, as the participants were scattered in villages and informal settlements. I had a puncture driving to Fafung village in Borakalalo North West and a week later another puncture driving to Madidi village in Klipgat. Some of the participants were located in the informal settlements which posed a challenge as some had relocated their shacks from one place to another. In Winterveldt, the landlord had terminated the rentals of two participants; they had moved to other places, and they had no cellphone numbers. Fortunately, one of them had a friend two houses from the landlord’s property. I asked her for the participants’ cellphone numbers. I managed to track one down to a new settlement in Soshanguve, while the other one was found at her place of work at the Shoprite Checkers store in Mabopane.

I had to go to the City of Tshwane to get the correct addresses, where participants’ identities from the hospital records had to be matched with their utility bills. I waited for a week to get a feedback from the official of the City of Tshwane. Unfortunately, most of the residents in informal settlements do not appear on the database of City of

Tshwane Water and Lights department. They have illegal connections for water and electricity. Because of poor service delivery, another problem was that the shacks were moved from one area to the other. Some of the selected sample could not be found, so I had to go back to the hospital to select the other participants to replace them.

Some of the participants around Mabopane and Soshanguve with authentic addresses were found through their utility bills from City of Tshwane. That helped considerably because most of the participants could be tracked via the addresses on the hospital records, although, in some cases, cellphone numbers given were no longer working. It took five months for me to collect data. I took a break as I was exhausted and traumatised by this exercise, and needed to heal emotionally, physically and spiritually. This is the time when I missed the support of my group. It was quite a lonely journey for me.

5.7 DATA COLLECTION

5.7.1 Pilot Test

A small sample was used to evaluate the feasibility of the interview approach and the instrument intended to be used before being administered with the sample. The instrument was tested with two participants to ascertain whether it was clearly worded and well understood before being administered on a larger scale (Leon, Davis, & Kraemer, 2011).

5.7.2 Data Collection Instruments

The interviews were conducted in each participant's preferred language and took between 30 minutes and one hour. I was guided by a set of questions on an interview schedule (Appendix 1), used an audio recorder and note taking to capture the data. The participants followed the questions listed in the unstructured interview guide as they used it as a platform or a tool to express their pent-up emotions, thus allowing me to probe deeper into emerging areas of interest and concerns that emerged.

Interviews with the participants were conducted in Setswana, Sesotho and Sepedi. These are the languages that are commonly spoken in the Tshwane municipality in Gauteng province.

5.7.3 The Procedure for Data Collection: Interviews

In-depth interviews were used to allow flexibility of the interview. I travelled to the different locations of the participants as determined by the sample. I was the main data collection instrument in this phenomenological study and played a pivotal role in determining the flow of the interview. These interviews were conducted face-to-face in the designated space in the homes of participants away from any distractions that could be caused by other family members. Kavle (1996) described an interview succinctly as the process of interchanging of views between two people who have a mutual interest in a common theme. In the current study, interviews were about gaining a mutual understanding of the bereavement of mothers due to perinatal death, and the different help-seeking pathways they adopted in alleviating their distress.

I attempted to understand the world from the perspective of the participants, so as to extract meaning out of their experiences. Phenomenologically, the intention was to understand the phenomenon in their own terms (Kavle, 1996). As the nature of the study had the potential of evoking some adverse reactions on the part of the participants, I had to use sensitivity and empathy throughout the interviews, according to the specific circumstances of each participant. The interview schedule allowed me to probe deeper into emerging areas of interest and concerns that were highlighted by the participant.

I asked questions that were directed at understanding the participants' experiences, feelings, beliefs and convictions about their grief process. The word of caution by Folkman (2001) that the equipment and the environmental factors might negatively tamper with the research proceedings was kept in mind. Given the travelling challenges and the widespread locations of the participants, I ensured that at all times that the recording equipment was functioning well. The interviews were audio-recorded after getting the permission from the participants to ensure that no significant data were lost during the interview. The audio recordings were transcribed and later translated into English by two independent translators.

5.8 DATA ANALYSIS

5.8.1 Data Analysis Method

I adopted the IPA as the method of choice to analyse data for the current study. The basic tenet of this approach is that people's actions are influenced by the meaning they derive from social interactions with others and what they perceive the concept means to them (Smith, 2004). Individuals create meaning and develop new ways that shape their own future and their reactions and responses through the process of interpreting meaning. Hermeneutic phenomenology provides the researcher with a tool to study subjective experiences of individuals and different meanings that they attach to these experiences (Smith & Shinebourne, 1996). In the current study, I strived to understand the interpretation and the meaning mothers attached to their grief caused by perinatal death and the processes that they adopted to develop new help-seeking pathways to alleviate their distress.

5.8.2 Data Transcription Process

I had to transcribe the digital recordings of the interviews of the participants and followed the four stages recommended by Smith (2004).

- *First transcription*: All interviews were in Setswana, Sepedi or Sesotho. They were translated into English, word by word. This was done by a translator in the Department of English at the Sefako Makgatho Health Sciences University.
- *Second transcription*: All audible material in the recorded interviews was transcribed. This included background noises, events, pauses, interjections and repetitions of words or sentences: nothing was overlooked. Emphasised words were underlined. Where there was a short pause an ellipsis […] was used, while for a long pause or a break in a conversation [Pause] was used.
- *Third stage of transcription*: This was a data-cleaning process, which involved the following actions:
    - Removal of repetition, interjections and the background noises;
    - Minimal punctuation was clearly inserted to produce a narrative;
    - Confidentiality was used at this stage, where names and places mentioned were replaced by coded identifiers; and,

- No corrections of grammar were done so that the spoken words were presented as is, so as not to lose the impact of what the participants expressed.

- *Fourth stage of transcription*: This was the final stage of transcription which involved checking the changes and the alterations in the second transcription. Once completed, the process of transcription would have met the IPA standard.

5.8.3 Data Explication Process

I used IPA and, in particular, Hycner's (1999) phenomenological data explication process to analyse the data. Hycner believed that explication is a better word than analysis as it implies the investigation of the constituents of the phenomenon, while keeping the whole intact. This is different from analysis which means the "breaking into parts and often means a loss of the whole phenomenon" (Hycner, 1999, p. 161). Specifically, in the present study, I followed Groenewald's (2004) five-step explication process which is a modified version of Hycner's original steps. An outline of Groenewald's explication steps and how they were applied in the present study is provided below:

- *Bracketing and phenomenological reduction*: The word reduction was coined by Husserl although it has nothing to do with reduction as in the natural sciences. It would do a great injustice to reduce a human phenomenon such as the bereavement of mothers and their help-seeking pathways to a cause-and-effect state (Hycner, 1999). Phenomenological reduction means a deliberate and a purposeful opening of the phenomenon by the researcher "in its own right and with its own meaning" (Hycner, 1999). It is an objective approach which refers to the suspension or bracketing out (epoche) of the researcher's own subjectivity and presuppositions (Creswell, 1998). This was followed by listening to the audio recordings repeatedly to familiarise myself with the words of the participants, to get an holistic sense of the phenomenon, i.e., the "gestalt" (Halloway, 1997; Hycner, 1999). At this stage, the important aspect was the immediacy of the personal experiences of the participants (Zinker, 1978).
- *Delineating units of meaning*: The researcher identified and isolated the statements or units of meaning which illuminated the phenomenon under study (Creswell, 1998; Hycner, 1999). The researcher continued bracketing her own presuppositions so as to avoid making an inappropriate and subjective

judgements. The list of extracted relevant units was made and carefully examined. The units that were identified as redundant were eliminated (Moustakas, 1994). I focused on the number of times those significant units of meaning were mentioned, paying attention to the non-verbal and paralinguistic cues.

- *Clustering of units of meaning to form themes*: I continued with the bracketing of my presuppositions, so as to remain true to the phenomenon. The extracted units of meaning were rigorously examined to draw out the essence of the meaning of the units within a holistic context. This is a phase that demands skill and mastery in terms of making judgement about the selection of the relevant units on the part of the researcher. The selected units of meaning were grouped to form clusters of themes, resulting in the formation of significant topics called units of significance (Sadala & Adorno, 2001). I went back to the recorded interviews (gestalt) and the non-redundant units of meaning to confirm clusters of appropriate meaning, which led to central themes that captured the essence of the particular cluster (Hycner, 1999).
- *Summarising each interview, validating it and where necessary modifying it*: Ellenberger (as cited in Hycner, 1999, pp. 153–154) succinctly described this stage as the reconstruction of the inner world of experience of the participants where each participant experiences their own temporality, spatiality and materiality. However, these individual characteristics must be seen in relation to other participants and the total inner world view. I conducted a validity check by returning to the bereaved mothers to determine if the essence of their interviews had been correctly captured and needed any modifications (Hycner, 1999).
- *Extracting general and unique themes from all the interviews and making a composite summary:* Having completed stage 1-4 on all the interviews, I identified common themes and individual variations, at the same time taking care not to cluster themes if there were significant differences. I highlighted the minority voices which are also important in the phenomenon of the bereavement of mothers and the different help-seeking pathways they chose to alleviate their distress. The process of explication was concluded by writing a composite summary which was to reflect the "horizon" from which the theme emerged (Hycner, 1999). According to Sadala and Adorno (2001), this is the final stage where the participants'

everyday expressions are transformed into expressions appropriate to the scientific discourse supporting the research.

The researcher adopted Van Manen's (1990) fundamental existential framework to present the psychological meaning of the themes that emerged from the participant's narratives. This led to the write-up process and the summary of all the participants' interviews, which captured the essence of their own personal "worlds" as they experienced their grief due to perinatal deaths, and the adoption of different help seeking pathways to alleviate their distress.

Table 5.2:

Summary of stages of IPA explication

Steps	**Activity**
1. Bracketing – process of reading and re-reading the transcripts	I familiarised myself with the transcripts by going through all of them. Then while reading each transcript, I listened to the recordings, noting comments and remarks, while continuing to bracket her own presuppositions.
2. Delineating units of meaning	I identified and isolated statements of units, highlighting the important units of information about the phenomenon, while continued bracketing my own concepts and experiences about perinatal deaths. Then I made a list of the relevant units, eliminating the redundant units, noting the number of times the significant units were mentioned, and paying more attention to the non-verbal and paralinguistic cues.
3. Clustering units to form themes	The process of bracketing continued so as to ensure the truth to the phenomenon. • The extracted units were rigorously examined to capture the essence of the meaning of the units within the holistic content. • Selected groupings were clustered into themes, resulting in the formation of units of significance. The audio recordings were listened to several times, resulting in the formation of the central themes.
4. Summarising each interview (Validation)	I returned to the bereaved mothers so as to determine if the essence of their interviews was correctly captured by gathering in groups depending on their location. The participants from Fafung, Legonyane, Letlhabile and Brits gathered together in Brits Town, while Soshanguve and Mabopane and Garankuwa participants gathered at one place on two Saturdays.

Source: adapted from Groenewald (2004)

Having concluded the stage of data analysis, I followed the discussion by looking at the measures of trustworthiness of the research so as to establish the quality of the research findings.

5.9 TRUSTWORTHINESS / QUALITY CRITERIA

Quality criteria are applicable to qualitative research. While quantitative research uses concepts such as internal validity, generalisation, reliability and objectivity to judge the quality of the research, qualitative research speaks of the trustworthiness of the research which poses the question of whether the findings of the research study can be trusted (Kortjens & Moser, 2014).

Trustworthiness, which is a term used in qualitative reach instead of validity which characterises quantitative research according to Lincoln et al. (2011), has four key components as discussed below.

5.9.1 Credibility

Credibility is the confidence that can be placed in the 'truth' of the research findings. It is the ability of the researcher to represent the findings as a true reflection of the information drawn from the participants (Korstjens & Moser, 2018). I used multiple sources of data and methods and prolonged engagements together with observation of the participants during the interviews to triangulate the results. Observations were noted by using field notes.

5.9.2 Transferability

Transferability is the degree to which the results can be generalised or applied in another context, which can either be in a similar setting or a similar population when a similar phenomenon is being investigated. I used multiple research tools to ensure transferability of the research findings.

5.9.3 Confirmability

Confirmability is the degree of neutrality adopted by the researcher. I ensured that the findings were based on the responses of the participants, not on my biasness. This was achieved by keeping an audit trail of the processes used to gather the raw data (as explained in the research design) notes and personal notes (Lincoln et al. 2011).

5.9.4 Dependability

Dependability refers to consistency of the findings; for example, if the research were to be repeated by other researchers, the findings would be consistent. I used the technique of external audit to determine the dependability of the research study. An outside researcher was asked to review and examine the research findings. This replaces the concept of reliability used in quantitative research (Korstjens & Moser, 2018).

5.10 ETHICAL CONSIDERATIONS

There were a number of ethical issues considered during this research project to protect and avoid the exploitation of participants as discussed in the following sections.

5.10.1 Permission for the Study

I was granted ethical approval by the University of Limpopo Ethics Committee before the study was conducted (Appendix A) Furthermore, I sought and received permission from the Chief Executive Officer of Dr George Mukhari Hospital to access the hospital records in the maternity ward (Appendix B and C)

I was granted access to the population of the study by the Dr George Mukhari Hospital research committee. I was able to easily access the maternity ward of the hospital, where the birth registers of mothers who experienced the trauma of perinatal death were kept. This was in line with what Sodi (1997) referred to as a good research setting; i.e., it provides the researcher with easy access and the ability to form immediate rapport with the participants and to gather data directly related to the research questions formulated.

5.10.2 Informed Consent

According to Manti and Licari (2018), the researcher has the responsibility to guide, protect and to oversee the interest of the participants in any health-related study. Having informed the participants about all aspects of the research, I sought permission from them regarding their participation (Appendix D and E). This was done so as to make the participants aware of the nature of the research and their right not to participate in the study or to withdraw should they wish to do so, even if they had initially agreed. These rights were explained to the participants before the

commencement of the study, and they were advised that their participation in this study was voluntary.

5.10.3 Confidentiality and Anonymity

I ensured that the information of the participants was not divulged to the public. Participants were reassured that the recordings of the interviews would be deleted after the transcription process had been completed. All written documentation was stored safely in a lockable drawer accessible only by the researcher. Computer files were protected by means of a password. The identities of the participants were not disclosed in any reports. The anonymity of all the participants was maintained.

5.10.4 Beneficence

I maintained privacy throughout the process. I maintained the dignity and respect of all the participants. Given the sensitiveness of the study, I adhered to the principle of beneficence (not causing any harm to the participants). This was achieved by making provision for any participant who might present with any untoward reaction or behaviour as a result of the study, to see a counsellor or a clinical psychologist at their local clinic or at the hospital.

5.10.5 Member Checking

Member checking is a technique adopted for exploring the credibility of the research results where data or results are returned to participants to check for accuracy and resonance with their experience (Brits et al., 2016). It is also viewed as the "way of finding out whether the data analysis is congruent with the participants' experiences" (Curtin & Fossey, 2007, p. 92). Member checking is best done with "polished" (p. 191) interpreted themes and patterns emerging from data rather than giving the participants the actual transcripts (Creswell, 2009).

In the current study, participants were divided in two groups according to their various locations. The first group was in Brits Town which comprised of participants from Fafung, Legonyane, Jericho, Letlhabile and Brits. There were eight participants, and they were given "polished" transcripts to verify the accuracy of the information given. They were given a chance to edit, clarify, elaborate or even delete whatever information they did not agree with. The same process happened with the remaining

12 participants who were from Winterveldt, Soshanguve, Mabopane, Garankuwa and Mmakau.

I asked them to check if what was written is indeed what they meant. Doyle (2007) stated that the researcher should view their research as a “negotiated process” to ensure that the participants are given power and a voice. He called the exercise “participant member checking” (p. 8).

The results of the member checking revealed that some participants were able to elaborate more about their inner self, what happened to them after arriving at home, who said what and who was supportive while others changed their responses and rephrased. One participant refused to reread the transcript as she said she did not want to go through the exercise again and again. The process allowed them to talk as they were meeting for the first time. They even suggested that they form a platform to deal with their emotional pain and challenges in the form of a support group.

CHAPTER 6

FINDINGS

6.1 INTRODUCTION

In this chapter, the researcher will first present the demographic profile of the participants, second will be the results of the study and lastly, themes and sub-themes that emerge from the study. In this regard, the following themes that emerged are presented:

1. Experiences of mothers

2. Understanding and describing coping strategies adopted by mothers.

3. Health seeking pathways adopted by mothers.

4. Reaction of the news of death of the baby immediately after delivery.

The chapter concludes by giving a summary of the results.

6.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS

Table 6.1:

Demographic details

PARTICIPANT	AGE	ADDRESS	GESTATIONAL PERIOD	MARITAL STATUS	EDUCATIONAL LEVEL	NUMBER OF CHILDREN	ANTENATAL CARE
1.	29	Bapong, Brits	28/40 weeks D.O.D 2017	Single	Grade 12	Para 1. Grav 2	Yes
2.	30	Bloemfontein	33/40 weeks D.O.D 2018	Married	Grade 9	Para1. Grav 2	Yes
3.	28	Soshanguve, Pretoria	32/40 weeks D.O.D 2017	Single	Grade 8	Para 1. Grav 2	Yes
4.	40	Jericho, Brits	36/40 weeks D.O.D 2018	Married	Grade 6	Para 2. Grav 3	Yes
5.	27	Mabopane, Pretoria	32/40 weeks D.O.D 2016	Single	Grade 8	Para 3 Grav 4	Yes
6.	27	Winterveldt, Pretoria	38/40 weeks D.O.D 2017	Single	Grade 7	Para 2. Grav 3	Yes
7.	26	Soshanguve, Pretoria	37/40 weeks D.O.D 2016	Single	Diploma in Marketing	Para 1 Grav 0	Yes
8.	25	Soshanguve, Pretoria	24/40 weeks D.O.D 2017 (F.S.B)	Single	Grade 12	Para 0. Grav 3	Yes
9.	28	Soshanguve, Pretoria	28/40 weeks D.O.D 2017	Single	Grade 11	Para 2. Grav 4	Yes
10.	26	Letlhabile, Brits	38/40 weeks D.O.D 2018	Single	Diploma in Water System	Para 0. Grav 1	Yes
11.	26	Letlhabile, Brits	38/40 weeks D.O.D 2018	Single	Diploma in Water System	Para 0. Grav 1	Yes
12.	28	Soshanguve, Pretoria	29/40 weeks D.O.D 2016	Single	Grade 9	Para 0 Grav 1	Yes
13.	39	Mmakau, Brits	38/40 weeks D.O.D 2017	Married	Grade 8	Para 2. Grav 3	Yes

PARTICIPANT	AGE	ADDRESS	GESTATIONAL PERIOD	MARITAL STATUS	EDUCATIONAL LEVEL	NUMBER OF CHILDREN	ANTENATAL CARE
14.	32	Soshanguve, Pretoria	28/40 weeks D.O.D 2018	Single	Grade 10	Para 0 Grav 3	Yes
15.	38	Soshanguve, Pretoria	36/40 weeks D.O.D 2016	Married	Grade 6	Para 2 Grav 3	Yes
16.	40	Soshanguve, Pretoria	35/40 weeks D.O.D 2018	Married	Grade 5	Para 4 Grav 5	Yes
17.	30	Fafung	30/40 weeks D.O.D 2018	Married	Diploma in Administration	Para 1 Grav 2	Yes
18.	35	Fafung, Brits	28/40 weeks D.O.D 2017	Single	Grade 9	Para 2 Grav 3	Yes
19.	34	Soshanguve, Pretoria	33/40 weeks D.O.D 2017	Single	Grade 4	Para 2 Grav 3	No
20.	32	Legonyane, Brits	28/40 weeks D.O.D 2017	Married	Grade 6	Para 2 Grav 3	Yes

Table 1 shows the demographic information of participants and the reasons for the perinatal deaths of their babies which are explained as follows:

- Parity (Para) means the number of births a woman has had after 20 weeks gestational period.
- Gravida (grav): it is the total number of confirmed pregnancies that a woman has had, regardless of the outcome.
- Gestational period: it is the period of development of the foetus that is how long the woman was pregnant before the delivery, for example (28/40Weeks).
- M.S.B (Macerated Still Born): it is the softening effect of the tissues of the foetus due to the degenerational process as a result of any damage that occurs in the uterus during pregnancy.
- D.O.D. (Date of Delivery) is the date when the mother lost her baby.
- F.S.B (Fresh Still Born) when the foetal death occurs during labour and delivery.

