COPING AND SUPPORT NEEDS OF MIDWIVES CARING FOR WOMEN WITH PERINATAL LOSS IN THE NELSON MANDELA BAY HEALTH DISTRICT

YEKISWA VICTORIA KAVE

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COPING AND SUPPORT NEEDS OF MIDWIVES CARING FOR WOMEN WITH PERINATAL LOSS IN THE NELSON MANDELA BAY HEALTH DISTRICT

BY
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DECLARATION:
In accordance with Rule G4.6.3, I hereby declare that the above-mentioned thesis is my own work and that it has not been previously submitted for assessment to another University or for another qualification.

SIGNATURE:

DATE: 24 MARCH 2020
DEDICATION

This dissertation is dedicated to

my beloved parents,

the late Mrs. Nosithile Nomama Kave and Mr. Mxolisi Armstrong Kave,

for their unconditional love and

contribution to what and who I am today; but

above all for the gift of education and supporting me.

Thank you for teaching me to believe in myself, in God and in my dreams

I also dedicate this work to my beautiful daughter, Yanda Likhanyisile Kave

with much love.
ACKNOWLEDGEMENTS

First and foremost, I wish to acknowledge our Lord Jesus Christ for His grace, love and guidance throughout my life; for without His everlasting love and protection I would have given up a long time ago. Above all He shielded me from all obstacles and challenges that came my way through this journey.

Secondly, I would like to extend my sincere gratitude and appreciation to the following people:

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- Prof James: Your sagacity, determination, sacrifice, patience and confidence in my abilities moulded me to who I am today. You played a big role in my journey when there were times I wanted to give up; for you saw right through my weaknesses and turned them into my strength.

- Mr Sonti: For agreeing to supervise and guide my dissertation. Thank you for your dedication, inspiration and unfailingly magnificent support. I could never have done this without your faith and constant encouragement.

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• Mr. Kave and “the late” Mrs. Kave: for encouraging me to study further and fulfil my dreams. You are the best parents ever. I love you.

• Yanda Kave: A big thank you to my daughter who showed me love and appreciation through this journey and never complained about my absence from most of her school activities and gave me support instead as she realised that I was caught up between my work and my studies.

• Mrs. Tuswa: A big thank you goes to you, my sister; for without your beatings when I was still a child (making sure I did my homework) and guiding my studies I don’t even think I would be where am I today. You were my first teacher from Sub-A. Even today you kept giving me your support and guiding my daughter through her studies. All your hard work has paid off. Look at where am I today.

• Thank you to the Department of Health and the Nelson Mandela Bay Health District for allowing me to conduct this study in their hospitals and MOUs.

• Thank you to all the midwives who participated in my study, who gave me an opportunity to investigate their experiences in coping and support needs while caring for women with perinatal loss.

• A special word of appreciation is extended to the National Research Fund (NRF) Grant for providing intellectual and financial support for commencement and completion of the study. Ms Ro Batchelor for lifting my study through your editing and the Research Capacity Development (RCD) for funding the editing of the study.
ABSTRACT

Midwives are part of the multidisciplinary team in maternal units and have the bulk of the obstetrical and midwifery responsibilities. The responsibilities being referred to include provision of perinatal care and support to grieving women who have lost their babies at birth and to their families. The care referred to in this study is focused mainly on the grieving women and not on the midwife. By virtue of midwives being present in the event of perinatal loss or caring for a woman who experienced perinatal loss, midwives are compelled to be involved and are bound to experience deep emotions. Furthermore, there is little formal support available for midwives caring for women with perinatal loss in Nelson Mandela Bay Health District (NMBHD) and South Africa at large.

The purpose of this study was to obtain a deeper understanding of coping and support needs of midwives caring for women with perinatal loss in the NMBHD. The objectives developed for this study were: explore and describe the facilitating conditions that will enable midwives to care for women with perinatal loss in the in NMBHD; explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in the NMBHD; identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD and develop coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD.

After permission had been granted by the Nelson Mandela university and approval from other relevant authorities had been received data collection was conducted between November 2018 and January 2019, using qualitative research design and interviews. The research population included all midwives working in Midwife Obstetric units (MOUs) and referral hospitals in NMBHD. Purposive sampling was used, and the data collection method was semi-structured and audio-taped in one-on-one interviews with midwives. Sample size was determined by data saturation. The number of participants was thirteen and two of these participants formed part of the pilot study.

The collected data was analysed using the seven steps of Framework Analysis from which three themes emerged namely: Midwives rely on their own coping mechanisms
to deal with perinatal loss; Midwives expressed how management influenced the way they coped with perinatal loss events; Midwives expressed the need for psychological and emotional support. Trustworthiness was maintained by observing Lincoln and Guba’s principles of credibility, transferability, dependability and confirmability. The researcher ensured that the Belmont Report ethical principles were maintained throughout the study.

Three main coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD were developed using an adapted version of the AGREE II Tool. The recommendations were: Recommendation 1: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss; Recommendation 2: Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss; and Recommendation 3: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.

