EXPERIENCES OF MIDWIVES CARING FOR MOTHERS WHO HAVE LOST THEIR BABIES AT BIRTH

By

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DECLARATION

In accordance with Rule G4.6.3, I hereby declare that the above-mentioned dissertation is my own work and that it has not been previously been submitted for assessment or completion of any postgraduate degree to another university or for another qualification.

SIGNATURE: 

DATE: 04 January 2016

DEDICATION

This study is dedicated to my late loving mother, Thenjiwe Dana and the midwives who work diligently in saving mothers and babies in labour wards.

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ABSTRACT

Midwives working in labour wards usually have the pleasure of delivering a live baby and rejoicing with the mother. However, the delivery could become tragic for the mothers and midwives when the baby dies at birth due to pregnancy related complications. The result is that midwives have to render care and support to mothers who have lost their babies at birth.

The objectives of this study were to explore and describe the experiences of midwives caring for mothers who have lost their babies at birth. A qualitative explorative, descriptive and contextual design was used to conduct this research study to gain an understanding of how the midwives experienced caring for mothers who have lost their babies at birth. A purposive criterion based non-probability sampling method was used. Ten semi-structured face-to-face interviews were conducted to collect data. Ethical considerations were observed throughout the research study. Measures of trustworthiness were ensured by using credibility, transferability, dependability and conformability. Data analysis was done using Tesch's method to make sense out of text and data.

Four themes were identified, namely, Midwives shared their diverse experiences relating to caring for mothers who have lost their babies at birth; Midwives expressed how their personal values and beliefs influenced the ways they dealt with babies dying at birth; Midwives described the organizational values and beliefs related to death and dying and how this influences their own experiences and lastly Midwives provided suggestions regarding how they can be assisted in caring for mothers who have lost their babies at birth.

Two main guidelines were developed based on the research findings and literature. The study concludes with recommendations made with regard to areas of nursing practice, education and research.

KEY WORDS

- Experiences
- Caring
- Mothers who have lost their babies at birth
- Labour ward
- Hospital complex
- Eastern Cape

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Midwives at the hospital complex in the OR Tambo district, Eastern Cape Province, are often faced with the challenge of providing continuous support and care to mothers who have lost their babies at birth. The challenge experienced by the midwives is thought to be aggravated by a lack of understanding of the experiences and the care-related needs of the mothers who have lost their babies at birth. These mothers are usually high-risk referrals from district hospitals to the hospital complex for further management from the 18 district hospitals in the OR Tambo district with a radius of between 40 and 300 kilometres.

This study was undertaken to explore and describe the experiences of midwives caring for mothers who have lost their babies at birth; this is followed by the development of guidelines that could assist midwives in caring for mothers who have lost their babies at birth.

1.2 ORIENTATION AND BACKGROUND

According to Dippenaar and da Serra (2012: 9) the perinatal neonatal mortality rate (PNMR) includes stillbirths and early neonatal deaths expressed per 1 000 live births. The above-mentioned authors further state that there is a vast difference between developed and developing countries in terms of perinatal mortality rates. In developing countries it is 30 per 1000 live births, whereas in developed countries it is 6 per 1000 live births. Oestergaard, Inoue, Yashida, Mahanan, Gore, Cousens, Law and Mathers (2009:1) published results of a systematic analysis of progress, projections and priorities regarding a neonatal mortality study done in 193 countries across the world between 1999 and 2009. The study showed a difference in declining rates of neonatal mortality rates (NMR). While the decline was halved in some regions around the world, Africa's NMR only dropped by 17.6%. The global estimation was at 23.9%, with Europe at 10. 7% while Africa had the highest rate at 35.9% in 2009.

According to Pattinson and Rhoda (Saving babies report, 2014: 30), Eastern Cape Province which is one of the nine provinces of South Africa has seven health districts and one metro namely, Alfred Nzo, Amathole, Cacadu, Chris Hani, Joe Gqabi, O.R. Tambo, UKhahlamba and Nelson Mandela Metro. According to statistics (South Africa, 2011) the O.R .Tambo municipality which forms the O.R.Tambo health district has a population of 1,364,943 and has the largest population among the eight municipalities According to the Saving Babies report (Saving Babies report, 2014:30) O.R. Tambo had 56.41% of perinatal mortality of babies born at 500g+ out of 139112 live births in the Eastern Cape Province between the years 2011-2013. Other districts ranged between 17.94% and 55.56%.

The World Health Organization states that there were six stillbirths and seven neonatal deaths per 1 000 live births in the European region in the year 2009, while there were 28 stillbirths and 28 neonatal deaths per 1 000 live births in the African region in the year 2009 (WHO, 2012:54). In South Africa, within the same period, there were 20 stillbirths and 28 neonatal deaths per 1 000 live births (WHO, 2012:54). However, in the year 2013, the Perinatal deaths statistics in South Africa was reported to be at 2.6% for babies dying under one hour after birth and 34.6% for babies dying one hour to 23 hours after birth. (www.stassa.gov.za/publications/P0394/P03942013-pdf). The aforementioned statistics showed a decreasing trend for babies dying less than an hour after birth compared to the year 2011 in which the rate was at 22.1%, however, the statistics showed an increasing trend for babies dying one hour to 23 hours after birth which was at 19.5% in 2011.

According to the statistics submitted by the academic referral hospital in the OR Tambo district to the Eastern Cape “Saving mothers, Saving Babies” enquiry, a total of 226 babies died out of 877 deliveries (normal vaginal and caesarean deliveries included) between January and April 2013. During the aforementioned four-month period there were 107 fresh stillborn full-term infants born to mothers admitted in the labour wards of the Regional hospital that forms the hospital complex under study (UGRH perinatal statistics, 2013).

The statistics presented earlier in this Chapter have shown that the death of babies is not uncommon in developing countries, however, Chan & Arthur, (2009:2539) state that irrespective of the extent of perinatal neonatal death rate, perinatal mortality rate

defies the modern expectation of a healthy outcome of pregnancy. The authors further report that perinatal mortality rate has been demonstrated to be as profound and significant as any other type of bereavement. McCool, Guidera, Morgan and Dauphine (2009:1013) further state that the adverse outcome of pregnancy is common and is experienced as painful by midwives around the world, which may be due to the expectation of life but which results in unexpected death.

The causes and related contributing factors to perinatal neonatal loss are sometimes avoidable but may be beyond the control of the midwives. The mother may need an explanation as to what caused the baby's death which may be emotionally disturbing to the midwife if the death was due to causes or related contributing factors that may be avoidable. According to Cronje, Cilliers and Pretorius (2011:750), the most common avoidable causes include administration causes, missed opportunities by the health-care providers and patient-related causes.

Administration causes often relate to the lack of available transport necessary for transporting mothers from a lower to a higher level of care, a shortage of staff or even a lack of equipment necessary for the management of mothers presenting with complications due to pregnancy and labour. The 2008 report on Maternal Death Inquiry in South Africa highlights these administration causes as a challenge in the rural areas of the Eastern Cape Province from where mothers are referred to the hospital complex. According to the Saving Babies report (2014:22) administrative factors contributed to 7.9% of neonatal deaths between 2011 and 2013. McCool et al. (2009:1011) state that the baby could have been saved in most of the cases related to administration causes if there was no delay in transporting the mother to a higher level of care, and that midwives feel very bad when administration causes lead to the death of the baby.

The healthcare-provider missed-opportunity may also probably have an impact in the death of the baby at birth. According to Cronje et al. (2011:752), health care-provider missed opportunities contributing to neonatal deaths can be due to an honest error, oversight by the health worker, for example failing to respond to information that was available, and/or gross deviation from accepted practice, for example carrying out a potentially inappropriate procedure on the woman or her baby. The Saving Babies report (2014:23) reported that 7.1% (682 deaths) of babies weighing 500g+ were

related to health-care provider associated facts. Moon Fai and Gordon Arthur (2009:2346) explain that some of the underlying reasons for errors committed by midwives are sometimes due to working under stressful situations such as being overworked due to a shortage of staff, poor support from management and a lack of equipment.

Patient missed opportunities reported in the Saving Babies report (2014:24) included late antenatal care booking and less frequent visits, delay in seeking care when there is a complication in cases where the death of the baby could have been prevented. According to Cronje & Grobler,(2011:752) if the latter was due to ignorance on the part of the mother, the midwife may experience personal failure, and feel helpless and unable to provide help.

The effects of perinatal loss on the mother will be viewed from the point of the mother who suffered grief as a result of the loss of her baby. The birth of the baby represents the beginning of life, hope and joy; the end or death is usually not the thought that comes to mind at birth (McDonald & Magill-Cuerden, 2012:940). Gardner (1999:121) describes perinatal loss as a life crisis for the parents. McDonald and Magill-Cuerden (2011:942) further articulate that the loss of the baby may be extremely painful for mothers and their families. Conry and Prinsloo (2008:15) support the significance of perinatal loss to the mother and that the process of grief, mourning and bereavement resulting from the pain of losing the baby is experienced as devastating because the death of the baby at birth or after birth is unique. Dippenaar and da Serra (2012:346), are in agreement with the aforementioned statement and stress the fact that the effects of perinatal loss can have devastating effects on the people experiencing it if the situation is not handled correctly.

Lowdermilk, Perry, Cushin and Alden (2012:933) state that the mother may suffer acute and distressing experiences due to perinatal loss which may manifest as sadness, devastation and depression, outbursts of emotion and crying. This situation may be aggravated by placing the bereaved mother in a unit with other mothers who are holding and feeding live babies (Lowdermilk et al., 2012:933). The aforementioned mother’s reaction may place a further burden on the midwife, especially if the midwife is not equipped with skills in caring for a mother who has lost her baby at birth.

The midwives are often the first people to interact with grieving mothers, as midwives are often the ones conducting the delivery. Even if the delivery was conducted by the obstetrician, the midwives remain with the mother for support and counselling. By virtue of their professional status, midwives are expected to give efficient care to these women whether they are capable of giving care to the mother or not (Modiba, 2008:247). The effects of babies dying at birth on the midwife will be therefore, better understood and dealt with in the context of midwives as caregivers to mothers who have lost their babies at birth.

According to de Kock and Van der Walt (2004:28), it is unavoidable that the midwife as the caregiver will be affected by the death of the baby because the midwife may have an intimate relationship created by sharing problems with the mother during the mother's stay in hospital while still pregnant. According to Meghan (2012:14), each day midwives encounter mothers and families, winning health victories when the baby is born healthy, but midwives also endure traumatic losses when the baby dies and when mothers and families suffer the loss of a child before or after delivery, midwives grieve with the mothers who have lost their babies at birth.

According to McGuinness, Coughlan and Power (2014:247), caring for and supporting parents whose infant has died is sad, difficult and stressful. Fenwick, Jennings, Downie, Butt and Okananga (2007:157) further explain that midwives become emotionally drained when the baby dies. In the words of these authors "… looking at the mother grieve is very stressful for the midwife". Consequently, the midwives may suffer traumatic stress when constantly caring for grieving mothers who experienced perinatal loss which may be worsened by the midwife's prolonged exposure to the situation. De Kock and Van der Walt (2004:28) further state that traumatic stress is associated with physiological and psychological symptoms such as tachycardia, raised blood pressure, irritability, aggressive episodes and even withdrawal symptoms, to name a few. These physiological and psychological effects may later affect the professional performance of the midwife.

The role of the midwife with regard to perinatal loss will be discussed based on the assumption that the midwives have the necessary training, experience and theoretical knowledge and skills to deal with perinatal loss (Modiba, 2008:246). The midwife is therefore expected to support the mother throughout labour and birth; but this process

of giving birth is sometimes not as positive and pleasant as expected as the child may die. (Fenwick, Jennings, Downie, Butt & Okanaga, 2007:154). Therefore the midwife has to provide supportive care for the vulnerable mother, while in some instances trying to cope with her own emotional responses to the situation. (Roehrs, Masterson & Alles, 2008:631).

The midwife's role is to recognize and acknowledge the mother's grief and give the necessary support, care and guidance. Roehrs et al. (2008:631) state that one of the most difficult situations in practice for midwives is caring for a woman when birth has resulted in the death of the baby. The aforementioned authors further explain that sometimes it is the midwife who needs to assist the mother in taking complex decisions, such as how to create memories of the dead baby, burial arrangements and how to tell siblings or other family members about the death of the baby. Therefore, the midwife has a unique role in caring for and supporting the mother who lost her baby at birth.

According to Fenwick et al. (2007:154), caring for a grieving mother can cause distress and discomfort that may be personally or professionally challenging for the midwife. Therefore, the support and caring provided by the midwife to the mother is not always an easy process, for various reasons. Some of the reasons are, for example, mothers react differently to situations of losing the baby; the mother may show signs of anger towards the midwife and the health system at large; sadness and irritability. Conry and Prinsloo (2008:15) explain that these reactions are normal reactions to grief, but the mother's reaction may put the midwife in a very awkward situation, and leading to confusion and difficulties in dealing with the mother who has lost her baby at birth.

According to Dippenaar and da Serra (2011:347), perinatal loss can have devastating effects on some midwives; this may lead to adverse manifestations in the workplace such as a lot of stress and depression which affects the optimum care of both mothers with live babies and those that have lost their babies at birth. The stresses related to perinatal loss may be due to difficulty in dealing with grieving mothers, limited resources, a lack of mentoring, poor competence and a lack of confidence in providing care to grieving mothers (Fenwick et al., 2007:157).

The needs of the midwives are discussed based on the support and care they themselves deserve in order to be able to function effectively as caregivers to mothers who have lost their babies at birth. According to de Kock and Van der Walt (2004:29), midwives work long hours, and a South African midwife may deliver a stillbirth and within 15-30 minutes deliver a live baby without receiving any official form of debriefing or counselling for the delivery of the dead baby. Wallbank & Robertson, (2013:1093) support that it is important to help midwives come to terms with perinatal loss using a form of debriefing or counselling to assist them in dealing with their own emotions.

Fenwick et al. (2007:154), Modiba (2008:247) and Roehrs et.al. (2008:631) all agree on the various needs of midwives caring for mothers who have lost their babies at birth. The most expressed needs by these authors are mentoring, bereavement counselling skills and theoretical knowledge on the management of bereavement to assist them when dealing with grieving mothers experiencing perinatal loss. Modiba (2008:247) identified further needs of midwives as support from the management, as the midwives sometimes work under a lot of stress due to an increased work load and a shortage of staff.

Baxter and Baron (2011:118) conducted a study day that focused on communication skills for midwives around the needs of mothers who suffer bereavement during the childbirth process. The communication study day for midwives arose as a result of identified needs for improving the communication skills of midwives. Fenwick et al. (2007:153) further explain that not knowing what to say to the mother may lead to fear of failure which leads to poor self-confidence, avoidance and neglect of the mother.

The needs of midwives may also be personal; for example they may have unresolved emotional issues due to previous traumatic experiences in their lives. The importance of midwives dealing with their own emotions is supported by MacDonald, Magill and Cuerden (2010:954) who state that when people are unable to deal with their emotions they develop protective strategies such as distancing themselves from other people's pain, appearing unaffected and detached to avoid their emotional pain. Puia, Lewis and Beck (2013:329) state that midwives need assistance from co-workers and chaplains to look after their spirituality, whereas social workers will deal with their personal issues, and debriefing should be available to them in the workplace.

Modiba (2008:38), in the study conducted on experiences and perceptions of midwives and doctors when caring for bereaved mothers, has stated, as one of the recommendations, that there should be a hospital policy that includes providing support to staff members because they are emotionally affected by working with bereaved mothers. McCool, Guidera, Stenson and Dauphine (2009:1007) further suggest that litigation related to the adverse outcome of pregnancy places further emotional stress on midwives; therefore they need support from management when the death of a baby leads to litigation. According to Dippenaar and da Serra (2012:19), litigation against midwives globally is increasing because of the nature and scope of midwifery practices.

The existing literature internationally and nationally highlights a gap regarding the experiences of midwives in perinatal loss. Although much has been written about helping mothers to cope with perinatal loss, there is limited literature focusing on midwives' experiences, their needs and responsibilities. Little has been written about guidance and support for midwives as caregivers supporting mothers with perinatal loss (Modiba, 2008:231; McCool et al., 2009:1000). However, de Kock et al. (2004:28), Modiba (2008:247) and Gardner (1999:120) explored the experiences of midwives and their needs regarding perinatal loss and reported that there were limited research studies on the needs and support programmes for midwives with regard to perinatal loss.

There is also a gap in the education and training of midwives in South Africa on the needs and care of midwives giving care to grieving mothers with perinatal loss. The existing curriculum (SANC Regulation R425, R254 & R212) for training and education of professional nurses and midwives respectively is silent about the care of the midwives as caregivers in perinatal loss. The midwifery textbooks, internationally and in South Africa, do provide information on the care of the mother and family but very little in some textbooks, such as Fraser and Cooper (2009), is written about the care of the midwife as the caregiver of mothers who have lost their babies at birth.

In conclusion, the existing literature has shown that the unfortunate situation of a baby dying either during intra-uterine life or immediately after birth is unpleasant but sometimes unavoidable; therefore, the people affected and involved, such as the healthcare professionals, also need to be emotionally cared for. Like any other

emergency in midwifery like post-partum haemorrhage, cord prolapse and others, midwives need competency in the management of perinatal loss to ensure that optimum care is provided to grieving mothers with perinatal loss.

The current proposed study seeks to investigate the experiences of midwives caring for mothers who have lost their babies at birth. Hopefully the results will assist in guiding the researcher to the identification of relevant guidelines to assist midwives caring for mothers who have lost their babies at birth.

1.3 PROBLEM STATEMENT

The hospital complex in the Oliver Reginald Tambo (O.R. Tambo) district is a combination of level two and three hospitals with the 18 peripheral hospitals of the O.R. Tambo district referring their patients to this hospital complex. Women who are referred to the labour wards of this hospital complex normally present with complications related to their pregnancies, labour or the pueperium and as a result sometimes their babies die at birth. According to the midwives working in the labour wards of this hospital complex, they are often the first contact for the mother who have lost her baby at birth. The midwives are to give care, support and counselling to the mother who sometimes would express grieving symptoms. Babies delivered with complications such as congenital abnormalities, prematurity and those babies that require post-resuscitation care are admitted to the neonatal unit but before the baby is transferred to the neonatal unit, the midwives in the labour wards also stated that they are to counsel and support the mother with regard to the condition and the prognosis of the baby.

The mothers who have lost their babies at birth are referrals from district hospitals and often stay longer in hospital. The lengthy stay is as a result of a delay by district hospitals to fetch these mothers and sometimes the condition of the mother does not allow her to return to her referring hospital, therefore the midwives are faced with providing continuous support and bereavement counselling for the mother's period of stay in hospital. Consequently, the prolonged stay of mothers and continuous bereavement counselling impacts on the midwives' emotional and coping strategies in caring for the mothers who have lost their babies at birth.

The researcher has been a midwifery lecturer at a nursing college for the past 14 years and often accompanies the students in the maternity units of a level-three hospital for their practical experience needs. The researcher has observed over these years that mothers, who have lost their babies at birth, at times appear as not to be coping very well with the situation and therefore the midwives are required to provide the necessary counselling and support to these mothers. There are no professional counselling services available to patients in this hospital. The midwives indicated to the researcher that they are themselves not coping very well because they feel ill-prepared and helpless, and find the situation emotionally draining. There are no debriefing sessions offered to the midwives at the institution and this may lead to emotional outbursts, burn-out syndromes and increasing staff turnover.

The aforementioned description of the problem prompted the researcher to undertake this study to determine the experiences of midwives caring for mothers whose babies died at birth in the hospital complex of the Eastern Cape Province. Although similar studies have been conducted in countries like China on experiences of midwives caring for mothers who have lost their babies at birth, only one published research study in South Africa is found in literature (Modiba, 2008). The aforementioned study was conducted in a different setting in terms of locality and population served from the setting where the study by Modiba was conducted.

1.4 RESEARCH QUESTIONS

The following research questions have been formulated from the aforementioned problem statement:

- How do midwives experience caring for mothers who have lost their babies at birth in an Eastern Cape Province hospital complex?
- What can be done to assist midwives in the provision of care to mothers who have lost their babies at birth?

1.5 GOAL OF THE STUDY

The goal of the study is to explore and describe the experiences of midwives in caring for mothers whose babies died at birth at a hospital complex in the Eastern Cape Province. The data obtained from this study will be used to develop guidelines which

could assist midwives in the provision of care to mothers who have lost their babies at birth.

1.6 OBJECTIVES OF THE STUDY

The objectives of this study are:

- To explore and describe the experiences of midwives in caring for mothers who lost their babies at birth at a hospital complex in the Eastern Cape Province.
- To develop guidelines based on the research findings that could assist midwives in the provision of care to mothers who have lost their babies at birth.

1.7 CONCEPT CLARIFICATION

As stated by Polit and Beck (2010:66), the theoretical meanings of concepts need to be clarified in order for the reader of the research and other researchers to understand the context of a specific study. In this study the following concepts are clarified:

1.7.1 Experience

Burns and Grove (2003:15) define experience as "gaining knowledge by being personally involved in an event, a situation or circumstances". In this study, experience refers to the personal involvement of midwives caring for mothers who have lost their babies at birth with regard to how they describe their feelings and thoughts while rendering care to mothers who have lost their babies at birth.

1.7.2 Midwife

> *"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery" (Fraser, Cooper & Nolte, 2009:5).*

The most recent South African Nursing Act (Act 33 of 2005, Chapter 2:30) defines a midwife as "a person who is qualified and competent to independently practice midwifery in a manner and to the level prescribed and who is capable of assuming

responsibility and accountability for such practice". For the purposes of this study, the midwife refers to practising midwives working in labour wards for a period of six months or more in a hospital complex in the Eastern Cape, where the study will be conducted.

1.7.3 Caring

Caring is seen as an ethical concept, a moral obligation or duty to promote the good of the patient. Caring has compassion, competence, confidence, conscience and commitment as its attributes (Noddings, 2012:52). For the purposes of this study, caring refers to a moral obligation of a midwife working in a labour ward to promote good health to a mother who has lost her baby at birth.

1.7.4 Mothers who have lost their babies at birth

A mother who has lost her baby at birth is a woman whose baby died at birth. The woman may experience long-lasting effects. The variables that affect her perceptual experience include social support, legitimization of her loss, opportunities for rituals and existential emotions such as shame and guilt. Some women may be helped by understanding their experience and psychosocial support (Cacciatore, 2010:140).

1.7.5 Labour ward

A labour ward is also called a delivery room and is generally a department of a hospital that focuses on providing healthcare to women and their children during childbirth. It is generally closely linked to the hospital's neonatal intensive care unit (Wikipedia.org/wiki/childbirth).

In this study, labour wards refer to delivery rooms of the hospital complex in the Eastern Cape Province where women are cared for during childbirth. There are three labour wards each with three beds in one hospital and three in another hospital.

1.7.6 Hospital complex

A hospital complex has no specific definition but will be described according to staffing, equipment and the functions that differentiate it from lower-level hospitals in the South African context. It is a complex in that it is a combination of two or more hospitals, a regional and an academic hospital which may be called a central or tertiary-care

centre. To qualify as an academic hospital, a hospital must have specialised combined clinics, specialised equipment and, for obstetric units, it must be staffed by specialist obstetricians, advanced midwives, midwives, enrolled nurses, nursing assistants and full-time medical officers and have sub-specialty skills like foetal medicine. One of its functions is to make advanced prenatal diagnoses such as chorionic villus and cordocentesis, and manage extremely ill or difficult obstetric patients. It is also responsible for policy and protocols in the regions served (Department of Health, Guidelines for Maternity Care in South Africa, 2007:16).

For the purposes of this study, the hospital complex refers to a complex comprising ~~of~~ two hospitals, one academic and another regional in the OR Tambo district, Eastern Cape Province, to which district hospitals refer their women with complications related to pregnancy, labour and pueperium for the purposes of further management.

1.8 PARADIGMATIC PERSPECTIVE

Theory is defined as “a set of interrelated constructs (concepts), definitions and propositions that present a systematic view of a phenomenon by specifying relations between variables with the purpose of explaining and predicting the phenomenon” (de Vos et al., 2011:36). In this study, Danai Papadatou’s (2000) proposed model of the health professional’s grieving process will be used as a lens to view the phenomenon of this study. Figure 1.1 below illustrates the *Health professional’s grieving process as described by Danai Papadatou*.

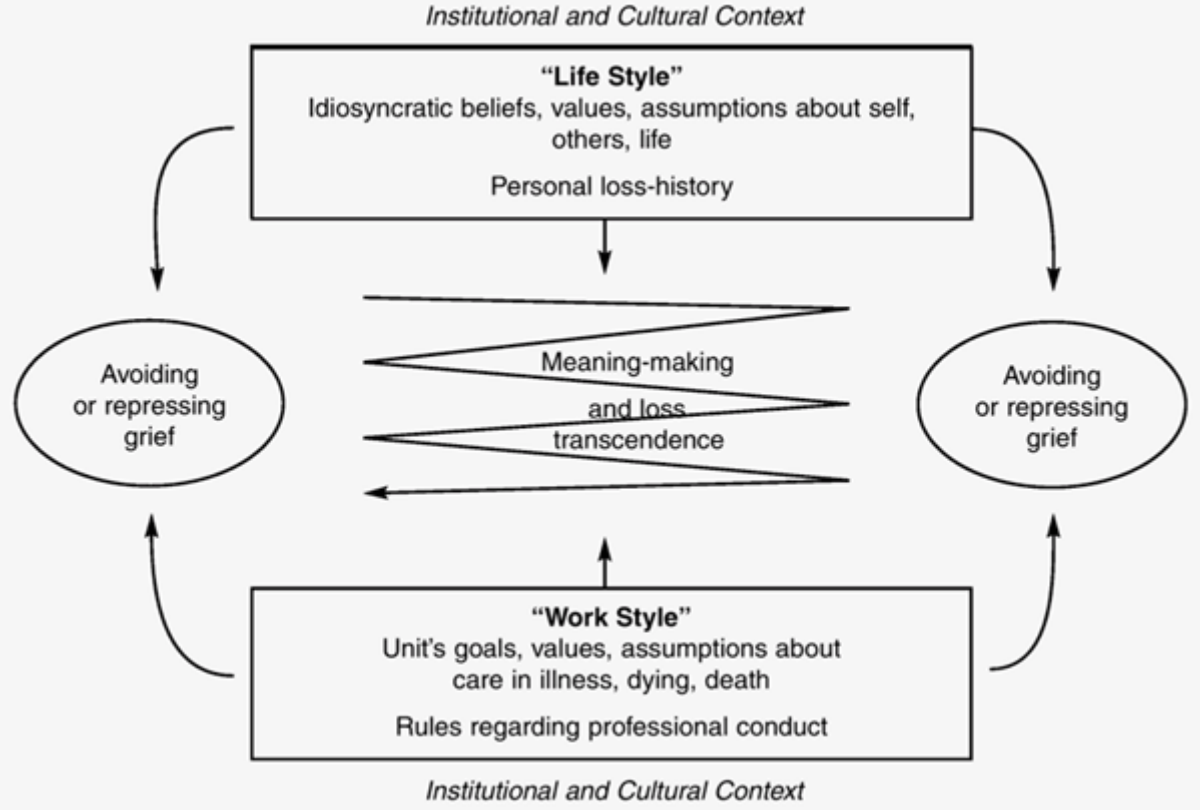

Figure1.1: Health professional's grieving process (Papadatou, 2000: 59)

The model provides an understanding of the unique grieving process that health professionals' experience when faced with the daily challenge of death and grief in their work environments (Papadatou, 2000:58). In this study, the term "health professionals" refers to midwives who care for mothers who have lost their babies at birth in a hospital complex, Eastern Cape Province.