The unique characteristics of the sample was beneficial for the study because of the rich knowledge from different perspectives on mental illness was obtained.

6.3 SUMMARY OF INTERVIEWS WITH THE PARTICIPANTS

This section presents the summaries of individual interviews. This is in accordance with Groenewald (2007) data explication process. Each of the integrated summaries incorporate participant's emergent themes.

6.3.1 Participant 1

Participant is a 29-year single mother from Brits with a Grade 12 certificate. She attended antenatal care, had a gestational period of 28/40 weeks D.O.D 2017, with Para 1. Grav 2. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

The participant reported that in the morning while wiping herself in the bathroom, realized that she had blood over her panties and that is when she started to worry, and feeling that something was wrong with the babies. She was expecting twins.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

The participant reported that she was honestly not sure. The medical practitioner told her that the twins were not the same, they saw that one had an umbilical cord around the neck. She said she was alone in the ward's cubicle feeling all the pains alone… I could not scream as I birthed them alone … I had no choice… I stood up, wrapped them (twins) and took them to the nurses, to let them know that they are out. When asked how she coped with neighbours and community, she said that people knew that I was pregnant they would even check at laundry/ washing line hoping to see if they are boys or girls even though they were not aware that they were twins. I kept to myself, people were just staring at me not expressing themselves... maybe they were afraid to ask me what happened... I kept quiet...dealt with pain my own way.

c) Theme 3: Health seeking pathways adopted by mothers.

Participant reported that as it was the first time it happened my mother took me to get cleansed and I also took traditional medicine to help me get cleansed inside the bodies and regain my energy. We visited a traditional healer and they gave me traditional medicine to clean me inside...when I drank them I discharged a lot of clots... I felt light and better... both the tablets from the hospital and the traditional medicines helped me a lot. I was all alone...the father of the babies was at Limpopo. He came after 3-4 days after the death of my babies however my brother and sister were there together with my mother who tried to comfort me.

6.3.2 Participant 2

Participant is a 30-year married mother from Bloemfontein, level of education is Grade 9. She attended antenatal care, had a gestational period of 33/40 weeks D.O.D 2018, with Para 1. Grav 2. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

As I was mopping the floor at work, I felt that something has broken underneath me as I checked... I realised that my water is broken... I ran to my room to call my employer. I was rushed to Dr George Mukhari hospital. The doctor came, as he was checking me...I would feel that there was something wrong with the baby... the nurses said I have lost a lot of water...the heart rate was low.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.
I don't know what caused the baby to die... because I was well and 8 months pregnant... maybe it is that I lost all the water... the nurse said that. The other nurse was checking on me... while the other nurses was looking for the doctor...The doctor checked me as he was checking ne I could feel that something wanted to come out... the baby came out and the doctor took the baby quickly... It was heart breaking but I had support...some neighbours were talking behind my back, I was even scared to go outside the house.

c) Theme 3: Health seeking pathways adopted by mothers.

They took me to the traditional healer, they gave me their medication to drink and to bathe with it...They said they were to cleanse me inside and outside... I don't want to lie they did help me.

6.3.3 Participant 3

Participant is a 28-year single mother from Soshanguve, level of education is Grade 8. She attended antenatal care, had a gestational period of 32/40 weeks D.O.D 2017, with Para 1. Grav 2. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I felt the baby was not moving-nor playing...At the clinic they connected me to the machine...the heart rate was low...Ambulance came to take me to Dr George Mukhari hospital I was connected to the machine again and it was confirmed that the heart beat had stopped... It was painful thinking that its the second baby passing like this...

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

With the 1st pregnancy I was 27/40 weeks the water broke upon my arrival at the hospital the baby dead...with this one I don't know what caused the baby to die...the nurses just said the baby is dead...I could not ask the doctor, as I was heartbroken... I just said "God does not want me to have babies maybe I am cursed...

c) Theme 3: Health seeking pathways adopted by mothers.

I took the hospital pills- we are born again family...we believe in the Power of Prayer. So my father and step-mother came to collect me from the hospital. My father took me to Free State to his traditional doctor. He gave me some medicine to drink, and I was bathed. I was told that I need cleansing, but I also took pills from the hospital, which dried the milk and I was healed. Both treatments helped me a lot.

6.3.4 Participant 4

Participant is a 40-year married mother from Jericho, Brits, level of education is Grade 6. She attended antenatal care, had a gestational period of 36/40 weeks D.O.D 2018, with Para 2. Grav 3. The interview was done at the participant’s home.

a) Theme 1: Experiences of mothers

I woke up in the morning at 3am, went to the bathroom, as I wiped myself, I realised that I have some blood... I went back to bed...experiencing pains until 5am in the morning...I then realised that I can't feel the pain any more. They called the ambulance...when I arrived at the hospital the heart beat was very low after they have connected me to the

machine... I knew something wrong is happening to the baby... The doctor told me that the baby is dead.

b) Theme 2: Understanding and describing coping strategies adopted by mothers

The doctor told me that the baby was exhausted that is why she died...But I think it was the distance I travelled from Jericho to Dr George Mukhari hospital. It took too long. I felt like it was the end of the world...I was heartbroken. I did not know how I am going to explain what happened to my husband. I waited for 2 hours for the ambulance to arrive to take me to hospital...I got in and had already lost hope...Upon my arrival... Doctors, students, nurses and medical students went up and down to help me...unfortunately the baby came out dead... I was heartbroken, I didn't know what I was going to do...when I get home and how I was going to explain what happened...Since I was sick...It was like I have lost my mind...but my husband was very supportive- He even took some days of from work-to take care of me. The neighbours made a joke about me...they were gossiping about me...I stayed indoor for a long period, as I was struggling to accept...my neighbours would laugh, when they see me outside...so I stayed inside the hours.

c) Theme 3: Health seeking pathways adopted by mothers.

I took the hospital pills...to prevent/stop the pain and to dry my milk...they helped me a lot...My family believes in traditional medicines...so I was taken to the traditional healer.

6.3.5 Participant 5

Participant is a 27-year single mother from Mabopane, Pretoria, level of education is Grade 8. She attended antenatal care, had a gestational period of 32/40 weeks D.O.D 2018, with Para 3. Grav 4. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I was booked to deliver at Boekenhout Clinic, but when I arrived at the clinic, they checked me, and could not hear the heart beat…they rushed me to Dr George Mukhari hospital as an emergency…I knew that something was wrong with my baby.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I think they are running short of staff…there are few nurses and doctors but the nurses are doing their work, but the doctors are few, when you call a doctor, you get helped by a student or the nurse who can't decide what to do…maybe this is the reason why my baby died. I just accepted…that maybe it is God's will. When I arrived at the hospital as an emergency from the Boekenhout clinic…I was not treated as an emergency…I was told to queue…just like any other person by the nurses…I was told that the doctor is still doing ward rounds in I.C. U…I was there at 7pm..the doctor arrived at 9pm… when he scanned me my baby was dead… I was not an emergency… I don't have a mother; I am staying with my father… my father helped to accept the death of my baby. He talked to me and told me that it is better because I have two boys who are alive…who need me. My stepmother is also supportive too. I thought I will come back with the baby just like any other woman but people judge me… I don't care about what they say about me…My customary husband chased me out of the house saying that I have killed his baby.

6.3.6 Participant 6

Participant is a 27-year single mother from Winterveld, Pretoria, level of education is Grade 7. She attended antenatal care, had a gestational period of 38/40 weeks D.O.D 2017, with Para 2. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I noticed that I was bleeding when, I wiped myself in the bathroom. I panicked because at the clinic the nurses told us bleeding is not good signs in pregnancy. So I knew that my baby is in danger.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I think bleeding…which I don't know why I was bleeding maybe I was not resting hard enough… Reaction to the news of death of the baby immediately after delivery. It was very painful for waiting nine months and I was already on maternity leave…coming back with no baby…It is very painful. The nurse at the clinic came and attended to me, she

looked for a doctor after an hour, I was transferred to Dr George Mukhari hospital… At the hospital the nursing sisters put the drip- supported me, encourage and helped me to push the baby…The baby was quiet and green… I stay with my mother and my 2 daughters. My mother took good care of me supporting me then I was well. The father of the baby left me after delivery… because he said I have killed her baby…but he came back weeks later when I was already at home… I was surrounded by my friends especially from my social club…colleagues from work-came and encouraged me to accept the death of my baby.

c) Theme 3: Health seeking pathways adopted by mothers.

I was weak when I was discharged from hospital. So I took the pills for energy-vitamin and pills to dry up the milk…But my mother took me to the traditional healer for cleansing. I was bathed with "muthi" and drank "dipitsana" to clear my dirty blood-clots came out…I felt better and light… I was able to go to work after 2 months.

6.3.7 Participant 7

Participant is a 26-year single mother from Soshanguve, Pretoria, level of education is Diploma in Marketing. She attended antenatal care, had a gestational period of 38/40 weeks D.O.D 2017, with Para 1. Grav 0. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I don't know what happened to the baby…As the taxi was hit by a truck and I was sitting in front… I was told that I fainted when I woke up in ICU at Dr George Mukhari hospital…I think the baby died in my belly during the accident.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I was done a Caesarean Section but I don't remember much…but the Doctor told me that the baby was a boy…and he was already dead when they took him out…I think the accident crashed him…As I was also trapped in the car… I was pulled out from the package of the car by the police with the machine they cut out the car to take me out.

Reaction to the loss of the baby when it hits me because it was my first born…I was going to be a mother like all other woman…I was going to walk with pride like all mothers…with my own flesh and blood… I am married and I don't have children. Am called names saying am a baby killer. Now I have also lost my womb…because when they took out the baby they told me that the womb had burst or teared badly. I was unconscious and don't remember what happened…I woke up in ICU surrounded by machines…Doctors and nurses were excited to see me awake after a week in a Coma… I think they really took good care of me…even after being told that I have lost the baby and my womb…that I will no longer have children they were there for me. This is what hurts me mostly I am all alone…you are talking to me in my mother's house in Soshanguve…My own house is in Hammanskraal- Majaneng. My husband wants nothing to do with me… I suggested adoption to my husband and he said " I am nothing in his eyes and he will marry another woman who can give him children and not a baby killer. When my in-laws came to the hospital, to see me they were so angry with me, they blamed me for the loss.

c) Theme 3: Health seeking pathways adopted by mothers.

I am a Christian; I believe in God. My in-laws when I arrived at home, they belittled my church and my God…They forced me to go to the traditional healer for cleansing…for peace sake I went…just to make them happy…I took the muthi mixture and bathe with it. But honesty I was drinking hospital treatment too…which I think helped me.

6.3.8 Participant 8

Participant is a 25-year single mother from Soshanguve, Pretoria, level of education is Grade 12. She attended antenatal care, had a gestational period of 24/40 weeks D.O.D 2017 (F.S.B), with Para 0. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I felt on Monday that the baby was not playing as usual, but I ignored the situation...continued with my work but on Tuesday it happened again...no movement...On Wednesday I decided to go to the clinic...I felt that something was really wrong with the baby...He was not playing for 3 days now...I was worried.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I don't know and understand what caused the baby to die. But in the ward after the baby was born- I heard the sisters screaming " cord around the neck- cord around the neck". Ijoo...I was so afraid...as it was my first experience to go through this...I was scared that the baby is dead inside me...I blamed myself for taking 3 days without doing anything when I did not hear the baby moving. The sister at the clinic screamed at me for staying 3 days without feeling the movement...She said are you mad...are you crazy...are you normal to stay 3 days without feeling the baby playing...I thought she was going to clap me the way she was so angry at me...Even at Dr George Mukhari hospital after delivery...the sisters were very harsh...One of them said here is your baby she is " rotten". I did not get counselling...I was discharged...after womb scrubbing but was given pills for pain. I got home without a child...the father was very angry saying that I have done that deliberately...how come that I stay 3 days without feeling the baby playing...He said I wanted to kill his child. I could not go outside because my sister in law works at the clinic, and it is close to my house, so she told people that my baby was 'rotten'. I am a laughing stock of my community. They are calling me names that hurts me...So I am no longer as free as I used to be.

c) Theme 3: Health seeking pathways adopted by mothers.

At home we are the Z.C.C. people. So they took me to church and I was given "ditaelo" to cleanse me inside...but I also continued with the pills from the hospital as they helped me with the pains. Both treatment helped me a lot but I still struggled with the imagination of the " rotten baby".

6.3.9 Participant 9

Participant is a 28-year single mother from Soshanguve, Pretoria, level of education is Grade 11. She attended antenatal care, had a gestational period of 28/40 weeks D.O.D 2017, with Para 2. Grav 4. The interview was done at the participant’s home.

a) Theme 1: Experiences of mothers

My water broke...and it was all of a sudden my tummy shrank...I was worried that my baby is going to die as there was no water around him.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

When I arrived at Dr George Mukhari hospital,I was told that there is little water in the womb... they admitted me at ward 25 for week as I was not in term yet...But after a week they delivered my baby in ward 29 and the baby was dead. I felt broken...why did they wait for a week to take out the baby. I was almost in term at 7 months. The nurse supported me in ward 25 said that it happens that at time the water broke...and there is no little water in the womb. I felt comforted. They also arranged the social worker to talk to me... I felt better but she also did not tell me what killed my baby. I called my family to let them know that the baby has passed away. My mother removed the baby clothes so that I should not get hurt. The baby's father does not stay with us...But he is supportive together with his family. I could not face them...with the previous miscarriage...my neighbour remarked that I have 2 children...what more do I want...So with this one...I am so afraid and I am ashamed...that maybe they are right...I should stop trying for a boy...I have 2 daughters one is not for my husband...So he wanted a boy.

c) Theme 3: Health seeking pathways adopted by mothers

When I was discharged from hospital they gave me tablets for pain and to dry up the milk. So I took the hospital tablets and felt well...I did not go anywhere for help. I went back to Dr George Mukhari hospital for checkup.

6.3.10 Participant 10

Participant is a 26-year single mother from Letlhabile, Brits, level of education is Diploma in Water System. She attended antenatal care, had a gestational period of 38/40 weeks D.O.D 2018, with Para 0. Grav 1. The interview was done at the participant’s home.

a) Theme 1: Experiences of mothers

I went to Bongani Clinic in Welkom, where I was working...I was told that I am high risk. I have Polyhydramnios- the water around the baby was too much...But I was over pregnant...I was 42/52 weeks pregnant. I was not in labour...I took myself to the hospital...because I felt am over pregnant. I am not getting pains...so I wanted the drip or pills to start the pain...I felt that something was wrong with my baby...I was worried and scared.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

The doctor told me that the baby did not have a diaphrogram. There is too much water...(Polyhydramnios), my baby might have drowned because I did a Caesarean Section- and the baby was not breathing...He was 3.9kg. The baby was quiet, big 3.5kg light in complexion as if sleeping...I am blaming the clinic in Brits...why when they see that I was over pregnant at 42 weeks DOD not act and take me to the hospital at 36/40 weeks of pregnant- their delay in referring me to the hospital- they have killed my baby. I feel let down by the nurse and doctors at the clinic... They failed to diagnose me properly...In the beginning the nurses said I have Polyhydramnios. The doctor said no it is not that...then am over pregnant at 42 weeks...I do Caesarean Section. I have polyhydromious and my baby is dead...I am heartbroken and disappointed by poor diagnosis...Even now after going home without the baby...I went back to the local doctor to check where does this polyhydramnios come from...they are not telling me...they don't know...so I am disappointed about the doctors. The father of my baby from day one said he does not want the baby. I must terminate it...I went to the clinic to terminate...But I changed my mind after the 1st appointment of termination. Maybe this is 'Karma'. I am all alone with my mother who is very supportive throughout till now. I want nothing to be associated with people who will ask me about the baby...especially from Welkom...because I left Welkom pregnant...After the boyfriend told me to terminate...I came to Brits-Letlhabile home to my mother. I will not go back to Welkom soon...I hate the memory of that pregnancy and the delivery.

c) Theme 3: Health seeking pathways adopted by mothers

My mother took me to the Faith healer who slaughter 9 white chickens, and sprinkled blood into the bath with holy water and bathe me to remove evil spirits (Sefifi). Then I was given some Holy Powered water to drink at home. I feel better and clean inside and outside...I am ok, able to start a new job in Brits-Water and Sanitation Department

6.3.11 Participant 11

Participant is a 31-year single mother from Letlhabile, Pretoria, level of education is Grade 9. She attended antenatal care, had a gestational period of 38/40 weeks D.O.D 2017, with Para 0. Grav 1. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

In 2017, when I was sleeping, I felt in my bed and I realised that its water that have broken. I felt sick and I was scared. I have 4 boys and I have never experienced something like this. My baby girl may not live.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I don't know what caused the baby to die, but i can blame the distance from Legonyane to Dr George Mukhari Hospital. The road is bad and there are animals on the road. The ambulance driver tried all huis best to help me not to deliver in the ambulance, my baby was born quiet. I was thinking that it was a girl and I was excited and I am very hurt and even said God has forgotten me after asking him for a baby girl for such a long time, but I consoled myself that it's the will of God. When I arrived at the hospital, the nurses and doctors used all their resources to help me deliver live baby and after all that the baby came out quiet. My husband collected me from the hospital, he was crying with me you could have seen the good and beautiful things he has done with the nursery. It was pink her name was put on the cupboard in pink. Even my boys were so quiet when arrived empty handed without their sister. It was so painful when my neighbour saw me and asked me the gender of the baby, I did not answer them but threw my hands. I think they are

women they will understand that I came back empty handed. The pain was deep so I could not talk.

c) Theme 3: Health seeking pathways adopted by mothers

I am an Apostolic Church member we don't clap hands we hit drums. I was bathed with *diwasho* and also drank d*iwasho* to be cleaned inside. I saw that i was clean a discharged lot of blood clots. I felt cleaned and regained my energy levels again, but i took them along with hospital treatment for pain and for drying of milk.