**Keywords:** Perinatal loss, Caring, Support, Coping, Midwife, Facilitative conditions and Inhibitory conditions
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<td>AACC</td>
<td>American Association Critical Care</td>
</tr>
<tr>
<td>DNS</td>
<td>Department of Nursing Science</td>
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<td>DHA</td>
<td>Department of Home Affairs</td>
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<tr>
<td>DoEDDET</td>
<td>Department of Economic Development, Environment and Tourism</td>
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<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DRC</td>
<td>Departmental Research Committee</td>
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<tr>
<td>EAP(s)</td>
<td>Employee Assistance Programme(s)</td>
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<tr>
<td>ECDoH</td>
<td>Eastern Cape Department of Health</td>
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<tr>
<td>ECP</td>
<td>Eastern Cape Province</td>
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<tr>
<td>ENAP</td>
<td>Every Newborn Action Plan</td>
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<tr>
<td>FPGSC</td>
<td>Faculty of Postgraduate Studies Committee</td>
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<tr>
<td>GMCSA</td>
<td>Guidelines for Maternity Care in South Africa</td>
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<td>HCOUs</td>
<td>High Care Obstetric Units</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>NPRS</td>
<td>National Perinatal Reporting System</td>
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<td>NDP</td>
<td>National Development Plan</td>
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<tr>
<td>MBRRACE-UK</td>
<td>Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>Midwife-Led Continuity of Care</td>
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<td>NHRD</td>
<td>National Health Research Database</td>
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<td>NMBHD</td>
<td>Nelson Mandela Bay Health District</td>
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<td>NMU</td>
<td>Nelson Mandela University</td>
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<td>NMR</td>
<td>Neonatal Mortality Rate</td>
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<td>MOUs</td>
<td>Midwife Obstetric Units</td>
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<td>NUR</td>
<td>Nursing</td>
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<td>NSBCFPLPD</td>
<td>National Standards of Bereavement Care following Pregnancy Loss and Perinatal Death</td>
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<tr>
<td>OHRP</td>
<td>Office of the Human Research Protection Program</td>
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<tr>
<td>PHC</td>
<td>Primary Healthcare</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PMRs</td>
<td>Perinatal Mortality Rates</td>
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<tr>
<td>PMMRC</td>
<td>Perinatal and Maternal Mortality Review Committee</td>
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<td>RANZCOG</td>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
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<td>RCM</td>
<td>Royal College of Midwives</td>
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<tr>
<td>RCMPG</td>
<td>Royal College of Midwives Practice Guidelines</td>
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<td>SAGE</td>
<td>Serial Analysis of Gene Expression</td>
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<td>SANC</td>
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<td>Sustainable Development Goals</td>
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<td>STATS SA</td>
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<td>TMSC</td>
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<td>UHC</td>
<td>Universal Health Cover</td>
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<td>UNFPA</td>
<td>United Nations Populations Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WCP</td>
<td>Western Cape Province</td>
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CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION TO THE STUDY

Because midwives are part of the multidisciplinary team in maternal units, they have the bulk of the obstetrical and midwifery responsibilities. The responsibilities being referred to include provision of perinatal care and support to grieving women who have lost their babies at birth and to their families. The care referred to in this study is focused mainly on the grieving women and not on the midwife. By virtue of midwives being present in the event of perinatal loss or caring for a woman who experienced perinatal loss, midwives are compelled to be involved and are bound to experience similar emotions to the women. Furthermore, there is little formal support available for midwives caring for women with perinatal loss in South Africa at large.

The Department of Health (DOH) 2015, Royal College of Midwives’ Practice Guidelines (RCMPG) 2012 and International Confederation of Midwives [ICM] 2011, which are the important guideline that guides the standard of midwifery practice in South Africa, do not refer to interventions or coping strategies for midwives caring for women with perinatal loss. Furthermore, caring for women with perinatal loss or perinatal death is not included in these regulations or in any regulations, guidelines and protocols guiding the practice of the midwife in South Africa and in the amended regulation (R2488 of 26 October 1990; R786 of 15 October 2013); yet midwives are expected to provide care and support for women and their families who are experiencing perinatal loss despite any form of formal training or guide that equips midwives to care for these women. This study used a qualitative research approach with an exploratory-descriptive design to investigate and describe the coping and support needs of midwives caring for women with perinatal loss in NMBHD.

1.2 ORIENTATION AND BACKGROUND

Pregnancy is associated with excitement and joy as a new life is about to be into the world. According to the World Health Organisation (WHO), the presence of a long-desired baby in the uterus of the woman is accompanied by thoughts and dreams about what the child will look like or what his or her future will be (WHO, 2016:4). The
birth of a child following the long wait during pregnancy is considered a happy event for families (Perry, Hockenberry, Lowdermilk & Wilson, 2014:546). However, in some women pregnancy does not proceed as expected and sometimes ends in a loss. Pregnancy loss comes with acute disappointment to most women as the expectation of the woman and family did not include the possibility of a loss. It therefore brings feelings of intense emotional pain for the mother. Some of the women may end up experiencing psychological morbidity and grief. Morris (2017:1) explains that grief can be described as the intense emotional and physical reactions that someone experiences following the death of a loved one.

Perinatal loss is defined as the death of the foetus which occurs from 28 weeks until the end of 40 weeks of gestation and includes both the death of a neonate which occurs in the first 7 days of newborn life (early neonatal death) and that of a neonate which occurs from 7 days to the first 28 days of newborn life (late neonatal death). The phenomenon of perinatal loss is a common global public health concern which has gained recognition over the years (Kissane & Parnes, 2014:83). Despite significant reductions having been made in perinatal mortality rates (PMRs) during the last two decades globally, there are still an estimated 2.7 million neonatal deaths and 2.6 million stillbirths reported every year (WHO, 2016:4). In addition, progress towards reducing perinatal loss has been slow over the years and 98% of these perinatal losses occur in developing countries (Statistics South Africa [Stats SA], 2015:2). In South Africa from 2010 to 2014 little reduction was noted with perinatal deaths dropping from 24,100 to 21,908 in 2014, while during the period 2013-2014 there was a further drop in perinatal deaths from 22 724 to 21 908 (Stats SA, 2015:5). Furthermore, although from 2015 to 2016 a further reduction in perinatal loss from 22,341 to 18,683 was noted, these numbers are still unacceptably high (Stats SA, 2018:10).