Traditional education has encouraged the "detached concern" of health workers when dealing with grieving patients and/or their families. This often led to "professional burnout" which was only more recently discovered to be related to the health professionals' lack of emotional expression regarding their emotional involvement in crisis situations (Papadatou, 2000:60). Papadatou cites a number of authors, dating back to 1982, who associated the professional burnout of health providers to the stresses in the workplace due to the nature of the work they do. However, Papadatou also argues that the concept "burnout" is still generalised and is not related to the pain and suffering of health providers working with illness. The effects of professional burnout among health professionals who experience traumatic stress, according to Papadatou (2000:60), have been recently identified by a number of specialists.

According to Papadatou (2000:60), health professionals exposed to the traumatic experiences of their clients are likely to exhibit characteristics of post-traumatic stress disorder in the same way in which these symptoms are experienced by the clients under their care. If there is no intervention for a prolonged time, professionals may experience “secondary or compassion stress”, presenting with exhaustion, and biological, psychological and social dysfunction. Therefore this traditional model of “detached concern” contributed to health professional burnout due to a prolonged exposure of health providers to traumatic experiences without intervention.

Consequently, Papadatou’s model focuses on the health professionals’ need for emotional expression when working with terminally ill patients, patients in crisis requiring specialised care (e.g. chronic depression) and their families. In this study, the health professionals will be the midwives with a particular focus on how they express their emotional experiences of caring for mothers who have lost their babies at birth.

The following concepts (Figure 1) of the model are discussed below as they have been chosen to build a framework for this study with the purpose of understanding, predicting and explaining the phenomenon under study:

Life style

The midwife has a world outside working life. He/she has personal values and beliefs about self, others and life which she/he uses to interpret the death of a newborn. She/he may also have experiences about personal loss that may go unresolved. Caring for a grieving mother in the unit may remind her/him of her/his own loss and grief. This idea is also supported by Roehrs et al. (2008:631) who suggest that death may “call up unresolved grief for nurses”. His/her life style may contribute to the assumptions he/she develops about the death of the baby, which might be positive or negative.

Experiencing grief

Papadatou (2000:65) attributes experiencing loss by health professionals as “focus on the loss”. The midwife may concentrate on the death of the baby or the grieving mother

which may lead to her/him suffering grief as experienced by the mother. The midwife may be angry at the death, may blame herself or the health system and sometimes go into depression; however, these symptoms may not last long. It is during the period of depression that the midwife needs support to avoid a state of prolonged depression.

Fenwick et al. (2007:154), Modiba (2009:247) and Roehrs et al. (2008:631) all agree on the various needs of midwives with regard to caring for grieving mothers, such as mentoring, bearevement counselling skills and theoretical knowledge on the management of bereavement.

Avoiding or repressing grief

According to Papadatou (2000:66), “moving away from grief” may be a way of trying to cover denial and or enclose one’s grief. When the midwife temporarily contains grief, it may give her/him a chance to continue with other routine duties like caring for the physical demands of illnesses the mother may have. Other common forms of avoidance reaction cited in the model may be “shutting-out of feelings or psychic numbing”, “avoiding contact with the patient” and “retreating to practical tasks”. The midwife may engage in these reactions at conscious or unconscious levels to limit the effects of loss and grief. Macdonald and Magill-Cuerden (2010:954) state that when people are unable to deal with their emotions they develop protective strategies like distancing themselves from other people’s pain, or appearing detached to avoid their emotional pain.

Fenwick et al. (2007:153) agree with the idea of denial, stating that the midwife may consciously avoid or repress grief due to fear of failure and lack of self-confidence to deal with the grieving mother. Sometimes there may be a continuous fluctuation between experiencing and repressing one’s grief. If the midwife becomes stuck in the aforementioned fluctuation, secondary traumatic stress disorder may develop which may affect her/his professional duties.

Meaning making and loss transcendence

According to Papadatou (2000:68), throughout the process of fluctuation between experiencing and repressing grief, the health professional midwife in the context of this

study may create a meaning of the death and the feelings of the person experiencing loss feelings, followed by transcendence, and invest in life and living.

Meaning making

Papadatou (2000:69) further states that the health professional (midwife in the context of the study) will make sense of the baby's death and feel at ease through medical or obstetrical explanations as to the cause of death. The health professionals will then experience a sense of integration that will allow him/her to invest in new relationships, new professional goals and clinical interventions. If they are unable to make sense of meaning, they will have difficult integrating the loss and grieving may be on-going. The aforementioned author also states that the health professionals may rely on their religious or cultural beliefs for explanations of the baby's death, but if these are of no comfort, the health professional may find meaning by explaining death in terms of the seriousness of the condition that led to death. The death will then be welcomed with a sense of relief. Understanding meaning may be achieved at team level even though the grieving process may be personal. Through discussions of events and clinical interventions leading to the death of the person (baby in the context of this study), members may shape one another depending on the unit‘s goals, values and assumptions.

Loss Transcendence and investment in life and living

Making meaning alone is not sufficient in itself; there is a need to outdo a series of behaviours, thoughts and emotions to facilitate "re-entering and re-connecting with oneself, and to invest in life and living" (Papadatou, 2000:69). The midwives should try to balance life between their life in and outside work situations. They need not enclose themselves within the daily losses at work but strengthen their relationships with friends and families. They also need to engage in outside activities, meet people, play sport, do some community work. If they develop themselves, they make a new sense of self and life and are able to invest in life and living. Hopefully, they will be able to accept their professional life where death is inevitable, and balance life with responsibilities attached to death and dying (Papadatou, 2000:70).

1.9 RESEARCH METHODOLOGY

Research methodology is described as the detailed discussion of the actual application of the design selected. It is a road map of how the study will be conducted (Streubert & Carpenter, 2011: 366). Watson, McKenna, Cowman and Ready (2010:119) describe research methodology as the provision of clear accounts on how the research will be conducted. It consists of different sub-sections such as research designs, sampling methods, data collection and ethical issues.

1.9.1 Research design

Houser (2012:151) describes the research design as the overall approach to or outline of the study that details all the major components of the research. Burns and Grove (2009:218) refer to a research design as the blueprint for conducting the study. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. In this study a qualitative, explorative, descriptive and contextual research design was used for the study to explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth. An in-depth discussion of the research design will be provided in Chapter Two.

1.9.2 Research method

Creswell (2008:15) describes research methods as involving forms of data collection, analysis and interpretation that researchers propose for their studies. As stated by Mitchell and Joley (2012:104), the research methods guide the researcher to who the participants are, how they will be recruited and selected, and how the study will be conducted.

1.9.2.1 Phase one: data collection and data analysis

The research population for this study included all midwives working in the labour wards who have cared for mothers whose babies died at birth at the selected hospital complex where this study was conducted. Purposive sampling was used to select the participants. Individual semi-structured interviews were conducted using open-ended questions. The questions posed to the participants were:

What are your experiences when caring for mothers who have lost their babies at

birth?

What does the death of a new-born baby mean to you according to your personal values and beliefs?

How do your organisational values and beliefs about care in dying and death influence your experience of caring for mothers who have lost their babies at birth?

What do you suggest could be done to assist midwives in caring for mothers who have lost their babies at birth?

An audiotape-recorder was used to capture the interviews which were transcribed verbatim. Data analysis was done using the eight steps proposed by Tesch in Creswell (2014:197). Details of these steps will be presented in Chapter Two of this study.

1.9.2.2 Phase two: development of guidelines

In this phase, guidelines were developed to assist midwives in caring for mothers whose babies died at birth in a particular hospital complex based on the analysis of the obtained data and literature reviewed.

1.10 TRUSTWORTHINESS OF THE STUDY

To ensure the truth value of this study, Lincoln and Guba‘s four constructs (de Vos et al., 2011:420; Streubert & Carpenter, 2011:48) were used to ensure the trustworthiness of the qualitative study. A detailed outline of the strategies used to ensure trustworthiness will be presented in Chapter Two of this study.

1.11 ETHICAL CONSIDERATIONS

Babbie and Mouton (2002:520) state that researchers have the right to collect data through interviewing people but not at the expense of the interviewee’s right to privacy. Researchers doing scientific research need to be aware of the general agreements about what is proper and improper in the conduct of scientific inquiry. According to Kvale and Brinkman (2009:62), ethical issues run through the entire process of an interview inquiry from start to finish. This study considered three basic human rights and research ethics namely, respect for the individual’s autonomy, the principle of beneficence and that of justice.

Permission for the study was requested and obtained in writing from the deputy director of Epidemiological Research & Surveillance Management of the Eastern Cape Province (see Annexure A). Permission was also requested from the management of the institution. The participants were requested to participate in the study and all the relevant information pertaining to the study was explained, clarification about the purpose of the study was done and the individuals were given explanations regarding their voluntary participation in the study without any risk or coercion. They were also informed of their right to withdraw from the study at any time and their right to refuse to give information (see Annexure C). A signed informed consent was obtained from all participants who agreed to participate in the study (see Annexure C).

The participants were protected from physical, emotional and social harm and the researcher also ensured that participants were not exploited. The information obtained was kept confidential. Details of the ethical principles observed will be provided in Chapter Two of this study.

1.12 DISSEMINATION OF RESULTS

A report will be written on completion of the data analysis. According to Brink et al. (2009:189) the report of the study confirms the end of the study and also contributes to the scientific body of the relevant discipline. Gray, Burns and Grove (2013:619) state that, before developing a research report, one needs to determine who will benefit from knowing the findings. The findings of the report will be communicated to the health professionals as follows:

- A hard copy of the research report will be available in NMMU library.
- The findings of this study will also be published in a peer reviewed journal,
- The findings of the study will also be presented to the Eastern Cape Department of Health and at midwifery conferences and seminars.

1.13 CHAPTER DIVISION

This research study will be discussed under the following chapters:

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Data analysis, Discussion and Literature control

Chapter 4: Summary, Conclusion, Guidelines and Recommendations

1.14 CHAPTER SUMMARY

Chapter One provided an overview of the study, problem statement, research questions, purpose and research objectives. A brief description of the research methodology was also provided. Trustworthiness and ethical principles were also highlighted.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter One presented an overview of the research study, the problem statement, research questions, purpose and objectives. The background of the study and the research paradigm underpinning this study were also described. The focus of this chapter will be to provide a thick description of the research methodology used to conduct this study.

2.2 RESEARCH OBJECTIVES

The objectives of this study were:

- To explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth.
- To develop guidelines based on the research findings and literature that could assist midwives in the provision of care to mothers who have lost their babies at birth.

2.3 RESEARCH METHODOLOGY

Research methodology is described as the detailed discussion of the actual application of the design selected. It is a road map of how the study will be conducted (Streubert & Carpenter, 2011: 366). Watson, McKenna, Cowman and Ready (2010:119) describe research methodology as the provision of clear accounts on how the research will be conducted. It consists of different subsections such as research design, sampling methods, data collection and ethical issues.

2.3.1 Research design

Houser (2012:151) describes the research design as the overall approach to or outline of the study that details all the major components of the research. Burns and Grove (2009:218) refer to a research design as the blueprint for conducting the study. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. In this study a qualitative, explorative, descriptive

and contextual research design was used to explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth.

2.3.1.1 Qualitative research design

A qualitative research design is described by Munhall (2012:23) as a systematic, interactive, subjective, holistic approach used to describe life experiences and to give them meaning. A qualitative research design explores and gives understanding of the meaning individuals or groups of people ascribe to a social or human problem (Creswell, 2009:4). According to Gray et al. (2013:23), this type of research is conducted to explore, describe and promote understanding of human experiences, events and cultures over time. Brink et al. (2008:112) also explain that qualitative designs could be used by researchers who wish to explore the meaning, or describe and promote understanding of human experiences such as pain, grief, hope or caring so as to generate important knowledge for appropriate responses to healthcare needs. The qualitative design was used in this study to explore and describe the experiences of midwives in caring for mothers whose babies died at birth.

2.3.1.2 Explorative Research

Explorative research is qualitative in nature and is used when the subject of study is new or when a new interest is examined, or when the researcher wants to develop the methods to be used (de Vos et al., 2011:134). Polit and Beck (2012:18) state that exploratory research investigates the full nature of the phenomenon that is beyond simply observing and describing it.

In this study, the researcher explored the experiences of midwives in caring for mothers whose babies died at birth in a hospital complex in the Eastern Cape. The researcher chose this approach to gain new insights into caring for mothers whose babies died at birth as experienced by midwives and to explore the full nature of the phenomenon. There is also limited literature worldwide on the experiences, needs and feelings of midwives in caring for grieving mothers who lost babies at birth. In South Africa, the experiences of midwives who care for mothers whose babies died at birth have not been explored extensively; thus exploration of the experiences of midwives in caring for these mothers will increase knowledge in this field of study.

2.3.1.3 Descriptive Research

This approach is used when the researcher wants to present a picture of the specific details of a situation, social setting or relationship (de Vos, Strydom, Fouché & Delport, 2011:96; Babbie, 2010:93). Terreblanche, Durkeim and Painter (2010:46) state that descriptive studies aim to describe the phenomenon accurately through narrative life descriptions. In this study, the experiences of midwives in caring for mothers whose babies died at birth were described as narrated by midwives from their lived experiences through intense examination using semi-structured interviews to obtain a deeper meaning of the phenomenon under study in order to provide a comprehensive description of the research findings.

2.3.1.4 Contextual Research

A contextual study is related to a specific environment in which the participants are found (Babbie & Mouton, 2010:80). According to Terry (2011:163), a contextual design selects participants within a specific group to accurately describe characteristics of the group context. Qualitative contextual research describes and understands the events within the concrete natural context in which they occur. This study aimed to capture the sense of actions as they occurred so that the reader may grasp the whole picture of the phenomenon under study. Martin, Durrheim and Painter, (2008:276) have stated that the meaning of human creations, words, actions and experiences can only be ascertained in relation to the context in which they occur.

In this study, the context of the study was the labour wards of a hospital complex situated in a rural area of the Eastern Cape Province. The communities served by this hospital are mainly deep rural, predominantly from the Xhosa culture and lower socio-economic groups. Xhosas have different cultural and religious beliefs in relation to childbirth. The population for the study was all Xhosa-speaking midwives working in the labour wards of the hospital complex. The research population was heterogeneous in terms of age, experience and qualifications (see Chapter 3, Table 3.1).

2.3.2 Research Methods

Creswell (2014:184) describes research methods as involving discussions of the sample for the study, forms of data collection, and analysis and interpretation that

researchers propose for their studies. As stated by Mitchell and Joley (2010:104), the research methods guide the researcher to who the participants are, how they will be recruited and selected, and how the study will be conducted. The research methods were divided into two phases, namely, Phase 1 and Phase 2. Phase 1 encompassed the empirical phase and Phase 2 in this study involved the development of guidelines.

2.3.2.1 Phase 1: Empirical phase

This phase comprises the research population, sampling method, the data collection method and data analysis, and literature control. Polit and Beck (2008:67) describe the empirical phase as a phase that involves collecting research data and preparing data for analysis. Each of these processes will now be described below:

2.3.2.1.1 Research population

Polit and Beck (2012:306) describe a population as the entire aggregation of cases in which the researcher is interested. Grove et al. (2013:44) define the research population as all the elements (individuals, objects or substances) that meet the criteria for inclusion in a given universe. De Vos et al. (2011: 223) further define a population as a term that sets boundaries on the study units, meaning only the individuals in the universe that possess specific characteristics of interest to the researcher. The research population for this study included all midwives working in the labour wards of the hospital complex in the Eastern Cape Province where this study was conducted.

2.3.2.1.2 Sampling methods

Polit and Beck (2012:307) define ‘sampling’ as the process of selecting a portion of the population to represent the entire population. Schmidt and Brown (2014:189) state that the researchers in qualitative research wish to obtain information from specific persons who could provide inside information about the subject under study. For the purposes of this study, a non-probability purposive or judgmental sampling was chosen to select the research sample.

Qualitative research often uses non-probability sampling methods. In non-probability sampling, the researcher does not know the population size; therefore the odds of selecting a particular individual are not known. The researcher selects those people

who know most about the phenomenon and who are able to articulate and explain to the researcher their experiences (de Vos et al., 2011:195). De Vos et al. (2011:392) describe purposive sampling as a type of sampling technique based entirely on the judgement of the researcher, in that the sample is composed of elements that contain the most characteristics with typical attributes of the population that serve the purpose of the study best. Moule and Hek (2011:97) state that a purposive sample is selected using the researcher's judgement with no external objective method used in sample selection. Polit and Beck (2012:516) further state that purposive sampling is purposeful in that selected cases are those that will mostly benefit the study.

In this study, participants were selected based on their experiences in caring for mothers whose babies died at birth in the labour wards. The inclusion criteria comprised:

- Midwives, males and females, who have cared for mothers who lost their babies at birth, one or more times in practice in the labour wards of a hospital complex in the Eastern Cape Province.
- Midwives who are currently working in the labour wards and have worked for six months or more and who have agreed to participate in the study.

The sample size was based on information gathered and was guided by the principle of data saturation that is collecting data until categories were saturated or when gathering new data no longer sparked new insights (Creswell, 2014:189). Data saturation was reached after ten in-depth interviews were conducted, as no new information surfaced.

2.3.2.1.3 Data gathering methods

Streubert and Carpenter (2011:33) state that, in qualitative studies, the researcher can use a variety of strategies to generate qualitative research data such as interviews, observations, narratives and focus groups. Data collection is the formal procedure used by researchers to guide the collection of data in a standardised way (Polit & Beck, 2008:751). Burns and Grove (2009:507), however, state that data collection in qualitative studies is complex and is not a mechanical process that can be completely planned before it is initiated. This is because the researcher is totally involved in

perceiving, reacting, interacting, reflecting and attaching meaning and recording.

Data was collected using semi-structured interviews and observations were also done to allow a more complete understanding of what is being studied, such as detailed description of the setting and the behaviour of participants (Holloway & Wheeler, 2010:17). Non-verbal communication actions, such as facial expressions and gestures, were observed during the interview sessions and noted on the field notes. Observations of activities happening in the unit were also observed and noted as field notes, for example the influx of referrals into the labour ward, how busy the labour wards were, and the limited number of staff at work per shift as related to influx of patients.

Individual semi-structured interviews were scheduled in advance with the participants at a time convenient to the interviewee. The location was a tearoom in the labour wards of the hospital complex. Interviews were conducted outside the tea or lunch breaks to ensure privacy in the tearoom. Individual semi-structured interviews were done for the purposes of the study to allow the researcher to delve deeply into social and personal matters related to the experiences, needs and feelings of the midwife in caring for mothers who have lost their babies at birth. Rapport was developed between the researcher and the participants to build trust so that the participants shared as much information as possible. Broad open-ended questions were generated within the framework of the health professionals' grieving process model (Figure 1). These predetermined questions were used as a guide. Other questions emerged from the dialogue between the interviewee and the interviewer. The following broad open-ended questions were posed to the participants:

- What are your experiences when caring for mothers whose babies died at birth?
- What does the death of a newborn mean to you according to your personal values and beliefs regarding your experiences of caring for a mother who has lost a baby at birth?
- How do your organisational values and beliefs about care in dying and death influence your experience in caring for a mother who has lost her baby at birth?
- What do you suggest could be done to assist midwives in caring for mothers whose babies died at birth?

2.3.2.1.4 Data collection process

According to Kvale and Brinkmann (2009:123), the research interview is an interpersonal situation, a conversation between interviewee and interviewer about a theme of mutual interest. Gray et al. (2013:271) describe interviews as interactions between the participant and the qualitative researcher that produce data as words. In this study, data was collected from the midwives working in the labour wards of a hospital complex, Eastern Cape Province. The participants were selected based on the inclusion criteria stipulated earlier, and their consent was obtained. The area and operational managers acted as the gatekeepers in the labour wards with authority to grant entry to the labour wards and the participants, thus helping to locate participants. The interviews were conducted based on the stages of interviewing by Kvale and Brinkmann (2008:128) as follows:

The researcher briefly introduced the research interview by explaining to the participant the purpose of interview, the purpose of using the audio-recorder and taking of notes. The participant was given a chance to ask questions and the researcher displayed good listening skills and respect to encourage the participant to talk freely.

A semi-structured interview guide script was used and follow-up on the interviewees' answers was done. The interview was conducted in English, taking into account the educational background of the participants in that they are professionals and fluent in English. Flexibility was observed as the researcher is fluent in both the English and the Xhosa languages but all participants responded to questions fluently in English.

An introductory question was posed from each of the four questions planned for in the interview guide, with follow-up questions and probing questions based on the interviewees' answers. Field notes were made and a recording was done during the process of the interview. Active listening by the researcher was adhered to, together with silent listening through observations of gestures and facial expressions. Observations, according to Green and Thorogood (2012:147), provide data on the phenomenon such as behaviour as well as on people's accounts of that phenomenon. At the end of the interview, debriefing was done allowing the participants to voice experiences about the interview, share concerns and/or give feedback. The feedback

from the participant was recorded in the field notes.

De Vos et al. (2012:342) describe interviewing as the predominant mode of data or information collection in qualitative research. The researcher used one-to-one interviewing to collect information regarding the experiences of midwives working in a labour ward when caring for mothers who have lost their babies at birth.

The following describes the preparations made by the researcher for one-to-one interviewing:

Setting the scene: The participants in this study were midwives working in the labour ward who have had an experience of caring for a mother who has lost her baby at birth. The participants were identified with the help of the unit manager and other midwives in the labour ward.

The researcher made contact with each participant and the objectives of the study were explained to all the participants. The participants were then invited to voluntarily participate in the study. The researcher obtained consent from the participants before the interviews to observe the ethical considerations, and the consent for using an audio-recorder was obtained (see Annexure C). The participants were also assured of anonymity and confidentiality.

The researcher made appointments with the participants at their convenience and the researcher honoured the times of appointments. The interviews were conducted in the labour ward's tearoom and the participants arranged themselves according to the needs of the ward to ensure that patients were cared for. There were no interruptions as other nurses in the ward agreed to use an alternative venue for tea. A 'no entry' sign was posted on the outside door of the tearoom whist the interviews were in progress. The researcher notified each participant that the interview should not last longer than an hour.

Learning the part: this refers to knowing as much as possible about the local setting and the participants themselves. The researcher worked in the labour ward for five years and is presently a midwifery lecturer in the nearby college, thus making her familiar with the setting of midwifery and the labour ward.

Equipment checking: Prior to each interview, the researcher ensured the following:

- The environment was quiet and private to ensure a relaxed atmosphere with no interruptions.
- The audiotape recorder was tested prior to the interview to verify audibility of the voices for interviewer and interviewee. Extra batteries were available in case of battery failure. The tape recorder was placed strategically to secure a good quality sound recording.

The interview: The preparations for an interview were made such as setting the stage for the interview and preparing a script in the form of an interview guide (Kvale et al., 2008:123). The interview was conducted after staging the scene. Throughout the interview period the researcher ensured that she was punctual for the scheduled interviews and that the participant was made to feel comfortable and at ease, for example small talk and jokes were made before the interview.

The researcher briefed the participant and handed her the interview guide. The participant was then given a few minutes to read the questions and was allowed to choose which question to respond to first. The participant was therefore allowed a strong role in determining how the interview proceeded.

- During the interview the researcher allowed the participant to speak about her experiences freely without any disturbances except for showing responsiveness by, for example, nodding of the head and “mh—mh…”.
- Probing was done where necessary to get as much information as possible.
- Accurate field notes were written down immediately after the interview, for example researcher impressions and any other observations such as the interviewee’s voice and facial or bodily expressions accompanying the statements.
- Points and gestures that showed anger or frustration was observed and the participant was given time to compose her as desired.
- The researcher was attentive throughout the interview and bracketing was observed during the interview to prevent bias and misinterpretation.

Post-interview evaluation:

- - Debriefing was done after the interview to obtain feedback on the interview from the participant, for example by asking the participant if she had anything more to say or any comments about the experience of the interview. The researcher assessed at this time as to whether the participant required referral to a professional psychologist as some became very angry, some very sad. However, in this study no participant required referral to a professional for debriefing.
- - The researcher thanked the participants who were informed of the possibility of a follow-up interview should the need arise.
- - The participants were also informed of their right to withdraw from the study at any time. The contact details of the researcher were given to each participant should they need to contact the researcher for further information or should they wish to withdraw from the study (see Annexure A).

The communication skills of the researcher are crucial in qualitative research. Giger and Davidhizar (2008:21) define communication as “a human process involving interpersonal relationships”. According to de Vos et al. (2012:345), active interviewing is not confined to merely asking questions and recording answers, but also relies on mutual attentiveness, monitoring and responsiveness. The communication techniques described by de Vos et al. (2012:345) were used by the researcher to obtain information from the midwives working in labour ward regarding their experiences when caring for mothers who have lost their babies at birth.

The aforementioned techniques are discussed below:

- Minimal verbal response: The verbal responses were occasionally made by the researcher during the interview to show the participant that the researcher was listening, for example “Mh—mh” or “OK” which coincided with movements such as nodding the head.
- Paraphrasing: The researcher made verbal responses in which the participants’ words were stated in another form with the same meaning to enhance the meaning of what is being said.
- Clarifying: This technique was used by the researcher to get clarity on unclear

statements, for example: “Could you tell me more about that…?”

- Reflection: The researcher reflected back on something important that was said to gain meaning e.g. “So you say it is very painful…”
- Encouragement: The researcher encouraged the participants to say more about what was said e.g. “You say you became scared; why is that?”
- Reflective summary: The participants’ ideas, thoughts and feelings were verbalised to ensure understanding of what the participant said and to stimulate the participant to give more information.
- Listening: The researcher actively listened carefully and attentively to ensure capturing everything the participant said.
- Probing: The purpose of probing is to deepen the response to a question so as to increase the richness of the data obtained. The researcher used this technique to persuade the participants to give more information, for example challenging by demanding more information, encouraging, direct questioning, showing understanding and allowing time for elaboration and procuring details.

2.3.2.1.5 Pilot interview

De Vos et al. (2012:484) describe pilot studies as tests that are designed to determine whether the interventions will work and to determine the effectiveness of the intervention and identify areas of the protocol to be revised. Brink et al. (2006:166) describe a pilot study as a study done on a small scale prior to the initiation of the main study. The researcher established access and made contact with three participants to conduct interviews for the pilot study. Ethical considerations were observed. The pilot study was conducted in the same labour wards of the hospital complex where the main study was conducted. The findings of the pilot study were not used in the main study.

2.3.2.1.6 The role of the researcher

Creswell describes qualitative research as interpretative research in which the researcher is typically involved in a sustained and intensive experience with participants (Creswell, 2009:177). The researcher in this study had reflected on ethical and personal issues and identified them as including being a midwife herself and having cared for mothers whose babies died at birth during the time of her clinical practice. This reflection was necessary so as not to shape the interpretations formed

during the study. Approval from the FRTI committee of Nelson Mandela Metropolitan University was obtained (see Appendix E). The researcher then requested permission to gain entry to the research site from the gatekeepers and all the ethical issues were explained and adhered to throughout the research process. Permission was requested from the participants after explaining the reasons why the site was chosen, the activities that would occur, how the results would be reported and what would be gained from the study (see Appendix B) (Creswell, 2009: 178) and only those who agreed to participate were interviewed.

The researcher made an appointment with each participant at a time suitable to the participant, but the researcher was also flexible in rescheduling if the time agreed upon became unsuitable due to unpredictable times of patient influx and emergencies in the labour ward. A quiet room conducive to interviewing was prepared in the ward as requested from the operational manager.

According to Creswell (2009:177), the researcher should comment on connections between the researcher, the participants and the research site to avoid a biased, incomplete or compromised reporting. Although the researcher is a lecturer in the nearby nursing college, there is no direct relationship with the participants as the participants are qualified midwives and were never colleagues of the researcher. Although some were former students of the researcher, there was no anticipated compromise or difficulty in disclosing any information obtained during the interview process.