6.3.12 Participant 12

Participant is a 28-year single mother from Soshanguve, Pretoria, level of education is Grade 9. She attended antenatal care, had a gestational period of 29/40 weeks D.O.D 2017, with Para 0. Grav 1. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I woke up in the early house of the morning with lower abdominal pain. I have to bathroom frequency when I wiped myself I saw a mucus like discharge when I walked to my mother's bedroom, the water broke…I got scared, fearful that my baby is going to die…as I was not yet in term …

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I think it is stress…. Because I was crying everyday… my boyfriend left me when I was five months pregnant… my mother tried to console me but it was difficult to accept… This was a planned baby… why did he abandoned me. I was crying throughout my labour delivery… I was broken emotionally. I had physical pains of the labour process, I remember one nursing sister putting my head on her chest… rubbing my back… I was inconsolable…but I felt the love…support… from the staff in the ward. The nurse brought the baby out---the baby was still, dead not crying…was dead quite… he was still… I touched her and could not stop cuddling her…until he was taken away. My partner abandoned me when I was five months pregnant. But my parents have been there for me since I fell pregnant up to now… The father of my baby comes from the same community

– divorced his wife and dated me and paid lobola for me… most of the community members were not supportive to see us together …I was called names as a man eater, husband snatcher… even before a fell pregnant…my boyfriend left to stay with his ex-wife and children… I was a joke…humiliated and broken now I can't even go outside…am so ashamed…

c) Theme 3: Health seeking pathways adopted by mothers

When my boyfriend left my mother took me to the tradition healer, as I was crying a lot, and I was 3 months pregnant… my mother has worked out that I may miscarry. So I was given *muthi* and I the pregnancy… then even after the miscarriage I was bathed, given *diwasho*: to drink. This was to wash my blood and forget him.

6.3.13 Participant 13

Participant is a 39-year married mother from Mmakau, Brits, level of education is Grade 8. She attended antenatal care, had a gestational period of 38/40 weeks D.O.D 2017, with Para 2. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

One morning, I woke up being dizzy being a chronic hypertensive patient, I got very worried… I quickly checked my blood pressure and it was very high, I got scared and anxious. I contacted my doctor and he summoned me urgently to his rooms… my blood was 180/140 mghb and I was in term.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I was quickly put on the machine; the heart beat was slow…one of the nurse did a PV examination… she screamed and said… meconium stain… they all rushed to me and prepared me for emergency caesarean section…when I woke up in the ward……my baby was not there…the nurse told me that they did everything possible, that the baby was not crying and they tried to resuscitate him, unfortunately he passed away. He was a boy…I think my blood choked him…. Heartbroken devastated because we planned for his for this baby… this was because we planned for this baby…this was the child for my

marriage…the other 2 are not…I feel that I have failed my husband…he was so excited to have this boy husband…he was so excited to have 2 daughters from previous marriage. When I arrived the ambulance parked night at the door of casualty. I was put on a stretcher as an emergency…the casualty ran and said high risk 38 weeks pregnancy…she called the labour ward, I was wheeled there straight to theatre for me that was total care and support unfortunately my baby passed…. My family both sides my parents-siblings, my in-laws and my husband are very supportive. They all hurting….my husband is not coping…he had to take leave for a while to be okay… Those that were close to my family, my parents and siblings were very supportive and even came to stay with us especially my mother and younger sister to help me with the two other kids. My mother-in-law did not come…but she is still attached to the first wife…so I understand but it hurts me.

c) Theme 3: Health seeking pathways adopted by mothers

I was discharged with medication for pains and to clean the caesarean wound and to dry muck. As Zulus, our clan believed in the traditional medicine. So I was taken to out. Tradition healer by my husband and my mother. I was cleansed of the evil spirit and to removes\s the dark cloud. So I was given *muth*i to drink to cleanse the blood. I was not well for +-6/52 because of the caesarean section, but I am strong and well now…

6.3.14 Participant 14

Participant is a 32-year single mother from Soshanguve, Pretoria, level of education is Grade 10. She attended antenatal care, had a gestational period of 28/40 weeks D.O.D 2018, with Para 0. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

This is the third time, I lose my babies almost or when I reach term I don't have children….I felt lower abdominal pain… I always even with the 2 previous still birth, I develop diarrhea even if it is not strong…I felt like that … I knew that this is amen … for me… I felt that even this one… at 28/40 weeks I am going to lose her… I was screaming and was frantic

that my husband should come back home from his nightshift…Saturday was badly wrong…with my baby.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I think it is witchcraft every time I am pregnant-there is a tall woman which I don't know, who passes at my gate-starring at my house… this woman relates to the ex-wife of my husband, the ex-wife of my husband has 2 children of my husband one day after getting married to my husband…she phoned and was swearing at me. She said you will be pregnant but you will never hold those children in your arms… this is the children in your arms…this is the third time and it is happening… A traditional healer said *ke lekone*!!!i don't know how to get rid of this, because I desperately need a child!!! But Ii strongly believe that it is witchcraft from a bitter ex-wife of my husband. I am finished… my marriage is finished… I wish the world can just open and I hide inside…I'm not a woman … I can't keep on asking some woman's children to buy bread at the shop…am called horrible names by women in our street, I can't even send the children to the shop…they call me a leaking basket…a pig that eat its babies.

c) Theme 3: Health seeking pathways adopted by mothers

My father in law together with my husband-they attend the ZCC church so they took me the church for cleansing-they given me *ditaelo*. My father also requested my uncle to buy a sheep to cleanse me and they put a *sbanxa* on my wrist…I think the 2 families are both desperate to help us…they don't know what to do…the ex-wife of my husband is using traditional medicines from Malawi…so I think it is strong. The doctor and nurses were very supportive one nurse said I know you…2016 you were here and delivered a full term stillborn… I can't look at you in the eyes…and give you this bad news again…the Doctors said I need more investigations etc., but I was looking at them. defeated and numb with pain…they were so supportive and shocked about this 3 stillborn babies at term at the same hospital…I am childless…I am childless. My husband is very supportive he said I should stop trying to have a baby otherwise one day he will lose me!!! It shows how supportive he is… My parents in particular my father is a Bishop at the Apostolic church. He took me to so many prophets for help – and also my mom and siblings are all so

supportive; my elder sister has given me her 7-year-old son for me to raise. I appreciated that… my in-laws are also concerned about my situation.

6.3.15 Participant 15

Participant is a 38-year married mother from Soshanguve, Pretoria, level of education is Grade 6. She attended antenatal care, had a gestational period of 36/40 weeks D.O.D 2016, with Para 2. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I was sleeping rest during the day when I woke up my water broke I got so anxious and called my husband at work…to find me at the clinic when I arrived the heartbeat of the baby was very low. I developed fear. I was literally shaking…I felt that my baby is not going to make it…I was waiting for the ambulance or my husband…the ambulance come and the nurse in the ambulance put up a drip and monitor my condition…but I could see that she was struggling to read the heart beat or not hearing it…something was utterly wrong.

b) Theme 2: Understanding and describing coping strategies adopted by mothers.

I don't know, the baby came out with the cord around her neck and the sister said the cord strangulated her. She was dead-still and very quiet…so I think that is what killed my baby. I am angry with myself because for me to sleep during the day, was that I was extremely tired often am awake and end up and about…but I felt tired…I should have gone about…but I felt tired…I should have gone to the clinic…I can't believe it that my baby is dead…after such a lot of planning…am just disappointed. The nurse from the clinic and also the ambulance helped me a lot. They contained my pain my fears they calmed me down. At the hospital I was given a chance to hold my baby by the staff…to name my daughter…to say good bye to her till my husband came and we stayed with her for an hour. Telling her how much we love her…and they took her away left us alone together with my husband…for me that was precious moments that I needed… My family and my in-laws and my older children are very supportive. They give me space if I want to be alone…they are there for me… I have wonderful friends in the neighbourhood some

come to help me with the older children, even took them along to their homes, for me to rest. Some brought home cooked meal for the family. They have been there for me checking on me and the kids regularly especially when my husband is not home.

c) Theme 3: Health seeking pathways adopted by mothers

My in-laws and my family we belong to the apostolic church ST JOHN'S church. I was attended to by the church elders. Women cleansed me by bathing me with holy water mixed with the holy powders (Diwasho). I was also given some holy water to drink mixed also with holy powders for cleanse the blood I felt good and healed.

6.3.16 Participant 16

Participant is a 40-year married mother from Soshanguve, Pretoria, level of education is Grade 5. She attended antenatal care, had a gestational period of 35/40 weeks D.O.D 2018, with Para 4. Grav 5. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I was doing the laundry for my family all of the sudden I started feeling tightness around my lower abdomen. I took rest, aid down on the bed, but the contraction start. I got scared fearful because according to the expected date of delivery it was very early… I still had some feels to go…I was worried that o might have strained the baby by doing the laundry…I knew something was abnormally wrong…I might have killed my baby.

b) Theme 2: Understanding and describing coping strategies adopted by mothers

I started bleeding as I was rushed by my husband to the clinic in Block BB, it is unusual to bleed before the baby comes out… I have 4 children it has never happened….the Doctor said the placental detached-separated prematurely…but I think I am the cause of that placenta loosening out before the baby came out. I think it was the strain I put on the baby…I blame myself. I am angry with myself…I blame myself I still don't understand why I did that laundry…I killed my baby…. The nurses upon my arrival at the clinic were supportive, concerned about my bleeding, I did not tell them the truth about the laundry story… but they supportive me and transferred me to Dr George Mukhari where I

delivered a stillborn baby boy, with the great care and support of the healthcare professionals… they took good care of me till they discharged me. My husband is very angry with me…because I told him what happened…he screamed at me why I did the laundry…when there is a helper in the house. He drove me to the clinic very angry not talking to me, but he is still angry even now about how careless I was, but he is becoming better, as he also sees that am also not well yet. We did not tell the rest of the family about what happened as a result. I have wonderful neighbours, we belong to the same society in the Block, and so they came and brought prayers to the family for few days, which strengthen me.

c) Theme 3: Health seeking pathways adopted by mothers

My family believe in God we are Apostolic, we went to church, for cleanse inside and to be washed. The Bishop prepared a holy bath to cleanse me, and also drank holy water with *diasho* for a month, to get rid of the dirty blood-which came out in clots. I am fine now but we decided no more babies.

6.3.17 Participant 17

Participant is a 30-year married mother from Fafung, Brits, level of education is Diploma in Administration. She attended antenatal care, had a gestational period of 30/40 weeks D.O.D 2018, with Para 1. Grav 2. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I was coming from work, as I work as an administrator in our company. I felt unusually tired, but thought it was work demands but I was still far for maternity leave…I laid down a bit…my water just broke…I screamed for my husband…for help…I was so anxious…I felt my tummy hardening up…becoming smaller…I thought my baby was going to die…the tummy just got small all of a sudden…I knew that something was happening to my baby…she may be suffocating and dying…I was choking with fear…

b) Theme 2: Understanding and describing coping strategies adopted by mothers

I don't know…even the Doctor could not tell me exactly what happened, it was maybe the strain of work, but maybe infection…I don't know… but the Doctor told me that it was footling-the foot came out first before the head…maybe that could be the cause but am still not sure. I felt broken, very hurt…a failure to my husband and my 6 years old son, they were looking forward to the younger sister Malehlogonolo…as we all named her after we saw the scan that she was a girl. I applaud my Gynaecologist he was there when I phoned him from home that my water broke…I found him waiting for me at the hospital...he rushed me in admission me with the help of the nurse who were running around for me…to safe my baby…unfortunately the baby died… For the first time I saw my husband crying, I saw his brokenness we hugged and cried together. It was so painful; my mother-in-law came from Kroonstad to stay with me for 3 months, as my mother is an educator, so both of them took good care of me, supporting and helping my husband. I am from a small village, where everyone knows each other, more over my mother is a teacher in the same community…We are close and supportive of each other as a community…must of community members reached out to us, for support and prayers…I healed quicker because of that…

c) Theme 3: Health seeking pathways adopted by mothers

My husband together with our parents decided to consult the traditional healer for answers and cleansing, I was washed with mixture of herbs "muthi" and was given mixture to drink 2 times a day for cleansing inside. The treatment from our traditional healer help me and strength me. He also protected me when I went back to work by bathing me again and gave me some ointment to apply all the time for protection.

6.3.18 Participant 18

Participant is a 35-year single mother from Fafung, Brits, level of education is Grade 9. She attended antenatal care, had a gestational period of 28/40 weeks D.O.D 2017, with Para 2. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

In the morning when I was preparing to go to school, I felt a sharp stabbing pain… I became worried because was just 32/40 wks but I thought it was a false alarm… but when the pain started being stronger… I saw blood on my panty… I knew that something is wrong with the baby… I thought he is going to die… just like all previous miscarriages…

b) Theme 2: Understanding and describing coping strategies adopted by mothers

My husband confessed in front of my gynaecologist in Bris that he has been using "Muthi" in all the miscarriages, to induce my miscarriages. He was drinking all concoction such as Sekanoma, Mothubadifala, and others and infected me… the I will miscarriage… I think it is witchcraft that causes my babies to die. I am so angry… very angry… especially after he confessed to the any Gynaeocologist, that he deliberately infected me… in all my pregnancies.

c) Theme 3: Social support from the health professional team.

I have a supportive Gynaeocologist in all this miscarriages, she was my mother, friend and she would get hurt every time a lose a pregnancy. I never changed a Doctor… because she was so supportive… I went home to empty house- as I don't have children… my in-laws are just next door to my house… My niece… would come over to prepare food for me and I will eat whenever ii was hungry as she had to go to school… my brothers and sisters were there for me. My husband avoided me all the time, there was a lot of tension between us, as I would get so mad towards him, asking myself why he was doing this to me. I had massive support from the school as am a teacher in the local school, even the community was very supportive. My principal would pray with me… and even attended my sick leave so as I was right…

d) Theme 4: Health seeking pathways adopted by mothers

I believe in the power of prayer I invited our prayer group daily at 18H00 to come to my house for prayer. It helped me… the I was strong to go back to school and be like this… the way you see me healed.

6.3.19 Participant 19

Participant is a 34-year single mother from Soshanguve, Pretoria, level of education is Grade 4. She never attended antenatal care, had a gestational period of 33/40 weeks D.O.D 2017, with Para 1. Grav 2 (MSB) The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

I stayed one day without feeling the baby' movement-she was not playing… the following day- I went to the Doctor he did not feel the heart-beart then I was referred to Dr George Mukhari hospital… the baby was still… my abdomen was unusually hard… I am used to her playing 3-4 times a day… now 2 days… no movement… something was badly wrong.

b) Theme 2: Understanding and describing coping strategies adopted by mothers

I don't know… but the Doctor said it must have been infection… as I did not attend the ante-natal care. I did not know anything about what to do… I blame myself because the clinic in our new settlement, where we stayed is far… but people attend anyway. I feel sad, very hurt… because could not touch my baby… she was green… with a foul smell… she was "rotten" the Doctor said… you can't touch her but I could see that she was a baby girl. The nurse shouted at me… they were very rude… they called me a irresponsible… that I wanted to kill my baby because I did not attend the clinic… I am not married… my mother has been telling me not to have another baby… as am not working too… she is supporting me and my children… she was angry with me… even told me to pack and look for an RDP house and … I felt so stupid… so useless… I could not grief for my baby as I had a lot going on. The baby father refused to be part of the baby from the start. In our settlement area we have shacks, and we are close to each other as we don't have water and electricity, so we depend on each other for every little thing because of high unemployment rate… but they were not happy in the beginning that am not attending the clinic… and they used to shout at me for not going to the clinic… how will I deal with the complications of birth etc. but now that it has happened is all we told you so… come back to me… I hide… I stayed at home… I was embarrassed even to get out.

c) Theme 3: Health seeking pathways adopted by mothers

My mother has a traditional healer, so she took me to her. I was given a mixture *Dipitsana* to drink, because I was having a foul smelling discharge after being discharged from the hospital. I took the mixture of herbs with antibiotics from the hospital. I was on treatment for 1 month, till I was completely cleansed. I was bathed with mixed herbs also to remove a dark cloud *Sefifi* as I have lost a baby.

6.3.20 Participant 20

Participant is a 32-year married mother from Legonyane, Brits, level of education is Grade 6. She attended antenatal care, had a gestational period of 38/40 weeks (MSB) D.O.D 2017, with Para 2. Grav 3. The interview was done at the participant's home.

a) Theme 1: Experiences of mothers

It was with my 2 younger children… I knew something was wrong… it was never happened. I started feeling lower abdominal pains… I was worried about the distance from my village to Dr George Mukhari Hospital is about 2 hours… my husband was not there… I got scared that my baby will not survive the trip.

b) Theme 2: Understanding and describing coping strategies adopted by mothers

I was told at the clinic that I am a high risk, as my baby did not turn; it was a breech, so I was booked for a caesarean section, the following week. Unfortunately, this happened… I don't know what caused the water to break… maybe distance, because when I arrive the baby was already dead… the Doctor said it was beech, with a little water when I arrived at the hospital. I was done a caesarean section with no baby to show for it!!!

"Heartbroken, with caesarean section scar with no baby to show for it. Why was I not booked early when I was at least 36/52. I am disappointed for being booked late by the Doctor.

I was taken care of and supported by the nurse at the local clinic, as they called the ambulance. It took longer but eventually it came, and even the ambulance people-nurse

and driver-helped me to arrive safe at the hospital. Even the Doctors and nurses helped me a lot… My family including my husband has been there for me, in terms of bathing me after the operation, taking care of the older children. My neighbour is the one who came to the house to help me, who called the ambulance and accompanied me to the clinic and to the hospital till my husband arrived at the hospital. I have a good support from the community that I live in.

c) Theme 3: Health seeking pathways adopted by mothers

My family becoming to apostolic church-the pastor and prophets at the church bathed me with holy water mixed with d*iwasho* and they gave me same to drink and I felt a light and cleansed.

6.4 COMPOSITE SUMMARY OF ALL EMERGING THEMES FROM THE INTERVIEWS

In this section a table with main themes and subthemes, and a composite summary of all the emerging themes from the interviews with the participants will be presented. All the themes presented will incorporate the units of relevant meanings that were isolated during each interviews explication.

The table below shows the main themes and the sub-themes that emerged during data analysis. Three major themes emerged from the data explication process. They are a) experiences of mothers, b) understanding and describing their coping strategies, and, c) help seeking pathways adopted by mothers.