Until recently, the Eastern Cape Province (ECP) had the highest percentage of perinatal losses in the country, but between 2014 and 2016, a decrease in inpatient early neonatal losses was noted, dropping from 14.1% to 13.3% (Massyn, Peer, Padarath, Barron & Day, 2016:79); but stillbirths increased from 20.6% to 21.6% (Massyn et al., 2016:84). Similar trends have been noted in NMBHD, where, for example, since 2013, the NMBHD had the highest inpatient early neonatal losses in the ECP. In view of such statistical patterns, the number of women who experience
the pain and trauma of perinatal loss on a regular basis throughout the province is noticeable. Such women must find their own ways of coping with perinatal loss, and midwives are often called to assist with this process shortly after the loss.

Perinatal loss usually occurs with little or no warning signs and the shock of this loss also has an effect on midwives, who themselves may not expect or be emotionally prepared for the death of a baby or with providing care to a mother who has lost her baby (Deery, Denny & Letherly, 2015:150). Midwives as much as they may be negatively affected by the occurrence of such loss expectation may overlook the emotions of the midwives are in the long run still expected to provide supportive care to women and their families. In this regard Andre, Dahlø, Ellertsen and Ringdal (2016:61) also note that stress and shock, guilt and self-blame are frequently reported emotions experienced by midwives after perinatal loss. Furthermore, as a rule, midwives are frequently reported to have difficulty in addressing adverse perinatal outcomes which demand great emotional competency (Montero, Sanchez, Montoro, Crespo, Jaene & Tirado, 2011:1410). In addition, owing to being overwhelmed by the situation some midwives withdraw from the situation and become depressed while others have trouble in handling the emotions and shock of bereaved parents (Andre et al., 2016:61).

In a study carried out at a maternity hospital in the Western Cape Province (WCP) which sought to investigate the experiences of midwives managing patients with perinatal loss, it was found that some midwives had reported that once a midwife delivers a diagnosed or undiagnosed stillborn, the memory of the event is ongoing and at times midwives find themselves discussing these events with family members, who are also affected by the midwives’ experiences (Williamson, 2016:50). Furthermore, in one study midwives caring for families who were experiencing perinatal loss were confronted with an unexpected and painful event that evoked anguished grief and they stated that a lack of debriefing and support from colleagues immediately after the occurrence of the perinatal event often led to prolonged grieving (Jonas-Simpson, Pilkington, MacDonald & McMahon, 2013:7). In addition, Montero et al. (2011:1410) state that midwives often use defence mechanisms like distancing themselves from
grieving parents to protect their own emotional vulnerability, and may, as a result, feel unprepared for providing care to the woman and her family.

While the midwives are expected to understand the needs of grieving women while coping with their own emotions regarding perinatal loss, their own understanding of and response to perinatal loss are vital to the provision of supportive care to women in their loss. In this regard Montero et al. (2011:1408) found in their study that midwives tended to focus on physical care, avoiding emotional aspects by reacting in a distant, almost cold manner, often denying the severity of the loss, especially in early pregnancy. Perinatal loss is believed to affect midwives caring for women with perinatal loss as they have limited grief counselling skills, by virtue of their training and education. Despite this fact midwives are often the only readily available persons to offer supportive care when perinatal death is anticipated or diagnosed. Furthermore, midwives appear to lack strategies, skills and resources to face these situations and are unable to respond adequately to the parents’ needs (Montero et al., 2011:1408).

There is currently no training in South Africa to equip midwives for perinatal loss. Relatively few studies have been conducted evaluating the experiences of student nurses and student midwives of caring for women who experienced stillbirth or perinatal loss in South Africa and in the United Kingdom. Those studies identified indicate that the training of student midwives worldwide does not prepare them emotionally to deal with the trauma of being exposed to stillbirth or perinatal loss events which may have a serious effect on their clinical performance (Morake, Phiri & van der Wath, 2016:966; Alghamdi & Jarrett, 2016:715). In Alghamdi and Jarrett’s study (2016:718) some student midwives considered that providing support to women and families following a perinatal loss, while distressing, was part of the student midwife transition to becoming a midwife. Furthermore, other student midwives believed that being able to cope with and being able to respond to stressful and challenging situations as being part of the role of a midwife (Alghamdi & Jarrett, 2016:718). It must be emphasised that coping strategies and support for midwives caring for women with perinatal loss are not included in DOH 2015 or in institutional protocols and policies guiding midwifery care in maternity units in NMBHD.
Midwives are at the forefront of midwifery care and have the responsibility of providing perinatal care to mothers and families who have lost babies before or during childbirth. By virtue of their being present in the event of perinatal loss, midwives are compelled to be involved and may experience secondary stress disorder before, during and after the event. This study sought to obtain a deeper understanding of midwives’ coping and support needs when caring for women with perinatal loss in the NMBHD. Considering the impact of perinatal loss on midwives, there is a need to explore their coping and support needs to develop recommendations that will assist them with caring for women with perinatal loss.