During the interview process a few sensitive issues arose regarding relationships between participants and their managers in the workplace. This was not a significant issue as the names of people and places were masked from the beginning of the interviews and each participant was identified by a number (see Annexure H). The names of persons and places mentioned by participants during the interview were omitted during transcribing.

2.3.2.1.7 Analysis of data

According to de Vos (2011:397), data analysis “is the process of bringing order, structure and meaning to the mass of collected data”. Sharon (2009:175) also defines data analysis as a “process of making sense out of the data which involves

consolidating, reducing and interpreting what people have said and what the researcher has seen and read". Data analysis is therefore a process of making meaning which in turn constitutes the findings of the study. Botman, Greeff, Mulaudzi and Wright (2010:220) explain that there is no clear point at which data collection stops and analysis begins.

For the purposes of this study, the researcher used the eight steps of data analysis as described by Tesch (Creswell, 2014:197) as follows.

- The data was organised and prepared for data analysis. Field notes were typed. The transcripts were read carefully and ideas jotted down as they come to mind to make sense of the information.
- Each interview was picked up and the underlying meaning interpreted and jotted down in the margin.
- A list of topics was then compiled. Similar topics were clustered together. Major and unique topics were arranged, including leftovers.
- The list was compared to the data to ensure trustworthiness. The topics were abbreviated as codes. Codes were written next to appropriate segments of the text. Preliminary organisation was done and new categories and codes emerged.
- New categories and codes that emerged were organised according to their relationship with other categories and codes. Similar topics that relate to each other were grouped together.
- A final decision was then made on the abbreviation for each category. The codes were then alphabetized.
- The data material belonging to each category was then assembled in one place and preliminary analysis was performed.
- Recoding was necessary and was done to generate a smaller number of themes; four themes emerged as major findings of the study. These themes are interconnected into a story line in Chapter Three of this study.

Recorded interviews, transcripts and field notes were sent to the independent coder accompanied by a letter in which the researcher explained how the data should be analysed according to Tesch's eight steps (see Annexure F). The themes were

discussed with the independent coder and consensus was reached. Thereafter the themes were further refined with the assistance of the supervisors. Field notes, recorded interviews and transcripts are kept safe to keep the audit trail for other researchers, and back-up copies of all the data were secured for safekeeping.

2.3.2.2 Phase 2: Development of guidelines

Guidelines were developed based on the research findings and suggestions provided by the midwives with regard to how they can be assisted in caring for mothers whose babies died at birth. The guidelines were also based on research findings of this study and research evidence available in literature.

2.4 MEASURES TO ENSURE TRUSTWORTHINESS

To ensure the truth value of this study, Lincoln and Guba‘s four constructs (de Vos et al., 2011:420; Streubert & Carpenter, 2011:48) were used to ensure trustworthiness of the qualitative study as follows:

2.4.1 Credibility/authenticity

According to de Vos et al. (2011:419), credibility is an alternative for internal validity used in quantitative studies to ensure that the study was conducted in such a manner that the participants have been accurately identified and described. Credibility includes activities that increase probability that credible findings will be produced (Streubert & Carpenter, 2011:48). In this study the activities to ensure credibility outlined by de Vos et al. (2011:420) and Streubert and Carpenter (2011:48) were addressed as follows:

- The respondents were clearly defined from a valid population of midwives working in the labour wards of a known hospital complex. The setting where observations and interviews were conducted was also valid as it is a known hospital complex in the Eastern Cape Province.
- The researcher ensured prolonged engagement with each participant and made time for each participant as the need arose. The time for interviews was 45 minutes to one hour.
- Formal qualitative methods, such as explorative, descriptive and contextual methods, were used to meet the goals of the study.

- Triangulation of different sources of information by examining evidence from the sources relevant to the study and using it to build a coherent justification for themes was also done. Triangulation of data collection methods, such as interviews and observations, was also used.

2.4.2 Transferability

According to Rees (2011:252), “transferability is also called fittingness to other situations” or the likelihood that the findings could provide insights into other situations. Streubert and Carpenter (2011:48) state that the expectation for determining whether the findings fit or are transferable rests with the potential users of the findings and not the original researchers**.**

The concepts and models available in literature have been used to develop the theoretical framework for this study. The methodology is described accurately and the population is well defined. More than one data-collection method was used, namely observations for field notes and semi-structured interviews. This, to a certain degree, ensured the generalisation of the study, although generalisation of findings is regarded as the weakness of the qualitative study by some traditional researchers (de Vos et al., 2011:420).

2.4.3 Dependability

According to de Vos et al. (2011:420), dependability is the corresponding concept to reliability as applied in quantitative studies in which the researcher accounts for changing conditions in the phenomenon, although quantitative reliability assumes an unchanging universe contrary to qualitative research inquiry which assumes that the world is always constructed. Dependability, according to Streubert and Carpenter (2007:48), is met if the researcher can demonstrate the credibility of the findings. In this study, dependability was met through observing the criteria for the credibility of findings. The data was well documented and the audio-taped data transcribed verbatim. Coding and thematic analysis was also done by an independent coder using the same Tesch method of data analysis as used by the researcher. Bias of the researcher was clarified to give an open and honest narrative discussion.

2.4.4 Conformability

The researcher should be able to provide evidence that can confirm that the findings and interpretation of the study corroborate by means of auditing (de Vos et al., 2011:421). Streubert and Carpenter (2010:49) state that researchers should leave an audit trail that can be followed by another individual.

In this study, all activities and events happening during data collection were recorded using audiotapes, and all field notes will be made available if the need arises while also keeping the anonymity of participants. The recorded and transcribed interviews are kept in a safe place and will serve as evidence leading to the conclusions of the study so as to leave an audit trail that can be followed by another individual or researcher, thus ensuring conformability.

2.5 ETHICAL CONSIDERATIONS

Nursing research requires not only expertise and diligence but also honesty and integrity (Grove et al., 2013:159). According to Kvale (2009:62), ethical issues run through the entire process of an interview inquiry from start to finish. In this study, in order to meet human research ethical considerations, the three basic human rights of respect for an individual's autonomy, the principle of beneficence and of justice were observed, as discussed below:

2.5.1 Principle of respect for persons

Brink et al. (2008:32) states that this principle involves three convictions, as follows:

- The participants have the right to self-determination, implying that an individual has the right to decide whether or not to participate in the study.
- The individual has the right to withdraw from the study and
- Individuals with diminished autonomy require protection.

In this study, the participants were given all relevant information pertaining to the study; clarification about the purpose of the study was done and the individuals were given an explanation regarding their voluntary participation in the study without any risks or coercion, their right to withdraw from the study at any time and their right to refuse to give information. An informed signed consent was obtained from all

participants who agreed to participate in the study (see Annexure G).

2.5.2 Principle of beneficence

De Vos et al. (2011:116) define the term beneficence as an obligation to maximise possible benefits and to minimise possible harm. There was no harm caused in this study. The participants were informed of their rights to withdraw from the study should they experience any form of discomfort. Questions were carefully structured and the researcher monitored the participants for any signs of emotional distress.

Anger was identified through verbal, facial and physical (beating the table with the hand) expressions; participants were given time to calm down and the interview only continued when the participant felt ready to continue. In cases of emotional distress arising from painful memories of experiences of caring for mothers whose babies died at birth, participants were informed beforehand of a possible referral to a psychological service should the need arise; however, no participant required professional help after the interview. Confidentiality and anonymity were maintained throughout the study to avoid any form of harm to the participants. Participants were identified as “participant one to ten”. Guidelines were developed that will hopefully benefit the participants, other midwives working in labour wards in provision of care to mothers who have lost their babies at birth.

2.5.3 Principle of justice

Rees (2007:105) states that justice relates to the fair and equal treatment of all participants in the study. In this study, participants were selected by a purposive criterion-based sampling strategy; selection was therefore fair and non-discriminatory. Midwives who declined to participate in or who decided to withdraw from the study were informed that they were free to do so without any form of punishment; however, no participant withdrew from the study after agreeing to participate. No male midwives were willing to participate in the study and were therefore not interviewed.

All agreements entered into between the researcher and the participants were honoured. Debriefing was offered after the interviews to clarify issues that arose during the study. The researcher was courteous and tactful at all times. Anonymity was adhered to as no names were used and no data will be connected to any of the

participants.

Code names were used when discussing data and the master list of the participants' names was kept under lock and key and was later destroyed after the final coding phase. The right to privacy was also observed as the interviews were conducted in a tearoom with only the participant present. The participant's permission to obtain data through a tape recording was requested and obtained.

2.6 CHAPTER SUMMARY

In this chapter, the research methods and designs used in this study were discussed. The process of interviewing and how data was analysed was described in depth. A description was given of the ethical considerations adhered to and how trustworthiness was achieved. A presentation of the in-depth data analysis will be presented in Chapter Three of this study.

CHAPTER 3

DATA ANALYSIS FINDINGS DISCUSSION AND LITERATURE CONTROL

3.1 INTRODUCTION

A comprehensive description of the research methodology used in this study was provided in Chapter Two. This chapter focuses on the discussion of the process of data analysis, the themes identified from the information obtained during the ten semi-structured interviews conducted, and literature control related to each theme and or sub-theme. The findings reflect the experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of a hospital complex in the Eastern Cape Province.

3.2 OPERATIONALISING OF DATA ANALYSIS AND LITERATURE CONTROL

Semi-structured interviews were conducted by the researcher to allow more flexibility for the researcher to gain a more detailed picture (de Vos et al., 2011: 340) of the participants' experiences in caring for grieving mothers with perinatal loss. Data saturation was achieved after ten semi-structured interviews were conducted. The semi-structured interviews were conducted in the tearoom of the labour wards since it was quiet with no disturbances. The average duration of each interview was between 40 to 60 minutes, although a few minutes were spent with the participants before and after the recording of the interview because of the participants' interest in sharing their frustrations and anger just by reading the predetermined questions.

The labour wards were busy almost all the time but the use of the tearoom guaranteed confidentiality and maintained a relaxed environment for the duration of the interview sessions. The following predetermined questions were posed to each participant and were underpinned by Papadatou's theory, which acts as a lens to view the phenomena of this study:

- What are your experiences when caring for mothers who have lost their babies at birth?
- What does the death of a newborn mean to you according to your personal

values and beliefs, and how do they influence your experiences regarding caring for mothers who lost their babies at birth?

- How do your organisational values and beliefs about care in dying and death influence your experience of caring for mothers who lost their babies at birth?
- What do you suggest could be done to assist midwives in caring for mothers who have lost their babies at birth?

Recorded interviews were transcribed verbatim and data was analysed by the researcher and an independent coder using Tesch's method of data analysis as described in Creswell (2008:185). The researcher and independent coder then met to discuss the themes and sub-themes identified in order to reach consensus (see Annexure F).

The research results revealed the demographic profile of the participants as depicted in Table 3.1 below:

TABLE 3.1: DEMOGRAPHIC PROFILE OF PARTICIPANTS

ITEM	GENDER	AGE	ETHNIC GROUP	EXPERIENCE AS A MIDWIFE	QUALIFICATIONS
1.	Female	50-55 years	Sotho	10 years	General nurse, midwife, psychiatry & advanced midwife
2.	Female	55-60 years	Xhosa	20 years	General nurse, midwife, community health nursing science, nursing administration & advanced midwife
3.	Female	50-55 years	Xhosa	20 years	General nurse, registered midwife & advanced midwife
4.	Female	50-55 years	Xhosa	20 years	General nurse & registered midwife

ITEM	GENDER	AGE	ETHNIC GROUP	EXPERIENCE AS A MIDWIFE	QUALIFICATIONS
5.	Female	30 years	Xhosa	3 years	Four-year comprehensive diploma in nursing
6.	Female	50-55 years	Xhosa	10 years	General nurse, registered midwife & advanced midwife
7.	Female	45 years	Xhosa	5 years	Four-year comprehensive diploma in nursing & Advanced midwife
8.	Female	34 years	Zulu	06 months	Four-year comprehensive diploma in nursing
9.	Female	38 years	Xhosa	3 years	Four-year comprehensive diploma in nursing & advanced midwife
10.	Female	50 years	Xhosa	12 years	General nurse, registered midwife

The above table reflects that all the participants were females, their ages ranged between 30-60 years and 70% of them were qualified advanced midwives and are therefore clinical specialists in the field of midwifery. Their experiences as practising midwives working in labour wards ranged between three to 20 years.

3.3 IDENTIFIED THEMES

The *Oxford English Dictionary* (2004:577) defines a theme as "a subject for discussion", while the *Concise English Dictionary* (2009:1494) defines a theme as the "subject of the talk, text, exhibition, a topic and a recurring or pervading idea in a work of art or literature". In this study, four main themes and 13 sub-themes emerged from the data analysis. The main themes and sub-themes are depicted in Table 3.2 below:

TABLE 3.2: IDENTIFIED THEMES AND SUB-THEMES RELATING TO MIDWIVES' EXPERIENCES IN CARING FOR MOTHERS WHO HAVE LOST THEIR BABIES AT BIRTH

THEMES	SUBTHEMES
THEME I Midwives shared their diverse experiences relating to caring for mothers who have lost their babies at birth	**Midwives experienced:** 1.1 Being emotionally and physically affected. 1.2 Professional role stress 1.3 Fear of being blamed for poor maternal or neonatal outcomes
THEME 2 Midwives expressed how their personal values and beliefs influenced the ways they dealt with babies dying at birth	2.1 Cultural ceremonies should be allowed for mothers and their families to assist with bereavement 2.2 Their belief in God assists them to cope with the trauma of the death of the baby after birth 2.3 They should be strong to cope with the trauma of the death of the baby at birth
THEME 3 Midwives described the organisational values and beliefs related to death and dying and how this influences their own experiences	3.1 The organisation follows its own rules, which contradict the community cultural beliefs 3.2 Management is unsupportive and lacks compassion 3.3 Management to be more approachable to staff and understand the stresses related to working in labour wards
THEME 4 Midwives provided suggestions regarding how they can be assisted to care for mothers who have lost their babies at birth	4.1 Midwives to be taught how to counsel the mothers 4.2 Midwives to receive counselling sessions and regular staff debriefing sessions for all staff in the unit 4.3 Emphasized patient compliance at ANC prior delivery 4.4 Procedures regarding referral from various hospitals to be reviewed

3.4 DISCUSSION OF THEMES AND LITERATURE CONTROL

The themes will be described according to the experiences shared with the researcher by the participants during face-to-face interviews relating to how they experienced caring for mothers who have lost their babies at birth. The four themes identified are not stand-alone themes but are interconnected with each other as they all describe the experiences of the participants when caring for mothers who have lost their babies at birth.

3.4.1 Discussion of theme one and sub-themes

Theme one will be discussed in the following paragraphs followed by the sub-themes that emerged from this theme. Theme one and its sub-themes are depicted in Figure 3.1 below:

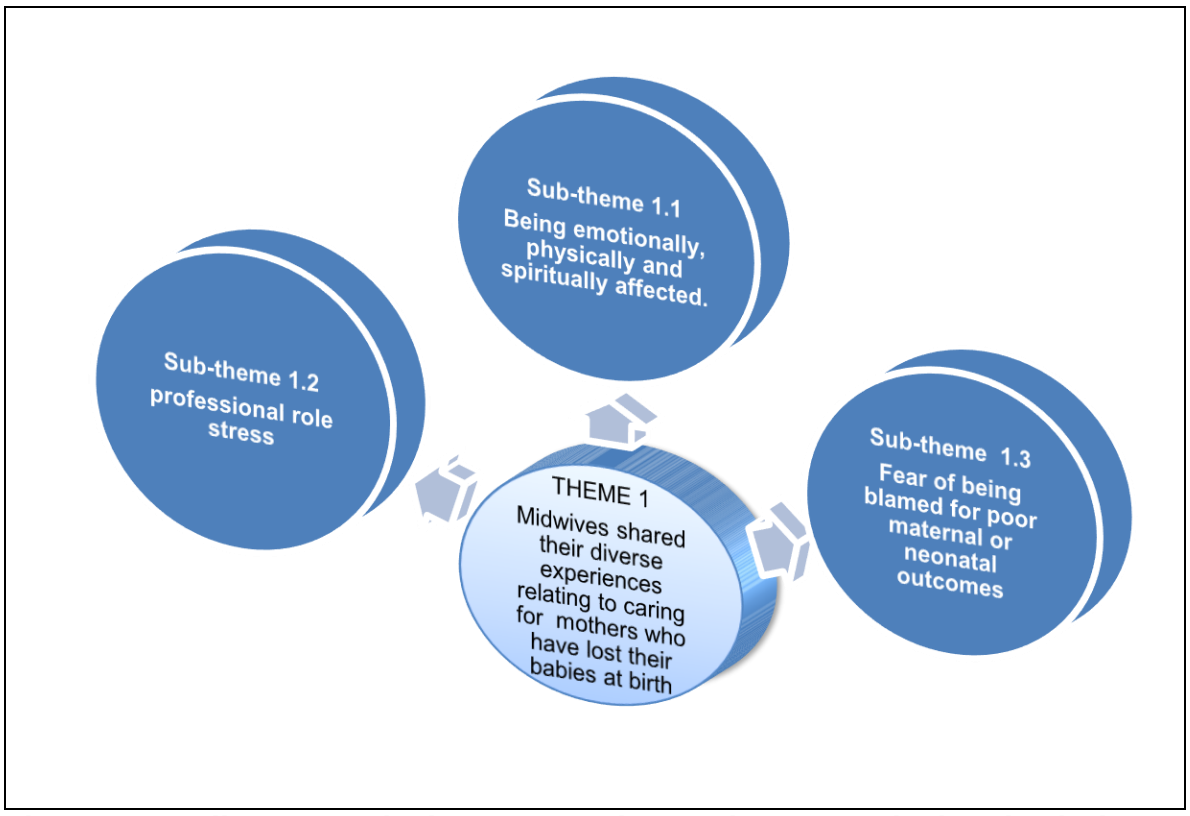

Figure 3.1: A diagrammatical representation of Theme 1 and related sub-themes.

3.4.1.1 Theme 1: Midwives shared their diverse experiences relating to caring for mothers who have lost their babies at birth

The midwives openly and earnestly shared their diverse experiences emanating from their caring for grieving mothers who have lost their babies at birth. The diverse

experiences included emotional and physical effects, professional role stress and the fear of being blamed for poor maternal or neonatal outcomes. The interviews seemed to have created a platform of airing what appeared to be a longstanding desire by the participants to share how they experienced caring for grieving mothers with perinatal loss. Participants were vocal about their feelings and emotions that they experienced when caring for mothers who had lost their babies at birth. Roehrs et al. (2008:634) indicate in their study on caring for families coping with perinatal loss that nurses reported their personal experiences as challenging in providing support and care to mothers who are experiencing perinatal bereavement.

The diverse experiences shared by midwives will be described below under the following sub-themes:

- Midwives experienced being emotionally and physically affected
- Midwives experienced professional role stress
- Midwives experienced fear of being blamed for poor maternal and neonatal outcomes

Sub-theme 1.1: Being emotionally and physically affected

The participants described the experiences of caring for grieving mothers who have lost their babies at birth as affecting them emotionally and physically. Many of the participants indicated that irrespective of the number of years of experience that they have as midwives, they still continue to be emotionally and physically affected by caring for grieving mothers who have lost their babies at birth. The following direct quotes illustrate the above:

> *"…even now though I have been practising for so many years I still feel hurt and it's very painful" (Participant 2, pg. 2).*

> *"…it occurred when I delivered a macerated stillborn, that was 20 years ago, it was so painful, I was deeply hurt…little has changed even now" (Participant 3, pg.1).*

> *"…I was still professionally immature, 20 years ago,...I was very hurt, but I still get emotional every time I deliver a dead baby" (Participant 4, pg.2).*

According to Giger and Davidhizar (2009:68), coping with occurrences such as death, pain and suffering is emotionally exhausting even for the most experienced nursing professionals. Roehrs et al. (2008:636) state that nurses caring for grieving families need to recover from the intense and stressful work of providing bereavement care using different strategies so as to lessen the emotional and physical effects associated with caring for grieving mothers. The participants in this study expressed similar experiences to the description provided by the aforementioned authors relating to being constantly faced with caring for grieving mothers who have lost their babies at birth. The participants also indicated that they experienced pain and suffering and are therefore unable to fully recover from the intense and stressful work of providing bereavement care.

Some participants expressed that it was easier for them to deal with the delivery of a stillbirth and to care for the mothers thereafter if there was a medical or obstetrical explanation that led to the death of the baby. They further explained that it became easier for them to make sense of the death of the baby, and they would therefore be able to be at ease in explaining the cause of death to the mother. The aforementioned is evident in the following quotes:

> *"It's better to explain though it's still hurting…but at least if you know what happened, you explain better to the mother…it's better" (Participant 6, pg. 2).*

> *"At least I can talk to these women; it's better than before, especially if the cause of death is known" (Participant 4, pg.3).*

Fenwick et al. (2007:157) in their study explored midwives' satisfying and dissatisfying aspects regarding the provision of perinatal loss care, and reported that midwives in their study expressed that they are expected by the families with perinatal loss to have answers as to why the baby died. The latter authors further reported that the midwives became distressed when they were unable to give a definite reason why the baby died. Papadatou's theory (2000:64), which acts as a lens to view the phenomenon of this study, also asserts that the midwife is more accepting of the baby's death when it is due to medical or obstetrical explanations. Similarly, participants in this study were found to experience solace in being able to understand the cause of death, and therefore found it easier to explain the cause of death to the mother.

The emotional effects were expressed by the participants as hurting, painful and making them feel angry. The researcher also observed the latter expressed feelings of the participants through their body language, such as their facial expression and a show of hands. Their facial expression indicated the hurt and pain, while banging on the table and was perceived as an expression of their anger at the death of the babies. The following quotes demonstrate some of the expressed responses of the participants' emotional feelings:

> *"It was so painful, so hurting [**touching her chest with both hands and frowning**] I was very frustrated and scared" (Participant 1, pg.1).*

> *"It hurts so much that I just feel, I just feel, like angry [**closing her eyes and banging the table**]" (Participant 5, pg.2).*

> *"I had a pain inside; my heart was pumping very fast, and my head was spinning; the pain inside was unbearable…" (Participant 9, pg.2).*

Some participants indicated that sometimes the emotional feelings were worsened by the mother's circumstances, such as in cases where the mother's chances of having another baby are least possible due to obstetrical reasons. For example, some of the participants said the following:

> *"It's so painful, especially if I know that she won't have another chance to have a baby; sometimes the mother is old, so it's so hard to counsel; you feel so hurt, so hurt **[closing eyes and looking down]"** (Participant 7, pg.3).*

> *"…sometimes she has a bad obstetric history; now she loses her baby, I feel sad and it hurts" (Participant 10, pg.4).*

The participants indicated that sometimes the mothers fear that the marriage could be destroyed because of the death of the baby, especially if it was the sex that was needed in that marriage. According to the participants it becomes very painful when the mother shows that she was desperate to have this baby and as such, the participants reported that they would often feel that they have destroyed the mother's marriage. The following quotes illustrate the above discussion:

"Painful to me, it's very painful, especially that the mother has got plans for the baby by the time she was conceiving that ooh! at least it must be a female or a male. For me it makes me so touched when the mother shows that she was really in need of this baby" (Participant 10, pg.3).

"…the mother told me that her husband was going to take another wife because he wanted a male child and now the baby is dead…I felt so much pain inside…it was like I have destroyed her marriage" [Participant 8, pg.5).

Mander (2003:231) explored stresses associated with perinatal loss affecting midwives, and identified a lack of a happy outcome as one of the four main factors that may lead to emotional effects. Although Mander identified this years ago, the participants in this study are still emotionally affected by the poor outcome of pregnancy. However, there is no literature specific to the loss associated with the sex of the baby as expressed by the participants in this study.

The participants described the delivery of a baby as something precious, therefore they experienced shock and trauma when delivering a dead baby, especially when it is unexpected. Some participants indicated that they would have felt better if they knew beforehand that they were going to deliver a stillbirth and it could have allowed them to prepare themselves and the mother before the delivery. The participants indicated that when they have to inform the mother of the death of their baby, it is like piercing her heart with a sharp instrument. The following quotes illustrate this:

"I was shocked, was shocked, so shocked ***[her eyes closed]*** *when I realized that the baby had demised, I kept on resuscitating the baby although I could see that there was no life but I was shocked, … I was scared to tell the mother" (Participant 1, pg.1).*

"It is very traumatising because you are expecting a live baby; suddenly the baby is dead and even the mother, you know… it's like you are piercing her heart with a sharp instrument…when you break the news, it's like someone else would tell the mother " (Participant 9, pg.6).

Henley and Schott (2008:326) agree that breaking the bad news to the mother is difficult and stressful. One participant indicated that she kept on resuscitating the baby

even though she knew it was not going to revive the baby because she was scared to face the mother. MacDonald and Magill-Cuerden (2012:960) support the notion that in cases of the unexpected death of the baby, practitioners themselves may experience shock, trauma and guilt.

Participants also indicated that they sometimes felt depressed even if the outcome of the delivery is good because of previous experiences of delivering a dead baby. One participant said*"…sometimes I feel depressed even if the outcome of the delivery is good because of the previous experience" (Participant 10, pg.3)*.

Some participants indicated that they were even more shocked at the death of the baby when the baby has gross abnormalities. They indicated that they felt like not showing the baby to the mother just to protect her, even though it would be against the hospital policy. The following quotes illustrate this:

> *"…I delivered a baby with gross abnormalities and I was so shocked, I did not want to show the baby to the mother; I was protecting the mother because I did not want her to see what I was seeing there…yes I know the hospital policy but because I was shocked by such gross abnormalities" (Participant 8, pg.1).*

> *"…the baby had gross abnormalities and was also dead…I felt like hiding the baby from the mother; it was very traumatising" (Participant 1, pg. 2).*

The abovementioned response as expressed by the participants was because they felt empathy and sympathy for a grieving mother who lost her baby at birth. Myers (2010:454) describes empathy as the ability to recognize and to some extent share the emotions and state of mind of another person. Empathy also entails understanding the meaning and significance of that person's behaviour as well, while being sympathetic refers to displaying compassion for another's grief (Myers, (2010:454). Sympathy of the participants with the uncontrollable cry of the mothers made them feel very sad. Henley and Schott (2008:325) explored good practice from a parent's perspective when there is a death of the baby at birth, and state that parents value empathy and kindness, but further state that offering this kind of empathetic support is difficult because what is right at one time may be wrong at another time. However, that should not be a reason for healthcare workers to be over-cautious as to what they

say or do to the parents. Cacciatore (2013:80) argues that healthcare providers who frequently encounter traumatic deaths are vulnerable to depressive symptoms, anger, helplessness and intrusive thoughts and may have difficult in expressing empathy. The empathy and sympathy expressed by the participants in this study is illustrated below:

> *"I feel sad and sorry for the mother because even me, I am a mother, I just think of myself losing a baby" (Participant 8, pg.4).*

> *"…the mother might cry uncontrollably, the pain of the mother comes to me and I become so sad" (Participant 2, pg.3).*

> *"…so sad, to carry a baby for nine months; why, why does God allow this to happen? She was not supposed to conceive…" (Participant 5, pg.7).*

The participants indicated that they often expressed their emotions by crying but had to do this out of sight of the patients as the nursing profession does not allow one to display emotion in front of patients. The participants indicated that they therefore had to suppress crying in front of the patient which, in the opinion of the researcher, was the effect of the nursing professional expectation. According to the researcher's experience as a midwifery lecturer, nurses are taught to be professional at all times and should not become emotional in front of patients. Puia, Lewis and Beck (2013:324) focus on the experiences of obstetric nurses who are present for a perinatal loss; many of the nurses in their study experienced emotions but also hold crying for later as this is what is expected of them as nurses.