Table 6.2:

Themes and subthemes

Main themes	Sub-themes
1. Experiences of the mothers	• Anticipated grief • No foetal movement, premature bleeding, ruptured membrane, premature onset of contractions • Multiple recurrence of perinatal death by mothers
	• Understanding of cause of death by mothers • Lack of information on when to get help

Main themes	Sub-themes
	• Distance to the nearest health facilities • Failure of medical team to treat the situation as an emergency • Witchcraft

	• Reaction of news of death of baby immediately after delivery
	  • Confirmation of the death by medical team
	  • Extra suffering of bearing a caesarean scar
	  • Feeling of disbelief, shock, anxiety, fear of humiliation and stigmatization and numbness
	  • Loneliness, abandonment

2. Understanding and describing their coping strategies	• Coping with the loss of the babies during labour and delivery
	  • Support from medical team, doctors, nurses and counsellors
	  • Spiritually dealing with the loss (accepting reality)
	  • Lack of support from medical team (doctors and nurses)

	• Coping with the loss of the babies at home
	  • Support from significant others
	  • Spousal rejection
	  • Feelings of rejection, isolation, stigmatization and humiliation

3. Help seeking pathways adopted by mothers	• Consulting traditional healers and spiritual healers as a way of dealing with the loss
	  • to seek answers about the cause of death
	  • burial of the baby
	  • cleansing of the mother
	  • disposing of the baby's clothes

	• Opting to accept reality
	• Conforming to pressure of parents to seek help from spiritual healers
	• Perceived benefits of alternative pathways. Others did not go anywhere for help, they just accepted reality

6.4.1 Theme 1: Experiences of the Mothers

Most of the participants in the study said that they had a hunch that something was going wrong with their pregnancies. The feeling to some participants was familiar because of the symptoms that they had experienced with their previous miscarriages. The premature

bleeding before the actual delivery of the baby, premature rupture of membrane and the lack of foetal movement aroused fear and anticipation of death of their babies. The following extracts attest to that:

> "*I knew that the baby was dead…every time when I lose a baby I go through this symptoms of frequent urination and mild diarrhoea ….this is my third stillborn [pause] I saw the sonar and could see that there was redness where the heart is …, I asked the doctor to explain what the sonar was revealing, but he said I should wait for another doctor for a second opinion….then I knew that the baby was dead."* (P16)

> *"The pain started, I felt that whatever I was dreading to see happening, is now happening, the contractions started, labour begins and the babies are dead."* (P1).

> *'I realized that my water had broken, I went to the clinic and they sent me to the hospital. When I got there they checked and after they said there's little water then they took me to ward 25, I stayed a week there then after a week they came to check me again and they said that there's no water at all and its emergency. They took me to ward 29 and did C-section, when I got there I stayed a day, the following day a new doctor came and said rather than doing C-section they should have given me some medication to reduce pains, they did. In the afternoon around 6 that's when the pains started and I called the nurse to at least check how far the baby was and when she checked she found out that the baby was close. They then said they'll call a doctor, the doctor came. They checked the heart of the baby through MST which is used to check the heartbeat of the baby, then they confirmed that there's no heartbeat. They took her out and came out dead."* (P2).

> *"They found out that the first doctor found out that i am diagnosed with polyhydramnios, and the second doctor said no, I don't have polyhydramnios because that one was not sure he sends me to the second one, the first one said no the nurse said there is a lot of water I think you have polyhydramnios, she referred me to another doctor who said that everything is normal is not polyhydramnios so they took me from high risk and they allowed me to rather*

attend the sessions at the clinic. I started attending sessions at the clinic. According to the scan I was supposed to deliver on the 08th November. According to scan the 08th has lapsed while I was still attending clinic until they saw that I am over pregnant of almost 42 weeks. After the operation they found out that the baby is not breathing, is alive but the oxygen is somehow not good, the baby is not breathing well." (Nomfundo).

"*… they did not check me they told me to sit down until I had pains and I left home with no pains no anything after then they told me to wait for the doctor to open a file, the doctor came but took some time, he asked what's wrong I said I have a problem of bleeding but he did not attend me immediately, after some time I had pains going and coming. The nurse took me to labor ward and did sonar and I felt a lot of pain but they did not tell me what's wrong they took me to the bed and checked and he looked like a student doctor I was in pain but he kept touching me after sometime told me to change and they took me to a chair where I sat until I felt more pain the other nurse who saw me in pain first came and checked me again. Immediately they told me the baby is no longer alive."* (Boitumelo).

"When I got to the clinic I felt pains even more, they suggested that I go put my urine in a test tube so that they can be able to test it, I went and gave it to them and they said I was not supposed to come to the clinic and that they'll call the ambulance so that I can go to Dr. George Mukhari. I waited there, having pains, I waited for about 2 hours for the ambulance to arrive. It came, I got in and I had even lost hope, they put me in their machines as we went to Dr. George Mukhari. When we got there they said I must get on the bed, I struggled to take off my clothes and finally did. Student doctors came and gave me a urine tube but said it was a false alarm. A doctor came to check me, he used the fetal heart rate monitoring to check the heart beat and said it beats slower. They went up and down to try and help me but unfortunately it was too late." (Phiri).

"I realised that something had broken under me as I checked… I realised that the water is broken… I would feel that there was something wrong with the baby … the nurses said I have lost a lot of water… the heart rate was low" (P2).

"I was told that I am high risk. I have Polyhydramnios- the water around the baby was too much...But I was over pregnant...I was 42/52 weeks pregnant. I was not in labour...I took myself to the hospital...because I felt am over pregnant. I am not getting pains...so I wanted the drip or pills to start the pain...I felt that something was wrong with my baby...I was worried and scared." (P10).

6.4.1.2 Sub-theme 2: Explanation of cause of stillbirth by health professionals

When the causes of stillbirth were given by the health professionals, it was extremely difficult for the mothers. This is what they said:

"When I woke up, the sister in charge phoned my gynecologist as I was expecting the other twin to have survived. I asked the doctor where the other baby is, but when she said unfortunately, immediately I knew that I don't have anything … it was so painful for me, I kept touching my abdomen. I was comforted by the medical team, the doctor, psychologist and nurses, until I said it was well… I accepted, but not completely." (P18).

" they failed to diagnose me properly … I was over pregnant and not in labour with too much water around the baby. I'm disappointed by poor diagnosis" (10).

It can be deduced from the above statements that the mothers had an inkling that their babies were not going to make it due to various reasons that they stated.

6.4.1.3 Sub-theme 3: Understanding of cause of death by mothers

The majority of participants lacked clear understanding and knowledge about what could have caused the death of their babies. Lack of information when to get help when there were complications during pregnancy was also identified as one of the causes that led to the stillbirth. This is what they said:

"I did not feel the baby playing on the 1st day, but I did not take that seriously, I continued with my household chores, doing the washing and cleaning, still on the second day I did not feel the movement but I thought the baby is sleeping and continued with my daily chores in the house, but on the third day I started feeling

restless and worried that maybe something is wrong with the baby, then I went to the clinic, the nurses checked me and referred me to Dr George Mukhari hospital, upon my arrival the sonar was done and the baby was dead…and the midwife said I could not see her as she was 'rotten'." (P6).

Others blamed the distance from the hospital and the time taken to get there as the reason for not accessing help timeously to save their babies.

> *"I was clueless on what was happening, they weren't helping, the ambulance was also taking time to arrive, that's when I realise that something was wrong with the babies."* (P1).

> "*I think the duration, the time that I took waiting for the ambulance and the travelling distance and bad roads delayed my arrival to get help."* (P6).

> *"The driver did everything possible to take care of me, but our roads are bad, full of potholes and animals, the driver tried to help me so as not deliver the baby along the way to the hospital, especially in the ambulance.*" (P11).

Other participants blamed the medical team for failure to treat the situation as an emergency.

> *"I was alone in the cubicle, feeling all the pain alone, I could not scream as no one was going to hear me … I birthed them alone … I had no choice, I stood up, wrapped them and took them to the nurses' duty room, and I said to them 'here they are, I have delivered them myself" (P1).*

Some participants reported that they had experienced stillbirth more than three times and cited witchcraft as the cause of their repeated stillbirth. The following extracts attest to that:

> *"My husband confessed to me that the doctor was right when he asked him what herbs he is drinking, as my blood result revealed that there was something that I was drinking that has also led to the previous stillborn … my husband confessed that he was drinking 'sekanama', 'mathuba difala' and other traditional herbs so*

that I can abort because he didn't want me to have children. He said I want you to raise my children…my seven children and I don't have even one child." (P18).

"There is a woman just in my street, who said I will have a child but I will die, and she will raise my child…meaning that all these evil deeds that they do, was to have me dead, not my babies…unfortunately, they can't get me…but my babies die…" (P13).

From the above statements, participants had various reasons that contributed to their grief such as lack of information as well as blaming the third party as to why they had a stillborn.

6.4.1.4 Sub-theme 4: Reaction of the news of the death of the baby immediately after delivery

The expectations of participants of having a live baby were crushed and the pain of loss increased their feelings of uncertainty about their futures. When the news was given to them, they had hoped for the positive outcome of taking the living baby home despite the warning signs of the high-risk situation that they were going through.

Some participants said that they had received positive social support from the medical team during the confirmation of the death of their babies. This is what they said:

"I don't want to lie the nurses did everything possible to help me deliver the baby…. It was hurt to push the baby out….as he was wrapped by the cord around the neck three times that strangulated him" (P16).

Participants who suffered an extra pain of bearing a caesarean scar had this to say:

"It was painful, first of all I have the scar with nothing to show for it. But now it is better to talk about it, but it was not easy … I was referred to a psychologist for trauma counselling and also the nurses accompanied me to see the baby. That also gave me closure too. I spoke to her, telling her about how much we loved her. After talking to her, I felt much better." (P17).

"It's hurting because I have a scar, I feel like in the future maybe if I want the baby and the baby died again, it is painful and I was told that I am left with two attempts to have a live baby." (P7)

"I had a caesarean scar with nothing to show for…" (P17)

Most participants had to go through Feelings of disbelief, shock, anxiety, fear, rejection, isolation, fear of humiliation and stigmatization. This is what they had to say:

"I was woken up and called to the office I went into a shock, but managed to stay calm, the nurses spoke to me in great kindness, and I was settled and politely given the bad news that the baby has passed away. It was a baby girl, I felt so devastated. Even if I can have the other babies, I will never replace this baby. They said the baby came out exhausted." (P14).

Participants revealed how they felt when the doctor notified them. The following extracts attest to that:

I felt like I was being punished, I thought God was punishing me… I felt as if I can die with them, the eight months that I was with them, I felt that my life has been sucked out completely…I could not even talk, eat, I just looked at them, I felt like dying with them." (P12).

"I gave birth, immediately after that, they showed me the baby and told them that it's a girl. They took her to the other room so that they can wrap her with a towel to avoid her getting cold, they came back alone, and when I asked them where the baby was they said unfortunately she had passed on." (Phiri).

Others felt lonely and abandoned while still in the care of the hospital. Some of the participants went through a lonely journey with hostile, harsh and unsupportive medical professionals. They received the news alone and were not given a clear explanation about the cause of the death. There was lack of privacy to deal with the emotional pain. One participants expressed suffering and emotional anguish for sharing the same room with other mothers that had given birth to healthy babies (P6).

> *“I was not able to recover on time as I saw babies being breast-fed in front of me, being taken up and down the ward, and I felt as if I could take them and make them mine.”* (P7).

6.4.2 Theme 2: Understanding and describing their coping strategies

i) Coping with loss of the babies at the hospital during labour and delivery

When the participants delivered a live baby they were happy, could not believe when subsequently were told the baby had died. The following extracts attest to that:

ii) Support from medical team, doctors, nurses and counsellors

> *“ …the other nurse was checking on me... while the other nurses was looking for the doctor...The doctor checked me as he was checking me I could feel that something wanted to come out... the baby came out and the doctor took the baby quickly...”* (P2).

> *I waited for 2 hours for the ambulance to arrive to take me to hospital...I got in and had already lost hope...Upon my arrival... Doctors, students, nurses and medical students went up and down to help me...unfortunately the baby came out dead...* (P4).

iii) Spiritually dealing with the loss (accepting reality)

One of the participants described the stillbirth as “karma” and that it happened because of the power of the tongue as she had intended to abort the pregnancy but later decided to keep the baby, then the baby died. The following response attests to that:

> *“When I realised that I was pregnant, I was scared. I told my boyfriend and he rejected and abandoned me. So, I went to the clinic in Welkom to ask for help to abort the pregnancy, but on the other hand I wished that I could have a miscarriage … maybe what happened was the power of the tongue…”* (P10).

Others accepted the reality of the loss of their babies and used their faith as a way of dealing with and working through their loss. This is what they said:

"Not that the question never crossed my mind […] I was in pain he was not mine; God did not want me to have a live baby." (P8).

iv) Lack of support from the medical team

Participants described the attitudes of the medical professionals especially the nurses' negative attitude and inappropriate use of language to them that contributed to their problem. The following extract attest to that:

"*The sister who took over from the midwife who delivered my baby said something like… 'can this really make you call so many people here' ….. I was very hurt […] the nasty sister came back attacking me again and said 'who do you think you are, your family and the people you reported me to are now gone."* (P15).

"I was alone in the cubicle, feeling all the pain alone, I could not scream as no one was going to hear me….I birthed them alone ….I had no choice, I stood up, wrapped them and took them to the nurses' duty room, and I said to them 'here they are. I have delivered them myself'." (P1).

The above extracts suggest that mothers coped differently at the hospital. Some said they got the support from the medical staff while others said they never got the support they expected after they were told of the stillborn. Others accepted the reality that the child was not theirs.

6.4.2.1 Subtheme 2: Support with the loss at home

i) Support from significant others; spouse, parents. friends and neighbours

Social support was found to be one of the factors that helped the participants to cope with their loss from spouses, families, neighbours and friends in the form of their physical presence, assistance with older children if they were available, doing household chores and shopping for them. The following extracts attest to that:

> *"On my way, I saw my husband crying quietly and this broke my heart, we drove in dead silence. I was with my sister too. My neighbours were at their house when we got out of the car waving at us […] I felt like running away because others were happy that I lost the baby and others were sympathetic even came to check on me later."* (P20).

> "… *My parents and my husband were also very supportive. Even some of my neighbours were supportive."* (P16).

> *"… My niece was helping, she is staying with my in-laws next door, she would cook mash potatoes at night put it ready and, in the morning, I will reach for it. She did that till I was strong to do things for myself."* (P18).

> *"… Friends that attended social club with me, visited me and consoled me by saying "you are not the only one, we have also passed there too."* (P13).

ii) Spousal rejection

Some participants found it difficult to discuss processes and challenges that they had experienced during labour and delivery with their spouses, as they feared their negative reactions to the death of the baby. The following extracts attest to that:

> *"My partner left me to be with his family*, *he was not there when I arrived* [crying]. *My mother came to fetch me to stay with her at Winterveldt. He never came back […] but my mother and sisters were there for me. He blamed me for killing his*

baby. He did not tell me but his sister told me. It hurts me because I did not do it deliberately.” (P19).

“It was my husband’s first child. He was hurt. He said “you killed my baby” as if I have done it deliberately, he went to his family but he is back again we are together. He was just hurt.” (P13).

iii) Feelings of rejection, isolation, stigmatisation and humiliation from others

Some of the participants expressed fears of discussing and sharing the news of the death of their babies with their neighbours and family members because they had no support and adopted an avoidance mechanism they can think of at the time. The following extracts attest to that:

“When I was discharged, we were three instead of four people. Upon my arrival at home first thing, I did was lock myself in the bedroom to avoid questions from family and neighbours, so I felt better asleep. I needed peace, but everybody needed answers from me. It was like living a nightmare… to avoid seeing the pain of others.” (P17).

“In Winterveldt, it is better because people just know that I had a miscarriage but in extension R where I stayed with my boyfriend, people are saying horrible things about me because my boyfriend and his sister have told people that my baby was rotten […].” (P19).

“I felt restless and I left home and went to my grandmother’s house in Mpumalanga. I could not face my neighbourhood people. They hurt me in 2016 when I lost the first baby, called me horrible names. I did not think I was going to cope with that one again.” (P9).

Most participants expressed feelings of rejection, humiliation, abandonment and stigmatisation. All participants expressed intense emotional reactions such as anxiety, depression and helplessness when they left the hospital empty-handed without their babies. However, some participants had no support from families, neighbours and friends.

6.4.3 Theme 3: Alternative pathways chosen by participants to deal with the loss

The following subthemes associated with the above theme were gleaned from the interviews with the participants. a) consulting traditional healers and spiritual healers; b) seeking answers about the cause of the death; c) burial of the baby; d) cleansing of the mother and, e) disposal of the baby's clothes.

6.4.3.1 Subtheme 1: Consulting traditional and spiritual healers as a way of dealing with the loss

Most of the participants found it important to consult the traditional or spiritual healers for various reasons. Some of the participants consulted the traditional and spiritual healers to determine the circumstances regarding the death of their babies, and to prevent the recurrence of the perinatal death with subsequent pregnancies. The following extracts attest to what they said:

> "*This was my third miscarriage and I don't have a child. My parents took me to the spiritual healer to determine why my babies died and to help me not to go through the same experience again."* (P16).
>
> *"I consulted the traditional healer to find out why my baby passed away because before pregnancy, he helped me by giving me dipitsana to conceive. When I conceived, he tied a rope around my stomach… now I have lost the pregnancy…. I needed answers…"* (P2).
>
> *"When I was eight months, my mother took me to a spiritual healer, mosebeletsi as I was bleeding with no pain. She tied a rope on my stomach to stop the contractions, then three days later, the contractions began, and I delivered a stillborn. I went back to her to determine what caused the premature labour."* (P18).

Other participants visited the traditional healer to assist with the process of resting the baby's soul in the grave. The following extracts support the statement:

> "*Traditionally, in my culture a stillborn baby is buried immediately after death by few family members. As a family we went to the traditional healer to perform the*

rituals before the burial of the baby, by washing the baby with muthi, this is to prevent witches to take her spirit and use it in an evil way…" (P13)

"I delivered stillborn twins, in our culture we used the traditional healer who bathed the babies with muthi before their burial, and also sprinkle some muthi inside the grave to rest them and to prevent their spirits from being taken by evil people." (P1)

i. Seeking answers about the cause of death

One participant, who struggled to conceive after a long wait for a child in marriage, sought answers about the cause of death by using the service of a traditional herbalist *ngaka tshotjwa* to help her forget and deal with the pain of loss. The following extract attests to this:

"I was taken to an old woman who is not a traditional healer who knows the herbs. They call her ngaka tshotjwa. She has a spiritual gift of treating special conditions like boswagadi, in cases where one loses a spouse. "She gave me Molebatsa, a black mixture which I licked to make me forget the deceased and bathed me." (P5).

ii. Burial of the baby

Participants described the emotional trauma of making quick decisions and being alone with regard to the burial of their stillborn babies. Most of the participants opted to leave the baby at the hospital for cremation and not to be part of the burial process as they did not want to complicate their grief by further making funeral arrangements.

"Having delivered the twins stillborn, I looked at them and they were taken away. Later the nurse came to ask me if I wanted to bury them. But I had to make the decision alone. I decided to leave them at the hospital for cremation, as I did not want to increase my pain of loss." (P4).

It was painful for me to take the dead baby home, as I expected to bring a live baby home. The thought of a funeral after the celebratory mood during the pregnancy

made me very sad….so I decided to leave her at the hospital for cremation. I did not want a funeral…” (P4).

However, there were those participants who took the baby's corpse home to bury as they felt that this would give them closure and a confirmation that they had indeed been pregnant. This is what participants said;

“I waited for a long time for a baby in my marriage, I was even given name of moopa even if I was married with a son from my previous relationship, so when the nurse asked me if I want to bury the baby or leave her at the hospital I decided to take her home for a funeral this healed me and silenced those who called me moopa.” (P17).