1.3 PROBLEM STATEMENT
The researcher has 12 years of experience as a practicing midwife at a maternity unit in NMBHHD during which time she has observed that midwives become overwhelmed by emotions when caring for bereaved women and at times are found crying after caring for these women. Also, through the researcher’s interaction with his/ her colleagues, was informed of concerns about the lack of support facilities available to them to debrief after the occurrence of the loss. Perinatal loss usually comes with little or no warning signs and shocks both the affected women and the midwives, as pregnancy is expected to end in a positive outcome. At times midwives feel as if they have failed the woman especially when a woman has a history of poor obstetric outcomes and when they cannot present the mother with a live baby.

Midwives working in obstetric units must deliver undiagnosed or diagnosed stillbirths, which is often a very emotional and stressful experience, even though other stillbirths are identified during the antenatal period. Also, sometimes midwives are required to care for the affected women in the high-risk lying-in wards, where they sometimes must diagnose intrauterine deaths and have the responsibility of informing the pregnant mother. Midwives “bear witness” to these perinatal loss events, are compelled to be actively involved and are bound to experience a variety of stressors by just “being there” (Jones & Smythe, 2015:17). Consequently some midwives find caring for women and families with perinatal loss extremely stressful and emotionally challenging while other midwives have trouble coping and feel unprepared for this area.
of practice due to a lack of support and training from their institutions (Ellis, Chebsey, Storey, Bradley, Jackson, Flenady, Heazell, & Siassakos, 2016:2).

There is paucity of literature on how midwives could be supported in the care they provide to grieving women. It is also particularly interesting to note that neither the DOH 2015, RCMPG 2012 nor the ICM 2011 provide interventions for midwives who provide women and their families with supportive care in the event of perinatal loss. The new midwifery curriculum which has been upgraded in nursing and midwifery schools across the country since 2012 to equip midwives with updated knowledge and skills does not include grief counselling skills and emotional preparedness for perinatal loss. The current study sought to obtain a deeper understanding of midwives’ experiences and their support needs for caring for women with perinatal loss in NMBHD. Based on the findings of this study, recommendations to support and assist midwives to cope when caring for women with perinatal loss were developed; the main research question the researcher sought to ask was:

“What are the coping and support needs of midwives caring for women with perinatal loss in Nelson Mandela Bay Health District?”

1.4 RESEARCH PURPOSE
The purpose of this study was to understand the coping and support needs of midwives caring for women with perinatal loss in the NMBHD. Data gathered was used to develop coping and support recommendations that would assist midwives caring for women with perinatal loss in NMBHD.

1.5 RESEARCH OBJECTIVES
The objectives of this study were to:

- explore and describe the facilitative conditions that enable midwives to care for women with perinatal loss in NMBHD.
- explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in NMBHD.
• identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD; and
• develop coping and support recommendations for midwives caring for women with perinatal loss.

1.6 CLARIFICATION OF TERMS
Ruane (2016:98) emphasises that, the abstract and theoretical meaning of concepts may have different meanings for other researchers. Therefore, the concepts used in this study are clarified for other researchers to understand the context of this study.

1.6.1 Caring
Caring refers to kindness and concern displayed for others or the work or practice of looking after those unable to care for themselves, especially in cases of age or illness (Newman & Newman, 2015:3). Collins Co-build Advanced Dictionary of English (2015:190) describes the act of caring as being affectionate, helpful and sympathetic. In this study “caring” referred to affection and compassion demonstrated by midwives caring for women with perinatal loss in NMBHD.

1.6.2 Coping
Coping is defined as the ability to confront, adapt and enable people to react to behaviours, thoughts and emotions caused by stressful events (Hirsch, Barlem, de Almeida, Tomaschewski-Barlem, Figueira & Lurnadi, 2015:502). Moreover, the coping process is described as a critical mediator of stressful person/ environment relations and their immediate and long-range outcomes (Baquatan, 2015:479). In this study “coping” referred to strategies adopted by midwives to prevent the stress triggered by caring for women with perinatal loss in NMBHD.

1.6.3 Facilitative conditions
Facilitative conditions are those conditions that are defined as unconditional positive regard, empathy and genuineness that enhance constructive change through counselling and psychotherapy (Chan, Berven & Thomas, 2015:226). In this study “facilitative conditions” referred to all the feelings and personal meanings that
midwives were experiencing and expressed as positive, meaning that those conditions facilitated their care of women with perinatal loss in the NMBHD.

1.6.4 Inhibitory conditions
Inhibitory conditions are defined as conscious or unconscious constraints or curtailment of a process or behaviour especially of impulses or desires which serve as necessary social functions, abating or preventing certain impulses from being acted on and enabling the delay of gratification from pleasurable activities (Sofroniou, 2015:155). Furthermore, inhibitory conditions are considered important components of cognition that affect an individual’s ability to function in everyday life, namely, an ability to control one’s mental processes and responses, to ignore an internal or external prompt and to perform an alternative action (Gandolfi, Viterbori, Traverso & Usai, 2014:1). In this study inhibitory conditions referred to all the feelings and personal meanings or subconscious constraints that midwives were experiencing and expressed as a negative meaning that prevented midwives from reacting to any negative constraint that would inhibit the care of women with perinatal loss in the NMBHD.

1.6.5 Midwife
A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery (ICM, 2017:1). In this study “midwives” referred to the healthcare practitioners working in maternity units and registered with the South African Nursing Council (SANC) as qualified midwives and caring for women with perinatal loss in NMBHD.