> *"I was shaking…I could not hold my tears and my whole body was trembling but I had to hide my emotions from the mother. It's not allowed in my profession to show how you feel" (Participant 1, pg.2).*

> *"…The mother was crying throughout. I could not show how I felt, I could not show my weakness in front of the mother, it would be unprofessional" (Participant 10, pg.4).*

"I felt like crying loudly but I would put the baby down and go to the toilet because I cannot show my emotions in front of the patient, it's unprofessional" (Participant 5, pg.6).

According to literature reviewed, nurses are privileged and have a responsibility to make a positive difference in the lives of patients and families that they care for in sometimes unexpected and almost unbearable life and death experiences. In certain situations, expressing genuine emotion can be a sincere way to provide emotional support. A few quiet tears with a bereaved family are a good way of showing that you are human and that you truly care (http://allnurses.com/nursing-and-spirituality/when-nurses-cry-797565.html.). The results of a study by Chen and Wen-Yu (2012:91), on the other hand, state that nurses do feel sadness when there is perinatal loss but should not cry in order to protect their professional image. The participants in the aforementioned study were of the opinion that the act of openly crying did not mean that the nurse temporarily abandons professionalism, but acknowledge it as being against the teachings of the profession. Banning and Gumley (2013:656) affirm the notion that the control of emotions is a central feature that is discussed and imbued in nursing education. Other authors that argue on the positive about crying in front of the patient/person are Jonas-Simpson, Pilkington, McDonald and McMahon (2013:7) and Lockwood, Milings, Hepper, Rowe and Angela (2013:42) by stating that it is okay to cry and be human with the bereaved family.

The feelings and emotions experienced by the participants were evident in the body language observed by the researcher whilst interviewing the participants. The observed body language expressing their emotions included periods of silence, using a very soft voice, a change of posture by almost putting the covered face on the table and sometimes merely closing the eyes for a moment. According to Van Rooyen, Williams and Ricks (2009:53), watching a mother grieve after a child's death is challenging to caregivers, even to professional nurses (midwives in the context of this study). Therefore in terms of the above discussion, the literature supports the emotional and physical effects experienced by participants in this study. These are not uncommonly occurring effects when mothers who have lost their babies at birth are cared for.

The participants in this study also indicated that over and above the emotional effects, they would sometimes be physically affected when caring for mothers who have lost their babies at birth. The participants indicated that the physical effects that they experienced as a result of caring for grieving mothers who has lost her baby at birth included sleeping problems, loss of appetite, body aches, headaches, tiredness and mental block. The following quotes are evidence of the physical manifestations described by midwives:

> *"I was unfortunate that day, I delivered two stillborns and one macerated foetus. I could not sleep at home, difficult to eat… my whole body was aching, I could not do anything" (Participant 5, pg.4).*

> *"The thought of going to work the next day, yho—oo! my whole body was aching; I had a terrible headache…" (Participant 7, pg.6).*

> *"You leave a mother in the ward who does not know why she is not breastfeeding like other mothers, why her baby is dead, why she is not carrying her baby; it's difficult to sleep… no sleep coming" (Participant 7, pg.4).*

The findings of this study are congruent with results from the study of Modiba (2008: 35) which state that midwives caring for grieving mothers often suffer a range of physical symptoms like loss of appetite, insomnia and body aches due to exposure to a stressful situation. Macdonald and Magill-Cuerden (2012:954) also support the notion that emotions can physically affect professionals and state that emotions are also felt physically and are carried in different parts of the body; grief and sadness can be carried around the neck, heart and stomach manifesting as difficulty in eating or sleeping, headaches or backaches.

The participants felt that the latter physical effects manifested because of long-term exposure to the stressful situation of attending to stillbirths and also caring for grieving mothers who have lost their babies at birth, with no intervention such as debriefing or counselling. The physical effects were often described as manifesting when they got home because they are forced by the situation in the workplace to suppress whatever they are feeling. The labour wards are very busy and therefore there is no time to

grieve; but at home they would reflect on all the adverse circumstances that they encountered at work.

The participants indicated that the effects of attending to a stillbirth had an impact on their relationships at home with their families. They indicated that they felt like doing nothing at home and that it even affected their love for their children. The participants indicated that they did, however, feel consoled when sharing their experiences with their family members at home.

> *"Even at home you do not have love for your children; it's unfair; my children do not deserve that, they need my love… you come home, share with my husband all the frustrations of delivering a stillbirth with him" (Participant 8, pg.7).*

> *"I could not do anything at home for my family… I was just tired for some days…" (Participant 4, pg. 4).*

> *"I just don't feel like doing anything at home; sometimes I just don't feel like talking, but I always speak to my mother and sister about the death that happened at work; they console me" (Participant 10, pg.6).*

It is evident from the above discussions that most of the participants in this study experienced emotional and physical effects as a result of delivering babies that die at birth, and caring for mothers who have lost their babies at birth.

Subtheme 1.2: Midwives experienced professional role stress

Louw, Edwards, Forster, Gilbert, Louw, Norton, Plug, Shuttleworth-Jordan and Spangenberg (2011:609) state that stress, in psychology, refers to 'the physiological (of the body) and psychological (of the mind) reactions people exhibit in response to environmental events called stresses'. According to Bacharach, Bamberger and Conley (1991:39); a number of studies have found that work-specific role stresses include work-based role conflict, ambiguity and work overload. Although the aforementioned authors conducted their study years ago, the participants in this study also indicated that they experienced role stress as emanating from their professional obligations and stresses associated with work overload, strenuous working conditions

and role conflict over and above the traumatic experiences of caring for mothers who have lost their babies at birth.

The extreme workload experienced by the participants in this study was due to the influx of patients with complicated conditions that were referrals from the 15 district hospitals with complicated conditions. These referrals resulted in an overflow in the labour wards and stressful to the participants. The researcher observed, at the time of her interviews, that the influx of referred patients presenting with pregnancy-related complications warranting emergency management, were even nursed on stretchers because there were no beds available. The following quotes are evident of the overcrowding related by the participants:

> *"In our hospital [there are] plus minus 15 hospitals that refer their patients; so, labour wards are always full; labour ward one is supposed to have two beds but there is an extra bed; labour ward two also has an extra bed out of two; there are patients on stretchers; there is one on the chair; others are in theatre every day. It's very stressful" (Participant 07, pg.6).*

> *"You know this hospital is very busy; other than the labour wards there are four beds in high care; you have to attend to these patients, go to theatre..." (Participant 5, pg.6).*

Louw, Edwards, Forster, Gilbert and Plug (2011:618) describe quantitative overload as when there is too much work to do either physically or mentally in the time available, and that it could lead to poor work motivation, low self-esteem and absenteeism.

The participants indicated that they often experienced exhaustion from being overworked and often stayed out of work or took sick leave in order to rest and to relieve stress. Some participants expressed that absenteeism due to sick leave contributed to a shortage of staff and that it was normal that in each shift someone was booked off sick. The participants stated that the habitual absenteeism of colleagues seemed to be an adaptive response to dealing with the psychological and physical demands placed on them by the stressful situations they experience in the workplace.

The participants expressed the following in this regard:

"Sometimes it's better to just take sick leave and stay home because of exhaustion" (Participant 6, pg.4).

"Sometimes you don't feel like going to work the following day because you are emotionally and physically drained; better if you just take sick leave" (Participant 7, pg. 7).

"Taking sick leave is the only way to get rest" (Participant 10, pg.5).

Mudaly and Nkosi (2013:625), Scott, Mathews and Gilson (2012:139), Munyewende, Rispel and Chirwa (2014:14) and Khamisa, Oldenburg and Peltzer (2015:2216) are all of the opinion that exhaustion, increased work overload and staff shortages are some of the contributing reasons for absenteeism among nurses in South Africa.

The participants indicated that the exhaustion experienced because of being overworked often resulted in them making a lot of errors in their daily work that could have been avoided if they were not under so much work pressure. Participants expressed bitterness and anger because they were unable to do the right thing because of the conditions under which they work.

"Yho—oo, you don't know; if I did not have a passion for midwifery I would leave this place…we are not doing justice to these mothers; you just feel tired, exhausted; sometimes you can't even think properly" (Participant 5, pg.5).

"It makes me angry that I can't do right by the mother" (Participant 4, pg.6).

"Sometimes there are three women with severe eclampsia but how are we going to attend to all of them? We are short-staffed, really short-staffed; sometimes they complicate, but when the baby dies you have to write a statement" (Participant 9,pg. 7).

"One time I had to leave the mother without even talking to her about the death of her baby, so ***[shaking her head]*** *I did not do my midwifery role of at least consoling the mother…" (Participant 5, pg.6).*

The findings above are congruent with Barnes and Dyne (2009:60) who state that physical and emotional fatigue could have a negative influence on work performance.

The participants also described the conditions under which they work to be very strenuous and stressful due to various circumstances such as being unable to fulfil the midwifery role of caring for mothers satisfactorily because of staff shortages, ineffective management of emergencies sometimes resulting in death of babies, and poor support from management. The following direct quotes from the raw data illustrate this:

> *"…it's always very busy here as you can see and we are short-staffed and yet when there is death no one supports you" (Participant 10, pg.5).*

Another participant narrated a story when she nearly misidentified a baby because she had delivered three babies minutes apart *"…yho-o-o, I was blushing but the other mother came to my rescue because she saw the wrong identity band before anyone else had seen it" (Participant 4, pg. 5).*

> *"We work under pressure and it makes you feel bitter inside, yes, I know it's not my negligence but I did not do right by the mother, it's like I neglected her…"(Participant 6, pg. 4).*

The participants also expressed that they experienced role stress due to role conflict because they were unable to provide compassionate care and support to the grieving mother who has lost her baby at birth because of other duties that need to be performed at the same time. Louw et al. (2011:618) state that role conflict is a source of stress and that it happens when people are expected to perform conflicting roles. Some participants expressed that they would want to render compassionate care to the mother who has lost her baby at birth but the situation in the labour wards makes it impossible because the midwife has to leave the mother and attend to another emergency.

Literature supports the fact that demanding work circumstances can be very frustrating to the passionate midwife resulting in compassion fatigue. Pienaar and Bester (2011:118) state that professional nurses in their study who considered quitting employment exhibited high levels of emotional exhaustion due to demanding work

circumstances which led to burnout. Authors like Papadatou (2000:60) and Todaro-Franceschi (2012:273) also support that compassion fatigue may result in high rates of burnout. The following quotes were uttered by the participants to express how they felt about the situation of role conflict:

> *"Sometimes you don't even have time to explain to the mother let alone talk to her about how she feels (because of other duties that call); it's like you are heartless" (Participant 7, pg.5).*

> *"I wanted to talk to the woman but there was no time; I had to go for another emergency but I could not forget her while I was in theatre" (Participant 9, pg.7).*

> *"Sometimes you deliver a macerated foetus and before explaining to the mother as to what happened you go and attend to another patient and come back later to explain to the woman you really feel bad" (Participant 5,pg. 6).*

Due to busy labour wards and shortages of staff, the participants in this study expressed that there is a lack of time for them to take care of their emotional feelings like talking to someone, or just expressing their feelings to a colleague after conducting a delivery of a stillborn in the workplace. The latter, as explained previously, explain why these midwives would always grieve at home. The participants expressed their concern with regard to suppressing their emotional feelings, denoting fears as how such emotional feelings may manifest later in their lives which might also affect their work performance negatively. Puia et al. (2013:332) agree that perinatal loss can have a lasting effect on nurses (midwives in the context of this study) and therefore that continued support may be needed. The following statements were uttered by the participants:

> *"…There is no time for grieving; someone will be calling 'midwife, midwife' it's time to go to theatre…" (Participant 7, pg.6).*

> *"You suppress your feelings and it's gonna come out somehow; maybe you abuse your own children, mh—mh—mh, it's gonna come out, I know it will come out" (Participant 5, pg.4).*

"If I was not a nurse I have got that feeling that I can just be alone…but due to being always busy in the ward that cannot happen…you have no time for yourself…yes—yes" (Participant 3, pg.5).

Work-based role conflicts and work overload as a result of a shortage of staff were expressed by the participants in this study as contributing to professional role stress. Compassion for caring was also highlighted as one of the factors that contributed to role stress. All the above- mentioned factors signified the impact the death of babies at birth and caring for grieving mothers had on the participants.

Sub-theme 1.3: Fear of being blamed for poor maternal and neonatal outcomes

The fear of being blamed for poor maternal and neonatal outcomes by mothers was commonly expressed by all the participants. One participant indicated that the people in the community also believe that the midwives are responsible for the death of babies at birth. *"Even in the community people talk, blaming us, saying we nurses kill babies" (Participant 7, pg.3).*

Other participants expressed fear of blame from the grieving mothers whose babies die at birth. The following direct quotes are evidence of this:

"…because sometimes the only thing that you think of first is the blame from the mother" (Participant 4, pg.5).

"…sometimes the baby is born fresh stillborn and the mother will cry bitterly asking what we did to her baby" (Participant 5, pg.3).

Mselle, Moland, Mvungi, Olsen and Kohi (2013:2) conducted a study on "Why give birth in a health facility, users 'and providers' accounts on poor quality of birth care in Tanzania". The aforementioned authors reported that mothers in their study expressed great dissatisfaction with the care that nurse-midwives rendered to them. They cite neglect and physical and psychological abuse while in labour as a reason for poor outcomes of pregnancy, while the nurse-midwives on the other hand blamed the health facilities for lack of motivation and poor working conditions for the death of a baby.

Conry and Prinsloo (2008:15) explain that the death of a baby appears to be outside the natural order and is painful and difficult; they further explain that although women grieve differently, they go through various stages of grief such as anger and bitterness following shock, denial and isolation. Moody and Arcangel (2009:38) explain that the type of anger expressed by grieving mothers when the baby dies at birth is a means of trying to replace guilt feelings by blaming others. The aforementioned authors further state that the doctors and midwives are easy to blame by grieving mothers because they are the ones bringing the bad news and have been caring for her and the baby. Liisa, Marja-Tertu, Páíví and Marja (2010:373) also agree that the death of a child is a stressful experience for parents.

The participants indicated that they would often blame themselves when pregnancy outcomes resulted in the death of the baby, whether the death was expected or not.

> *"I delivered two FSBs and three MSBs one day, so I felt I had bad luck; I was confused, why deliver dead babies? So I thought I was the one at fault" (Participant 5, pg.3).*

> *"I am the one who resuscitated the baby so I am to blame" (Participant7, pg.6).*

In a study conducted by Beck, LoGiudice and Gable (2015:21) on secondary traumatic stress in certified nurse-midwives, guilt was another pervading emotion highlighted. The aforementioned authors reported that the midwives in their study stated that they continued to feel guilt and blamed the entire death of the baby on themselves.

The participants indicated that they were annoyed by the fact that they might be blamed for deaths that occurred at their hospital but in actual fact were referrals from another hospital. In the fifth South African report on the confidential enquiries into maternal deaths, it is stated that the referral pattern dictates that some cases of maternal complications resulting in stillbirths were from one district and died in another district, increasing the mortality rate for that district in which they died. (National Confidential Inquiry into Maternal deaths, 2002:69.) To that matter the participants uttered the following statements:

> *"In this hospital of ours, we have got this problem of mothers coming from their hospitals as already having a baby dead; it's very annoying because we are the*

ones that have to deliver and talk to the mother but we are trying by the way I understand it might be due to delays in their hospitals" (Participant 4, pg.1).

"…it's worse when the mother was told by the midwife in her hospital that the baby is fine and now delivers a macerated foetus" (Participant 8, pg.4).

"Some women will explain that the baby was moving in her hospital but sometimes the baby is born fresh stillborn and the mother will cry bitterly, asking what we did to her baby" (Participant 5,pg.3).

The participants experienced being treated harshly by management when a baby dies at birth as if they were to blame for the death of the baby. They also indicated that management showed no compassion towards them and expected them just to get on with the completion of the necessary documentation in the event of a baby dying at birth. The managers are perceived as non-caring due to how they conduct themselves when they are dealing with the participants who have conducted a delivery of a stillbirth.

"…That day I had bad luck. I had three MSBs. Yho-o-o! I was grilled; all the blame was put on me; imagine MSBs…" (Participant 5, pg.3).

"…No, no, they don't consider your feelings; these managers don't care about us as if they were never midwives" (Participant 6, pg.3).

"The way the managers deal with you, the person who delivered the baby, you write all sorts of reports… they are not sympathetic as they are supposed to be; they don't bother how you feel" (Participant 3, pg.4).

The participants, however, did mention that the blame from management was because of increasing litigation from the mothers whose babies die at birth, and/or their families. Literature has shown that litigation is not uncommon in midwifery practice and often comes up when there is an adverse outcome of pregnancy. In a study conducted to explore the midwives' experiences of loss and adverse outcomes around the world, McCool, Guider, Stenson and Dauphine (2009:1003) identified litigation as a common outcome of an adverse pregnancy outcome. Dippenaar and da Serra (2012:18) state that midwifery practice carries the highest risk of litigation in nursing. The same could

be said about South Africa, as stated by Pepper and Slabbert (2011:29) namely that South Africa as a whole is witnessing a sharp increase in medical malpractice litigation as patients are increasingly becoming aware of their rights. The following responses refer to the experiences of fear caused by litigation as a concern.

> *"Ever since the interrogations were introduced three years ago, no midwives want to come to work in the labour ward for the fear of litigations …" (Participant 10, pg.7).*

> *"… how you are questioned, it's like you are in court, guilty already" (Participant 3, pg.4).*

> *"The young midwives resort to being sick all the time so that they are said to be problematic and changed to other wards because we are also faced with court cases" (Participant 6, pg.3).*

In conclusion, the discussions in the above sub-theme clearly demonstrate how the participants experienced fear of being blamed for poor and neonatal outcomes by grieving mothers, the community and management, and also how they would sometimes blame themselves.

3.4.2 Discussion of theme two and its sub-themes

Theme two will be discussed in the following paragraphs followed by the sub-themes that emerged from this theme. Theme two and its sub-themes are depicted in Figure 3.2 below:

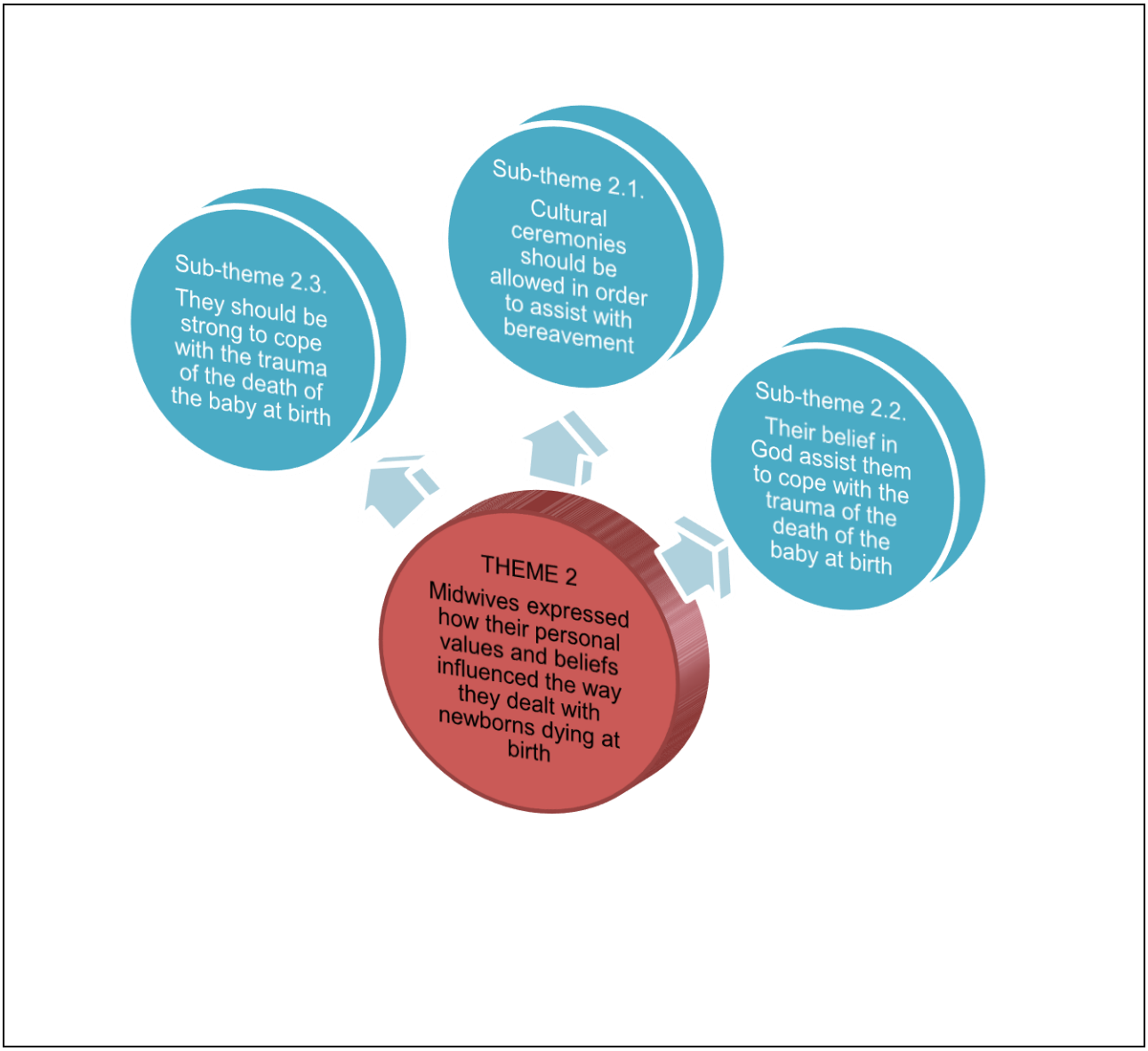

Figure 3.2: Diagrammatical representation of theme 2 and its sub-themes

3.4.2.1 Theme 2: Midwives expressed how their personal values and beliefs influenced the way they dealt with babies dying at birth

The participants in this study expressed their personal values and beliefs and how they influenced the way they dealt with mothers whose babies died at birth. The personal values and beliefs expressed by participants were based on their cultural beliefs relating to death. The personal values and beliefs were described by some participants to be deeply infused in religious and/or spiritual beliefs such as cultural rituals and belief in God.

The participants strongly felt that the institutions did not consider the need for cultural ceremonies for grieving mothers who have lost their babies at birth as important. Giger

and Davidhizar (2008:34) state that culture was defined as early as 1924 by Taylor as "a complex aggregate of knowledge, belief, art, morals, laws, customs as well as other skills and habits which one acquires as a member of society". The personal values and beliefs of midwives and how they influence the way they dealt with babies dying at birth will be discussed under the following sub-themes of theme two:

- Cultural ceremonies should be allowed in order to assist with bereavement.
- Their belief in God assists them to cope with the trauma of the death of the baby after birth.
- They should be strong to cope with the trauma of the death of the baby after birth.

Sub-theme 2.1: Cultural ceremonies should be allowed in order to assist with bereavement

The participants in this study expressed a need for allowing cultural ceremonies to be performed by grieving mothers whose babies died at birth in the institution so that the mother could find closure and in this way be assisted with the grieving process. The participants also indicated that allowing mothers to perform cultural ceremonies relating to the death of their baby would be an indication that the dead baby is valued and respected, and that the mothers' wishes are also being respected. The participants regarded giving respect to the dead baby as important in the culture of their grieving mothers, irrespective of the gestational age because there was life. The gestational age was specifically emphasised by some participants due to the fact that sometimes pre-term babies do die in their labour wards and are often not regarded as important as are full-term babies. Some of the participants felt that they were affected by the death of a pre-term baby in the same way when a full-term baby dies, and regarded the death of pre-term and full-term babies as a loss of life. Some participants valued life and described the death of the baby as a loss of life; therefore, a life of a human being is gone irrespective of the circumstances surrounding the death of the baby and irrespective of the gestational age. According to Giger and Davidhizar (2008:31), values express what is desirable and are the common notions of what is right or wrong, good or bad, desirable or undesirable. The participants expressed themselves as follows:

"I personally believe that the grieving mother and her family should…and be allowed to do their cultural rituals if they feel like something that is not provided for here in the institution" (Participant 1, pg.3).

"…the death of the baby means loss of life based on the premise that the baby bonded with the mother in utero. To some it starts when the pregnancy test became positive, so it means loss of life at whatever stage of pregnancy, so, beside the fact that the baby will have a little ceremony at home, even here mothers should be allowed to perform their rituals" (Participant 3, pg.3).

"The death of the baby means a loss of life, so, no matter how small the baby is, she deserves respect, so, a cultural ceremony should be allowed by the institution to be performed by the mother" (Participant 10, pg.3).

Some participants felt that grieving mothers should be allowed to perform rituals in the institution, such as inviting the presence of an elderly female family member when the mother is shown the baby, expressing that, according to Xhosa cultural beliefs, an elderly female member at home usually shows the baby to the grieving mother, asking the mother and her family about burial wishes and assistance with arrangements, and also the procedure of taking the soul of the baby from the hospital back home according to the grieving mother's culture. The participants also highlighted the fact that if the ritual ceremonies could be allowed in the institution, they (the participants) would feel fulfilled because they would feel as if they were part of assisting the mother to meet her wishes regarding the death of her baby.

The following excerpts are some of the views shared by participants in this regard:

"I only wish the hospital would allow the mother to call her priest to come and pray for the soul of the baby before taking the baby to mortuary" (Participant 9, pg.5).

"If only these mothers would have their family members here in hospital to assist them, like when they see the baby; that's what is done at home at least" (Participant 2, pg.4).

"I believe the soul of babies should be taken back home; the hospital should allow their families to perform such rituals; maybe babies die often because the souls of dead babies are never taken back home ***[laughing]****" (Participant 5, pg.5).*

Only one participant expressed the importance of understanding different cultures in order to facilitate the caring provided, especially with regard to death and bereavement: *"I think understanding different cultures will assist me to understand the grieving pattern of different mothers and assist in caring for other mothers in future" (Participant 3, pg.4).*

In a study conducted by Fenwick et al. (2007:157), midwives described how important it was for the hospital to acknowledge the loss of a baby at birth by caring for the mothers who have lost their babies at birth in totality, within an integrated system according to the mother's wishes, as this would be satisfying and extremely comforting to them as midwives. Gardener (2012:120) states that nurses and midwives should make a continual effort to establish cultural awareness, cultural knowledge, cultural skill and cultural exposure to be able to understand the spiritual beliefs of bereavement care. Spencer (2011:52) is of the opinion that grief reactions in other societies must be understood within their cultural context otherwise they could be interpreted as pathological, because what is an abnormal reaction to death in some societies may be normal and accepted in another society.

The midwives in this study felt that neglecting the importance of performing rituals after the death of the baby at birth by their profession was like abandoning something important towards the grieving mother's healing process, and that the profession is not assisting in easing the grieving mother's pain. They expressed helplessness because there was nothing they could do for grieving mothers with regard to assisting mothers with cultural ceremonies, whether traditional or with Christian-based beliefs, as this is not included in the hospital policy pertaining to the death of the baby at birth.