“*As I was involved in a motor vehicle accident and stayed in ICU for three weeks, my husband and family decided that the baby should be buried at home as he was a fully formed baby…. as I was too weak even to attend, I did not bury him.”* (P7).

“She was so cute, light in complexion. I thought I was going to see someone who had changed colour. As she was a full human being, I decided to bury her, as she was above 1kg. I needed closure, so I can say that this is where I have buried Malehlohonolo, my daughter.” (P20).

Other participants who delivered macerated stillborn babies were not given an option to decide or to see their babies. They were told by the midwife what the sex of the baby was and decisions were taken by the hospital to cremate the babies as they had grossly disintegrated. This is what they said:

“I did not see the baby, the midwife told me that the baby was already rotten so they took the baby away.” (P6).

“The midwife told me that I could not touch nor see my baby as she was already green and watery as I stayed longer days with him dead inside my womb… they will bury her at the hospital as the baby was already rotten…” (P19).

iii. Cleansing of the mother

Participants indicated that they used various cleansing rituals after the death of their babies. The cleansing rituals were done to cleanse them from the outside by bathing them with *muthi* or *diwasho* from the church. The following extracts support the above statement:

> *"I was bathed with different powders diwasho from the church, to remove dark cloud around me, as it is commonly believed that one has it after a death experience, sefifi, the dirty water was poured inside the hole that was dug by the spiritual mother, and I felt cleansed thereafter…"* (P15).

> *"My husband decided that we consult the traditional healer, to remove the dark clouds around me sefifi. She bathed me with muthi and steamed me with boiling water and hot stones sefuthu."* (P4).

Other participants consulted both traditional and spiritual healers to be cleansed inside of dirty blood by drinking mixed herbs *muthi dipitsana* or *diwasho*. The following responses attest to that:

> *"I drank the treatment from the church diwasho, I felt cleansed because with the spiritual treatment I discharged lot of clots, which I did not see with the hospital treatment."* (P11).

> *"My father-in-law took me to their church ZCC where I was given light teas to cleanse my blood."* (P16).

> *"My mother took me to the traditional healer, who gave me dipitsana, a mixture of herbs to drink for a month. That was to clean my womb as I still had smelly vaginal discharge after I delivered a macerated stillborn."* (P19).

However, there were other participants who did not want to consult either traditional or spiritual healers but conformed to the pressure of the family members just for peace sake or as they still under the guardianship of their parents. The following extracts support that:

"My mother in-law took me to traditional healers and said they are going to consult with ancestors so that they can see what is wrong because I always lose children and it is like I have a hand in this…I was given dipitsana, a bitter sour mixture by their traditional healer, I had no choice but to take it to satisfy them, but according to me I wouldn't have…because I was not able to bring what they hoped for." (P17).

"As a child, at home we are the ZCC people so we went to church and they gave me ditaelo in the form of light tea to cleanse my blood." (P8).

iv. Disposal of baby's clothes

Some of the participants felt that they needed to go through the grief process and decide later what to keep and what to donate to charity or to family and friends. The following extracts attest to that:

"I did not see the baby's clothes, my mother disposed them, and before I arrived at home from the hospital…she donated them to the church to give to the needy." (P3).

"In my culture, the clothes of a deceased we don't give them to anybody as we believe that they have sefifi a dark cloud around them…so we burn them…" (P19).

"My parents decided that I keep them, it was my first-born baby…they believe that I should have another baby soon… so I will need these clothes…but they will take them to the traditional healer to wash them with muthi and be ready to be used…" (P12).

The above abstracts show that while mothers believed in the western healing methods, when they are in distress they look back and make an introspection of their lives and revert to their African beliefs by going to traditional healers and spiritual healers as way of trying to reach closure as well as seeking answers to what has happened.

6.4.3.2 Subtheme 2: Opting to accept the reality of the loss

Most of the participants indicated that they benefited from the treatment given at the hospital. Some indicated that the hospital treatment relieved them of pain after delivery and also dried up the breast milk. The following extracts attest to that:

> *"They were for drying up the milk and for the abdominal pains. I also use advice from people to steam my lower abdomen and pelvis with hot water mixed with spirits to reduce the swelling and to get rid of the discharge after delivery."* (P14).

> *"The pills helped me more, because they dried up the milk, something that the church could not do".* (P12).

The above abstracts show that while participants trust the western health methods in relieving their distress, they sometimes goes further by using alternative ways of healing themselves.

6.4.3.3 Subtheme 3: Conforming to the pressure from parents to seek help from the traditional and spiritual healers

Most of the participants indicated to have benefited from the treatment of the traditional healers. The following statements attest to that:

> *"Since it was the first time experiencing this, my mother is the one who got me cleansed, so I drank dipitsana to get cleansed inside because the pills are just for pains and energy…"* (P1).

> *"My mother took me to the traditional healer and I was given dipitsana which I took for the whole month to cleanse my blood and womb as I still had a lot of smelling virginal discharge."* (P19).

Other participants indicated that they had benefited from the spiritual intervention from different church groups:

"I drank the spiritual treatment diwasho and i felt cleansed because with the traditional treatment I discharged clots which I did not see when I drank the pills from the hospital." (P11).

"…but as the traditional people, my family attends ZCC so I was given ditaelo in the form of the light teas to cleanse me." (P6).

"We belong to the Apostolic church, so we went to the pastor and prophets of the church and they bathed me with holy water and sewasho then they gave me a bottle of holy water with sewasho to drink." (P20).

"At home, we are Christians, we believed in the power of prayer…so we just went to church and prayed and I got healed." (P17).

"I am a born-again Christian. I am deep in believing in God but my husband believes in traditional medicines but he respected my belief system so I used power of prayer to heal myself." (P18).

6.4.3.4 Subtheme 4: Perceived benefits of alternative pathways

However, there were those who used the power of prayer to console and to heal themselves. The following extracts attest to that:

The present study found that participants having tried to have a baby, and for some twice or trice by following the normal way, and not finding positive results and closure, they had to look for an alternative path which might be beneficial to them. From what they said they were looking for closure to their distress. Some preferred traditional healers, others sought relief from spiritual healers while others decided to accept reality.

6.5 SUMMARY OF FINDINGS

The findings of the study reflected on the journeys of the participants who experienced perinatal death and they alternative pathways they took to seek closure. The participants were bereaved by this life-changing problem which impacted their world.

The researcher presents the discussion of the findings in the next chapter.

CHAPTER 7

DISCUSSION

7.1 INTRODUCTION

The aim of the chapter is to discuss the research findings in relation to the psychological theory and the literature in the previous chapter of the study. The chapter is organised in two parts; Part A and Part B. Part A covers the shared experiences of participants in relation to the existing literature. Part B provides the conversion of the experience narratives of the participants according to Van Manen's (1990) four fundamental existential dimensions to the emotional journeys of these participants according to the five themes as identified in the data analysis.

7.2 PART A: DISCUSSION OF THE SHARED EXPERIENCES OF PARTICIPANTS IN RELATION TO THE LITERATURE

The loss of a child perinatally can pose a serious challenge to and a strain even on the strongest marital relationship. Women are more expressive when it comes to the grieving process compared to their male counterparts. This may be mistaken for someone being less affected, thus pushing the couple apart instead of bringing them closer. These are some of the participants' experiences in this journey.

In the current study, all participants experienced a common phenomenon, namely, perinatal death. However, the precipitating factors that led to perinatal death presented themselves differently to all participants. The experiences of the participants in terms of how they managed the condition was also not the same. They coped differently as determined by their personalities, attitudes and the support system they had as individuals. The following themes were identified from the analysis of the results; 1) perceiving the threat and anticipation of death; 2) understanding and knowledge of what caused perinatal death of their babies from the participants' perspective; 3) reaction of the news of the death of the baby immediately after delivery; 4) coping with the loss of the babies during labour and delivery; 5) coping with the loss at home, and finally 6) the alternative pathways chosen by the participants to deal with the loss.

7.2.1 Perceiving the Threat and Anticipation of Death

Anticipated grief according to the literature of the study is the reaction that occurs in anticipation of an impending loss. According to Wortman and Boemer (2011), within the dual process model of grief, the individual having lost a loved one oscillates between two coping mechanisms, that is loss-oriented coping where the bereaved individual focuses primarily on the attempt to conceptualise and resolve some of the emotions of loss, or restoration-orientated coping where the individual strives towards the adaptation and mastering of the life challenges that may have occurred due to the loss of life. Wortman and Boerner (2011) further pointed out that in the beginning of the grief process, the individual adopts loss-orientated coping strategies, namely, dealing with the overwhelming emotional challenges of grief such as shock, anger, aloneness and sadness, and later shifts towards the restoration-orientated coping mechanism.

This model provides a way of determining how different individuals cope with grief and the aftermath of the loss, such as financial challenges, burdens of responsibility in terms of caring for their children, or possible relocation. Women have been found to be more loss-orientated than men, and their grief-coping mechanisms are more predictable in terms of coping with stressful life events such as death (Stroebe & Schut, 1999). The grief work is characterised by the process of loss orientation, whereas the restoration orientation deals with the secondary losses that occur as the aftermath of the death (Dent, 2005).

One can conclude that confronting the issues around the loss of a loved one by adopting the avoidant grief pattern, impacts equally negatively on the bereaved, but the positive aspect of the dual model of grief is that the bereaved has more control over the process of grief in terms of what to focus on during the acute phase of bereavement and when to do so. Since the model does not adopt a linear process in dealing with grief, it allows people to experience their grief from their own perspective and not adopt a uniform way of following stages and tasks. The dual model of grief allows one the opportunity to reconstruct one’s life without feeling guilty about the deceased and affords the bereaved the opportunity to revert to the grief process as and when the need arises.

Bowlby (1980) believed that attachment is influenced by the following three functions: 1) proximity to the attachment figure provides the child with a safe haven; 2) accessibility of the attachment figure provides the child with a secure base from which the child can confront challenges; and 3) separation from the attachment figure may trigger separation anxieties which is a distress emotional state, where the child's energy may be directed to the attachment figure. From these three attachment functions, Bowlby (1980, cited in Denhup, 2014) described how the loss of parents in childhood can result in possible emotional reactions in children.

The attachment model is based on the developmental stages of children and how individuals deal with mourning. According to Bowlby (1980), during the normal development process, children and parents instinctively form attachment bonds or affectionate bonds, which are later formed between adults. He further suggested that the type of affectionate bonds formed between the child and the parent tend to influence how one will deal with separation or bereavement later in life. Any threat to the affectional bond results in the activation of powerful emotions such as crying or angry protest, with the longing for reunion with the departed loved ones, but in the case of permanent loss, proximity with the attachment figures is viewed as pathological.

It is the grief that is experienced by the mothers in this current study, who are informed that their unborn child will not survive in utero, during labour or after delivery (Bennet et al., 2011). All participants in the current study experienced anticipated grief, when they felt that something was wrong with their babies in utero, during labour and after delivery.

> "*I knew that the baby was dead…every time when I lose a baby I go through this symptoms of frequent urination and mild diarrhoea ….this is my third stillborn [pause] I saw the sonar and could see that there was redness where the heart is …, I asked the doctor to explain what the sonar was revealing, but he said I should wait for another doctor for a second opinion….then I knew that the baby was dead.*" (P16)

Although the participants had not built up a relationship with their babies outside the utero, the grief after the pregnancy loss does not differ in intensity from any other loss

(Kersting & Wagner, 2012). Similarly, even in the current study, participants experienced the outpouring of emotions such as anxiety in particularly the fear of the unknown.

> "*The pain started, I felt that whatever I was dreading to see happening, is now happening, the contractions started, labour begins and the babies are dead."* (P1).

This outpouring of emotions laid the foundation of how they would manage and cope with the loss should the baby not survive. Most of the participants experienced premature ruptured membranes, while some experienced premature bleeding, and others had a lack of foetal movement. These symptoms were the trigger point of premature labour as they were followed by contractions. Except where participants experienced lack of foetal movements, there was no bleeding, no ruptured membrane and no contractions; hence, the two participants who delivered macerated stillborns stayed at home for 2-3 days without any foetal movement, resulting in the disintegration of the foetal tissues in utero.

The findings of study revealed a glaring lack of knowledge and information from the antenatal care services, to the signs and symptoms of premature labour, and what to do when foetal movement was minimal or not felt. The analysis of the study, revealed that all participants attended the antenatal care clinics, even though some participants commenced their classes late in their second trimester, as they believed that the pregnancy should be hidden in its early stages for fear of witchcraft.

Ngomane and Mulaudzi (2010) agreed with findings of the concept of the current study as they cited in their research findings that pregnancy is kept a secret for fear of bewitchment and pregnant women prefer to stay at home during the first trimester of their pregnancy. One other reason for poor compliance that was revealed by the current research findings is that some participants delayed attending antenatal classes timeously and regularly due to overcrowding at the clinics and shortages of medical personnel.

7.2.2 Understanding and Knowledge of what caused Perinatal Death of Their Babies from the Participants' Perspective

It is only when participants know that perinatal death is the definition of stillborn that they will be able to conceptualise the cause of what could have happened that their babies

die. According to the literature, perinatal death as defined by WHO (2011) as the combination of foetal death, commonly called still birth and infants dying within 28 days of being born. This includes neonatal deaths, whereby infants die within the first week of life. However, from the research study conducted by Kiquli et al. (2015) with mothers who suffered perinatal death in Uganda, participants defined perinatal death as *empuna* or *ekitu* meaning "a thing". Some defined it as a baby born dead with no breath of life or movement. Others defined it according to their physical characteristics, such as a baby born deformed or with a peeled skin.

However, in the current study, none of the participants described their stillborn baby as "a thing". The participants described their babies with great compassion and empathy, still shocked and crying as they described their ordeal. Most of them described them according to their physical appearance when they were brought or shown to them for identification. Some referred to them as a baby who did not cry at birth, or born silent, without breathing. The two participants, who delivered macerated stillborn, described their babies as born "rotten and green" and could not see them.

The findings of the current study highlight the need for more education and training of nurses and midwives in particularly to impart knowledge and understanding about perinatal death and how it happens to pregnant mothers, and how to prevent it. In some instances, midwives talk to pregnant mothers but they may be talking above their heads, making it difficult for pregnant mothers to understand and conceptualise the information given.

In the literature review, Karlsen et al. (2011) and Oji (2008) emphasised the lack of maternal education as one of the risk factors that contributed to perinatal deaths.

> *"I did not feel the baby playing on the 1st day, but I did not take that seriously, I continued with my household chores, doing the washing and cleaning, still on the second day I did not feel the movement but I thought the baby is sleeping and continued with my daily chores in the house, but on the third day I started feeling restless and worried that maybe something is wrong with the baby, then I went to the clinic, the nurses checked me and referred me to Dr George Mukhari hospital,*

upon my arrival the sonar was done and the baby was dead…and the midwife said I could not see her as she was 'rotten'." (P6).

According to these scholars, pregnant women with less than a secondary education had a higher chance of perinatal death compared to women with higher educational levels, meaning that health professionals imparting knowledge to pregnant women, need to take cognisance of their level of education.

In the current study there were only two participants with tertiary education and most of the participants, had an educational level lower than Grade 12. Most of them had Grade 8 and 10. The lowest educational level was Grade 5. The participants who delivered macerated stillborns had Grade 5 and Grade 8 as their highest qualifications. This is supported by Chomba et al. (2017), whose study with pregnant mothers in Nigeria showed that perinatal mortality rate was higher among mothers with no formal education than those with higher educational levels. Even Sami et al. (2018) in his study with Sudanese pregnant mothers revealed that perinatal death decreased as the number of years of full-time studies increased among women.

Some participants accepted the medical health definition as given by the medical health professionals mainly in biomedical terms. This included infections, haemorrhagic or gross abnormalities such as Trisomy 13, 18, and 21 (Sharma, 2016; StatsSA, 2013).

However, Kiguli et al. (2015) according to the literature mentioned that in sub-Saharan countries such as Uganda, the major cause of perinatal death was infections, such as syphilis although some of the pregnant mothers perceived the cause of perinatal death to be the heat in the womb, tired babies, narrow birth canals, strangulation of the baby due to the umbilical cord around the neck and a weak uterus which could not support the foetus.

Similarly, even in the current study, most of the participants gave similar responses to their Ugandan counterparts such as infections with vaginal discharges, the baby coming out tired, strangulation, a small pelvis preventing the smooth birth passage of the baby, bleeding and ruptured membranes.

The research studies conducted by Kozuki et al. (2013) as indicated in the literature review, affirmed these findings that nulliparous women, who are mostly younger women, are mostly at a higher risk of perinatal death due to narrow birth canal (cephalon-pelvic disproportion (C.P.D.)) which predisposes them to problematic delivery, such as forceps or vacuum extractions resulting in perinatal death.

In the current study, participants also mentioned certain contributing factors that could have caused their babies to die before birth. Most of the participants were from the rural areas, such as Legonyane, Jericho, and Madidi, and blamed delays in accessing health services. These participants were transferred as emergencies from their local clinics to Dr George Mukhari due to birth complications that needed specialist treatment. Participants blamed the distance decay with financial barriers, bad roads with potholes, animal crossing from one side of the road to the other delaying the ambulance from reaching the hospital timeously to save their babies.

> *"I was clueless on what was happening, they weren't helping, the ambulance was also taking time to arrive, that's when I realise that something was wrong with the babies."* (P1)

> "*I think the duration, the time that I took waiting for the ambulance and the travelling distance and bad roads delayed my arrival to get help."* (P6).

> *"The driver did everything possible to take care of me, but our roads are bad, full of potholes and animals, the driver tried to help me so as not deliver the baby along the way to the hospital, especially in the ambulance.*" (P11).

These challenges are supported by Gabrysch et al. (2019) and Målqvist et al. (2010) that mothers living far away from a health facility have an increased risk of perinatal death. According to the researcher, effort should be taken to reduce the perinatal mortality rate if the Millennium Development Goal is to be achieved.

7.2.3 Reaction of the News of Death of the Baby Immediately after Delivery

7.2.3.1 Social support: At the hospital

Social support has been found to be the buffer in a stressful situation, especially when the individual perceived the stressor as overwhelming, resulting in a feeling of helplessness and inability to cope (Cohen & Wills, 1985). Similarly, perinatal deaths have been found to be one of the most stressful events which may result in post-traumatic stress disorder of the bereaved mother (Horsch & Stuijfzand, 2019). This finding was confirmed by Bhat and Byatt (2016) in the literature review that there is a high suicidal tendency among the bereaved mothers due to perinatal death.

The findings in the current study revealed that upon the confirmation of the death of the babies, some participants' anxiety and distress were reduced by the support of medical personnel such as doctors and nurses. Some participants acknowledged being referred for counselling, psychotherapy and given sedatives to calm them down.

7.2.4 Coping with the Loss of the Babies during Labour and Delivery

The findings in the current study revealed that upon the confirmation of the death of the babies, some participants' anxiety and distress were reduced by the support of medical personnel such as doctors and nurses. Some participants acknowledged being referred for counselling, psychotherapy and given sedatives to calm them down.