1.6.6 Perinatal loss
Perinatal loss is the foetal or neonatal death occurring from 20 weeks of gestation to the first 28 days of a newborn life (Khong & Malcomson, 2015:142). The definition includes the death of a foetus weighing 500g or more, from 22 weeks of gestation (Mosby, 2016:1367). In this study “perinatal loss” referred to any foetuses that are born
with no sign of life from 28 weeks of gestation and neonates that die from birth until the end of 28 days of life after birth.

1.6.7 Support
Support is defined as to help, encourage or to have sympathy towards another person (Hornby, 2010:1501). In this study support will refer to the biopsychosocial support referring to biological, psychological and social factors that play a vital role in human functioning in the context of disease or illness (Pilgrim, 2015:166). In this study “support” referred to biologic, intellectual and community-based elements that play an essential role in midwives caring for women with perinatal loss.

1.7 THEORETICAL FRAMEWORK
A theoretical framework is the foundation upon which a research study is built, such as an existing theory and which is often adopted by other researchers in a field of inquiry that reflects the assumptions of a study (Adom, Huissen & Adu-Agyem, 2018:438); therefore the Transactional Model of Stress and Coping (TMSC) guided the research in this study and acted as a lens through which the researcher investigated and described coping and support needs of midwives caring for women with perinatal loss in NMBHD (Glanz, Rimer & Viswanath, 2015:226). A detailed explanation of TMSC is presented below.

1.7.1 Transactional Model of Stress and Coping (TMSC)
TMSC theory was developed by Lazarus and Folkman in 1984 with the understanding that stressful experiences are constituents of person/environment transactions whereby the impact of an external stressor is mediated by the person’s appraisal of the stressor and the psychological, social and material resources at his/her disposal (Glanz et al., 2015:226). TMSC integrates personal and environmental issues with the focus on the cognitive ability to evaluate the harm caused by reaction to the threat that may lead to stress. This theory helped to gain an insight into how perinatal loss experienced by women impacted on the care provided by midwives to the women. TMSC focuses on the following six concepts (See figure 1.1), namely: Primary appraisal; Secondary appraisal; Coping efforts; Adaptation; Dispositional coping styles; and Meaning-based Coping.
The TMSC is based on the theoretical propositions such as the fact in the event of perinatal loss and midwives’ experiencing a range of emotions of being exposed to events of perinatal losses, that could be detrimental to their lives, causing stress. The use of TMSC assisted the researcher in exploring and describing the definite views of the midwives about the significance of a stressor (in this case exposure to perinatal loss) on one’s wellbeing (Primary appraisal). Based on these experiences the researcher sought to explore midwives’ ability to control the outcome of exposure to perinatal loss and their perceived coping resources to manage the reaction to these outcomes while providing care to grieving women (Secondary appraisal). Midwives’ coping efforts in dealing with the range of emotions triggered by exposure to perinatal loss in order to mediate the primary and secondary appraisals were ascertained, by exploring what cognitive and behavioural/ emotional mechanisms and actions along with available psychological, social and cultural resources adopted by midwives resulting in stress reduction. The extent to which the mental and observable efforts at coping, adopted by midwives to manage the coping stressor (perinatal loss) and which ultimately influenced their emotional well-being, functional status and health
behaviours was evaluated (Adaptation). Lastly the researcher developed coping and support recommendations for midwives, which were aimed in assisting midwives to cope better when providing care for women with perinatal loss through identification and description of their coping and support needs (emotional regulation/adaptation). A conceptual presentation of the model is demonstrated in Figure 1.1

1.8 RESEARCH DESIGN
A research design forms a blueprint of the different steps undertaken, starting with the formulation of the hypothesis to drawing inferences during the research process (Sahu, 2013:25). Furthermore, a research design is the plan that provides a framework which then specifies the type of data collected, the sources of data and data collection procedure adopted. The purpose of a research design is for the preparation, arrangement and develop a strategy of examination to acquire answers to the investigation problem or questions from the participants’ point of view (Mukherji & Albon, 2018:57). In addition, a research design directs coordination of any study at any given time.

The researcher in this study used a qualitative research design, using an exploratory and descriptive approach to gain insight into the coping and support needs of midwives caring for women with perinatal loss directly from their perspective. A detailed discussion of the applied research design will be described in Chapter 3.

1.8.1 Research methods
All methods namely various procedures, schemes, algorithms, etc. used by a researcher during a research study are termed as research methods (Goundar, 2013:10). These methods include theoretical procedures, experimental studies, numerical schemes, statistical approaches and help us collect samples, data and find a solution to a problem (Goundar, 2013:10). The research methods for this study included the research population, sampling and sample size, data collection process, data analysis and pilot study. A brief discussion of the research methods for this study follows below.
1.8.2 Research population
Research population refers to a group of people who meet the sampling criteria and share similar characteristics (Grove, Gray & Burns, 2013:351). The target population for this proposed study was all midwives working in MOUs and referral hospitals, maternity units in the NMBHD, meeting set inclusion and exclusion criteria and who had given permission to participate in the study. This section will be discussed in detail in Chapter 3.

1.8.3 Sampling and sample size
According to Polit and Beck (2014:177), sampling involves the selection of a portion of the population of interest that represents the entire population by the researcher and uses it for data collection purposes. In this study the researcher used the purposive sampling method to select midwives who were working in NMBHD and who met the inclusion criteria, to participate in the study.