In supporting the above discussion, Spencer (2011:53) states that women may perceive the absence of mourning rituals as reflecting a society that does not recognize their experience of the loss of a baby. Dippenaar and de Sierra (2013:153) agree that cultural wishes and practices should be observed as part of caring for a

bereaved family and, as long as it is within the law. The authors further state that grieving parents should be assisted with their cultural ceremonies. Gardener (2012:120) also supports the view that it is important for nurses and midwives to be familiar with the traditions and beliefs of others as well as the meaning of loss to each person. Lobar, Youngblut and Brooten (2006:44) support the fact that grieving and death rituals across cultures vary and are sometimes influenced by culture and religion. This is also in line with what Chinese nurses practise, according to Chan et al. (2009:2345) who state that Chinese nurses adopt culturally-specific communication practices when caring for grieving families within the accepted ways of Chinese people. The following statements were uttered by some participants:

> *"In my profession death is never mourned because there is rush and there is nothing much said about it; mothers don't have time to grieve and perform their rituals; we are doing nothing to ease their pain" (Participant 2, pg.4).*

> *"…I feel we are not helping them to heal, but there is nothing we can do about it…maybe if it was provided for here in the hospital policy" (Participant 7, pg.9).*

One midwife in this study also expressed her personal feelings about the cultural rituals that she wished to observe for herself related to touching and wrapping dead babies. She indicated that she believed in cleansing after touching a dead body and that you will have to remain single as long as you are working in labour wards. Although she acknowledged the impossibilities around performing such rituals of cleansing after touching the dead baby for midwives, she also voiced that it always remains in the back of her mind that she needs to be cleansed so as to have a good life without misfortune. There was no evidence found in literature with regard to the feelings and beliefs of midwives associated with touching and wrapping dead babies. However, Gardner (2012:127) recommends that the feelings of midwives about death and dying unique to each cultural need should be explored to support midwives so that they are able to cope when supporting grieving mothers.

The following excerpts were uttered by this participant with regard to touching and wrapping dead babies:

"What I believe is that if you have touched a dead person you must be cleansed; touching, wrapping dead babies, I feel there is no luck for me, I'll die single because as long as I am working in the labour ward I can't even get marriage, it's just bad luck (Participant 5, pg.5).

In conclusion, the participants in this study expressed a need for cultural competence to enable them to render total care to the mothers who have lost their babies at birth. Incorporating cultural practices in the hospital policy for care of mothers who have lost their babies at birth was regarded by the participants in this study as a way of recognizing the mother's grief by the institution.

Sub-theme 2.2: Their belief in God assists them to cope with the trauma of the death of the baby at birth.

All the interviewed participants in this study expressed a strong belief in God and that their faith in God gave them strength to cope with the trauma emanating from caring for grieving mothers who have lost their babies at birth. Most of the participants stated with confidence (nodding their heads whenever speaking about their belief in God) that the fact that they cope with the everyday stresses of working in labour wards was evidence that they have God as their pillar of hope and strength. God was mentioned as the reason they still wake up and go on duty that they still have the strength to care for labouring women and babies in the labour wards, inclusive of the mothers who have lost their babies at birth. The latter findings are congruent with Bakibinga, Vinje and Mittelmark (2013:186) who report that all nurses in their study revealed that religious beliefs and values affect their performance positively, enabling them to find meaning even in difficult situations. Authors like Puia et al. (2013:322) also agree that obstetric nurses in their study revealed that because of religious beliefs they had a positive attitude towards bereavement care. The following excerpts are evidence of how the participants in this study articulated their belief in God and how they found comfort in their beliefs:

"…I know it's God's plan, if [I] did not believe in God I would not accept, I would cry endlessly and blame myself but, because I know if God wanted the baby to be alive, the baby would be alive…It comforts me to know that it's God's plan and it ends there; I am comforted" (Participant 9, pg.5).

"Mh—mh—by the way I am a Christian, I put all these things to God, my Saviour, that God helps me to accept these things as they come…I just ask God to strengthen me…the only thing that makes me cope is that I trust in God" (Participant 5, pg.3).

"…I saw that the baby was changing, I was doubting if she would make it because of her weight, but I hoped for God's mercy" (Participant 7, pg.5).

The researcher also observed during morning interviews that there was prayer for everybody in the unit, including general assistants and support staff. The prayer included Christian bible readings and preaching the word of God for everybody that was not busy at the time. This strong spiritual belief has been proven in literature to be one of the contributing strategies in coping for nurses and midwives when faced with diversity in the workplace. Linhares (2012:166) states that midwives believe that their dependence on spirituality and belief in a higher being has guided their lives and their calling in midwifery and enabled them to counsel the mothers. The following direct quotes illustrate this:

"…but you counsel her and give hope that God will give her another child if she is still young" (Participant 7, pg.3).

"I become close to them most of the time, praying for them, trying to comfort them more and more" (Participant 5, pg.6).

"We do intervene with the mothers to try and to counsel them that everything is coming from God, if God has a plan that this child is going to be yours so you can, so they can accept that God is going to give you another child in other time, this time it was not the time for them to get this baby" (Participant 4, pg.2).

The participants in this study relied on their belief in God to assist the grieving mothers with perinatal loss, taking into consideration that all the midwives in this study did not have formal training in grief counselling. However, there is no evidence in literature that this type of counselling assists the grieving mothers with perinatal loss towards healing, and the participants were uncertain if their goal to assist the grieving mother towards healing was achieved.

One participant expressed that, although she believed that God is powerful, she also did not believe that every death is the will of God but believes that God wants them to strive to save mothers and the babies under their care. She further pinpointed negligence as sometimes being a factor contributing to the death of babies, emphasizing that negligence is not the will of God and citing different examples of negligent behaviour by midwives that may lead to the death of babies, such as exposing the baby to cold, leaving the mother unattended, or not providing any necessary care to the mother and baby. She believed that the skills they have as midwives are a gift from God, and God hates negligence. She voiced out the following quote*:*

> *"I… have to do my best to save the babies because it's God's gift; I have to give the mother and baby the best care because God will punish me if I don't; I cannot say it's the will of God if I deliver the baby and don't provide warmth because the baby will die of hypothermia; I must fear God and give the best to the mother; if I don't perform my duties right I don't fear God, I am not happy to say that when the baby dies it's the will of God and yet there was negligence" (Participant 8, pg.6).*

The researcher, as a midwife herself, found the above statement very powerful, although there was no evidence in literature supporting it. Negligence is not only punishable by God, as per the above view, but also by the South African Nursing Council (R387, Acts and Omissions).

It was also clear that although death is inevitable and working conditions not providing conducive environments for caring adequately for their patients, faith in God gave the participants love and purpose for their job, and also alleviated pain and suffering for both staff and the mothers they cared for. Their love, hope and faith in God also helped them to cope with challenges even within their families. This is in accordance with the Christian bible (*Good News Bible*, 2013:227) that "…*meanwhile, these three remain: faith, hope and love and the greatest of these is love".* The following voiced statements were evidence of how trusting God by the participants was expressed as a coping mechanism, even within their families:

"God is my comforter even If I want my husband to change; I just ask God to change him, and I have a strong belief in God" (Participant 6, pg.3).

"My parents died when I was young. I don't have an immediate family but I have God and that's what keeps me going. I get help from God, if anything happens to me or my family, I know God is my helper, I know I am not alone; even if my husband does not support me, I have God" (Participant 8, pg.6).

It was interesting that all the participants in this study strongly believed in God irrespective of the age gap, which ranged from 30 to 60 years of age. According to them, their faith in God was the pillar of their coping mechanism both in the workplace and within their families.

Sub-theme 2.3: Midwives should be strong to cope with the trauma of the death of a new-born

Being strong was expressed as being necessary by the participants so that they could cope with the trauma of the death of the baby at birth when caring for the grieving mother. The term 'strong' in this context means the ability to cope with the death of the baby without becoming too emotional and dysfunctional when caring for the bereaved mother. The participants also expressed that they had to be strong because they deliver more than one dead baby in one day, and have to provide care to the grieving mothers as well as provide care to the mothers who have delivered live babies.

According to Jonas-Simpson et al. (2014:2), nurses have limited preparation for encountering grieving situations in formal training, and this became evident from the responses of the participants who indicated that they needed to be strong but did not always know how to achieve being strong for the grieving mother. The following extracts were evident of this:

"…I have to try and be strong to show her that it's not the end of life but it is very difficult, you just don't know how" (Participant 6, pg.2).

"We must be strong for other patients who are to be attended by us; we have to try" (Participant 4, pg.3).

Faith in God was once again cited as the main strengthening strategy for these midwives, as cited below:

> *"I go to God to ask Him to strengthen us midwives; we need to be strong" (Participant 4, pg.3).*

> *"…I ask God to make me strong for the woman" (Participant 9, pg.6).*

The participants in this study indicated that although they would sometimes be overwhelmed by personal grieving when the baby dies and when caring for the grieving mother, they always strived to be strong by developing coping strategies that kept them going. The coping strategies employed by the participants in this study seemed to be working for them because the majority of the participants had been working for over ten years in the labour wards and only four of the participants had less than ten years' experience.

3.4.3 Discussion of theme 3 and its sub-themes

Theme 3 will be discussed in the following paragraphs, and sub-themes that emanated from this theme will also be discussed below. Theme 3 and its sub-themes are depicted in Figure 3.3 below:

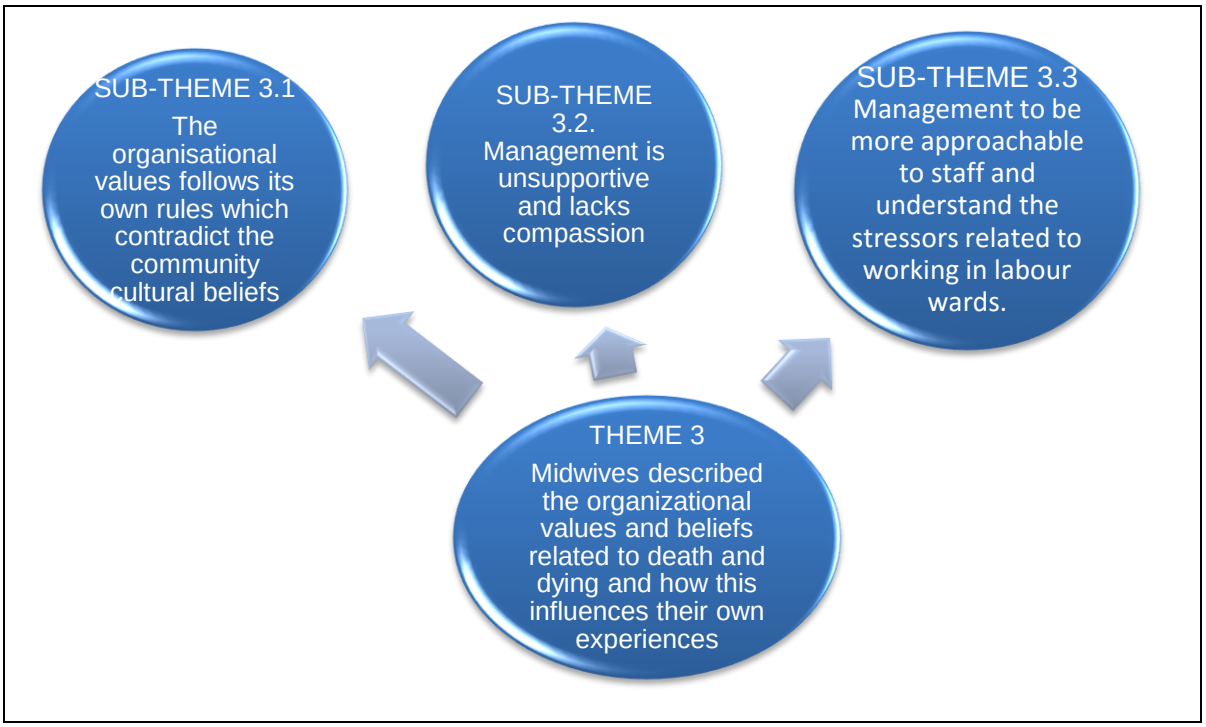

Figure 3.3: Diagrammatical representation of theme 3 and its sub-themes.

3.4.3.1 Theme 3: Midwives described the organisational values and beliefs related to death and dying and how these influence their own experiences

The organisational beliefs and values are based on the hospital policies pertaining to the deaths of babies at birth. The latter policy stipulates that a midwife will ask the mother if she wants to see the baby; if yes, the midwife will show the baby to the mother and if the mother refuses to see the baby, the midwife will tell the mother the sex of the baby and proceed to prepare the baby for the mortuary. The hospital policy was experienced by the participants as not benefitting anyone because the focus was more on handling the baby that had died than on caring for the grieving mother, and how the midwife who delivered the baby feels.

> *"…The policies here, maybe its me but mh----mh they do not benefit anybody, even our mothers, you know [**shaking her head**]…because here things are done for the hospital not caring how you feel" (Participant 5, pg. 8).*

> *"The organisation I work for has its own policies but they don't take any notice of the grieving mothers; the policies here only favour the institution…" (Participant 2, pg. 4).*

> *"…their policies favour them, just to protect them if there is a court case; they don't favour us or our mothers" (Participant 4, pg. 3).*

The decisions taken at the weekly perinatal meetings which are held to discuss among others things the death of babies at birth also have an impact on the organisation's values and beliefs regarding this matter. The perinatal meetings are attended by all healthcare professionals involved in the obstetric team, that is obstetricians, paediatricians, advanced midwives, midwives, medical doctors involved in obstetric care, medical interns and midwifery students. Perinatal meetings are experienced as a learning opportunity for the obstetric team with regard to identifying and correcting mistakes pertaining to management of the pregnant woman and the baby. One midwife uttered the following:

> *"We usually have perinatal meetings where we discuss what went wrong with the death of the baby or the mother so that we can correct it …there we have*

one goal of saving the mothers and babies, so, we have one common goal, so, we identify where we need improvements" (Participant 8, pg. 7).

Perinatal audits according to participants are also undertaken by the unit management whenever there is a perinatal death to determine the circumstances surrounding the death of the babies at birth. The findings of these audits are used to adapt policies and procedures to be followed with regard to the death of babies at birth. Alderliesten, Stronks, Bonsel, Smit, Campen, Lith and Bekker (2008:141) describe perinatal audits as a process whereby perinatal deaths are investigated for any presence of sub-standard care, and they may be performed at any level of care. The perinatal audits were experienced by the participants as torture to the midwife who conducted the delivery because of the manner in which these audits are being conducted in their institution. The participants also experienced the audits to be time-consuming and interfering with patient care at the time of the audit because of lengthy meetings during interrogations. The following quotes illustrate the aforementioned:

"…you will be called for interrogations, sitting there answering all sorts of questions related to the mistakes they picked up on the chart; sometimes other midwives may be called too as witnesses and sometimes, you know, the ward routine is just disturbed…" (Participant 7, pg. 7).

"…the meetings are the worst…they kill you inside, you feel like you are just tortured…" (Participant 6, pg. 4).

Alderliesten et al. (2008:144) state that the participants in their study also said that the audit process was time-consuming and emotionally affecting them, but were willing and secure to discuss their opinions freely with regard to sub-standard care in the meetings. To them it was an opportunity for learning and development in performance of skills. However, the participants in this study were unwilling to have these audit meetings perceiving them as forums to discredit their performance. This is evident in the following quotes:

"The meetings are called to pinpoint mistakes only, sometimes just to threaten you" (Participant 4, pg. 6).

"…you wait for the outcome, scared most of the time; it would be better if you were told where you went wrong so that you can improve" (Participant 5, pg.7).

The sub-themes of this theme will now be discussed below to demonstrate how the organisational values and beliefs related to death and dying of a baby at birth influenced the participants' experiences of caring for mothers who have lost their babies at birth:

- The organisation follows its own rules which contradict community beliefs
- Management is unsupportive and lacks compassion
- Management to be more approachable to staff and understand the stresses related to working in labour wards.

***Sub-theme 3.1: The organisation follows its own rules which contradict the community cultural beliefs*.**

The midwives described the hospital policies pertaining to the death of babies as contradicting community cultural beliefs because the policy stipulates a more westernised approach to dealing with the issue of the death of babies at birth and does not take community cultural beliefs relating to death and dying into consideration. The hospital policies stipulate among other things that mothers who have lost their babies at birth cannot be discharged without taking the corpse home with them. Therefore the mothers have to wait for transport from their respective hospitals to take them; this could take up to two or more days. Any further management, if their condition allows, can be continued in their respective hospitals

The policy also stipulates that mothers must leave with their babies dead or alive back to their hospitals where they will be discharged if their condition allows. This policy does not take into consideration that in the Xhosa culture a baby born dead must be immediately buried by the women of the family, and the grieving mother must be cleansed by family members.

"…she can't even leave the corpse behind; the policy of the hospital does not allow it" (Participant 7, pg.1).

"I wish they could go home to be with their families so that they can do their rituals within the accepted time, things like burial and cleansing ceremonies that are part of rituals performed 'eMaXhoseni' (Participant 1, pg.3).

Mojabelo-Batka (2013:1) states that within the African culture, prescribed rituals have a symbolic meaning and therapeutic effect, specifically bereavement rituals, but the opportunity to go through such rituals may interfere with the needs and belief systems of the Western world. The aforementioned author further states that there is a belief that there is a reciprocal relationship between the ancestral spirits and their descendants. Martin, Van Wijk, Hans-Arendse and Makhaba (2013:3) viewed the significance of bodies in black South African bereavement rituals and mourning practices and state that a child who dies before or after birth is given a name and is washed and prepared for burial by elder women of the family because it is viewed as already imbued with the spirit of the ancestors.

The participants felt that the policy of not allowing the mother to go home until the ambulance had arrived undermines the cultural beliefs of this community. Therefore, some of the participants expressed that it would be better if the institution would expedite the discharge of these grieving mothers by arranging transport for them back to their respective institutions instead of depending on being fetched by their referring hospitals.

The referral policy in this institution is that the women admitted as referrals are to be fetched by their respective hospitals to be discharged only by their hospitals; but the participants felt that if the discharge were to be expedited it would enable the grieving mothers and their families to perform their cultural rituals pertaining to the death of babies at birth within a reasonable time and according to their community beliefs.

The following quote illustrates the above discussion:

"The hospital policy only allows referrals to be discharged in their referring hospitals; sometimes the ambulances delay coming and these women often stay longer here, so, they wait longer to go home where they can be with their families who understand the culture to be followed" (Participant 7, pg. 3).

Williams, Munson, Zupancic and Haresh (2008:339) share the same view with the participants in this study who also believe that culture and religion may influence the handling of the new-born at the time of death.

Some participants indicated that, if possible, the family should be allowed to fetch the grieving mother if she has had no complications during or after delivery, instead of adhering to the hospital policy with regard to the transporting of the grieving mothers back to the hospital that referred them. The participants indicated that the latter action would shorten the stay in hospital and also not subject the grieving mother to driving home with the corpse in the ambulance with the ambulance driver, but rather to drive home in the comfort and care of her family. Waiting for the ambulance and travelling back to the institution with the corpse were felt to be traumatic by the participants. The following statements illustrate how the participants felt about this:

> *"At least it would be better if the family would be arranged to come so that we know what is expected than to let the woman wait for the ambulance and go with the ambulance driver and the corpse…" (Participant 6, pg.6).*

> *"…it's traumatic to see a mother going with her corpse to the ambulance; it's against the community beliefs and expectations" (Participant 2, pg.4).*

> *"… [It is unacceptable] to let the woman go back to her institution with the ambulance driver and the corpse" (Participant 6, pg.6).*

Dippenaar et al. (2011:32) state that maternal healthcare services exist for the benefit of civil society and should meet the standards and criteria that will meet the needs of society for safe care. The authors further explain that the midwifery care promotes, protects and support women's reproductive rights; however, according to de Kock and Van der Walt (2004:2-8) health workers have been criticised for imposing their values and practices on their patients.

The longer stay in hospital because of delayed transport results in grieving mothers, who are overshadowed by the darkness of death, having to observe mothers holding and breastfeeding their live babies while they are struggling with engorged breasts and oozing milk. The participants indicated that it was painful for them to observe the trauma being experienced by the grieving mothers and indicated it would be better for

grieving mothers to be separated from mothers with live babies. The following excerpts were evidence of the participants' expressions:

> *"… these mothers end up staying longer here with other mothers holding live babies while they are overshadowed by the darkness of death" (Participant 2, pg.4).*

> *"I don't know if it would help but I think it would be better if these mothers would separate from breastfeeding mothers; it's bad even for the mothers with live babies" (Participant 7, pg.11).*

> *"It is very painful to see a mother struggling with oozing milk from the breasts while she should be with her family; you feel very bad, it is sad ..." (Participant 3, pg.4).*

However, Cameron, Taylor and Green (2006:338) argue that, regarding removing bereaved women from other women, it is not clear whether it is better for the distressing woman or it is done to protect staff from emotions produced by the loss.

The participants indicated that they experienced the current policy to be mean and unpleasant with regard to the grieving mother because nothing pertains to the inclusion of the grieving mother's family. The midwives expressed their concerns as follows:

> *"If only these mothers could have their families to assist them when they see their babies; that is what is done at home at least" (Participant 2, pg.4).*

> *"…It's worse when you ask her if she wants to see the baby and she refuses and says she will see the baby at home; you know she wants to do it with her family" (Participant 7, pg. 2).*

> *"Sometimes the manager will come to talk to the mother but not to all of them…but I think they should ask the woman how she feels and what they want" (Participant 3, pg.4).*

The midwives in this study acknowledged that every institution should function within rules that regulate how things are done; but they also felt that community cultural

beliefs should not be overlooked. Chen and Wen-Yu Hu (2012:67) state that it is important to develop hospital-based evidence-based nursing care standards for bereavement care. They further suggest that future policies, nursing strategies, be developed relevant to the needs of bereavement care, and that future research be considered in this regard.

Sub-theme 3.2: Management is unsupportive and lacks compassion

The participants in this study indicated that management was unsupportive and did not show any compassion towards them when a baby dies at birth. This was evident from the manner in which the management dealt with the situation of when a baby dies at birth. The following quotes illustrate the above discussion:

> *"They take the chart to look for your mistakes; no one talk to you at that time and it is very cruel to treat us like that" (Participant 7, pg. 7).*

> *"Ever since I remember, nothing, no counselling, no support, nothing is done; it's only these meetings yho-o—yho-o! they are like a court of law; no one cares how you feel, no mercy at all from management; they started three years ago, they are scary maybe it's the way they are handled" (Participant 10, pg.4).*

This display of a lack of support and compassion displayed by management angered and frustrated the participants. They openly demonstrated their anger and frustration by various non-verbal cues like banging the table, shaking their heads and frowning in conveying what they described as an unsupportive lack of compassion from their managers.

The participants also felt that some of the policies were abused by management to torture them. The policy of convening a perinatal audit in the unit by unit management when the baby dies at birth was described by the participants as torture and abuse, instead of being supportive and educational. One midwife narrated a story where one male midwife was called to come to the unit perinatal audit meeting whilst on leave out of the country; this incident was described as one of the things that was according to her most heartless from management. *"He was called to come and answer all the way from (name of place omitted) and there was nothing we could do about that, yho—o-o, he really suffered psychologically and emotionally; no one would talk to*

management about it, if it's not you today it's you tomorrow; it was very bad and as a result he resigned after that" (Participant 6, pg.5).

Roberston and Thomson (2014:123) state that midwives are unfamiliar with writing statements and being witnesses in court cases because they come from a caring relational paradigm. In a study conducted on the effects of clinical negligence on midwives in England by the abovementioned authors, midwives suffered emotional, psychological and physical harm during the inquiry. Hunter and Ogungbure (2013:40) concur that the midwives in his study agreed that there are sometimes challenges to resilience and midwives become vulnerable to workplace adversity.

The midwives explained that they were not against the inquiry but the managers changed the meetings into courts of law. The participants felt that the manager was obliged to find out what led to the baby's death but were bitter about the way questioning was done. They described the managers as unsympathetic, cruel and heartless towards them and had no regard that the midwives were affected by the death of the baby.

> *"…you know no one cares about how you feel and I mean mh—mh—yho—o—you don't know, the managers just attack you, you feel like you are the killer…" (Participant 5, pg.10).*

> *"…then comes the time for your questioning, yho-o-o its bad…I don't say the inquiry about death is wrong, it's okay to find out what happened but yho-o! the way it's done it's like you are judged already; no one supports you from management, you are just on your own" (Participant 7, pg.8).*

> *"Yho-o-o, the questions you are asked and there are also threats like you are going to pay…it's very frustrating, no support; they just look for any mistakes, circumstances around are not considered…they just look for your mistakes, no support at all from our managers" (Participant 10, pg. 7).*

One participant shared a view that management might be doing this vigorous inquiry as a defence mechanism to try to have something to defend the hospital in case of litigation; however, management was not part of this study and was therefore not interviewed. This is evident in the following statement:

"If there is a litigation you will be answerable to the lawyers of the hospital or the Department of Health; they also grill you, so, you sometimes think that the managers are preparing you but they do not support you even when there are those lawyers" (Participant 10, pg. 7).

Welch et al. (2013:10) share the view of participants in this study stating that meetings discussing the care of the woman who had a stillbirth or neonatal death should provide a safe and confidential environment to care providers. The aforementioned authors further state that healthcare providers should work in a supportive environment that has a no-blame culture so as to provide better, more effective care, and that fear of litigation needs to be acknowledged so that it does not affect future practice adversely. According to de Kock and Van der Walt (2004:1-4), midwives are increasingly finding their professional practice under scrutiny and may be legally challenged by consumers of healthcare. Fraser et al. (2010:51) support the fact that fear of litigation acts as a guiding principle in modern practice.

The midwives also expressed their concern with regard to poor support from management when they experience hurt feelings, pain and when they are not coping with the stress of the death of the baby at birth. They claimed that management never shows sympathy and empathy as if they were never midwives, and management never offers assistance even in times when a midwife conducting the delivery is not coping. Management was also alleged to be lacking flexibility when a midwife makes a request because he or she is not coping at that moment. Participants also felt that they needed time to reflect and deal with their emotions, something they claimed was never supported by management. The following statements were uttered by the participants to express their dissatisfaction with regard to poor support from management:

"I once asked (name omitted) our operational manger to allocate me in a postnatal unit. I was pregnant and I was not coping at all; I was so scared and whenever I deliver a stillborn I would feel very hurt but she said she is short-staffed so I had to beg my colleague that I don't deal with IUDs at least; there must be flexibility. They must be parents, and they must have motherly care" (Participant 5, pg.6).

"There is no support from management…I just prepare myself on my way home…I say 'God help me'" (Participant 8, pg.7).

"If you think you go to the tearoom just to think about what has just happened, you are called and shouted at" (Participant 5,pg.10).

The last mentioned view of reflecting after a perinatal loss is supported by Puia et al. (2013:322) who state that nurses (midwives) need time to reflect, share and regain strength after perinatal loss.

Midwives also explained that they often resort to their colleagues for support; their colleagues were more understanding and would console them as one midwife said:

"…You just talk to your colleagues because at least it would be better if one of the managers would call you and console you, but my colleagues console me" (Participant 7, pg.7).

Jonas-Simpson et al. (2013:2) also support this view that nurses in their study wished for support and to be listened to. Price (2013:226) agrees that appropriate support should be available from the supervisors of midwives as required. De Kock and Van der Walt (2004:28-12) state that midwifery managers should create a supportive environment for all staff members working under stressful circumstances and that midwives working with grieving parents are entitled to a fair amount of support.

There were few instances where participants described managers as showing empathy and support to them but these isolated cases were related to their own personal issues rather than issues related to the death of babies in the workplace. One midwife said, "*Sometimes the managers will call a staff member if there is a crisis at home or the death of a family member and talk to that staff member and console her" (Participant 9, pg.6).*

Welch et al. (2013:12) recommend that there should be policies and guidelines to support obstetric staff, and that support networks should be made available. The aforementioned authors further recognize the United Kingdom for providing a framework of professional support in which there is a named supervisor readily available to listen, advise and offer support in times where clinical incidences arise.

The latter in the United Kingdom is done to ensure that the practitioner is given time to reflect and begin to process the emotions and experiences that may persist for a longer time if not addressed after the birth crisis.

The researcher was astonished by the revelations of poor support from management shared by all the midwives in this study. This is so because during the time she practised as a midwife in labour wards, management was very supportive when there was a death in the labour ward, maybe because the challenge of litigation was not common. The participants in this study regarded poor support from management as unacceptable and felt that resorting to other means for support was not encouraging to them because they regarded management as their pillar of strength and support.