> *"I don't want to lie the nurses did everything possible to help me deliver the baby…. It was hurt to push the baby out….as he was wrapped by the cord around the neck three times that strangulated him."* (P16).

Cacciatore et al. (2014) concurred with the findings of the current study, as they revealed that social support plays an important role in lowering levels of anxiety and depression following stillbirth. This is a finding about negative social support and health workers which needs urgent attention in the training, staff development around mental healthcare of bereaved mothers. Some participants described negative treatment from medical personnel. One participant described the midwife as nasty and rude towards her after

delivery of her stillborn baby. The participant called her family for support, as she was heartbroken but the midwife told the participant:

> "*…. can this really make you call so many people here ….. do you think that such a thing warrants your family to come here in their great numbers?" I was very hurt […] the nasty sister came back attacking me again and said who do you think you are, your family and the people you reported me to are now gone."* (P15).

One of the participants was left alone while in labour and she delivered stillborn twins on her own, managed to wrap the babies herself and walked to the duty room carrying her twins and said:

> *"I was alone in the cubicle, feeling all the pain alone, I could not scream as no one was going to hear me….I birthed them alone ….I had no choice, I stood up, wrapped them and took them to the nurses' duty room, and I said to them 'here they are. I have delivered them myself'."* (P1).

Participants advanced several ways of how they were verbally abused by midwives. Kiquli (2015) also revealed in their study with Ugandan pregnant mothers, how rude, arrogant and abusive midwives were to mothers, especially if the mother had never attended antenatal care or if she was a multiparous woman. Both studies revealed how vulnerable pregnant mothers are. The research study revealed an urgent need in terms of positive management of women in labour and delivery, to protect these mothers in maternity wards from abusive midwives.

Lastly, the negative attitude of health workers, in particular midwives, who were described as rude, arrogant and negligent to the participants who blamed them as the reason for the perinatal death. Some of the participants felt neglected when they approached the midwives for help as they were bleeding, but they were told to sit down and wait for their turn as they were not emergencies. Unfortunately, when it was their turn to be attended to, they delivered stillborn babies.

7.2.5 Coping with the Loss at Home

The death of a child is profoundly distressing to the family of the bereaved mother. These deaths are hidden along with the grief of the mother, father and the families at large. In most instances, the grief of family members is unrecognised, dismissed leading to disenfranchised grief (Cacciatore et al., 2014).

However, participants in the current study, acknowledged social support of their families, who made their loss more bearable. Most of the participants described how their families helped them to make decisions about the burial of their babies, how they assisted them to get alternative help from traditional and spiritual health practitioners for their cleansing and also for disposal of the clothes of their babies.

> "… *My parents and my husband were also very supportive. Even some of my neighbours were supportive."* (P16).

Others attested that when their spouses rejected and abandoned them, their families took them in and provided them with great support. These findings were supported by Kiquli et al. (2015) who revealed that support from partners, the family and the wider social network could reduce long-term psychological distress.

7.2.5.1 Spousal support

Studies revealed that the impact of perinatal death of the spouses of bereaved mothers to perinatal death was underestimated, but they were found to need to work through their grief too. However, they were also found to be pillars of support to the mothers and the family during perinatal deaths

> *"On my way, I saw my husband crying quietly and this broke my heart; we drove in dead silence…"* (P20).

However, Kiquli et al. (2015) advanced that stillborn birth can have a negative impact on marital attachment as pressure from the families and the community may lead to the dissolution of the marriage. In the current study, some partners described positive social support from their spouses. Others reported rejection, humiliation and emotional and

verbal abuse from their spouses after failing to deliver a live baby. Their spouses accused them of killing their babies.

> *"It was my husband's first child. He was hurt. He said "you killed my baby" as if I have done it deliberately, he went to his family but he is back again we are together. He was just hurt."* (P13).

The findings are confirmed by the finding of Koblinsky (2014) that post-perinatal death women experienced marital distress with their husbands, resulting in reduced social support to bereaved partners.

7.2.5.2 Community support

Motherhood to some degree confers a societal value on the woman, and it is often celebrated. It is considered to be a respectful event within the society (Kiquli et al., 2015). However, participants in the current study described the emotional pain of being rejected and humiliated by some community members. According to the participants the stillbirth stole their happiness from their family and caused societal separations. Some of the participants were called derogatory names such as *moopa*, 'baby eaters', or 'leaking baskets'. They were ridiculed by in-laws who called for separation from their sons

> *"When I was discharged, we were three instead of four people. Upon my arrival at home first thing, I did was lock myself in the bedroom to avoid questions from family and neighbours, so I felt better asleep. I needed peace, but everybody needed answers from me. It was like living a nightmare… to avoid seeing the pain of others."* (P17).

Kiquli et al. (2015) concurred with the findings that women who have experienced still birth are often ridiculed and rejected by their in-laws, who encourage their sons to leave the bereaved wives. Often the woman will be regarded by the community as a curse or someone who is shaming her husband.

There is a glaring gap in the education, knowledge and awareness of the community about perinatal deaths. There is a need to reduce the stigmatisation and to create a supportive structure within the communities for the bereaved mother and families. The

community needs to be sensitised about the problem of bereaved mothers due to perinatal deaths.

7.2.6 Alternative Pathways Chosen by Participants to Deal with the Loss

Participants after being discharged from hospital embarked on different pathways to relief their distress. Most of the participants, due to distance decay, could not easily access the services of the western doctors, as they were transported by ambulance to Dr George Mukhari Hospital for their deliveries. The participants therefore used the services of traditional health practitioners as they were part of their community and readily accessible and affordable (Bojuwoye et al., 2011). Many of the participants in the study (50%) used the services of traditional healers, while 30% used other spiritual healers such as those from the ZCC.

> *"I consulted the traditional healer to find out why my baby passed away because before pregnancy, he helped me by giving me dipitsana to conceive. When I conceived, he tied a rope around my stomach… now I have lost the pregnancy…. I needed answers…"* (P2).

> *"When I was eight months, my mother took me to a spiritual healer, mosebeletsi as I was bleeding with no pain. She tied a rope on my stomach to stop the contractions, then three days later, the contractions began, and I delivered a stillborn. I went back to her to determine what caused the premature labour."* (P18).

On the other hand, 20% of the participants did not consult either traditional health practitioners or other spiritual advisers; they accepted the diagnosis of the perinatal death from the hospital and believed in the power of praying for themselves.

> *"At home, we are Christians, we believed in the power of prayer…so we just went to church and prayed and I got healed."* (P17).

7.2.6.1 Traditional healing interventions

Most of the participants who used traditional medicines described that they were cleansed through using herbal medicines to remove the dark cloud of death around them *(sefifi)* and they were also given *muthi* to drink, to cleanse them inside. Some were steamed with

boiling water and hot stones. Participants attested to positive benefits from the treatment given by the traditional healers. Some described the benefit as feeling light in their spirits and cleansed and able to get out of their homes, without fear of contaminating people's houses with the dark cloud of death. Others drank herbal remedies. One participant explained that she had taken *bolebatsa,* a black herbal mixture, which made her think less about the loss.

7.2.6.1.1 Burial of the stillborn baby

Stillbirths are often unreported and unrecognised as a result the grief of the mother goes unnoticed as they weep in silence. The silence occurs as result of the lack of value that the society attaches to the death of a stillborn baby. This diminishes the grief of mothers and makes those deaths invisible to the community, but not to the families of those experiencing the emotional trauma.

Burial practices of stillborn within the cultural context differ from clan to clan. Stillborns are commonly not announced in the villages or communities. As a result, their burials are quick and only attended by close family members. "It is culturally assumed that the community cannot grieve for the loss of a thing". This stems from cultural belief that the baby who did not cry cannot be buried in the same graveyard with adults and or babies who cried as it will fail to communicate in the spirit world (Kiguli et al., 2015).

The graves of a stillborn differ from culture to culture. Some would bury the baby within the yard; some burials will be conducted by the women only and no one is supposed to wail as they do for a baby born alive or older child. In some cultures, the mother stays at home without saying her final goodbye to the baby. These cultural practices compound the grief of mothers who weep in silence, predisposing them to long-term psychological trauma (Kiguli et al., 2015).

Most of the participants who used traditional medicines described that they were cleansed through using herbal medicines to remove the dark cloud of death around them *(sefifi)* and they were also given *muthi* to drink, to cleanse them inside. Some were steamed with boiling water and hot stones. Participants attested to positive benefits from the treatment given by the traditional healers. Some described the benefit as feeling light in their spirits

and cleansed and able to get out of their homes, without fear of contaminating people's houses with the dark cloud of death. Others drank herbal remedies. One participant explained that she had taken *bolebatsa,* a black herbal mixture, which made her think less about the loss.

7.2.6.1.2 Disposal of the baby's clothes

Death makes life more transparent as it reveals some fundamental values around the social and cultural issues. In some cultures, everything connected to the dead person becomes taboo. Failure to dispose the possessions of the deceased together with the corpse is viewed as an incomplete transition of the deceased from the world of the living to the world of the dead. In most instances, the person assigned to perform the ritual would destroy the possessions of the deceased by breaking them into pieces, burning, wrapping and tying them together and throwing them into the sea. All the remaining earthly belongings of the deceased are left to decompose at the grave site or are buried with them. This is a symbolic killing by those who are left behind to sever all the ties they had with the deceased, as they want nothing that reminds them of the baby or connects them to the deceased (Venbrux, 2007).

Culturally, the personal belongings of the deceased represent the corpse itself; hence the grave with the personal belonging of the deceased is viewed as the same as the one with the actual body itself. Clothes are viewed in certain cultures as the outer layer of the body and the extension of the deceased body; hence, they are burned together with the corpse, with the belief that the fire would free the spirit essence in the clothes and be used by the deceased in the other world. The destruction of the possessions of the deceased such as clothes either through fire or burying them, in some cultures, it is believed to be equal to killing the person and removing all the attachments that he had on earth. Hence, the adoption of the process of exchanging of clothes of the deceased is viewed culturally as a way of forging friendships, trust, or for emotional remembrance (Venbrux, 2007).

Similarly, disposing of the belongings of the stillborn baby was a daunting challenge to the mothers. It was not just about clearing the closet of the baby, but entailed a lot of emotional processes, with flashbacks of the pregnancy, labour and delivery. Others

believed that it has to be done in a hasty manner to get closure, but down the line, some mothers felt that they could have held onto certain items to remember their babies.

7.2.6.2 Other spiritual healing interventions

Similarly, some of the participants sought religious intervention for deeper meaning about what could have caused their babies to die. Religion has been found to play an important role in stressful situation such as perinatal death. The church as an institution has been found to have great influence over personal behaviour, family life and beliefs. It is regarded as a spiritual home for people and place where they find solace, strength and hope when they are in distress (Lesolang, 2014). The findings of the current study concur with these statements. Most of the participants who failed to "contain" their grief viewed the church as a fortress to handle their rejection, humiliation and abandonment. They felt healed after being bathed with holy water and holy ash and being prayed for. Those who belonged to the ZCC performed their rituals by drinking *ditaelo* and light teas. They felt cleansed and light in spirit.

7.3 PART B: CONVERTING PARTICIPANT NARRATIVES TO PSYCHOLOGICAL MEANINGS

In this section, I present the psychological meanings of the shared experiences of the participants in the current study. Three themes emerged from the narratives of participants' experiences from perinatal death on mothers, that is: 1) perceiving the threat and anticipation of death; 2) understanding and knowledge of what caused perinatal death of their babies and the 3) perceived social support from others.

The meaning-making process is critical to participants as it determines how they cope with the pain of loss at the hospital and at home. The meaning that participants attached to the grief influenced the type of the treatment and the help-seeking pathways they adopted to alleviate the distress. The researcher adopted Van Manen's (1990) hermeneutic phenomenological approach as a guide to the interpretation of the participants' psychological journeys.

According to Van Manen's fundamental existential dimension, human beings have their own ways of perceiving and understanding their lived experiences in the world according to four dimensions: temporality – the lived time; corporeality – the lived body, spatiality – the lived space; and relationality – the lived other.

These four dimensions assisted the researcher to interpret and analyse the lived experiences of participants bereaved by perinatal deaths and distilled the psychological meaning from this narrative of participants. Van Manen (1990) described it as the "lived world" which cannot be separated as it forms a unity of our world being.

Table 7.1:

Van Manen's (1990) four fundamental existential dimensions

Theme	**Superordinate theme**	**Sub-theme**
Lived time (Temporality)	Bearing the loss of perinatal At home At hospital	Depression Anxiety Rejection, guilt, humiliation, shame and abandonment Avoidance
Lived body (Corporality)	Dealing with the body that failed to achieve a successful procreation Unable to deliver a live baby	Challenges on marriage, rejection, stigmatisation Isolation, ongoing fear of unknown Looking for other options e.g., adoption
Lived space (Spatiality)	Living in the world of uncertainty – as conception labour and delivery are process beyond them The desire to understand the unknown	More consultation to gain information Change of lifestyle in terms of pregnancy management e.g., antenatal care, accessibility to healthcare facility such as clinic/hospital
Lived other (Relationality)	Perceived support from others	Building of close trustworthy relationship with others Unwavering support from loved ones

7.3.1 Temporality (Lived Time)

All 20 participants described the devasting life-altering outcomes of their failed pregnancies and the crushed hopes of bringing a healthy baby to life. The life-changing experiences of dealing with the grief of perinatal death often lingered even after five years. The attempt to make sense of what could have caused the spontaneous onset of labour and death which occurred without warning still baffled them.

All participants grieved with intense feelings of depression and helplessness. They were overwhelmed by feelings of uncertainty and anxiety as they tried to understand what could have gone wrong with their pregnancies. Most of the participants tried to figure out the reasons for the perinatal death by looking at the circumstances within and around their processes of conception, labour and delivery. Their anxieties were increased by the difficulties and failure to access the healthcare services promptly due to distances, bad roads and delays in accessing ambulance services.

These delays subjected the participants to anxiety that they may not arrive timeously at the hospital to deliver a live baby. Participants had to deal with daunting levels of anxiety and the fear of not knowing whether their babies would survive or not. The final outcome of the stillborn delivery led to deep sadness which gave rise to feelings of depression, accompanied by increased levels of bottled-up anger, rejection, guilt, humiliation, shame, and abandonment and avoidance.

7.3.2 Lived Body (Corporality)

This theme is about participants struggling with procreation and no longer trusting their own bodies to bear children in the future. It is the continuous stress of trying to figure out what it is that they are not doing right and challenging their womanhood especially their sexuality in terms of their reproductive abilities. Participants who were mostly affected were those who had experienced perinatal deaths more than once. For example, two of the participants in this study experienced perinatal death three times and remained childless. These participants presented a lot of anger, frustration, and a sense of helplessness and hopelessness.

They were still tearful and had outbursts of anger as they narrated their emotional and psychological journeys. They presented with clinical symptoms of PTSD, as they still had vivid flashbacks of their difficult conceptions, labour and deliveries of the previous stillbirths. The most significant and negative outcome of perinatal death of these participants was dealing with the possible childlessness as the two of them were already over 40 years of age. They had to endure stigmatisation, ostracisation, rejection, abandonment and humiliation from the significant others as they were continuously called harsh words like *moopa*, especially by their spouses who had already had children with other women. Some of these women lived close by and within their own communities and were continuously inflicting emotional pain on the participants through their stares and negative remarks whenever they met the participants. One of these participants presented with intense suicidal ideations and was referred for psychotherapy.

Those who delivered macerated stillborns were overwhelmed by guilt, self-blame and massive rejection from their spouses and next of kin. They were humiliated and unsupported by their neighbours. According to the lived body theme, participants were overwhelmed by knowing that they had been carrying 'dead' babies for more than two days which predisposed them to the loss of their uterus as a result of infection and possible childlessness. Even if their uterus was saved, the nagging question within them was whether they would ever carry a subsequent pregnancy to term.

The possibility of the recurrence of the stillborn even to those who were experiencing perinatal death for the first time was also a thorny issue for participants. The fear of the unknown and the ongoing questions of what it was that they had done to end up with a stillborn baby were the lingering thoughts in all of them. They were overwhelmed by guilt and anxiety as they continuously searched for answers in the form of 'doctor shopping' and seeking further help from traditional and spiritual interventions.

Over and above the shame of childlessness, some participants approached their partners to look at the possibilities of adoption or artificial insemination but unfortunately, their requests were met with hostile emotional reactions from their spouses. This reaction brought many insecurities to these participants, feelings of unworthiness, abandonment and regrets.

7.3.3 Lived Space (Spatiality)

This is the impact of perinatal death on the day-to-day life of the participants. The fear of the unknown and the desire to understand what had happened to their pregnancies was paramount. This is the stage of information-seeking, gathering of knowledge about perinatal death and seeking solutions to achieve successful procreation. Participants voiced the ongoing state of uncertainty whether the condition would recur with subsequent pregnancies. The fear of the unknown and the symptoms of PTSD from caesarean section scars affected the participants' lived space. Most of the participants left the hospital without a clear understanding of what caused the baby to have a "cord around the neck" or polyhydramnios, bleeding or a ruptured placenta.

This resulted in participants living in the world without closure: a world of unpredictability as they continuously struggled to make meaning out of their experiences and find closure to their grief. These predisposed participants to increased levels of anxiety and depressive tendencies, especially among those with repeated stillborn deliveries.

The theme of lived space involves the day-to-day experience of mothers living with perinatal grief. It involves the yearning to understand what happened and the fear of the unknown that preoccupies their lived space. Participants lived in an unknown territory without answers. The unknown onset of the stillbirth predisposed them to an emotional state of confusion, mistrust and an involuntary degree of shock on being told that the baby was 'dead' or that there was nothing that could have been done to save the baby. This made the participants question their womanhood and their sexuality in terms of their change of lifestyle in terms of pregnancy management e.g. antenatal care and accessibility to healthcare facilities such as a clinic or hospital.

7.3.4 Lived Other (Relationship)

The theme put emphasis on the established concrete relationships that the participants had with other human beings, that is, the perceived social support from the significant others. In spite of our individual existence, we are also in the world with others (Dahlberg, Drew, & Nyström, 2001). Each individual becomes human through their encounters with others. This was evident in the participants' appreciation of the unwavering support from

healthcare workers in particularly nurses, doctors, psychologists, family members and spiritual and traditional health practitioners.

Most participants expressed that they gained encouragement, empowerment, and strength when they were faced with the news that they had lost their babies and felt that they could have not gone through the process without the support of others, in particular, from the medical professionals. However, some participants perceived a lack of social support from medical professionals upon their arrival at the hospital, as they were transferred from their various local hospitals as emergencies, but they were treated like any other casualty upon their arrival. Doctors were not there as they had expected; there were only a few nurses who were busy with other patients, while some were available but did not attend to them. As a result, they perceived this medical neglect as the reason why they delivered stillborn babies.