1.8.4 Data collection process
Data was collected after permission had been obtained from the Nelson Mandela University Department of Nursing Science (DNS) research committee and the Faculty Post-graduate Studies Committee (FPGSC) (H18-HEA-NUR-017) as well as various relevant authorities, such as the Eastern Cape Department of Health (ECDoH) (EC_201810_016), Clinical Government Manager-NMBHD (RES KAVE/2018), Chief Executive Officer (CEO), nursing services manager, unit managers and midwives (See Annexures F, G & H). The researcher made use of gatekeepers who were the unit managers of the different maternity units in the NMBHD and wrote and hand-delivered 138 letters inviting all midwives meeting the inclusion criteria to participate in the study (See Annexure B and Table 3.1). A brief description of the study and its purpose were included in the invitation letters. A demographic form with the research title, brief demographic data and inclusion and exclusion criteria which was formulated under the guidance of an experienced research supervisor was used for the purpose of selection criteria and was attached with each invitation letter (See Annexure E). The researcher hand delivered all letters and the checklist forms to all midwives working in the NMBHD, the title, the purpose and objectives of the research study was explained and the midwives were given a time frame of two weeks to submit the checklist forms if permission to participate to the study granted. A sealed box for collection of checklist
forms provided in each labouring unit. After two weeks all the boxes were collected from each unit and all those participants who met the study inclusion and exclusion criteria were selected. Preparation for conducting semi-structured interviews were done and the data collection process will be discussed in detail in Chapter 3.

1.8.5 Data analysis
Data analysis refers to the transformation of collected data and processing of it through analytic procedures into a clear, understandable, insightful, trustworthy and original analysis (Schneider, Whitehead, LoBiondo-Wood & Haber, 2013:142). Data analysis progressed simultaneously with data collection. Data analysis for this study was guided by using Gale et al. (2013:4-5) seven steps of framework analysis, which are:

• transcription,
• familiarisation with the interview,
• coding,
• developing a work analytical framework,
• applying the analytical framework,
• charting data into the framework matrix and
• interpreting the data.

The application of this method of analysis will be discussed in detail in chapter 3

1.8.6 Pilot study
A pilot study is a smaller version of the main study conducted to pre-test and refine research methodology, using similar subjects, same setting, same data collection process and same data analysis techniques (Grove, Gray & Burns, 2014:49). The purpose of undertaking a pilot study is to test current research procedures and to confirm the feasibility of the study (Arain, Campbell, Cooper & Lancaster, 2010:1; de Vos, Strydom, Fouché & Delport, 2011:237). The researcher conducted pilot study on two midwives who met the set inclusion and exclusion criteria. Three themes emerged from the findings of the pilot study namely, Midwives rely on their own coping mechanisms to deal with perinatal loss; Midwives reported how management influenced the way they coped with perinatal loss events; Midwives expressed the need for psychological and emotional support. These findings were included in the main study findings since there were no methodological changes to be made.
1.9 TRUSTWORTHINESS

Truthfulness of the study was enhanced using Lincoln and Guba’s Model of Trustworthiness (Jeanfreau & Jack, 2010:613). The model is founded on four different criteria, namely: credibility, transferability, dependability and conformability. All non-verbal events expressed by participants and asked the research supervisor to critique data collection process to maintain truthfulness of the study. According The researcher was closely linked to the participants since she is also working in NMBHD and some of the participants are her colleagues, so the researcher in this study strove to bracket self and kept on reflective and reflexive field notes throughout data collection process by writing field notes. Holly, Salmond and Saimbert (2017:255) stated that, in understanding the components of validity in qualitative work, it is critical to ensure that the qualitative methods used enhance the trustworthiness of the findings and therefore their utility to inform practice. A detailed description on how trustworthiness was maintained in this study is presented in Chapter 3.

1.10 ETHICAL CONSIDERATIONS

Research participants and society need to be respected and protected against harm. For this purpose, codes of ethics were developed for human research, for instance, the Belmont Report. The principles of the Belmont Report indicate a profound respect for the voluntary nature of research participation, true informed consent and ethical responsibilities of the researcher to ensure human welfare (Hulley, Cummings, Browner, Grady & Newman, 2013:225). In this study therefore the ethical principles that guided the research with human participants were the principle of respect for persons, principle of beneficence, principle of justice and anonymity, confidentiality and privacy. These principles and their application in this study will be discussed in Chapter 3.

1.11 DISSEMINATION OF RESULTS

One copy of the research report will be submitted to the university for library purposes and another will be given to the relevant health authorities. An article will also be published in an accredited peer-reviewed national journals. Data gathered in this study will be presented in the form of a poster and/or podium presentation at midwifery conferences and seminars. In-service education sessions will also be conducted to inform the management, policymakers, EAP coordinators and midwives of the
developed coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD.

1.12 CHAPTER LAYOUT
The research report is divided into the following chapters as illustrated in Table 1.1 below.

Table 1.1 Presentation of the chapter layout

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1</td>
<td>Overview of the study</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>Literature review</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>Research design and methodology</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Data analysis and discussion of findings</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>Development of recommendations for support of midwives to cope with caring for women with perinatal loss.</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>Conclusions, limitations and recommendations</td>
</tr>
</tbody>
</table>

1.13 CONCLUSION
Globally midwives have a responsibility of providing supportive care to women suffering perinatal loss and their families; yet these midwives do not receive any kind of formal training or guidance that would equip them to care for these women. Moreover, these midwives often become overwhelmed with the task of caring for women with perinatal loss. The researcher sought to make coping and support recommendations that would assist midwives caring for women with perinatal loss in the NMBHD.
CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION
The previous chapter presented an introduction and overview of the study which highlighted the literature review, problem statement, research question, purpose and objectives and included a brief presentation of the methodology. This chapter will focus on a range of activities associated with conducting a literature search on the topic with a focus on the coping and support needs of midwives caring for women with perinatal loss in the Nelson Mandela Bay Health District (NMBHD).