Sub-theme 3.3 Management to be more approachable to staff and understand the stresses related to working in labour wards

Throughout the presentation of this report, management is regarded as not being supportive to the midwives when the baby dies at birth. The participants also expressed a desire for management to be more sensitive in their approach towards them when there is a death of a baby at birth; they also expected managers to understand the stresses related to working in labour wards. According to these participants, management was less understanding of the situations they work under and cite busy wards, shortage of staff and stresses related to death of babies as the examples of such situations. They were longing for appreciation and acknowledgement by management for the hard work they do, taking into consideration the circumstances they work under.

The participants uttered the following statements:

> *"We really work under stressful situations but no one appreciates; we need to be appreciated" (Participant 1, pg.6).*
>
> *"I only wish they would at least understand that you feel bad as a midwife because it's not nice to deliver a dead baby" (Participant 3, pg.7).*
>
> *"I wish the managers would not forget that we are short-staffed and we are overcrowded with referrals but still we try our best" (Participant 6, pg.8).*

"Midwives work under very strenuous conditions; at least we need to be recognized by our management that we work hard" (Participant 4, pg. 7).

Wright et al. (2010:1020) state that midwives need support worldwide when there is an adverse outcome of pregnancy. They further state that defaming or humiliating the midwife and her skills does not assist personal healing and that midwives in their study wanted the development of preventative measures as their primary concern. Welch et al. (2013:11) agree that it is important for managers and others in leadership positions to look after their own team members involved in caring for families that have experienced perinatal loss.

The midwives suggested various ways to be approached by their managers that were more positive. Some of these suggestions included positive talking, even if something went wrong, being easy-going on them because they work under pressure, summoning them to explain before blaming them, always considering the circumstances around each delivery that goes wrong and at least comforting them. Furthermore, they suggested that managers stop looking for mistakes so as to pin blame but should criticize constructively, avoid negative talks generally in the ward when the midwife concerned knows they are referring to her or him, and acknowledge working hard. The midwives described these suggestions as ways they think might improve working conditions, prevent staff turnover and abseentism in labour wards, and improve caring for all mothers in maternity because working in labour wards would be less stressful.

The following quotes from participants suggested the approach they expected from their managers:

"Mh—mh--from the managers we really need them to say things that are positive …then maybe young midwives would stay in the labour ward" (Participant10, pg.7).

"If there could be support from managers that at least, irrespective of what happened, you tried your best under the circumstances, at least be on your side; even if there's litigation it would at least be nice to come to work"(Participant 05, pg. 9).

"If managers would at least talk to you nicely and say, 'My dear, don't worry much,' and perhaps talk about the gestational age just to comfort you…so that you can express how you feel and explain what happened that led to the death of the baby without being harassed" (Participant 7, pg. 9).

Halperin (2011:389) suggests that experienced midwives can serve as a supportive framework for other midwives.

Midwives in this study were not reluctant to express their views with regard to a positive approach by management, and the researcher deduced that they were longing for a better change in working relationships in their labour wards between them and their management.

3.4.4 Discussion of theme 4 and its sub-themes

Theme 4 will be discussed in the following paragraphs followed by sub-themes that emerged from this main theme.

Theme four and its sub-themes are depicted in Figure 3.4.

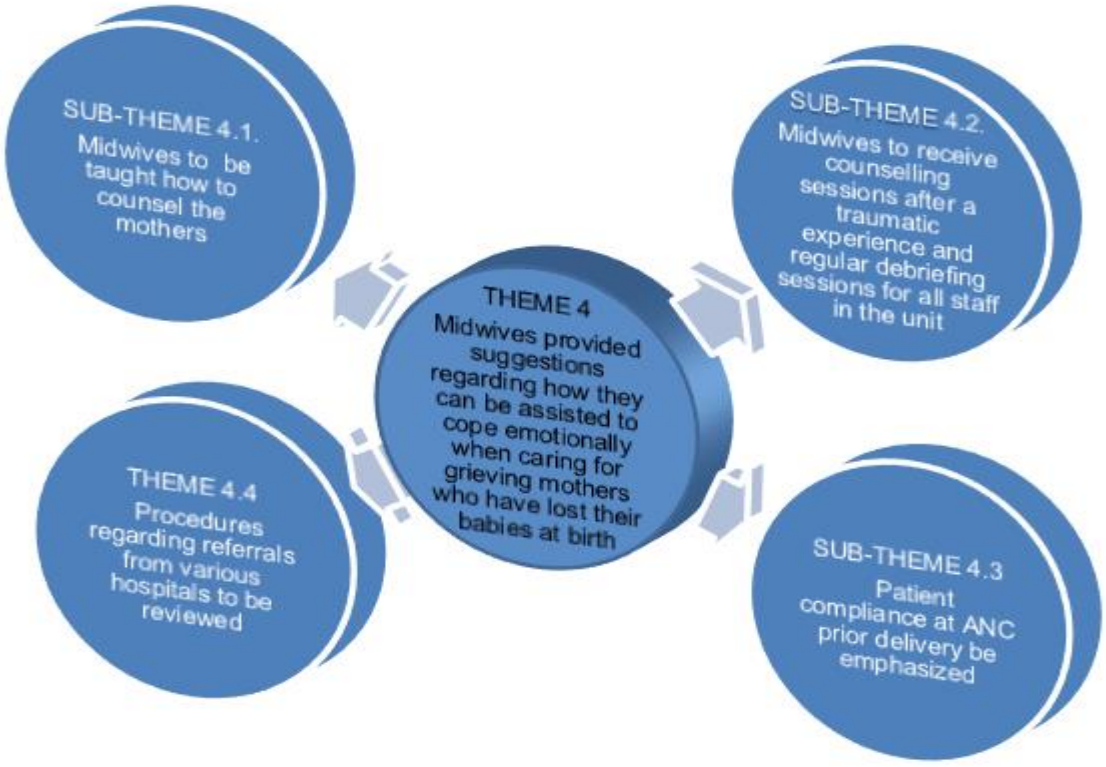

Figure 3.4: Diagrammatical representation of theme 4 and its sub-themes

3.4.4.1 Theme 4: Midwives provided suggestions regarding how they can be assisted to cope emotionally when caring for mothers who have lost their babies at birth

Throughout this study the participants expressed how they are emotionally affected when caring for grieving mothers who have lost their babies at birth. Various suggestions were provided by the participants with regard to how they could be assisted to emotionally cope when caring for mothers who have lost their babies at birth. The suggestions provided by midwives in this study will be discussed under the following sub-themes:

- Midwives to be taught how to counsel the mothers
- Midwives to receive counselling sessions and regular staff debriefing sessions for all staff in the unit
- Emphasized patient compliance at ANC prior delivery
- Management to be more approachable to staff and understand the stresses related to working in labour wards
- Procedures regarding referral from various hospitals to be reviewed.

Sub-theme 4.1: Midwives to be taught how to counsel the mothers

The participants all indicated that they should be taught how to counsel mothers who have lost their babies at birth because they all expressed that they had received no formal training with regard to grief counselling. Some participants indicated that they were scared to counsel the mothers because they did not know how to counsel. Thus all the participants expressed a need to be assisted with training in counselling techniques because they were not sure whether they were doing the right thing. They all indicated a willingness to provide counselling to mothers who have lost their babies at birth but indicated that they experienced challenges when they had to counsel the mothers because of a lack of training. The need for counselling skills on bereavement was repeatedly emphasized by the participants, as illustrated below.

> *"Young midwives need counselling skills but I think I really need training, I have counselling skills in other areas but we need counselling skills on how to deal with grieving mothers; I need the skill to do better" (Participant 2, pg.4).*

"I don't have an experience in grieving counselling, I use my own experiences and beliefs and yet I don't know the other person's belief; I don't know if it's helping her" (Participant 8, pg.9).

" I have no counselling skills; that's why I become scared to talk to the mother; I know no one here in the ward who have counselling skills on death, I think just short courses on grief counselling or just a person who is experienced to come train us" (Participant 7, pg. 9).

The notion of the importance of training programmes and on-going education on bereavement counselling is supported by different authors (Jonas-Simpson et al., 2014; Chen & Hu, 2012; Welch et al., 2012; Roehrs et al., 2008; Chan & Arthur, 2009) as they all agree that training programmes on bereavement counselling need to be offered to midwives and all other perinatal nurses so that the midwives are able to care for and support the grieving parents, and also deal with their own unresolved issues related to grieving. They further state that there has not been much attention paid to midwives with regard to training needs concerning grief counselling, and yet they are expected to care for and support the grieving parents whether they are equipped or not.

The participants voiced the following:

"It [training] would assist you to deal with your own unresolved grief issues" (Participant 9, pg. 7).

"We really need counselling skills…so that at least we are able to assist these mothers" (Participant 4, pg.7).

The participants indicated that they believed that the receipt of the necessary training with regard to grief counselling will assist them to adequately counsel the mothers and will also assist them in dealing with their own unresolved grief issues. Roehrs et. al.(2008:632) support the aforementioned statements expressed by participants in this study and affirm that the events surrounding the birth and death of babies may bring up unresolved grief issues for some nurses (midwives in the context of this study).

The need for training was so great that the participants indicated that they even registered and paid for short courses on bereavement counselling on their own in order that they are better equipped in providing counselling to the mothers. This attested to the need that they expressed for skills in grief counselling. However, the participants indicated that the short course was not enough and therefore they still felt a need for on-going training in grief counselling skills. The following excerpts are evidence of the above discussion:

> *"After the first experience I just decided to take a short course on counselling so as to acquire some counselling skills. I was then able to deal with other grieving mothers but I still need training" (Participant 2, pg. 5).*

> *"I do counsel these mothers. I think I am being helped by the short course I did on counselling but it was long ago" (Participant 1 pg.4).*

> *"…I don't have counselling skills on grief but at least I did a counselling course on PMTCT but it's not enough, not at all…that is why it is difficult to talk to the mother, you take time trying to prepare yourself; it's really not easy" (Participant 4,pg.6).*

According to Baxter and Baron (2011:116) there is an increasing demand from midwives for additional training on the needs of women who have been bereaved during their childbirth experiences. Welch (2013:11) suggests that education and training is not only important for initial education and training but also should be part of continuous professional development and on-going study days or seminar attendance. Although training on bereavement counselling has been cited as of paramount importance by different authors, Wallbank and Robertson (2013:1095) agree that training is necessary but also state that training may not be sufficient to support staff and may erroneously imply that emotional responses to death are containable and may undermine extreme responses of staff to loss.

Sub-theme.4.2: Midwives to receive counselling sessions and regular staff debriefing sessions for all staff in the unit

The participants in this study expressed a need for debriefing and counselling sessions after they had experienced the death of a baby at birth because they also grieve the

death of the baby. Different authors confirm the reality that nurses (midwives in the context of this study) also grieve when there is death but also agree that this (that nurses also grieve) has not been sufficiently addressed in nursing practice (Jonas-Simpson et al., 2014:10; Chan & Arthur, 2009:2533; Putten, 2013:10). The following quotes illustrate this:

> *"One thing is that if there can be debriefing sessions for midwives, we also need to be counselled ourselves" (Participant 10, pg.4).*

> *"By the way I think we are supposed to go for grief counselling because we experienced bad things" (Participant 4, pg.6).*

> *"The institution should provide debriefing sessions for us midwives in the workplace because this is where we are faced with the death of babies or mothers every now and again at the same time are expected to perform good [work]" (Participant 1, pg.5).*

One participant expressed the need for nursing assistants to also receive counselling because they have to wrap the dead babies and arrange for them to be taken to the mortuary. Sometimes the nursing assistants would pretend to be busy with something else so that they do not have to wrap the babies because, according to her, they are also saddened by the death of babies at birth.

> *"We are all affected; this affects everyone in the ward, and we all need counselling, even nursing assistants; sometimes they refuse to wrap babies, pretending to be busy and you can see they are affected" (Participant 4, pg. 5).*

Different views of suggestions as to how to and who may provide counselling and/or debriefing sessions were shared by the participants. The people who were suggested by different participants to conduct the debriefing and counselling sessions for midwives and nursing assistants included the unit manager, a psychologist employed by the hospital, and persons who have been trained in counselling or the social worker.

> *"I think managers should provide counselling because she started by being a midwife; the unit manager must be trained in doing debriefing sessions" (Participant 5, pg.8).*

"I think it should come from inside a psychologist employed by the hospital for maternity staff" (Participant 7, pg.9).

"There are people who are trained in counselling here in hospital; they can be assigned to do debriefing sessions…only if they are not involved in conducting deliveries" (Participant 10, pg.5).

"There was a social worker in casualty. I think she can be used for debriefing sessions…she is good" (Participant 3, pg.5).

The participants indicated that the need for counselling was expressed by some midwives to the nursing managers but nobody had acted on it as yet. They indicated that they did not know why the managers were not acting on their request for counselling. The following quotes illustrate their argument:

"I don't know why this [debriefing and counselling] is not considered by our managers" (Participant 3, pg.5).

"I once spoke to our operational manager about at least asking a priest [to do debriefing and counselling] for visiting staff but nothing happened up to now" (Participant 4, pg.5).

One participant, however, laughed when probed as to why debriefing and counselling was not being done in their institution although they are aware that they are in need of counselling and debriefing services. The participant uttered the following quote:

"I don't see anybody suggesting that [debriefing and counselling] to our managers…no one can ever raise it, that's why I'm laughing" (Participant10, pg.5).

The participants indicated that sometimes they make use of colleagues and family members for debriefing but need a better forum than just to talk. They stated that they felt better after speaking about the death of the babies with a colleague or family member.

"I think we, as midwives, we need to come together and talk about our feelings" (Participant 3, pg.6).

"I usually talk to my colleagues; at least it makes me feel better, so at least if there's a way of doing this in an accepted way, arranged in the institution, it would be better" (Participant 5, pg.8).

"I talk to my husband, just to talk" (Participant 8, pg.10).

"You just talk to your colleagues, they console you; sometimes there is no time to even talk about your feelings to colleagues, I just talk to my daughters, they are young but they listen" (Participant 7, pg.7).

According to Puia et al. (2013:328), Jonas-Simpson et al. (2014:10) and Welch et al. (2013:9), peer support both emotional and practical is essential to assist midwives to reflect and deal with their emotions because their peers understand the situation with regard to perinatal loss. The last-mentioned authors also agree that talking to family members can be helpful although the family members may be confused about the feelings displayed by midwives as they are not well versed with the circumstances surrounding the work in the labour wards.

One of the participants also identified awareness as one important step necessary for midwives in assisting them to realise that some of their behaviour, like uncontrolled anger towards their patients or choosing to run away instead of assisting the grieving mother, was related to the effects of caring for grieving mothers who have lost their babies at birth. "…*I think the awareness first, so as to make the midwives aware first that they are affected; sometimes you are not aware that you are hurt that is why you run away from the woman…yes I think awareness first, make midwives aware that they are affected by these deaths, the debriefing sessions will follow to deal with situations" (Participant 9, pg.7).*

In a paper that explored how midwives manage the emotional demands of their work (Evidence-Based Midwifery, 2013:40) it was stated in other settings such as intensive care units work is recognised to be emotionally stressful. However, maternity staff struggle to be identified as needing staff support such as debriefing and/or counselling, perhaps because they are associated with good outcomes and positive events. The authors further state that midwives are therefore not associated with stress related to deaths. Evidence of how to care for midwives as carers of grieving mothers was also

not found in South African literature and in very few studies in countries abroad (Roehrs et al., 2008; Homer & Lewis, 2013; Wallbank & Roberston, 2008).

Sub-theme 4.3: Emphasised patient compliance at ANC prior delivery

Pregnant women are expected to attend antenatal care clinics as early as when they miss their menstruation period onwards, in order to ensure a healthy mother and baby outcomes. The National Confidential Committee of Enquiry into Maternal Deaths in South Africa strongly recommends that the primary healthcare team must encourage pregnant women to start antenatal care in the first trimester (Department of Health, Saving Mothers 2011-2013, sixth report). However, the indicator of early antenatal booking below 20 weeks is a challenge in the Eastern Cape Province because of poor antenatal care attendance, especially below 20 weeks' gestational age. The target of the National Department of Health for early antenatal care attendance below 20 weeks' gestational age is 70% but according to reports presented at an elimination of mother-to-child transmission (EMTCT) conference in East London, the districts in the Eastern Cape were still very far from reaching the target as most districts are still at 0% (EMTCT conference, 27 October 2014, East London). The participants in this study expressed a need for all mothers to attend antenatal care clinics early in their pregnancy so that any abnormalities could be detected early and be dealt with appropriately. Compliance in the attendance of antenatal care prior to delivery would eliminate unnecessary shock and prepare the mother and midwife with regard to what the outcome of the birth would be. Concerns were expressed by the participants with regard to poor antenatal attendance among some of the mothers from rural hospitals that were admitted to their hospitals. They indicated that some of the complications that the rural women presented with at birth could have been avoided if only they had attended antenatal clinics before the delivery.

> *"I want to emphasise that the pregnant mothers must be encouraged to attend antenatal clinics early so that any abnormalities are diagnosed and managed early" (Participant 1, pg.6).*

> *"…and sometimes women themselves attend ANC [antenatal care] very poorly and only come when there are complications…" (Participant 6, pg.4).*

According to Dippenaar (2011:179), the aim of antenatal care is to observe the progress of the pregnancy and to ensure the wellbeing of the mother and the foetus. Problems are identified early and referred to the relevant higher levels of care. De Kock and Van der Walt (2004:9-2) emphasise that women who have more antenatal visits tend to have lower perinatal mortality and better pregnancy outcomes.

With reference to this statement, the participants in this study were also devastated by the fact that some babies were born dead or die after birth with gross abnormalities which could have been identified early, and the pregnancy terminated before it is carried to term. Midwives acknowledged that every adverse pregnancy outcome is traumatic but the common feeling was that even if the problem is irreversible, at least having diagnosed that the baby is dead before birth, the midwife would prepare the mother before delivery. It would therefore be better than breaking the news of the unexpected birth of a dead baby.

> *"…at least if the mother has been diagnosed early and told that the baby is no more alive, that death is expected and less traumatic to the midwife delivering the baby" (Participant 4,pg.6).*

> *"…at least mothers are prepared in time if the problem is irreversible because an unexpected death of the baby is more traumatising…at least she knew nothing could be done; she knew there was a problem" (Participant 1, pg.6).*

> *"…and sometimes I wonder why we are still having delivering babies with gross abnormalities; every hospital has an ultrasound, why are we still having such shocking deliveries? Because that [baby with gross abnormalities] should have been diagnosed early and the pregnancy terminated, why put us in such situations, mothers to [**shaking her head]** but…" (Participant 5, pg. 5).*

Williams et al. (2008:336) agree that when parents understand the complexities of a diagnosis, the anxiety of the unknown is decreased. Communicating the news of the complication or death to the woman should be done in a culturally sensitive way and according to the level of education to ensure that parents understand (Williams et.al. 2008:336).

The midwives felt that pregnant women need to be empowered so as to know more about their pregnancies so that they can seek medical advice timeously when something goes wrong. The following quotes strengthen the above discussion:

> *"Sometimes I feel sorry for these mothers because they are not empowered, so, it's due to lack of knowledge; they must know about dangerous conditions like pregnancy-induced hypertension and seek help in time" (Participant 6, pg.4).*

> *"We need to empower the mothers as to know what is happening in their bodies so that they know when the baby is not kicking and go to hospital in time so that an ultrasound is done" (Participant 4, pg.6).*

> *"…but women themselves might have not attended antenatal care because sometimes they just don't know the importance" (Participant 5, pg. 5).*

Empowering pregnant women would save midwives from stressful situations in the labour wards and would also be beneficial to the society and the country at large by 'Saving babies and saving mothers'.

Sub-theme 4.4: Procedures regarding referral from various hospitals to be reviewed

The participants in this study made suggestions on how the referral system can be improved so that perinatal deaths could be avoided if possible. The participants suggested that obstetricians visit the peripheral hospitals on scheduled times so that some mothers are managed in their respective hospitals to prevent the problems of babies dying during transportation. It was also suggested that the peripheral hospitals be improved in terms of resources so that the midwives and doctors in those hospitals are able to screen, diagnose and manage complications timeously. It was also suggested that those mothers with intra-uterine deaths be delivered in their respective hospitals, unless the mother has a complication that warrants a higher level of care. The participants uttered the following statements with regard to improving the referral system:

"I have been asking the doctors in our institution to consider visiting these peripheral hospitals so that they identify women at risk and refer them here timeously" (Participant 4:pg.1).

"I don't think that they should refer mothers with macerated foetuses here; they should tell them and deliver them other than bringing them to us unless there is another complication" (Participant 7:pg.10).

The referring hospitals are regional or level one and level two hospitals, and according to the Maternity Guidelines for Care in South Africa (Department of Health, 2007:15), regional hospitals function with skilled personnel, for example advanced midwives, medical officers, a visiting obstetrician and other related healthcare personnel. These hospitals are supposed to be having all the facilities to diagnose and manage high-risk conditions of pregnancy, labour and pueperium, including the neonate.

Therefore the concerns of midwives in this study related to the influx of patients from referral hospitals, mismanaged conditions and the referral of women with macerated foetuses are not unfounded as they are supported by the aforementioned guidelines in that these hospitals have the mandate from the Department of Health to manage high-risk conditions and only refer those conditions that are beyond their control due to the scarcity of human and material resources. The referring hospitals were not part of this study; therefore, their views regarding the challenges they face pertaining the referral system were not explored.

3.5 CHAPTER SUMMARY

This chapter focused on the discussion of the results that emanated from the data collection and the process of data analysis in this study. The experiences of midwives in caring for mothers who have lost their babies at birth have been described based on the data generated from ten semi-structured interviews. Diverse experiences of midwives emerged from the interviews and were described in this under specific identified themes. Research findings were placed within the context of a broader body of scientific knowledge, as found in literature.

Broad guidelines for midwives that could assist them in caring for mothers who have lost their babies at birth, as well as the limitations of the study and recommendations, will be dealt with in Chapter Four.

CHAPTER 4

SUMMARY, CONCLUSIONS, GUIDELINES AND RECOMMENDATIONS

4.1 INTRODUCTION

In the introductory, Chapter One, an overview of the study was presented and the problem statement, research purpose and objectives were described. Chapter Two provided an in-depth discussion of the research design and methods used to conduct this study. The focus of Chapter Three was the data analyses and discussion. In this chapter, the summary and conclusions, the guidelines, recommendations and limitations will be described below.

4.2 SUMMARY OF RESEARCH FINDINGS AND CONCLUSIONS

During the research process, midwives working in the labour wards of a hospital complex in the Eastern Cape, and who formed the target population in this research project, were interviewed; they voiced their experiences with regard to caring for mothers who have lost their babies at birth. Information-rich data was generated by the semi-structured individual interviews. Data was analysed and four main themes and 13 sub-themes emerged (see Table 3.1).

In **Theme One** participants shared their diverse experiences relating to caring for mothers who have lost their babies at birth, which included being emotionally and physically experienced. The majority of participants shared periods of sadness, being hurt, crying episodes, insomnia, tiredness and loss of appetite because of some of the emotional and physical effects they had experienced. The aforementioned effects were described as occurring every time a baby died at birth irrespective of the gestational age. Although the participants had a vast difference of years of experience ranging between three and 20 years, the effects of a baby dying at birth were not different irrespective of age or years of experience working in labour ward. The participants also shared a fear of being blamed for poor maternal and neonatal outcomes by mothers who have lost their babies at birth and management. Some participants justified the blame from the grieving mothers explaining that the grieving mothers were referred from peripheral hospitals and were therefore expecting a good outcome of their pregnancy in the referral hospital. Contrary to the aforementioned

statement, the blame from management was experienced negatively by the majority of participants and such blame was described as torture from their managers. They voiced that they expected support from their managers because they were also once midwives and were also aware of the circumstances they work under. Some of the participants expressed that they would sometimes blame themselves for the death of the baby at birth, especially if the death of the baby was related to administrative factors such as a delay from the referring hospital or if it was due to failed resuscitation. Self-blame was common for the midwife conducting the delivery; they expressed that the midwife would often wonder what she/he did wrong and most of the time blame was associated with a feeling of failure, especially failing the mother. Breaking the news to the mother was also described as sad and hurting often because the midwife would feel the mother would blame her while she/he is blaming herself/himself – even if the death was not his/her fault. They explained that blaming themselves was worsened in situations where the death of the baby had no obstetrical explanation because they would often not know what to say to the mother. Professional role stress was also highlighted by the participants and was associated with work overload due to the influx of patients with complications of pregnancy and/or labour, strenuous working conditions due to shortage of staff, and role conflict related to multiple job demands.

Theme Two highlighted how the midwives' personal values and beliefs influenced the way they dealt with new-borns dying at birth. The participants in this study expressed a strong belief with regard to performance of cultural ceremonies related to babies dying at birth and the grieving of mothers. They believed that such ceremonies should be allowed to be done in a hospital setting by grieving mothers to assist with bereavement according to the wishes of the grieving mothers who have lost their babies at birth. The participants also wished that the performance of cultural ceremonies and rituals could be incorporated in the hospital policy as part of caring for grieving mothers so as to give respect to the baby and to respect the cultural beliefs of the mother. Participants openly expressed their desire to be developed by management towards cultural competence so as to be able to give comprehensive care and support to the grieving mothers. The participants also expressed their belief in God as being one of the coping mechanisms they employed to deal with the trauma of babies dying at birth. Belief in God was shared by all the participants as their source

of strength in the workplace as well as when they encounter personal challenges within their families. Some of the participants believed that they should be strong to cope with the trauma of the death of a baby at birth as it is necessary for them to be able to care for the grieving mother and also for the mothers whose babies are alive. Being strong was also associated with professional socialisation and obligation in nursing but it was also expressed that it is at times very difficult for them to contain themselves in front of the grieving mother, as is expected of them by their nursing profession, and that they often would cry at home filled with sadness.

Theme Three highlighted a description of the perceptions of the midwives' organisational values and beliefs related to death and dying, and how they influenced their own experiences of caring for mothers who have lost their babies at birth. The participants expressed their perceptions that the organisation follows its own rules, which contradict community cultural beliefs. They voiced that the hospital's policies on death and dying are silent about caring for grieving mothers and do not observe the cultural beliefs and values of grieving mothers pertaining to the death of the baby at birth. The aforementioned hospital policies were said to be specific to the handling of the corpse of the baby and nothing related to a care programme involving the mother. They also expressed that this policy is imposed as a uniform standard for all babies dying at birth with disregard for the individual needs of the grieving mother. Participants also expressed dissatisfaction on how management was unsupportive and lacking compassion towards them when a baby dies at birth. The managers were also blamed for using the hospital rules and policies to torture them whenever there is a baby's death at birth. The policies referred to by the participants were those related to an inquiry about the circumstances and/ or causes around the death of the baby such, as perinatal audits. The participants expressed that they expect support from management such as allowing them time to reflect, counselling them and showing sympathy and empathy as opposed to being harsh and inconsiderate. The perinatal audits were described by the participants to be like a 'court of law' because of the ways employed during interrogations. However, the participants were not against the questioning but only if it was not intimidating but rather educational even if there was an error in the management of the mother or the baby that died. Poor support from management was regarded by participants as one of the factors contributing to a negative environment not necessary for delivering care to mothers who have lost their

babies at birth. Participants openly expressed that managers ‘did not care about their wellbeing’; however, escalating litigation was believed by participants to be one of the contributing factors to the harsh ways employed by managers during an inquiry into the death of a baby at birth.

In **Theme Four** midwives provided suggestions regarding how they can be assisted in caring for mothers who have lost their babies at birth. The suggestions provided included that they be taught how to counsel mothers who have lost their babies at birth as they voiced that they had no formal training with regard to grief counselling and often did not know what to do or say to the mother whose baby had died at birth. They also suggested that they themselves receive counselling and debriefing sessions through a psychologist, a priest or somebody trained in counselling. The reasons cited for counselling and debriefing were because they also grieve when a baby dies at birth and consequently suffer emotional and physical effects.