Participants usually had strong connections with their family members, spouse, and friends and neighbours, although some could not establish that connection as they felt ostracised, marginalised, humiliated and stigmatised by the neighbours. Some of the participants ran away from their primary homes to stay with relatives to avoid the stares and scrutiny of others. Some participants experienced good social support from trusted relationships with health workers, family support and neighbours and managed their bereavement process better. Participants stated that having a trusted family member, husband or spouse, friend and neighbours impacted positively on their coping with the bereavement after the perinatal death. Participants expressed that most of their support, especially those who were single, came from their mothers, although one participant revealed that she had received support from her father, as her mother had passed way.

Over and above the social support from significant others, most of the participants adopted other help-seeking pathways for support, such as western medical treatment after being discharged from hospital or help from traditional practitioners or spiritual groups. Through these approaches, most participants wanted to get a deeper meaning and understanding about their loss from the Supreme Being (God) Participants presented a strong connectedness with the church as an institution or traditional healers as places

to run to when they failed to derive meaning from the earthly definitions, causes and treatment of perinatal deaths

Spouses can be a valuable source of support following a perinatal death, but lack of such support can increase the negative psychological outcomes for bereaved mothers. Marital disharmony and divorce were common following perinatal deaths (Alvelin et al., 2012). Similarly, even in the current study, some participants experienced rejection, humiliation and abuse with abandonment by their spouses after a perinatal death. They were blamed for the death of the baby. However, there were those who reported positive social support from the spouse, even becoming closer rather than growing apart. As far as the bereaved participants' relationships with neighbours were concerned, some participants experienced negative reactions from their close neighbours such as hostile humiliation and name-calling. As a result, bereaved participants avoided contact with their neighbours for a few weeks. They stayed inside their homes or changed homes to go and stay with extended family members elsewhere.

CHAPTER 8

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

In this chapter, the summary of the thesis is presented. The implications of the study are outlined, and the contribution and the recommendations of the study are discussed, followed by a brief presentation of the limitations of the study. Finally, suggestions are made for further research.

8.2 CONCLUSIONS

The layout of this research study was guided by the identified research objectives. The objectives of the study were: a) to determine the understanding of perinatal death by participants; b) to investigate the experience of the bereaved participants of the perinatal death; c) to understand and describe their coping strategies; d) to investigate the help-seeking pathways they followed; and e) to present the psychological meanings distilled from the experiences of the bereaved participants. From the above objectives, six themes and subthemes emerged from the study (Section 7.2).

8.2.1 The Understanding and the Meaning of Perinatal Death by Participants

The study aimed at establishing the meaning and the understanding of perinatal death by African participants from their own perspectives. The study explored the knowledge that participants have about the causes of perinatal death and their own beliefs and attitudes pertaining to the causes of perinatal death.

The study revealed a lack of knowledge of symptoms that precipitated perinatal death such as ruptured membrane, bleeding and lack of foetal movements, which came as a shock to most of the participants and increased their level of anxiety. Those who had experienced perinatal death more than once could also not understand what was causing the recurrence. As a result, most of the participants had unsubstantiated beliefs of what could have led to the death of the baby.

Most mothers could not define and explain the process of stillbirth. Most of the participants explained from the physical appearance of how the baby was when it was presented to them. Some said it is a “floppy tired baby”, these who delivered macerated stillborn, defined the stillborn as a “rotten-greenish” baby. Others saw a cord around the neck of the babies which led to strangulation of their babies.

There is a need for the provision of knowledge about perinatal death to pregnant mothers during internal care visits (Kiquli et al., 2015; Mulaudzi & Ngomane, 2010)

8.2.2 The Causes of Perinatal Death

The study revealed that poor knowledge about the causes of perinatal death contributed to high levels of maternal and child mortality. Factors such as maternal illiteracy in terms of family planning, childcare, poor socioeconomic factors that influenced proper nutrition, hygiene and proper sanitation and inaccessibility of proper health facilities were cited as risks in perinatal deaths.

These risks ranged from reasons such as bad roads and inaccessible health facilities which led to delays in accessing help and saving their babies timeously. Others blamed attitudes and a lack of sense of urgency by the medical teams as the cause of the perinatal death. Some believed that it was the spiritual reasons that caused the death of their babies such as punishment from God or that it was God’s will or witchcraft by jealous family members, spouses and neighbours or ex-partners of their spouses. Some believed it was “karma”, as they had actually wanted to abort the pregnancy, but on second thoughts decided to keep the pregnancy which subsequently ended in a perinatal death.

The increase in perinatal deaths due to the lack of knowledge of the mother is a reflection of the under-utilisation of maternal health services in the form or antenatal care. Many pregnant participants in the sub-Saharan countries lacked knowledge and skill in terms of best health practices during pregnancy, labour and deliveries that could have saved their lives and those of their babies.

In the current study, most of the participants had attended the antenatal care in their clinics but their failure to notice and handle symptoms of premature bleeding, premature

ruptured membranes, and lack of foetal movement for 2-3 days indicated a gap in the provision of knowledge by health professionals at their local antenatal care clinics, resulting in the perinatal deaths. Some of the participants failed to access antenatal care due to inaccessibility of services from their rural environments which resulted in poor attendance and compliance and missing out on identifying the key factors that could have prevented the occurrence of perinatal death.

Lack of knowledge about the causes of perinatal death led to some of the participants believing that there was an element of witchcraft that could have caused the death. These beliefs led to participants focusing on a search for the cause of perinatal death from the spiritual or traditional health perspective instead of seeking medical help, thus predisposing themselves to the occurrence and recurrence of perinatal death.

Another significant challenge identified in the study was lack of knowledge in terms of six weeks compliance visit to the gynaecologist or obstetrician after perinatal death. Most of the participants resorted to accepting the cause of death given either by the medical doctor, spiritual or traditional healers forgetting or ignoring their post-natal check-ups which could have further diagnosed the cause of perinatal death such as infections or auto-immune diseases such as rhesus factors. This could perhaps have prevented the recurrence of perinatal deaths in the subsequent pregnancies.

There is a need more knowledge to be provided to pregnant mothers during anti-natal care about pregnancy labour and delivery and the signs of being identified as a high risk or complications of labour (Kiguli et al., 2015)

8.2.3 Knowledge and Management of Causes of Perinatal Death

Participants lacked the knowledge about perinatal death. This influenced the manner in which they managed the condition. The limited knowledge aggravated their fears and anxieties when they realised that something was wrong with their pregnancies. Some could not identify the urgency when there was a lack of foetal movement, and they did not seek help timeously. As a result, they gave birth to a macerated stillborn.

Some of the participants consulted traditional healers to determine what could have caused their babies to die as they left the hospital with lot of unanswered questions about what could have caused their babies to die and whether the condition would recur. Rituals were performed by family members to cleanse the participants of dirty blood and to remove the dark cloud hovering around them *(sefifi).* They were also given *dipitsana, ditaelo* and *diwasho* which are traditionally mixed herbs, light teas and spiritual powders from spiritual practitioners. This shows how cultural beliefs and values influenced the management of perinatal death.

Upon their discharge from hospital, most of the participants were given treatment to take home to dry up their breast milk as most of them were in their last trimester of their pregnancy. Others were given painkillers to reduce the abdominal pains and to manage the caesarean section operation site. However, there were those participants who revisited their gynaecologist as they were concerned about the subsequent pregnancies. Most of the participants used traditional and spiritual treatment concurrently with that of the hospital treatment. This indicates that culture influences the type of service sought and the management of perinatal death. While other studies agree that most of the participants in the study preferred to use the services of the traditional healers because of their accessibility and that in most instances, they are part of the community. This attests that the cultural belief system may influence the use of the healthcare system and also influence the coping strategies adopted by participants towards the problem.

Other authors agree that the adoption of these treatment modalities if used simultaneously seems to be creating complexity and complication within the healthcare system. The complexity that may arise is that the two treatment modalities, namely, the western approach and traditional treatment operate on different epistemological bases making it difficult for participants to be compliant with the western treatment. This may be one of the reasons why the perinatal death rate remains very high (Fridgen et al., 2013; Zondo, 2010).

8.2.4 Summary of Conclusions

Lack of knowledge about what precipitates the onset of premature labour and how to manage the symptoms presented by participants, such as premature ruptured membrane, bleeding, and a lack of foetal movement played a major role in the meanings that the participants ascribed to be the cause of their perinatal deaths. This indirectly influenced the help-seeking pathways that some of the participants adopted to manage their distress. Participants' cultural beliefs about the causes of perinatal death played a significant role in determining how to cope with their distress.

8.3 COPING STRATEGIES

Alternative help-seeking pathways influenced the coping strategies adopted by bereaved parents. Stillbirths remain one of the most distressing experience of bereaved parents, health professionals and society at large. Bereaved parents adopt various coping strategies which influence the alternative help-seeking pathways they chose as a way of coping with the distress.

Research studies revealed that perinatal death results in multiple mental health conditions. People in most instances consult the general health practitioners, traditional and spiritual healers to cope and relieve their distress and this is achieved by adopting two types of coping strategies to manage stressors; that is, problem-focused strategies and emotion-focused strategies (Schoenmaker et al., 2015).

These coping strategies are aimed at changing the impact of the stressors on the individual. The problem-focused strategies are active problem-focused action to be taken to resolve the problem that causes the stress, whereas the emotion-focused coping strategies are those aimed at changing the perceptions and thinking processes of the individual and how the person feels about a stressor. In the current study, the participants used emotion-focused strategies to self-regulate their emotional trauma after the loss of the baby. They could not change what had happened but rather needed to find a way of living with the trauma and to accept that it had happened. The participants sought help from traditional healers and spiritual groups for support and for deeper meaning about the

cause of perinatal death and how to prevent a recurrence of the situation (Schoenmakers et al., 2012)

8.3.1 Spiritual Coping

Religious beliefs and practices during illness were found to be commonly used by many participants with distress. Women were found to depend on their faith to cope with stressful conditions to derive meaning about life, death and other health issues. While religion was recognised as an important coping process in the current study. The meaning-making capacity of religion was used by participants to process their grief perinatally.

Some of the participants viewed religion as a complementary and alternative medicine over and above the hospital treatment prescribed. They used religious rituals such as cleansing in the form of bathing and steaming with boiling water and hot stones. Some drank holy water with holy powders *(diwasho)* to get rid of evil spirits *(sefifi).* There are those participants who used the Zionist Christian Church (ZCC) light teas to cleanse themselves inside and *ditaelo* for external cleansing. However, there were participants who adopted religion as a spiritual journey to heal and comfort themselves. They felt healed and were able to accept their loss by engaging in prayer, which helped them to accept that it was God's will to have lost their babies, while others blamed God for their loss and view their loss as punishment by God.

There were participants who consulted their spiritual advisers long before the occurrence of perinatal death. This was for support and assistance with difficult conception, labour and delivery complications, especially those who had experienced stillbirths more than once. Participants expressed that they found inner peace, strength and hope through the religious interventions. They also reported feeling cleansed outside and inside after bathing and drinking light teas from the church, and holy water with *diwasho*. One participant revealed that after taking *diwasho,* she discharged lot of clots which she did not see when taking hospital treatment.

Participants used different religious groups for support. Most of them used ZCC and the Apostolic Faith church group. The participants in the process of meaning-making about the loss and to cope with the loss, reached out to a 'higher power' to help them reach the stage of acceptance of the loss. Religion has always been a source of comfort for the afflicted. The Bible is a source of comfort and a spiritual balm for society that provides hope, reassurance and joy to those that are afflicted. Most of the participants consulted their churches for support, for cleansing, and for advice in terms of the mourning period and how to stop the recurrence of the condition.

Some of the participants were prompted by family members to approach the church for support, comfort and treatment. Some participants consulted their spiritual advisers long before the occurrence of perinatal death for support and assistance with difficult conception, labour and delivery complications especially those who had experienced stillbirths more than once. Participants expressed that they found inner peace, strength and hope through the religious intervention (Salsman et al., 2015)

8.3.2 Traditional Healing Intervention

Despite the lack of research evidence about the effectiveness of traditional medicines in treating mental health disorder such as postpartum depression and others, traditional healers form major part of the healthcare system. Some evidence revealed that traditional medicine forms the integral part in the management of distress. The popularity thereof is attributed to the accessibility, affordability and their flexibility, as in most cases traditional healers are part of the community (Sodi et al., 2011).

Many people within South Africa use the services of traditional healers to cope with their emotional distress. As a result, there is increasing evidence of collaboration between traditional healers and the western treatment of mental disorders, to facilitate effective coping of patients suffering from various forms of mental health conditions such as depression and anxiety disorders. However, the different viewpoints in terms of medical competence of traditional healers and their failure to identify and manage serious conditions hampered and delayed the effective collaboration of the two healthcare systems.

Nevertheless, it is said that most of the population in Africa has been found to be using the services of traditional and religious healers to cope and manage mental illness before accessing the services of the biomedical healthcare practitioners. Similarly, even in the current study, participants sought the services of traditional health practitioners to cope with their emotional distress and to derive deeper meaning and understanding about the perinatal death.

Women were found to have used traditional medicine during pregnancy and labour for various reasons. This tradition was found to have been passed from one generation to the next. Even during the postpartum period, women have used traditional medicine to reduce bleeding and to prevent engorged breasts. Similarly, participants' narratives revealed the use of traditional medicines to cleanse their wombs and to remove dark spirits *(sefifi).* Participants believed that after the death of their babies they had a dark cloud around them, so they used traditional medicines *dipitsana* to remove the dark spirit around themselves.

One participant acknowledged being given *Bolebatsa,* a black herbal mixture, that she licked to forget the deceased baby and she acknowledged that after using this black powder, the pain of thinking about the deceased was not as severe as it was at the hospital.

Others were given charms to wear during pregnancy when they started spotting or showing signs of threatening miscarriage or even after perinatal death. One participant acknowledged being tied with a rope with *muthi* around the waist *(motlamo)* after realising that she was pregnant to avoid losing the pregnancy as a result of witchcraft. One participant revealed being tied with a *motlamo* by a traditional practitioner upon realising that she was experiencing sporadic bleeding. Having suffered three stillbirths and still being childless, one participant revealed that according to the culture, her uncle had to slaughter a white goat and made a bracelet for her from the goat skin called *sbanxa*. This was to appease the ancestors in terms of the recurrence of the stillbirths.

However, over and above the spiritual and traditional healing interventions, social support played a pivotal role in the coping processes of bereaved participants in distress (Lesolang, 2010).

8.4 SOCIAL SUPPORT

Social support has been found to be an important protective factor for psychological distress, partners and wider family networks were found to have played a vital role in helping mothers who experienced perinatal death. Similarly, even in the current study most participants derived emotional and physical support from their families, partners, friends, community and health professionals (Cohen & Wills, 1985).

8.4.1 Support by Health Professionals

Participants revealed the role of social support in coping with their perinatal loss. Most of them derived support from their friends, family, especially their spouses, neighbours and healthcare professionals. The intervention of primary healthcare practitioners to parents when the baby dies provides invaluable support. Social support before and after perinatal death was found to be a priority in helping bereaved participants to cope.

Most of the participants revealed that supportive healthcare professionals made it possible for them to bear the physical pain and emotional pain of loss. Some participants revealed that after experiencing the perinatal death, it was difficult for them to push the baby out, but they managed to deliver the stillborn baby with the support of the nurses. The confirmation of the death of the baby and the decision whether to take the corpse home or cremate the body was made easy through the support of the healthcare professionals. However, some participants revealed that they experienced negative and harsh treatment from the health professionals. This negative attitude exacerbated their psychological trauma of loss (Kiguli et al., 2015).

8.4.2 Social Support

Family support was found to be of a great help in dealing with maternal depression after a perinatal death (Lazarus & Folkmans, 1984). The postpartum period after a perinatal

death demands a lot of physical and psychological adjustment. Lack of support from the family members may have an adverse effect on the quality of life of the mother. Social support provided by family members, friends and spouses has been found to have a positive effect on the mental wellbeing of the mother after a perinatal death.

In the current study, from the narrative of some participants, positive social support from spouses, family, members and friends increased the quality of life after birth. Lack of spousal and family support was found to have predisposed participants to health problems and psychological distress. Some of the participants in the current study experienced a lack of support from their spouses and family members, especially the in-laws. They felt rejected, abandoned and humiliated for failing to give birth to a live baby. (Lazarus & Folkmans, 1984).

Other participants received strong positive support from their neighbours and friends who came over to console and comfort them, although there were those participants who experienced a negative attitude from some of their neighbours. These neighbours used abusive language against the bereaved participants, humiliating and stigmatising them, thus aggravating their pain of loss and their distress. As a result, some participants avoided them by staying indoors or moving to other places to stay with other family members.

8.5 IMPLICATIONS OF THE STUDY

Perinatal death is not recognised and does not receive the urgency it deserves in terms of global public health. These deaths are just statistics within the national registers, but they leave a lasting mark in the lives of their families, especially participants. This is due to the little information that is known about the experiences of those living with the trauma of losing a child perinatally. Perinatal death has a devastating effect on participants as they weep in silence. The pain of participants of African descent is hidden within the sociocultural myths as perinatal deaths are often unreported and unrecognised by the community. In most cases, perinatal deaths often are surrounded by stigmatisation, rejection and humiliation of the participants.

These deaths are hidden along with the grief of participants that happens in silence. The ongoing social stigma and the negative attitude of families, friends and partners are linked to failure of the society to value and recognise the stillborn child as a human being, not a "thing". Acknowledging perinatal death will bring this problem out of the shadows, thus allowing the participants to openly grieve. This grieving process will facilitate closure and prevent long-term mental health disorders of the participants. There is a need for more education and creation of awareness about perinatal death in the early stages of pregnancy at antenatal care services. These early interventions will encourage pregnant women to start antenatal care early thus preventing birth complications.

These measures will reduce stigmatisation and humiliation that bereaved participants are subjected to. In some communities, if a mother has experienced stillbirth more than once, this is considered to be a bad omen and her contribution to family and community meetings would not be taken seriously and her worth as a woman would be questioned.

Bereaved participants suffered massive condemnation from their in-laws in particular as they were viewed as bringing shame to the family and the clan. Open discussions about perinatal death would provide more knowledge to the communities and families and mobilise support for bereaved participants, thus minimising their negative myths and condemnation of bereaved participants.

Despite the magnitude of stillborn death within the maternal and child healthcare systems, there is little response from the healthcare system to improve and provide support to the affected participants. There are very few counselling centres for bereaved participants. Most of the participants were discharged from the hospital without being counselled by a social worker or the psychologist. Those who received counselling only had one or two sessions and were discharged without being referred to their local primary care clinics to continue with counselling. In most cases, there are no counselling facilities or counsellors at all in the clinics, and those that are there, are often overcrowded with no resources to reach out to those in need of such services.

The "replacement of baby" syndrome is also common advice that bereaved participants are given by unqualified health workers or families as a way of coping with the loss. In the

current study, one participant agreed to the advice after stillbirth in 2017; in 2018 she had a baby that was one-year-old when I interviewed her. The participant was still crying for the stillborn baby and stated that it was not a good idea to have fallen pregnant so soon after the stillbirth as felt that she had not healed yet. There is a gap within the healthcare system in recognising the value of a stillborn baby. Simply registering the perinatal death on the statistics book is not enough in terms of healing and supporting the bereaved participants. Instead, it adds to the grief of the bereaved participants. There is a need for the creation of awareness about the causes, precipitating factors and knowledge about management of stillbirths by healthcare systems within the communities. These strategies will demystify the challenges and the plight of participants who have experienced perinatal death.