2.2 LITERATURE SEARCHING PROCESS
To provide the reader with a reliable, scientifically robust and accurate literature review of the coping and support needs of midwives caring for women with perinatal loss in the NMBHD, a literature search strategy was needed for the study. A literature search is a systematic and explicit approach to the identification, retrieval, and bibliographical management of independent studies for the purpose of locating information on a topic, synthesizing conclusions and developing guidelines for clinical practice (Ridley, 2012:4). A review of the applicable literature as a background to the problem statement and the evolution of the interview protocol for this study was conducted as well as a search for relevant material to expand the researcher’s understanding and to establish the experiential descriptions of coping and support needs of midwives (Moule, Aveyard & Goodman, 2014:210).

The literature search undertaken included any available information published on experiences of midwives caring for women with perinatal loss globally, including that of perinatal mortality worldwide, nationally and locally. Information on the effects of perinatal loss on bereaved women and on the midwives was also part of the focus of the literature search conducted. All support services offered to both bereaved women and affected midwives were also included in the literature search. An electronic search was conducted for publications such as Google scholar, Google scholar books, ScienceDirect, PubMed, Elsevier, Wiley online library, SAGE, MEDLINE, SciELO, Springer, ERIC, Taylor & Francis Group and Cochrane library. The search also included relevant books from Nelson Mandela University (NMU) and Dora Nginza Hospital libraries. The DOH policy documents, protocols, research articles and
references that were frequently cited by the by other authors including journals recommended by my research supervisors were searched. All literature covering coping and support needs of midwives caring for women with perinatal loss was explored in order to create a clear picture of the topic being investigated.

2.3 GLOBAL OVERVIEW OF PERINATAL LOSS

Globally, about 4 million babies of the 140 million babies born every year die in their first 4 weeks of life and another 3.8 million die even before their first breath of life. In this context low-income and high-income countries account for over 99% of these perinatal deaths (Daftary, Chakravarti, Pai & Kushtagi, 2016:523). Disparities and inequalities surrounding perinatal mortality rates remain constantly unchanged within the countries and regions. Worldwide, over 14,500 perinatal deaths occur each day, with almost 99% of them occurring in developing countries (Paudel, Javanparast, Dasvarma & Newman, 2018:2). These disparities and inequalities have become a concern for international public health. World leaders have signed various declarations and strategic health policies have been mandated and reduction of perinatal losses including neonatal survival have been prioritised. In addition, most countries, including South Africa, failed to meet the targeted levels of Millennium Development Goals (MDGs) for maternal and child health by the end of 2015 (Pillay & Barron, 2018: S2). Furthermore, despite the impressive progress gains for maternal and child health during the MDG era, over 5.6 million women and babies died in 2015 due to complications during pregnancy, birth and in the first month of life (Lawn, Blencowe, Kinney, Bianchi & Graham, 2016:169). The failure in programmes implemented during MDGs era to meet the required target for MDG four and five has been noted since all these member countries have failed to meet the targeted levels.

At the end of the MDG era the rate of stillbirths remained high for most countries. Failure in reaching these goals mandated the implementation of the emerging post-2015 development agenda, including the set of Sustainable Development Goals (SDGs) which were adopted by all United Nations Member States in 2015. Additionally, a systems approach is critical to address the unfinished business of the MDGs, ensure sustainability of results achieved, build resilience and realise the ambitious SDG targets (UNICEF, 2017:3). The transition from the MDGs to the SDGs requires a reconceptualization of ‘child health’. Whereas the MDGs aimed to reduce
under-five mortality, the SDGs aim to end preventable child deaths and give every child the best possible chance to thrive, from preconception through adolescence, by 2030 (UNICEF, 2017:4). The United Nations Inter-Agency Group for child mortality reported that from the global neonatal mortality rate (NMR) which fell from 36 per 1000 live births to 19 per 1000 live births from 2005 to 2015, about 99% of all neonatal losses had occurred in low- and middle-income countries. Africa is ranked with the highest neonatal mortality rate of 40 per 1000 live births while the Eastern Mediterranean is in the second position with 38/1000, followed by South-East Asia with 35/1000 followed by America with 11/1000 and Europe with 10/1000 (Saugstad, 2011:251). In Australia, stillbirth and death of the neonate in the first month of life (perinatal death) is common and the perinatal mortality rate between 2013-2014 was 9.7 per 1000 live births (Australian Institute of Health and Welfare, 2018:1).