Emphasis on the compliance of patients with antenatal care attendance was also made because they felt that some complications would have been diagnosed and treated promptly during antenatal care and thus prevent the death of babies. Their concerns emanated from frequent encounters they had with pregnant women presenting with pregnancy-related complications and/or labour, and most of these women had either seldom attended antenatal care clinics or had not used these services at all. There were suggestions such as empowering pregnant women through educational programmes so that they know the importance of attending antenatal care services and understand pregnancy-related complications so that they would seek medical help promptly. The participants also cited the delivery of fresh stillborn babies with gross abnormalities as an example of poor antenatal care attendance because such babies could have been diagnosed with the use of modern technology, mothers counselled and pregnancies terminated timeously. They expressed shock and trauma as a result of delivering such babies.

The participants also suggested that management should be more understanding and approachable to them when there was a death of a baby at birth. They suggested positive talking if something went wrong, such as being called to explain after the baby dies at birth in a calm environment, constructive criticism and the avoidance of negative talk which they claimed was employed by managers. The participants

expressed bitterness toward what they regarded as negative comments, such as threats that someone is ‘going to pay or ‘be expelled’.

Lastly the participants suggested that procedures regarding referrals from other hospitals be reviewed. They suggested, regarding referrals, that obstetricians should visit various hospitals at scheduled times so that most mothers are managed in their respective hospitals. In addition district hospitals should be improved in terms of resources and mothers with intra-uterine deaths managed in their respective hospitals unless there is another complication.

It can therefore be concluded that in view of the discussion above and the description of the guidelines to be presented below, the research aim and objectives relating to this research study have been achieved.

4.3 BROAD GUIDELINES FOR MIDWIVES THAT COULD ASSIST THEM IN CARING FOR MOTHERS WHO HAVE LOST THEIR BABIES AT BIRTH.

The main focus of this study has been the experiences of midwives caring for mothers whose babies die at birth. The information shared by the midwives in this study form the basis of the broad guidelines developed. The researcher used the experiences of the midwives in this study and the suggestions they provided to construct the guidelines that will assist midwives in caring for mothers who have lost their babies at birth.

The broad guidelines have been constructed from the following sources:

- Research findings
- Relevant literature
- The experiences of the researcher and field notes
- Discussion of midwifery experts such as advanced midwives working in labour wards; midwifery lectures in the nursing education fraternity
- The theoretical framework by Papadatou also underpins the development of guidelines

The two principal guidelines that have been formulated are to:

- Create a positive practice environment for delivering the necessary care to mothers who have lost their babies at birth.
- Develop assistance to acknowledge the role of traditional, cultural and professional values and beliefs for midwives caring for mothers whose babies die at birth.

The guidelines will be presented in the following manner:

- The principal guideline will be presented with associated sub-guidelines supported by the rationale and operational implications
- The principal guidelines and corresponding sub-guidelines will be summarised in a table format (see Table 4.1.) followed by a detailed discussion of operational implications.

TABLE 4.1: PRINCIPAL GUIDELINES AND SUB-GUIDELINES RELATING TO ASSISTING MIDWIVES TO ADEQUATELY PROVIDE CARE TO MOTHERS WHO HAVE LOST THEIR BABIES AT BIRTH

PRINCIPAL GUIDELINES	SUB-GUIDELINES
Principal guideline 1 Create a positive practice environment for midwives who care for mothers who have lost their babies at birth	1.1 Ensure an environment for midwives and mothers that address their personal and psychological issues pertaining to their personal wellbeing. 1.2 Provide a structural environment that facilitates the midwife in the provision of care to mothers who have lost their babies at birth. 1.3 Address issues of staffing in labour wards. 1.4 Address administrative factors contributing to neonatal mortality.
Principal guideline 2 Provide training and education to midwives regarding provision of culturally sensitive care to mothers who have lost their babies at birth	2.1 Assist midwives towards cultural competence. 2.2 Develop a care programme for mothers who have lost their babies at birth that is based on essential core competencies of midwives.

4.3.1 PRINCIPAL GUIDELINE ONE: Create a positive practice environment for midwives who care for mothers who have lost their babies at birth

A positive practice environment refers to the physical, social and psychological characteristics of a work setting (Coetzee et al., 2012:686). Such characteristics are determined by many factors including the physical features, the organisational policies and the characteristic behaviours of employees at work. A healthy positive practice environment is defined as a work setting in which policies, procedures and systems are designed so that employees are able to meet the organisational objectives and achieve personal satisfaction in their work. Criteria for a positive practice environment focus on the quality of leadership, provision of quality care, nurse autonomy and active participation in decision-making, adequate staffing and resources to ensure job satisfaction, the retention of nurses and favourable nurse outcomes.

Rationale

An enabling positive practice environment is crucial to job satisfaction, higher employee retention, decrease rates of absenteeism, improved staff morale, increased productivity and work performance as a whole. In this study a sub-guideline that addresses the personal and psychological needs of midwives who care for mothers who have lost their babies at birth will be provided to address issues pertaining to their wellbeing, thus ensuring a positive practice environment.

4.3.1.1 Sub-guideline 1.1. Ensure an environment for midwives and mothers that address their personal and psychological issues pertaining to their personal wellbeing

Rationale

Addressing personal and psychological issues of midwives in the workplace could ensure that their personal wellbeing is promoted and a healthy positive practice working environment developed and an enabling environment in the provision of care to mothers who have lost their babies at birth could be created. The midwives in this study expressed experiences of traumatic stressful moments when the baby died at birth; therefore a stress management programme could assist. Cacciatore (2013:80) argues that healthcare providers who frequently encounter traumatic deaths are

vulnerable to depressive symptoms, anger, helplessness and may have difficult in expressing empathy. Healthy midwives could contribute to a positive practice environment by meaningful active participation in decision making in their labour wards pertaining to the provision of care to mothers who have lost their babies at birth.

Operational implications

Management should:

- Develop a stress management policy and communicate the content thereof to all staff members.
- Develop a stress management programme and display all activities on noticeboards in tearooms and working stations that will be visible to everyone who has a need for such a programme. Activities may include the following:

  - Learning cognitive skills about the causes and consequences of stress. Learning assertiveness versus aggressiveness.
  - Schedule group physical activities during lunch breaks to metabolise the excessive stress hormones and restore physical health.
  - Encouraging talking to release built-up tension by discussing stressful thoughts and finding solutions.
  - Keep a stress diary so that you become aware of situations that cause you to become stressed and develop better coping mechanisms.
  - Encourage more sleep at least eight hours a night; it helps to relax the mind.

- Establish a support group to assist midwives to cope with environmental stresses in the workplace and to sustain and enhance their coping abilities in caring for mothers who have lost their babies at birth. A support group is a gathering of people who share a common health concern or interest and focuses on a specific situation or condition (http://www.mayo clinic.org/healthy-lifestyle//…stress management/in-depth support-groups/art-20044655). A support group could constitute obstetricians, neonatologists, midwives and unit managers and could also act as a form of debriefing. The following activities could act as guidance during the gathering of the support group:

- The midwife who conducted the delivery could initiate and open an informal discussion about the management of the mother and or the baby who died at birth within the group.
- Refrain from blaming anyone; try to be positive as much as possible.
- The midwife who conducted the delivery could also be given a chance to share his/her feelings and fears with the group openly.
- A future management of the same problem could be discussed with the assistance of experienced professionals within the group.
- Make available the telephone numbers for professional people such as psychologists; priests should be available for easy referral in case a member of the group needs further management.

4.3.1.2 Sub-guideline 1.2 Provide a structural environment that facilitates the midwife in provision of care to mothers who have lost their babies at birth

A structural environment refers to an:

Arrangement of lines of authority, communications, rights and duties of an organisation. An organisational structure determines how the roles, power and responsibilities are assigned, controlled and coordinated. Decision making may be centralised or decentralised depending on the type of the organisation (http://www.businessdictionary.com/definition/organisational-structure-html).

Rationale

Provision of a structural environment that facilitates caring for mothers who have lost their babies at birth by midwives could promote a healthy work environment, improve low professional status and working relations between managers and midwives and lessen workplace hazards. Mothers who have lost their babies at birth could therefore be cared for by midwives in an environment that enhances recovery and healing.

Operational implications

Management should identify the needs of midwives for on-going education and training on bereavement care and:

- Organise week-long workshops on training and education of bereavement care and counselling to improve knowledge and skills.
- Organise study days for continued professional development in bereavement care and counselling.
- Make provision for inclusion of bereavement care and counselling during induction of new staff.
- Organise communication study days to improve communication strategies for midwives to build their confidence in order to succeed in facilitating care of mothers whose babies die at birth.

Management should create a positive environment in the labour wards by:

- Provision of adequate supplies and equipment in the labour wards to lessen the risks of health hazards that may contribute to death of babies at birth.
- Allowing autonomy of midwives in recognition of the midwives' professional status as independent practitioners. Recognition and decentralization of power where necessary will improve the professional morale of midwives. When morale among employees is high they tend to work enthusiastically, courageously, confidently and productively but when their morale is low, employees are timid, unruly and display indifferent attitude towards their job (Booyens, 2014:151).
- Improving working relations between managers and midwives by showing positive verbal and non-verbal communication when there is a death of the baby. A good flow of information during perinatal audits when the baby dies at birth will lessen the blame culture.
- Recognizing the rights of midwives and mothers when the baby dies at birth and show positive attitudes and respect towards them in line with the fundamental ethical concept of respect for human dignity, protection of dignity and privacy, personal values, beliefs and cultural traditions (Searle, 2006:72).
- Promoting and encouraging team work among staff working in labour ward.
- Equipping themselves on matters of effective communication, interpersonal skills, effective conflict management and problem-solving to ensure a positive climate in the labour wards by displaying good leadership. The nurse manager is the key to harness a positive practice environment (Coetzee et al. 2012:693).

4.3.1.4 Sub-guideline 1.3: Address issues of staffing in labour ward

Rationale

Adequate staffing will ensure fair and manageable workloads and create settings that support excellence and ensure healthy and motivated midwives, improve productivity and performance. Abseentism could be lessened and staff retention may improve. Mothers who have lost their babies at birth will receive proper care and complications related to poor management of the grieving process might be reduced.

Operational implications

The nurse managers should strive for safe staffing norms by working together with Human Resources (HR). Urge the National Department of Health (NDoH) through the Eastern Cape Department of health to fund and fill vacant posts and develop staffing norms so as to:

- Address shortage of staff so as to lessen professional role stress associated with extreme workload and role conflict.
- Improve the staffing norms that are realistic and practical to labour wards situation so that mothers who have lost their babies at birth could be cared for adequately.

Management should ensure that policies are available and utilised within the accepted norms of the nursing profession with regard to:

- Work schedules designed to ensure that the labour wards are enabled to also cater for the needs of the mothers who have lost their babies at birth.
- Policy on absenteeism adhered to without favouritism to reduce conflicts in the labour ward and to ensure sound leadership management.
- Promoting the culture of a multidisplinary approach to lessen role conflict for midwives and ensuring comprehensive care provision for mothers who have lost their babies at birth. Identify key stakeholders in a care response for mothers such as obstetricians, social workers, psychologists, psychiatrists, church leaders and primary healthcare midwives to offer their skills in the management of mothers and to provide debriefing to needy midwives.

- Striving to ensure non-performance of non-midwifery duties by midwives leaving midwives to do midwifery duties only to ensure proper utilization of human resources and to lessen workloads.
- Instilling the culture of team work among staff to ensure good working relations.
- Be conversant with moonlighting and utilise it effectively for the benefit of addressing staff shortages in the labour wards.

4.3.2.5 Sub-guideline 1.4: Address administrative factors contributing to neonatal mortality

The most common avoidable causes of neonatal mortality are administration causes which often relate to delay in transportation of the mother from lower to a higher level of care (Cronje & Grobler, 2011:750).

Rationale

Addressing administrative factors – such as transport delays from peripheral hospitals while referring their mothers with complications related to pregnancy or labour, poor communication between the hospital complex and the peripheral hospitals during transfer of mothers and a lack of skilled personnel in the peripheral hospitals – could prevent avoidable deaths of babies, thus reducing a high neonatal mortality and therefore lessen the number of mothers losing their babies at birth.

Operational implications

Management should:

Review policies on referral from peripheral hospitals by:

- Inviting managers, midwives and doctors from peripheral hospitals to meetings on monthly basis to discuss issues pertaining to referrals of unjustified cases causing unnecessary influx of patients to the hospital complex.
- Advocating that obstetricians visit peripheral hospitals so that some complicated pregnancies and or labour are managed at their respective hospitals where possible.
- Discussing with management of peripheral hospitals the factors associated with

transport delays that may contribute to further complications to referred mothers.

Management should advocate for professional development of midwives, emergency services personnel (drivers) and doctors in peripheral hospitals by:

- Offering opportunities for training of midwives in management of obstetric emergencies (ESMOEI). Midwives and doctors from peripheral hospitals could be invited to join trainings in the hospital complex.
- Offering training to emergency service drivers regarding care during transportation of mothers with complications such as eclampsia, premature labour and obstetric shock.
- Ensuring that communication during referrals is improved through training of midwives in filling of relevant documentation for transfer and in proper recording of documents such as the labour graph to avoid missed opportunities and mismanagement of mothers with complicated labours.

4.3.2 PRINCIPAL GUIDELINE 2: Provide training and education to midwives regarding provision of culturally sensitive care to mothers who have lost their babies at birth

Culturally sensitive care refers to recognition of cultural perspective of loss and grief. Knowledge and understanding of key religious and cultural rituals by health professionals can facilitate difficult decision making around the death of the baby (Koopmans, Wilson, Cacciatore & Flenandy, 2013:8).

Rationale

Provision of education and training to midwives on areas of culturally sensitive care to mothers who have lost their babies at birth could enable midwives to provide quality holistically care inclusive of traditional and cultural perspectives of dying and grief while also observing professional values and beliefs in the care of mothers whose babies die at birth.

4.3.2.1 Sub-guideline 2.1: Assist midwives towards cultural competence

Cultural competence is used to describe a set of behaviours that reflect appropriate

application of knowledge and attitudes while rendering care in cross cultural situations. Being cultural competent implies having the capacity to function effectively in cross cultural situations (Sutton, 2000:58).

Rationale

The midwives should be proficient to provide culturally sensitive bereavement care to mothers who have lost their babies at birth by accrual of knowledge and skills that will enable them to adapt healthcare in accordance with ethno cultural and religious heritage of the individual mother, her family and the community together with professional values and beliefs.

Operational implications

The operational manager could organise a one-week workshop for midwives at least twice a year to ensure that new employees are also put on board and the existing midwives are updated from time to time. The operational manager could invite people from diverse cultural backgrounds as speakers in the workshop so as to share sound educational base of different cultures concerning birth, dying and grieving. The workshop will create an opportunity for the midwives to engage in cross-cultural interactions and could include the following topics for discussion:

- Midwives' self-awareness of unconscious competence in lacking knowledge about other people's cultures.
- Midwives' conscious incompetence about how to act in a culturally sensitive manner that would exhibit biased behaviours.
- Small group-formation comprising different cultures to share the dynamics of differences related to dying of a baby at birth and grief.
- Practise skills to fit the cultural context of the grieving mother that will include communication and a culturally sensitive assessment of different cultures' response patterns to the death of the baby so as to assist midwives in facilitation of the grief process for the mothers who have lost their babies at birth.
- National patients' rights charter according to Constitution of the Republic of South Africa 1996 (Act No. 109 of 1996) could be included so that health practitioners reminds themselves of the commitment to uphold, promote and

protect this right. Also to bring awareness of the responsibilities of mothers towards advising healthcare professionals of their wishes concerning death of their babies (Department of Health, Guidelines for good practice in the healthcare professions, 2008:1).

- The unit manager could encourage the staff to acquire knowledge by reading research articles on different cultures and participating in conducting research studies on different cultures pertaining to death of babies at birth and provision of culturally sensitive care to mothers who have lost their babies at birth.

4.3.2.2 Sub-guideline 2: Develop a care programme for mothers who have lost their babies at birth that is based on essential core competencies of midwives

Competency # 1 and 5 are two of the six Essential Core Competencies of midwives that are defined by the International Council of Midwives (ICM). South Africa is also a member of the ICM through the Society of Midwives of South Africa (SOMSA). Competency # 1 state that midwives require knowledge and skills from the social sciences, public health and ethics that form the basis of high quality cultural relevant care for women and Competency # 5 state that midwives are to provide comprehensive culturally sensitive care (Dippenaar & da Serra, 2013:14).

Rationale

Midwives could be able to provide comprehensive bereavement care guided by a care programme inclusive of traditional and cultural care within their professional practice. The nurse managers could also be setting standardised practices of care for mothers across their labour wards and be able to supervise and support their subordinates in caring for mothers who have lost their babies at birth guided by a documented care programme.

Operational implications

The unit manager could, together with the midwives working in labour wards, formulate a care programme for the care of the mothers after the baby dies at birth that will integrate traditional, cultural and professional values and beliefs. The unit manager could organise a one-day workshop and in-service training for midwives caring for

mothers who have lost their babies at birth. The programme will also be included in the procedure manual of the unit so that even the newly employed midwives will be oriented about the care programme. The following care programme could act as a guide:

- Have a written policy on how to manage the death of the baby and the holistic care and support to be given to the mother who has lost her baby at birth.
- Breaking the news of the death of the baby could be better done by a skilled midwife or an obstetrician or a medical doctor. If the baby died in utero, it may be advisable that an obstetrician who did the ultrasound and confirmed the diagnosis break the news to the mother. If the baby died after birth, the midwife or obstetrician who conducted the delivery is the suitable person to break the news. Breaking the news should be done in an unhurried manner and in a private room. It is important to be honest to the mother about the causes of death of the baby by giving complete and understandable information. If possible, a family member can be invited during the breaking of news.
- Ask the mother if she wishes to see the baby, if yes, allow it even if the baby is malformed, if no, respect and support their wishes.
- It is appropriate that care providers express empathy and show their feelings and concerns, the mother may appreciate that the caregiver is showing caring and understanding.
- It is also advisable that after the death of the baby the mother is never placed with other mothers with babies unless the mother wishes so.
- It is important to allow the mother to express her fears and needs while the midwife is available for support.
- Also consider that the mother might be in shock and people in shock do not take messages in so the midwife may have to repeat the message now and again.
- Consider including other professionals such as psychologists, social workers and psychiatrists if the risk factors warrant it
- Consider genetic counselling if required
- Observe and respect cultural wishes and practices to ensure provision of individualized care. Ask what the mother prefers in terms of traditional cultures

and rituals and as long as it is within the law, assist the mother to carry out such rituals.

- Communicate with the mother in a sensitive manner and respect for different cultures so as to understand what the individual mother regards as normal expression of grief and acceptance of the loss.
- Explain legal issues like the birth and death certificate in cases where burial should be immediately done as according to family traditions and cultures.
- Ask the wishes of the mother with regard to family's cultural traditions such as taking photos of the baby, making a foot or hand print, giving the baby a name, and or cutting a piece of hair.
- Take care of the physical needs, the wound, the drying of breasts and the normal postnatal care.
- Refer the mother to relevant outside support upon discharge.

4.4 LIMITATIONS OF THE STUDY

The researcher experienced a paucity of South African literature relating to experiences of midwives in caring for mothers who have lost their babies at birth. Many interviews had to be rescheduled due the labour wards being very busy, thus resulting in a two-week delay in data collection.

4.5 RECOMMENDATIONS

In view of the findings of this study, recommendations are made with regard to nursing practice, education and research.

4.5.1 Recommendations for nursing practice

The following recommendations are proposed for nursing practice:

- Midwives and doctors working in labour wards should be made aware of the findings of this study and guidelines through dissemination of the results.
- The guidelines need to be made available in all labour wards
- Training programmes should be scheduled to train midwives on the guidelines and on-going in-service trainings be continued. Midwives should be encouraged to utilise the guidelines in caring for mothers who have lost their

babies at birth.

- Managers to consider the time needed to care for grieving mothers concerning communication, interaction and listening to grieving mothers and review the staffing norms so that they are calculated to cater for the time needed to care for the emotional support required for the grieving mothers.
- Restructuring of the labour units so as to cater for the needs of the grieving mothers such as a unit suitable for the observance of traditional, cultural and professional values and beliefs without discrimination embarrassment.
- Implementation of guidelines should be monitored and evaluated by managers for effectiveness and practicability in their settings.

4.5.2 Recommendations for nursing education

The following recommendations are made with regard to nursing education:

- The guidelines should be included in the curriculum of midwives for both basic and post basic training and education programs.
- The students should be equipped with knowledge and skills on bereavement care during their training so that when they complete training they have the necessary skills and coping strategies when encountering the death of babies in labour wards.
- Nursing facilitators should familiarise themselves with guidelines through workshops and in-service trainings so that they are able to design teaching strategies relevant to teaching of bereavement care.
- Culturally sensitive care should also be incorporated in the curriculum as it is also an important element in bereavement care.
- Supportive communication techniques should also be part of the training of students through role plays so as to make them better prepared to support and care colleagues and grieving mothers.

4.5.3 Recommendations for nursing research

The following recommendations are made with regard to research:

- Further research should be conducted in different institutions and in different racial groups to determine the experiences of midwives in caring for grieving

mothers in other labour wards settings.

- A quantitative research approach should be undertaken to measure the quality and effectiveness of implementation of guidelines suggested in this study.
- A comparative study could be done to compare the effects of caring for grieving mothers on midwives working in labour ward and those working in postnatal units.
- Also studies on the perceptions of managers regarding the experiences of midwives caring for grieving mothers could be done as a follow-up of this study.

4.6 CHAPTER SUMMARY

Chapter Four has focused on development of guidelines that could assist midwives working in labour wards in caring for mothers who have lost their babies at birth. The guidelines that were developed were based on identified needs during data collection and suggestions made by the participants. The researcher also used literature and her own experience as a midwife was of great assistance.

Limitations of the study and recommendations were also dealt with. The focus of the recommendations was on nursing practice, nursing education and areas of research that still need further attention.

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APPENDIX A: EPIDEMIOLOGICAL RESEARCH &SURVEILLANCE

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19 March 2013
The Eastern Cape Research Directorate
Department of Health
Dear Sir/Madam

A REQUEST FOR PERMISSION TO CONDUCT RESEARCH

A request is hereby submitted for permission to conduct research among the midwives in the labour wards of one of hospital complexes in the Eastern Cape. I am currently registered for my Magister Curationis Degree in the Faculty of Health Sciences, Department of Nursing Science, at the Nelson Mandela Metropolitan University in Port Elizabeth. My supervisors for the study are Dr E Ricks and Dr S James.

The title for my study is: Experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of a hospital complex, Eastern Cape. The goal of the study is to explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of one of the hospital complexes. A qualitative, explorative, descriptive and contextual design will be used to conduct the study. The data obtained from this study will be used to develop guidelines that could assist midwives in caring for mothers who have lost their babies at birth.

The proposal will be presented at the university FRTI committee for ethical approval. A copy of the proposal will be made available to you on request. My supervisors will be available to address any ethical concerns you may have related to the study. You will be free to contact them at any stage during the course of the study.

Thank you

Yours sincerely

Mrs. P. Dasi
Magister Curationis student
Student number: 212449648
Contact number: 047 531 22 33
Cell number: 0833 688 004

APPENDIX B: LETTER TO PARTICIPANT

Lilitha College of Nursing
Private BAG X5104
MTHATHA
5100
FAX/ Tel+ (0)47 522-33
13 August 2012

Ref: (number will be supplied upon granting by Ethics Committee)

Contact person: Peggy Dasi

Dear Participant

You are requested to participate in a research study. All the necessary information will be provided to you to assist you in understanding of the study. Guidelines explaining what would be expected of you during the course of the study will be explained and made clear to you, the participant.

Participation in research is entirely voluntary and you may withdraw from the study anytime you feel uncomfortable to continue and there will be no penalty and or loss of benefit However, if you withdraw from the study, you will be asked to come for discussions to finalize the resrach in an orderly manner. Your participation in research may be terminated by the researcher should it be deemed necessary that it is not in your best interest to continue with the study either due to physical or emotional medical reasons. You will be required to sign and initial a written consent which has been prepared in compliance with current statutory guidelines to verify that you understand and agree to the conditions of the study.

Please be free to query any concerns you may have during the study. The contact numbers of the researcher are provided are provided at the end of this letter.

Your attention is also brought to the fact that the integrity of the study has been approved by the Research Ethics Committee (Human) of the university. This committee consists of experts that have a responsibility to ensure that the rights of participants are protected and the study is conducted in an ethical manner throughout.

You are also free to contact this committee should you have queries with regards to your rights at the Department of Research Capacity Development, P.O. Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031. Should you not get assistance, contact the Chairperson of the Research Technology and Innovation Committee at the same address.

Confidentiality will be maintained throughout the study; however, the results of the study may be presented at scientific conferences or professional publications.

Thank you

Peggy Dasi (Researcher)

Contact number: 047 531- 2233 (work)

E-mail: peggydasi@yahoo.com

APPENDIX C: INFORMED CONSENT

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

RESEARCHER'S DETAILS	
Title of the research project	**EXPERIENCES OF MIDWIVES IN CARING FOR GRIEVING MOTHERS WITH PERINATAL LOSS IN THE POSTNATAL UNIT OF A PUBLIC ACADEMIC HOSPITAL, EASTERN CAPE.**
Reference number	
Principal investigator	**MRS PEGGY DASI**
Address	**LILITHA COLLEGE OF NURSING, MTHATHA CAMPUS, PRIVATE BAG X5014, MTHATHA**
Postal Code	**5100**
Contact telephone number (private numbers not advisable)	**047 502 2233**

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT		Initial
I, the participant and the undersigned		
ID number		
OR		
I, in my capacity as	(parent or guardian)N/A	
of the participant	(full names)N/A	
ID number	N/A	
Address (of participant)		

A.1 HEREBY CONFIRM AS FOLLOWS:		Initial
I, the participant, was invited to participate in the above-mentioned research project		
that is being undertaken by	MRS PEGGY DASI	
from	LILITHA COLLEGE OF NURSING, MTHATHA CAMPUS. STUDENT AT DEPARTMENT OF NURSING SCIENCE,	
of the Nelson Mandela Metropolitan University.		

2. THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:			Initial
2.1	**Aim:**	The goal of this study is to explore the experiences of midwives in caring for mothers with perinatal loss. The focus will be on midwives working in postnatal units of a public academic complex hospital, Eastern Cape.	
2.2	**Procedures:**	I understand that: I will be asked questions by the investigator and thirty minutes of my time or more will be taken. I also understand that I will withdraw from the study anytime i feel without being punished.	

2.3	**Risks:**	There are no risks anticipated from this study but I understand that I have a right to voice out to the investigator any feelings of discomfort physically and emotionally during the period of the study.	
2.4	**Possible benefits:**	As a result of my participation in this study, the Data obtained from this study will hopefully assist in developing coping and supportive strategies for midwives so as to help midwives in provision of sensitive, supportive and therapeutic interventions to grieving mothers experiencing perinatal loss	
2.5	**Confidentiality:**	My identity will not be revealed in any discussion, description or scientific publications by the investigators.	
2.6	**Access to findings:**	during the course of the study will be shared as follows: Midwives working in postnatal units of the Nelson Mandela Academic hospital complex and the Department of Health will have access to the results of the study. Funders of this project and the Nelson Mandela Metropolitan University Academic staff will also have access to the results but I understand that my identity will not be revealed	
2.6	**Voluntary participation / refusal / discontinuation:**	My participation is voluntary	
2.6	**Access to findings:**	My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	
			YES TRUE

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:									**Initial**
(name of relevant person)									
in	**Afrikaans**		**English**	*	**Xhosa**		**Other**		
and I am in command of this language, **or** it was satisfactorily translated to me by									
(name of translator)N/A									
I was given the opportunity to ask questions and all these questions were answered satisfactorily.									