8.6 IMPLICATIONS FOR TRAINING

The management and help-seeking pathways adopted by participants' post-perinatal death are entrenched within the cultural content. There is a need for incorporation of cultural belief systems with the curriculum for nurses and medical doctors training programme, especially midwives, community health nurses and doctors during their training. This will facilitate a clear understanding of the impact of cultural factors on conception, labour, delivery and perinatal death. The ultimate goal will be to produce a well-trained health professional who will have the expertise to provide comprehensive care within the cultural context.

8.7 IMPLICATIONS FOR POLICY

The findings of this study revealed an alarming lack of knowledge about perinatal death within the black communities. None of the participants knew about the precipitating causes of premature labour which finally led to perinatal death. The onset of premature labour, in most instances, was sudden symptoms such as a ruptured membrane, bleeding, and lack of foetal movement which led to high levels of anxiety and anticipated grief. Participants lacked information of how to manage these signs and symptoms of premature labour which subsequently led to perinatal death.

Great strides have been made in terms of the reduction of mental health problems and child health mortality rates according to the MDGs. However, the rate of perinatal deaths seems not to be getting the attention it deserves, despite the statistics showing that 2.6 million newborn babies die perinatally worldwide every year. There is a great need for policy makers to attend to this growing health problem as a matter of urgency. This research has shown that more policies around provision of healthcare facilities such as antenatal care, post-natal care of bereaved participants and training of medical personnel are needed in terms of conception, labour and delivery problems of pregnant women.

Healthcare professionals need to understand that most pregnant women consult traditional and spiritual healers for assistance with conception, labour and delivery of their babies. As a result, there is a great need for healthcare policies to incorporate cultural factors that may influence the management and understanding of perinatal death from the perspective of the bereaved participants in their statutes. There is also a need to change policies to reduce the gap and facilitate more understanding and appreciation of traditional African treatment pathways in managing the mental health complications induced by perinatal death. Furthermore, policy healthcare makers need to include indigenous traditional and faith healers alongside the formal biomedical healthcare system in the formulation of standardised healthcare models.

Healthcare policies regarding education of pregnant women at the antenatal care level need to be communicated at a lower level and with great sensitivity to accommodate all pregnant women even those with lower educational levels. In the current study, most participants had an educational level of lower than Grade 12. The two participants who gave birth to a macerated stillborns had very low educational levels and one had started antenatal care classes late in the 3rd trimester of her pregnancy. Even when she did not feel the foetal movement for days, she ignored the symptoms. This is an indication of lack of knowledge or failure of the health professionals to come down to the level of the pregnant participants during their presentation of antenatal care classes. Efforts should be taken by healthcare professionals to assist pregnant women to understand all the information given during antenatal care and the need to review the antenatal care policies in terms of training and communication of information given to pregnant women.

Fragmentation of government departments has also contributed to the increased rate of perinatal death. There is a need for collaboration between the Departments of Health and Transport in provision and prevention of perinatal deaths. Structural policies need to be looked into in terms of road maintenance and keeping animals off public roads with walls or fences. Most of the participants from rural communities complained about bad roads due to potholes and animals on the road which caused delays for the ambulances arriving timeously at the hospital resulting in the loss of their babies upon their arrival. Policies around the provision of mobile clinics and well-trained medical professionals are required, supported by the provision of effective equipment, which will prevent pregnant participants from travelling to distant hospitals to access specialised care especially in the rural communities and rural settlements.

8.8 IMPLICATIONS FOR PRACTICE

The adoption of an Afrocentric approach will result in the understanding and the appreciation of the role of cultural issues in the understanding and management of perinatal death. The Afrocentric approach provides a dimension and understanding of perinatal death that was lacking in the health belief model. The current study has provided more insight into the influence of the cultural factor on the causes and management of perinatal death. The Afrocentric approach adopted in the study allowed the bereaved African participants a voice to share their experiences of perinatal death from their own experiences. As a result, the psychological fraternity should embrace this approach if it wants to remain relevant to South Africans.

8.9 CONTRIBUTIONS OF THE STUDY

The study has contributed to:

- Understanding and appreciation of the impact of cultural factors on perinatal death.
- The combination of Western treatment of perinatal death vs women' African culture/tradition belief systems in the management of perinatal death.
- Recognition of the experiences of participants perinatally as one of the important conditions in psychological disorders within the mental healthcare system.

- Highlighting the lack of poor policies in terms of structural problems such as bad roads maintenance and accessibility of the clinics and hospitals as contributory factors in perinatal death.

8.10 Strengths of the study

The strengths of the study are:

- The study was able to contribute and uncover a wealth of knowledge necessary to the Healthcare system and psychology at large of women in the rural areas who do not have a voice.
- There is a need for collaboration between western health medicine and the traditional healthcare system in addressing the maternal needs of pregnant mothers in terms of management prenatally and postnatally especially around perinatal deaths.
- The findings reaffirm that despite the increased rate of perinatal deaths, the healthcare system and the community support structures have been largely unresponsive with regard to the prevention efforts and providing adequate support to mothers who have experienced perinatal deaths.

8.11 THE LIMITATIONS OF THE STUDY

- The study focused on rural women residing in the Tshwane District and therefore cannot be generalised to other ethnic groups or provinces.
- The study comprised mostly Setswana, Sepedi and Sotho-speaking participants who had experienced perinatal deaths in the Tshwane District which might be different from other cultural groups in South Africa. The study cannot, therefore, be generalised to other population groups.
- The narratives provided by the participants may not be the true reflection of their lived experiences because of the time frame between the time of the occurrence and the date of the research.
- Furthermore, the narratives provided by the participants may not be a true reflection of their lived experiences. Some of the participants may have given the researcher

what she wanted to hear and may not be a true reflection of what was going on in their lives.

8.12 RECOMMENDATIONS FOR FURTHER RESEARCH

The study revealed a gap in the understanding of the lived experiences of bereaved participants as a result of perinatal death and the various help-seeking pathways they chose to alleviate their distress. It is recommended that future research studies could address the following:

1. A similar study with other cultural groups within the South African context.
2. An investigation of the knowledge and management of causes of perinatal deaths within other ethnic groups.
3. An investigation into the preferences of the alternative health-seeking pathways adopted by bereaved participants among other ethnic groups.
4. An investigation of the long-term role that alternative help-seeking pathways sought by bereaved participants play in relieving their distress in terms of reducing the recurrence of perinatal death.
5. An investigation into various healthcare approaches in minimising stigmatisation and mobilisation of support for bereaved participants due to perinatal death.
6. The development of a cultural model for understanding and management of perinatal death.
7. The development of a framework for how western health practitioners and traditional health practitioners can work together in hospitals towards the strengthening of the healthcare system in South Africa.

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APPENDICES

APPENDIX A: ETHICAL CLEARANCE

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: **27 November 2018**

PROJECT NUMBER: **TREC/217/2018: PG**

PROJECT:

Title: Establishing help seeking pathways by mothers bereaved through perinatal deaths in Dr. George Mukhari Hospital, Gauteng Province.
Researcher: JM Moloisane-Ledwaba
Supervisor: Prof T Sodi
Co-Supervisor/s: Dr N Lesolang
School: Social Sciences
Degree: PhD Psychology

PROF TAB MASHEGO

CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX B: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date

The Chief Executive Officer

Department of Health

Dr. George Mukhari Hospital

Re: Permission to conduct research writing in Dr. George Mukhari Hospital.

I am a registered student in the above-named institution. As part of the requirement for a PhD degree in Psychology, I am doing a research project. The title of the research project is: *Help-seeking pathways followed by mothers bereaved through perinatal death in Dr. George Mukhari Hospital in the City of Tshwane, South Africa.* The purpose of the study is to explore the pathways followed by mothers bereaved through perinatal death. I have already obtained ethical clearance for the study through the University of Limpopo's Research Ethics Committee (see attached Ethical Clearance Letter).

I hereby apply to be granted permission to be given access to the perinatal death register of the hospital to determine the sample for the study. I undertake to maintain confidentiality in this research project. The participants will be assured of voluntary nature of this study. Furthermore, the participants are free to withdraw from the study at any time should they wish to do so.

The method of data collection will be semi-structured one-to-one interviews with mothers at their homes or any place of their choice where they feel comfortable.

Yours Sincerely

J. M. Moloisane-Ledwaba Date

______________________ ___________________

Prof T. Sodi Date

Supervisor

APPENDIX C: PERMISSION TO CONDUCT RESEARCH

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Dr. George Mukhari Academic Hospital

Office *of the Director Clinical Services*
Enquiries : Dr. C Holm
Tel : (012) 529 3691
Fax : (012) 560 0099
Email:Christene.Holm @gauteng.go.za
keitumetse.mongale@gauteng.gov.za

To Mrs JM Moloisane-Ledwaba
Department of Psychology School of Social Sciences
University of Limpopo
Private BAG X1106
Sovenga
0727

Date : 08 February 2019

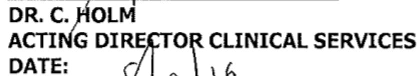
PERMISSION TO CONDUCT RESEARCH

The Dr George Mukhari Academic Hospital hereby grants you permission to conduct research on "Establishing help seeking pathways by mothers bereaved through perinatal deaths " at Dr George Mukhari Academic Hospital, Gauteng Province

This permission is granted subject to the following conditions:

- [✓] That you obtain Ethical Clearance from the Human Research Ethics Committee of the relevant University
- [✓] That the Hospital incurs no cost in the course of your research
- [✓] That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.
- [✓] That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.
- [✓] Formal written feedback on research outcomes must be given to the Director: Clinical Services
- [✓] Permission for publication of research must be obtained from the Chief Executive Officer

Yours sincerely



DR. C. HOLM
ACTING DIRECTOR CLINICAL SERVICES
DATE: 8/2/19

APPENDIX D: INFORMED CONSENT LETTER: ENGLISH

University of Limpopo
Department of Psychology
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2318/3505, Fax: (086) 672 6201, Email:Tholene.Sodi@ul.ac.za

---

Date: 07 February 2020

Dear Participant

RE: INFORMED CONSENT LETTER

Thank you for showing interest in this study that focuses on help-seeking pathways followed by mothers who have experienced perinatal loss at Dr. George Mukhari Hospital in the City of Tshwane, South Africa.

Your response to this interview will remain strictly confidential. The researcher will attempt not to identify you with responses you give during the interview or disclose your name as a participant in the study. Please be advised that your participation in this study is voluntary and that you have the right to terminate your participation at any time.

Thank you for your time.

Yours sincerely

______________________ _________________

Johanna Moloisane-Ledwaba Date

PhD Student

07 February 2020

________________________ ____________________

Prof T. Sodi

Date

Supervisor

PARTICIPANT'S CONSENT FORM

I ___________________________________ hereby agree to participate in a PhD research project on the help-seeking pathways followed by mothers who have experienced perinatal bereavement at Dr. George Mukhari Hospital in the City of Tshwane, South Africa.

The purpose of the study has been fully explained to me and I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue, and that decision will not in any way affect me negatively.

I understand that the purpose of this research project is not necessarily to benefit me personally. I am also aware that my details as they appear in this consent form will not be used in the thesis and that my personal particulars will remain confidential.

Sincerely

____

Signature of the participant

____

Date

APPENDIX E: INFORMED CONSENT LETTER: SETSWANA

University of Limpopo
Department of Psychology
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2318/3505, Fax: (086) 672 6201, Email:Tholene.Sodi@ul.ac.za

---

Date: 07 February 2020

Motsea karolo

RE: INFORMED CONSENT LETTER

Ke leboga fa o bontshitse kgatlego go tsaya karolo mo letsholong la dinyakisiso tsa ditsela tse basadi ba ba fetetseng ke bana mo pelegong ya bona ba di tsereng bookelong jwa Dr. George Mukhari kwa teropong ya Tshwane mo Afrika Borwa.

Dikarabo tsa lona go dipatlisiso tse di tla tshwarwa ka mokgwa wa sephiri. Monyakisisi otlo leka ka bokgoni jotlhe jwa gagwe gose le amanye le dikarabo tse, le go se ntshe maina a lona jaak a batsaya karolo dipatlisisong tse. Le a itsisiwa gore o tsaya karalol ga lona go dipatlisisong tse ke go etsa ka boithaopo, le gore lena le tokelo yago ikgogela morago nako engwe le engwe fa le batla.

Le kopiwa go araba dipotso tse ka botshepegi bo bogolo. Go tsaya karolo ga lona go botlhokwa ele tota.

Ke lebogela nako ya lona.

Wa lona

____________________ ______________

Johanna Moloisane-Ledwaba Letlha

PhD Student

07 February 2020

_____________________ ________________

Prof T. Sodi Letlha

Supervisor

FOROMO YA TUMELANO

Nna ____ ke dumela go tsaya karolo mo dipatlisisong tse di tlhalositsweng tsa basadi ba ba tlhokofaletsweng ke masea mo pelegong ya bone ko Bookelong jwa Dr. George Mukhari kwa teropong ya Tshwane, mo Afrika Borwa.

Ke tlhaloseditswe ka maikemisetso a di dipatlisisong tse, ebile ke tlhalogantse gore ke tsaya karolo ka boitshepo le ka ntle ga kgapeletso epe. Ke utlwisisa gore nka ikgogela morago o go tseyeng karolo dipatlisisong tse nako engwe le engwe gake sa tlhole ke batla go tswela pele, le gore kgano ekase ntlisetse bobe gotlhelele.

Ke utlwisisa gore maikaelelo a dipatlisiso tse ga se go thus anna fela, le gore leina lame lekase tlaisisiwe letlo bolokega.

Motsea karolo

Letlha

APPENDIX F(1): INTERVIEW GUIDE (ENGLISH VERSION)

Thank you for agreeing to this interview. My name is Joey Ledwaba. I understand that you lost a baby shortly after its birth and wish to extend my condolences to you and your family at this difficult time. During this interview, I am going to ask you about your experience

Objective	Interview questions
1. To explore the bereaved mother's subjective understanding of help-seeking pathways through perinatal deaths	a. I would like you to share with me your subjective understanding of the pathways you undertook after losing your baby. b. Kindly share with me your understanding of what are the causes and reasons of your baby's death?
2. To explore the mothers' subjective experiences of perinatal deaths in terms of their physical, psychological and social wellbeing	c. As a person who has experienced perinatal bereavement, please share with me your experiences in terms of your physical, emotional and social wellbeing?
3. To determine the help-seeking pathways that mothers adopt after they have perinatal bereavement, why they chose them and their experiences in their chosen pathways	d. Having realised that the baby has died, after being discharged from the hospital, where did you go to seek help so as to deal with your pain of loss? e. Kindly share your experiences from this chosen pathway?
4. To determine whether mothers who experienced perinatal death used other healthcare interventions in addition to the formal treatment they received from the hospital	f. Kindly share with me if there are other treatment agencies that you are using in conjunction with the prescribed hospital treatment and why? g. If you are using both treatments simultaneously, what are your experiences?
5. After the death of the baby perinatally what did you do with babies belongings e.g., clothes, toys, cot bed	h. Kindly explain how you dealt with the disposal of these items
6. After the death of your baby, did you bury the body or did you give the hospital permission to cremate the body	i. Kindly explain the burial processes of your baby

APPENDIX F(2) INTERVIEW GUIDE (SETSWANA VERSION)

Maikemisetso	Dipotso
1. Go utlwisisa gotswa mo mosading wago fetelwa ke ngwana mo pelegong ya gagwe gore o tlhaloganya gore ke eng le gore go ka be go tlhodilwe ke eng.	a. Jaaka mosadi wago fetelwa ke ngwana pelegong ya gagwe, ke kopa o ntlhalosetse gore go etsagetse eng gore ngwana a fete? b. Go fetelwa ke ngwana o sa le mo mmeleng kgotsa o mmelega ka tlhaloganyo ya gago go bakwa ke eng?
2. Go tlhomamisa gore mosadi o a fetetsweng ke ngwana mo pelegong ya gagwe, o amegile jaang mo mmeleng wa gagwe, maikutlong le mo kamanong ya gagwe le batho ba bangwe.	c. Ke kopa o ntlhalosetse gore morago gago fetelwa ke ngwana mo pelegong ya gagwe go go amile jang mo mmeleng wa gago, maikutlo le kamano ya gago le batho ba bangwe?
3. Go tlhotlhomisa ditsela tse mme o a tlhokafaletseng ke ngwana mo pelegong ya gagwe a ditsereng go bona thuso mo botlhokong bo a leng mo go bona.	d. Ke kopa gore o ntlhalosetse gore ga otswa ko bookelong o sat shola ngwana, oile waya kae go bona thuso mo botlhokong jo, le gore goreng oile wa tlhopa tsela eo?
4. Go tlhotlhomisa fa go nale ditsela dingwe tse mosadi o a tlhokofaletsweng ke ngwana mo pelegong ya gagwe a di dirisitseng mo godimo ga kalafi e a e filweng ko sepetlele le gore lebaka ke eng, le gore o ikutlwa jang kago dirisa ditsela tse ka bobedi.	e. Ke kopa gore o ntlhalosetse fa gona le ditsela dingwe tse o ileng wa di dirisa mo godimo ga kalafi e o efilweng ko bookelong? f. Ke lebaka lefe le le go rotloeditseng go dira jalo? g. Morago gago dirisa ka bobedi ditsela tse, o ikutlwa jang?
5. Morago gago tlhokofaleng ga ngwana wa gago, o ile wa dira jang ka diaparo le dithotho tsa gagwe?	h. Ke kopa o ntlhalosetse gore o dirile eng ka diaparo tsa lesea la gago
6. Morago gago tlhokafaleng ga lesea la gago o ile watla le lone fo gae go le boloka kgotsa o nnetse bookelo go mmoloka	i. Ka boikokobetso ntlhalosetse ka poloko ya lesea la gago

APPENDIX G: TURNITIN REPORT

APPENDIX H: DECLARATION OF PROFESSIONAL EDITING

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2 December 2020

Declaration of professional edit

ESTABLISHING HELP-SEEKING PATHWAYS BY MOTHERS BEREAVED THROUGH PERINATAL DEATH IN DR GEORGE MUKHARI HOSPITAL, GAUTENG PROVINCE

by

JOHANNA MMASETLA MOLOISANE-LEDWABA

I declare that I have edited and proofread this thesis. My involvement was restricted to language usage and spelling, completeness and consistency, referencing style and formatting of headings, captions and Tables of Contents. I did no structural re-writing of the content.

I am qualified to have done such editing, being in possession of a Bachelor's degree with a major in English, having taught English to matriculation, and having a Certificate in Copy Editing from the University of Cape Town. I have edited more than 200 Masters and Doctoral theses, as well as articles, books and reports.

As the copy editor, I am not responsible for detecting, or removing, passages in the document that closely resemble other texts and could thus be viewed as plagiarism. I am not accountable for any changes made to this document by the author or any other party subsequent to the date of this declaration.

Sincerely,

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University of Cape Town: Certificate in Copy Editing
University of Cape Town: Certificate in Corporate Coaching

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