4.	No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	

5.	Participation in this study will not result in any additional cost to me.	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:		
Signed/confirmed at	on	20

Signature or right thumb print of participant	Signature of witness: Full name of witness:

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)										
I,	Peggy Dasi							declare that:		
1.	I have explained the information given in this document to							(name of patient/participant)		
	and / or his / her representative							(name of representative)N\A		
2.	He / she was encouraged and given ample time to ask me any questions;									
3.	This conversation was conducted in	**Afrikaans**		**English**	*	**Xhosa**	*	**Other**		
	And no translator was used OR this conversation was translated into									
	(language) N\A		by	(name of translator)N/A						
4.	I have detached Section D and handed it to the participant					YES		NO		
Signed/confirmed at				on				20		
Signature of interviewer				Signature of witness: Full name of witness:						

C. DECLARATION BY TRANSLATOR *(WHEN APPLICABLE)*			
I,	(full names)N/A		
ID number	**N/A**		
Qualifications and/or	**N/A**		
Current employment	**N/A**		
confirm that I:			
1.	Translated the contents of this document from English into	(language)N/A	
2.	Also translated questions posed by	(name of participant)N/A	as well as the answers given by the investigator/representative;
3.	Conveyed a factually correct version of what was related to me. N/A		
Signed/confirmed at	on		20
I hereby declare that all information acquired by me for the purposes of this study will be kept confidential.			
Signature of translator/A	Signature of witness. N/A Full name of witness N/A		

D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant's participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

Any emergency on your part that will make it impossible for you to continue with the study. Any health related problems whether physical or emotional. Any time you require further information or you have queries with regard to the study.

(indicate any circumstances which should be reported to the investigator)

Kindly contact	Peggy Dasi (Researcher) and or Dr Ricks, Department of Nursing Science, NMMU (SUPERVISOR)
at telephone number	041-504 21 22/0833688004

APPENDIX D: LETTER: INDEPENDENT CODING

05 August 2014

Dr. Williams

Department of Nursing Science

Nelson Mandela Metropolitan University

PORT Elizabeth

6031

Dear Dr Williams

INDEPENDENT CODING DETAILS

Thank you for agreeing to do my independent coding. Attached please find a clean set of transcriptions of the ten interviews to be analyzed.

Please use the Tesch's method for coding the interviews (Creswell, 2014:197) as listed below:

- Organize data and prepare for data analysis. The transcripts are to be read carefully and ideas jotted down as they come to mind to make sense of the information.
- One shortest and most interesting interview to be picked up and the underlying meaning interpreted and jotted down on the margin to make sense of its contents.
- Compiled a list of topics. Similar topics clustered together. Major and unique topics arranged including leftovers.
- The list to be compared to the data to ensure trustworthiness. The topics to be abbreviated as codes. Codes written next to appropriate segments of the text. Preliminary organization to be done and see if there new categories and codes that emerge.
- New categories and codes that emerge are to be organized according to their relationship with other categories and codes. Similar topics that relate to each

other to be grouped together.

- A final decision is then made on the abbreviation for each category. The codes are then alphabetized.
- The data material belonging to each category is then assembled in one place and preliminary analysis performed.
- Recoding if necessary is done to generate a smaller number of themes. My research proposal is attached to give you a better understanding of my study.

Thank you

Mrs. Peggy Dasi (212449648)

Mobile number: 0833688004

e-mail: peggydasi@yahoo.com

APPENDIX E: APPROVAL- FRTI ETHICS COMMITTEE

Nelson Mandela Metropolitan University

for tomorrow

Copies to:
Supervisor: Prof E Ricks
Co-supervisor/s: Prof S James

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042854
Nouwaal.Isaacs@nmmu.ac.za

Student number: 212449648

Contact person: Ms N Isaacs

28 November 2013

Mrs P Dasi
PO Box 66
Vidgeville
5102

FINAL RESEARCH/PROJECT PROPOSAL
QUALIFICATION: **MCUR NURSING (RESEARCH)**
TITLE: **EXPERIENCES OF MIDWIVES IN CARING FOR GRIEVING MOTHERS WITH PERINATAL LOSS IN THE POSTNATAL UNIT OF A PUBLIC ACADEMIC HOSPITAL, EASTERN CAPE**

Please be advised that your final research project was approved by the Faculty Research, Technology and Innovation Committee, subject to the following amendments/recommendations being made to the satisfaction of your Supervisor/Promoter:

COMMENTS/RECOMMENDATIONS

1. Title
   - It was recommended that the word "grieving" be removed.
   - That a full stop be put in after loss (remove the words "in the postnatal unit of a public academic hospital").
2. Problem statement
   - The problem statement suggested that guidelines will be developed on page 1, so does the 2nd objective on page 12.
   - It was indicated that guidelines will be developed. It was recommended that this be included in the title.
3. Hypothesis
   Grieving was in the first research question but absent in the 2nd research question.
4. Supportive literature
   The researcher needs to attempt integration in the literature review. One reference was listed after another, each in its own paragraph, all disconnected to each other. There was no connection and integration between sentences.
5. Ethical considerations
   Indicate that ethics approval will be sought from the relevant institution/s.
6. Writing style
   There were editorial corrections to be made. The name of the language editor was not provided.

FRTI grants ethics approval. FRTI committee reference number: H13-HEA-NUR-019.

APPENDIX F: LETTER: REQUEST TO CEO- HOSPITAL COMPLEX

Peggy Dasi
Lilitha College of Nursing
Private Bag X5014
Mthatha

peggydasi@yahoo.com
09 September 2013
The CEO
Hospital complex
Dear Sir/Madam

A REQUEST FOR PERMISSION TO CONDUCT RESEARCH

A request is hereby submitted for permission to conduct research among the midwives in your labour wards. I am currently registered for my Magister Curationis Degree in the Faculty of Health Sciences, Department of Nursing Science, at the Nelson Mandela Metropolitan University in Port Elizabeth. My supervisors for the study are Dr E Ricks and Dr S James.

The title for my study is: Experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of a hospital complex, Eastern Cape. The goal of the study is to explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of your hospital complex. A qualitative, explorative, descriptive and contextual design will be used to conduct the study. The data obtained from this study will be used to develop guidelines that could assist midwives in caring for mothers who have lost their babies at birth.

The proposal will be presented at the university FRTI committee for ethical approval. A copy of the proposal will be made available to you on request. My supervisors will be available to address any ethical concerns you may have related to the study. You will be free to contact them at any stage during the course of the study.

Thank you

Yours sincerely

Mrs. P. Dasi
Magister Curationis student
Student number: 212449648
Contact number: 047 531 22 33
Cell number: 0833 688 004

APPENDIX G: LETTER: REQUEST TO ASSISTANT DIRECTOR

Peggy Dasi
Lilitha College of Nursing
Private Bag X5014
Mthatha

peggydasi@yahoo.com
09 September 2013
The Assistant Director
Hospital complex

Dear Sir/Madam

A REQUEST FOR PERMISSION TO CONDUCT RESEARCH

A request is hereby submitted for permission to conduct research among the midwives in your labour wards. I am currently registered for my Magister Curationis Degree in the Faculty of Health Sciences, Department of Nursing Science, at the Nelson Mandela Metropolitan University in Port Elizabeth. My supervisors for the study are Dr E Ricks and Dr S James.

The title for my study is: Experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of a hospital complex, Eastern Cape. The goal of the study is to explore and describe the experiences of midwives in caring for mothers who have lost their babies at birth in the labour wards of your hospital complex. A qualitative, explorative, descriptive and contextual design will be used to conduct the study. The data obtained from this study will be used to develop guidelines that could assist midwives in caring for mothers who have lost their babies at birth.

The proposal will be presented at the university FRTI committee for ethical approval. A copy of the proposal will be made available to you on request. My supervisors will be available to address any ethical concerns you may have related to the study. You will be free to contact them at any stage during the course of the study.

Thank you

Yours sincerely

Mrs. P. Dasi
Magister Curationis student
Student number: 212449648
Contact number: 047 531 22 33
Cell number: 0833 688 004

APPENDIX H: TRANSCRIBED INTERVIEW

PARTICIPANT 7

KEY WORDS- I=INTERVIWEE

R= RESEARCHER

DURATION: 60 MINUTES

FIELD NOTES: ***Female midwife aged 45 years, has worked in labour for five years. She is married with two children, both alive. She speaks confidently. She has just passed advanced midwifery last year.***

The setting is the labour ward; busy as always, too much influx of women coming in from referral hospitals with different complications.

R	What are your experiences when caring for mothers who have lost their babies at birth
I	Firstly it *becomes so* painful, sometimes the mother is old and get a still born and you must tell her so as a midwife ,you first blame yourself, thinking of where you failed, what did you not do, so, you think how are you going to start telling the mother of the child, you would wish that someone would tell the mother, you think of the cry, the blame on you from this mother, perhaps there was a problem and the baby would not survive anyway this spoils your day and not be okay in the ward, even to other patients thinking what this mother will say to her family, sometimes I even ask a senior person to tell the mother mh—mh--mh—you find that she is also scared. Ultimately you go to tell the mother it becomes worse when you explain to her about all what you did, resuscitation that failed and she is all quiet, nodding, mh…mh....it becomes very painful because when she is quiet you don't know what she is thinking, wish she would say something because you don't know what she is thinking, it's even worse in our institution because these women are referrals from other institutions, so she

	is still going to wait for her ambulance here in the ward staying with other mothers who are breastfeeding so when she sees them breastfeeding while milk is coming out her breasts, her child dead *oho-o-o-oho-o- to* me, midwife becomes very painful, sometimes you even think that 'oho-o-o, I chose a wrong profession" because of the pain you are feeling when looking at these mothers. It's worse when you ask if she wants to see the baby and she refuses and say she will see the baby at home, you know very well that she wants to see the baby with her family.
R	Mh..mh.., okay, so you say you feel you don't like to be a midwife sometimes?
I	It is not nice at all to be a midwife, you think a lot about this woman, you know, this other time, the mother was crying throughout I could not show how I felt, I could not show my weakness in front of the mother, it would be unprofessional.
R	Mh-mh—so when you say during the course of the day you don't feel right, can you explain your feeling?
I	You think many things, the family of this woman, what are they going to say, what is she going to say to them, you even afraid of looking her in the eyes in the ward because you are to blame because even if she was attended by another team if the baby dies in your hands you are to blame, may be when you come the fatal heart is 120 and nothing was done, maybe she goes to theatre with a fetal heart of 110 and she gets a FSB, you feel the pain, it's worse she goes to theatre knowing that her baby is alive so this mother obviously has a question in mind "what did they do to my baby?"
R	Mh—mh--
I	Now you are to blame, so even if you explain, she will not understand all she wanted was a live baby and there you are

	telling her that her baby is dead. I am the one who resuscitated the baby so I am to blame. Even in the community, people talk blaming us saying we nurses kill babies.
R	So you say it is very painful, can you explain that exactly, that pain you feel?
I	Your conscience will eat you, blaming yourself, you can't blame another person, you ask yourself so many questions like, where did I fail, what is it that I did not do, where did I go wrong especially somebody who was in your care and yet sometimes the mother will tell you that the baby was not moving for a week but you find nothing on the chart and again the mother was never taught what to do when the baby is not moving.
R	MH-MH--
I	It becomes painful sometimes you feel it's better if you avoid this mother, you just don't look at her, you feel even if she does not say but deep inside she blames you, you were supposed to save her baby but no you didn't so you are to blame
R	So you say this mother will be in the unit for some time and sometimes you don't want to look at this mother, so, can you---(interrupted by I)
I	Especially when she is sitting with other children , you think she looks at you, she blames you for her loss, she will not understand even if her condition is the one that caused the death of the baby, if you try to explain all she wants is her baby she expected from the hands of a professional
R	Do you think its worse for you when she is staying with other breastfeeding mothers?

I	Yes because you will see the pain in her eyes and it becomes very painful for you because you know the baby died in your hands, you just wish she could be discharged home but she has to wait for the ambulance and she can't even leave the cops behind, the policy of the hospital does not allow that. The hospital policy only allows referrals to be discharged in their referring hospitals sometimes the ambulances delay to come and these women stay longer here, so, they wait longer to go home where they can be with their families who understand the culture to be followed. I don't know if it would help but I think it would be better if these mothers would separate from breastfeeding mothers it's bad for the mothers with live babies as well.
R	So you say it becomes more painful when she is old, so what—(interrupted by I)
I	It's because *y*ou know chances are that she won't have another baby so it's hard to counsel, what do you say, sometimes she is married and we know that many marriages are destroyed by not having children, so you feel her pain. It's so painful if I know she won't have another chance to have a baby, sometimes the mother is old, so, it's so hard to counsel her, you feel so hurt, so hurt [closing her eyes and looking down].
R	Mh—mh--
I	You don't even know what you say to her, there is no hope, you feel you have destroyed her dreams, of her family, you can't be happy in that situation because even the community people talk blaming us saying nurses kill babies.
R	So if you are dealing with a younger mother, does it make any difference?

I	It's painful *even* if it's a child but you counsel her with hope that God will give her another child
R	Mh—mh--
I	The older one, what hope do you give her, you really don't know what to say, it becomes even more painful
R	Okay, what does the death of the baby mean to you according to your personal values and beliefs and how does it influences you in caring for a mother who has lost her baby at birth?
I	A child is very important especially in marriage, I don't say it's not important for single mothers but for me in marriage a baby is in demand and is planned so, for a married woman it is a great loss and ,you think *of* the suffering this married woman is going to go through in her marriage
R	MH—MH--
I	So you put yourself in her shoes, how she is feeling even if she is not saying anything, it's worse if she is crying. When you go home you leave a mother in the ward who does not know why she is not breastfeeding like other mothers, why her baby is dead, why she is not carrying her baby; it's difficult to sleep, especially if she is married, no sleep coming.
R	So you say the baby is very important, you value the life of the baby, is that what you are saying?
I	Mh…mh…mh…, a child is very important especially in marriage. In other instances you find that the baby was already given a name immediately the mother became pregnant, may be by an elderly person in the family, maybe they have been wanting a child for a long time, and the name give to the child is based on that, for example they said they finally got the child to find out it won't

	be so. The husband might have been supportive during pregnancy, clothes bought and everything for the baby but now you failed him as a mother and this mother was failed by you, the midwife, so, the value of the baby becomes meaningless like you midwife, you don't care, just think of what happens in that family, how do you feel *as a* midwife, you feel like you destroyed a family though it was not your fault.
R	Mh—mh—so you say you blame yourself and when you blame yourself, can you describe that feeling?
I	Oh…oh…—I cry, no sleep coming, difficult to sleep at home, you leave in the ward a mother who does not understand why she is not carrying her baby, she is not breastfeeding like other mothers in the ward, sometimes it's difficult when you see her in the streets after she is discharged. Sometimes you don't even have time to explain to the mother let alone talk to her about how she feels because of other duties that call, it's like you are heartless. There is no time to grieve, someone will be calling 'midwife, 'midwife' it's time to go to theatre and you have to leave there and then.
R	MH—MH--
I	Mh—mh—one time I delivered a baby, the mother had mild abruption and was at 28 weeks gestation, so, I arrived doing night duty and she was 8cm dilated and the fetal heart was okay, so, I told her that she was about to deliver, she said she thought that she will be given medication so that she won't go to labor because she understood that the baby was still small, so, I explained to her that her mother brought her late and there is nothing that can be done to stop the labour, so the baby was delivered very small but pink and crying. I immediately resuscitated the baby mh—mh—was about 7500g mh—mh—something like that, then I showed her the baby, it was her first pregnancy, she was so excited then I sent the baby to neonate but when I put the baby at neonate*, I*

	saw that she was changing but I left her alive but I was doubting if she will make it because of her weight but I hoped for God's mercy.
R	Mh—mh—mh--
I	The following day, the baby died, so, it was very painful although the baby was very small but I still blamed myself because I was the one who managed the delivery of this baby. I knew the mother wouldn't understand, the smile she had when I showed her the baby, when she was looking at her baby, so, I delivered the baby not the neonate people, so, what did I do wrong during delivery, during resuscitation?(silence)
R	Mh—mh—so you are saying is----(interrupted by I)
I	Was afraid when I met her again. I could not face her with my own eyes although I knew what I would say to her but I was scared to talk to her, I thought of her smile when she was looking at her baby, so, now she was going to cry although she knew the baby was small
R	So you are saying irrespective of the weight of the baby it's still life?
I	Mh—mh--, I still value that life, there was life, so, it should be saved, for the mother, it's her baby
R	So you say you were scared to see this girl, can you—(interrupted by I)
I	Oh…oh..oh…he way she was happy when I showed her the baby irrespective of my explanation that the baby was very small but I don't think she ever thought that the baby wouldn't survive, she was so happy, so, how do you I look her in the eye so I avoided

	her . I knew her sister but I also avoided her if I see her even in town
R	So what you are saying is that even if you deliver the baby alive and the baby dies in neonate you are still affected?
I	Oho-o-oh…, mh—mh—mh--, the mother is here in the ward and you are the one who delivered the baby, you are still to be blamed, you conducted the delivery, did first resuscitation, so---ja—so it's better to take sick leave and stay home for few days at times because you are sad and tired , you know, in our hospital plus minus 15 hospitals refer their patients, so, our labour wards are always full, labour ward one is supposed to have two beds but there is an extra bed, labour ward two also has an extra bed, there are patients on stretchers, there is one on a chair, others are in theatre every day, it's very stressful. Sometimes you don't feel like going to work the following day because you are tired emotionally and physically drained, better if you just take sielve,..
R	So you say you cry even at home, can you explain what happens?
I	You arrive at home being kindles, not having an appetite to eat, thinking about tomorrow *that you* have to go on duty, it might happen again and sometimes, he—e-oho….there is this book for entering FSB's and one for MSB's, so, when you deliver an FSB you go and enter the delivery in that book, MSB, enter in MSB book. When you open that book and see your writing above, I just close the book for a moment, yho-o—o—it's my writing again, my signature again, you ask yourself what is wrong with me, why is it me again
R	So you are saying most of the time you blame yourself?
I	A lot, even if it's not your fault, even if you did everything or maybe it was the fault of the mother or doctor or another midwife, now it's you who conducted the delivery, it's you opening that book, it's

	you who is accountable for the death, at the end you are to explain, you know, one mother came here from----(name of the place omitted) with obstructed labour but there was nothing on her labour graph, I mean just nothing, clean, clean, clean.
R	Mh—mh--, so, how does that make you feel?
I	Helpless, sometimes angry but what can you do, nothing, it is now you and the death of the baby, you are now to face the mother, to deal with the situation, no one else. The thought of going to work the next dat, yho-o-yho-oo my whole body was aching; I had a terrible headache; I could not sleep, very worried and sad.
R	Okay, how do your organizational values and beliefs about care in dying and death influence your experience of caring for a mother who has lost her baby at birth?
I	Here in the institution there is this policy on the death of the baby that you ask the mother if she wants to see the baby, if yes, show her the baby, if no, you don't then take the baby to mortuary. I know every organization has its own rules but some of them are contradicting with community cultural beliefs I feel we are not helping them to heal, but there is nothing we can do about it because its not our decision to make, maybe if it was provided here in the hospital policy but to me the institution does not care about the feelings and beliefs of the mother in fact even me as a midwife it makes me feel bad. Sometimes you learn from your mistakes so that you do not repeat them in future although it is painful because you learn at the expense of the mother, at the expense of the baby, it's still hurting when the baby dies.
R	So what does the organization do?
I	What is painful here in the ward is the perusing of the chart by managers. They take the chart to look for your mistakes, nobody calls you, you don't even know what they are picking up from the

	chart, and then the chart is sent away to------for further perusing, you are never right during all this time because you don't know the outcome, you stay worried, no one talks to you, at least if someone would say something----(silence)
R	So whilst you are blaming yourself, you are also blaming the organization?
I	Yes because you do not matter to them, they just take the chart and leave you like that, how you feel, no one cares. They take the chart to look for your mistakes, no one talks to you at that time and it is very cruel to treat us like that.
R	So according to your organizational values and beliefs mh—mh—do they include any support systems for midwives?
I	As I say you do not matter to them because at least it would be better if one of the managers would call you and tell you what is discussed by you or even ask you what happened so that you can express to her how you feel about the whole situation but you wait and wait, it never happens, you just talk to your colleagues, because it would be better if one of the managers would call you and console you but my colleagues console me, other midwives they console you and say you must endure.
R	So when it comes to this chart perusing, is it done in your presence?
I	No it is kept away from you, no one say anything to you, they just take the chart and sometimes you just took over you did not even read the chart, you don't even know what is there, you just remain worried, nobody talks to you, the chart will then be sent to ---------
R	How does that make you feel?

I	Mh---mh--, you feel eh—eh—I don't know (shaking her head), you are restless, you wish to be called now but at the same time you wish you would not be called. It is not nice to wait for a bomb, you know you are blamed for sure, sometimes you don't feel like going to work the following day, better if you just take sick leave because you just want to be away and just rest.
R	Is there a stage when you are called?
I	No, only if there is a court case otherwise the manager will talk generally in the ward, quoting things from the chart, not talking directly at you, just talking sometimes she would say *"oh….o..* what you are doing is scary sometimes you will be called for interrogations sitting there answering all sorts of questions related to the mistakes they picked up on the chart, sometimes other midwives may be called too as witnesses, you know, the ward routine is just disturbed, then comes the time for your questioning, yho-oo-yho- its bad, the way you are treated, I don't say the inquiry about death is wrong, it's okay to find out what happened but yho-o the way it's done it's like you are judged already, no one supports you from management, you are just on your own.*"*
R	Okay, so what do you think can be done to assist midwives to cope in caring for mothers who have lost their babies at birth?
I	I think it would be very important to provide counselling for us midwives, not being neglected although it is difficult to say that to our managers, you can't even go to them to tell them how you feel about the death, the policies here, may be it's me (shaking her head), they do not benefit anybody even the mothers, you know, how do you care for this mother, she has lost a baby, but you are worried about what's coming to you, what about other mothers—yho-yho (a sigh).

R	Why is it so? Why is it difficult to go to the managers to tell them how you feel?
I	Most of the time the blame is put on you, they look for any mistakes you did, no matter how small as if she was never a midwife like you or at least just talk to you nicely and say my dear don't worry much perhaps talk about the gestational age or something just to comfort you
R	So you say it is you who do not want to go to the managers because you are scared of being blamed?
I	Yes—yes—yes--, you know that you are going to be blamed even if you took over a woman already having a problem
R	Okay, so you say the midwives need to be counseled. How do you suggest this could be done?
I	I think we need somebody to talk to here in the ward so that we can express how we feel and explain what happened that lead to the death of the baby without being harassed. We need somebody to counsel us especially in cases of unexpected deaths and not to go home with the same pain.
R	MH—MH—so what type of a person do you suggest to do this counselling?
I	I think we need a psychologist for the maternity staff mh..mh…yes (silence)
R	So you think the psychologist should be in the ward?
I	Yes not someone from outside, somebody who understands the ups and downs of the maternity ward because that person will counsel you with understanding because when you go to her she will know how to counsel because she understands. I think it

	should come from inside, a psychologist employed by the hospital for maternity staff
R	You said earlier you become scared to tell the mother, what scares you…mh…mh do you have counselling skills?
I	No, no, no at all, no counselling skills you only work through them because you have been facing such challenges for a long time now, that is why you become scared to talk to the mother, you don't have a skill, you take time trying to prepare yourself, it's really not easy. It's worse because I also feel we are not helping them to heal but there is nothing we can do about it, maybe if it was provided for as a hospital policy we would be provided with training on counseling grieving mothers.
R	So you say you don't have formal training in counselling?
I	Not at all and I know no one who does here in the ward, yes other counselling but not related to death
R	Do you think you need counselling skills about death?
I	Yes a lot, every midwife conducting a delivery or working in postnatal unit, you don't know when you'll need those skills anything can happen, I think it is important
R	How do you suggest this could be done?
I	If there is a way, I think just short courses on counselling of grieving mothers or when we go for other short courses a person trained in grieving counselling can assist us in strategies to deal with these grieving mothers, train us on how we can handle these situations at least.
R	Okay, you said earlier sometimes you cry at home, do you think if you had seen a psychologist, do you think it would help?

I	At least you would have someone to talk to, you know when you have spoken about something that is bothering you, it makes it better at least even give you advice and suggestions on how to cope because there is always a next time, talking about it helps.
R	Okay, you have been mentioning God in that and that, so, how do you associate God with death?
I	We know that everything depends *on God* when we call on him
R	So even death depends on Him?
I	Yes, God is everything to us
R	You said something about a psychologist but you also mentioned that you are scared to go to the managers, what do you suggest the managers to do for you when there is death?
I	I wish the managers would come to you and not always blame, blame, at least talk with you until you are okay
R	You said sometimes you blame yourself and ask why you became a midwife, what do you think can be done to make you like to be a midwife?
I	Mh—mh—(silence)
R	You explained earlier that sometimes you don't like writing in the FSB or MSB book, you feel sometimes that you took a wrong profession. What do you suggest can be done to make you live with the situation irrespective of deaths in the ward?
I	I think when death occurs, at least there is a place where one can learn even if you are to blame, at least show you where you went wrong you will develop interest, and carry on, if no one cares how you feel, you don't feel like going to work, sometimes you just take sick leave because sometimes you are scared to face people, it's

	worse if it's a maternal death knowing that the family is going to come tomorrow, how will you face the family*?,* even if they do not ask who was conducting the delivery but looking at them feeling guilty, so, rather take sick leave, sometimes it's only the mother you left in the ward, you just don't want to see her again but I also blame the failure on referring hspitals, I don't think they should refer mothers with MSB's, they should tell them and deliver them other than bringing them to us unless there's another complication.
R	Earlier you mentioned something about asking a senior person to talk to the mother, why do you ask a senior person?
I	It's like she would do better because facing that mother crying makes me cry and sad, you think the senior person knows how to deal with the situation and can handle it better, you feeling bad, but most of the time they refuse
R	Okay, so you say you feel weak, let's go back to the psychologist, how often do you suggest it would be okay for you to see a psychologist?
I	I think every three months at least than now that there is nothing done because you might deliver a FSB this week and then may be in a months' time if you are lucky but sometimes the mother stays longer here in postnatal next to us with other mothers breastfeeding their babies, you see her every day, its traumatic, I don't know if it would help but I think it would be better if these mothers would separate from breastfeeding mothers, it's bad even for the mothers with alive babies.
R	So you think if it's done every three months it will also cover for any deaths encounters in between. Will that assist you in your daily functioning?

I	No, I mean when it occurs you go for counselling so that at least you are right for that day then may be every three months
R	Okay, so, you say sometimes you are not right the whole day, how can you describe your caring for other women in the ward?
I	You have that feeling and think you don't wish maybe it can happen again. Mh…mh—anyway mh-mh--(silence)
R	Okay, so, other than the psychologist, is there anything else you can suggest?
I	The managers if after a death they would call a meeting in the ward and correct mistakes without blaming anyone
R	Is there anything you would like to ask from me?
I	No nothing for now
R	Thank you very much.
I	Thank you

APPENDIX I: LETTER- EDITOR

J&T Dorrington

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TO WHOM IT MAY CONCERN

26 March 2016

MASTER OF NURSING (RESEARCH): MS PEGGY DASI

Dear Sir or Madam,

This is to confirm that I have edited Ms Peggy Dasi's Master's Thesis on the subject of Nursing Research. My contribution to her dissertation was solely for the purpose of checking and editing her writing style, language and syntax, as she is not a first-language English speaker.

In no way did I assist her in the subject matter of her dissertation, which remains her work and hers alone.

Sincerely,

John Dorrington.