While there has been a decline in neonatal deaths worldwide, has been slower than mortality among children aged 1-59 months. As a result, the share neonatal deaths among all under-five deaths (indicating that the neonate dies before the first 28 days) increased from 40% (39,45) in 1990 to 47% (45,49) in 2015. From 1995-2014 the stillbirth rate remained relatively unchanged. Significant reductions of neonatal mortality since 2007 to 2015 have been noted internationally in the United Kingdom, Australia and Scandinavia; yet no change has been noted in New Zealand since this period (PMMRC, 2017:2). In the United States the National Centre for Health Statistics (NCHS) reported a further reduction of perinatal mortality rate from 11/1000 to 6.24 per 1,000 live births (MacDorman & Gregory, 2015:3). In the United Kingdom Mothers and Babies Reducing Risks through Audits and Confidential Enquiries across the UK (MBRRACE)-UK reported the perinatal mortality rate as being 5.61 per 1,000 births (Manktelow, Smith, Prunet, Smith et al., 2017:8), while in Ireland, the National Perinatal Reporting System (Manning, Leitao, Corcoran, McKernan, de Foubert & Greene, 2018:15) reported a perinatal mortality rate of 6.5 per 1000 live births.

Every Newborn Action Plan (ENAP) targeted less than 10 neonatal losses per 1000 by 2035. In the latest statistical report in South Africa it is noted that, although the total neonatal losses appear to be decreasing with development and social progress, these trends may not be reflecting the true neonatal mortality rate in South Africa, based on
the death notification data collected by the Department of Home Affairs (DHA) which is analysed and published by Statistics South Africa (StatsSA) Since there is a delay of two years, the death notification for neonatal losses is often incomplete for the year due to under-reporting and delay or late registration, meaning that the NMR in South Africa does not represent the true NMR even though it is believed that the number of NMR presented by Statistics South Africa is probably closer to the true NMR occurring in the country (Nannan, Dorrington, Laubscher, Zinyakatira, Prinsloo, Darikwa, Matzopoulos & Bradshaw, 2012:1; Velaphi & Rhoda, 2012:67). In the report given by the Director-General of WHO, in developing countries in many cases births of newborns who die soon after birth are neither recorded nor counted (WHO, 2016:4). Based on the literature it is therefore clear that South Africa is one of the countries that is still experiencing challenges with registration of neonatal losses.

Among developing countries, sub-Saharan Africa and South Asian countries record over three-quarters of the world’s stillbirths and neonatal deaths and these regions have experienced slow progress in reducing perinatal mortality rates in the past two decades (Paudel et al., 2018:2). In 2012 South Africa adopted the National Development Plan (NDP) with an idealised outcome of a long and healthy life for all South Africans and the target of reducing infant and child mortality. SDG 3 which calls for an ‘end to preventable deaths of newborns and children under five years’, demands a reduction of under-5 mortality to <25 per 1 000 live births and the neonatal mortality rate to be <10 per 1 000 live births in every country by 2035. According to the United Nations (UN), there has been a distinctive decline in perinatal losses from 2009 to 2016 of 26.4% whereas in South Africa perinatal loss has remained the same between 2010 and 2014; but a further decline from 2015 to 2016 of 16.4%, which is still above the SDGs target, has been noted (StatsSA, 2017:5). In 2015, however, it was reported that there were 21 378 perinatal losses in South Africa, which was a 6.8% decline from 22 948 perinatal losses in 2014 (StatsSA, 2017:5).

The perinatal health outcomes of South Africa were poor as out of 960 000 birth occur in the public sector of which 23,547 were stillbirths and 11 404 were early neonatal deaths (World Report, 2011:1303). Furthermore, perinatal mortality accounted for about 40% of infant mortality and 75% of all neonatal deaths for the first 22 weeks gestation of intra-uterine life to the first 7 days after birth (Ezechi & David, 2012:1).
Furthermore, South Africa presented perinatal loss which peaked at 25 389 in 2009 and declined to 18 683 in 2016, amounted to 26.4% decline between 2009 and 2016 and particularly declined by 16.4% between 2015 and 2016 (StatsSA, 2017:10); but the national stillbirths in facility rate was 21.1 deaths per 1000 total births which increased by 10.1% between 2014 and 2015. Although the decline in perinatal losses is significantly noticeable over the past two decades the performance and progress of South Africa in reducing perinatal mortality rate is slow as compared to other countries and the perinatal loss rate is still higher than the global target set by the SDGs (StatsSA, 2017:32).

In the Eastern Cape Province the same trends of perinatal loss have been noted, for example, between 2013 to 2014 Eastern Cape Province (ECP) presented with 14.1% of inpatient early neonatal deaths with a notable 2.9%, higher than the National Department of Health (NDOH) target of 10.9% (Maysson et al., 2016:89). Furthermore, these authors reported that between 2014 to 2015, the ECP was ranked the second province with the highest of 13.3% of early neonatal deaths per 1000 live births. The rationale for these losses is associated with inadequate care provided in labouring facilities or may indicate poor service delivery at lower levels of care within the district or may also be due to delay in referral to facilities who are able to provide care to neonates (Maysson et al., 2016:89). From 2015 to 2017 some reduction has been noted in the trend of inpatient early neonatal rate which was still above the target rate. The same trend of perinatal losses has also been noted in the NMBHD where the highest inpatient early neonatal death rate at 19.5 deaths per 1 000 live births were reported in the ECP.

Despite progress over the past two decades, in 2017 alone, an estimated 2.5 million newborns died in their first month from preventable causes. In 2014, WHO released an Action Plan to end preventable deaths which aims to reduce the stillbirth rate to 10 or fewer per 1000 births, and the neonatal mortality rate to 10 or fewer per 1000 live births by 2035, to reduce equity gaps and to strive to continue to reduce the risk of death and disability (Australian Institute of Health and Welfare, 2018:2). Research shows that a significant number of neonatal losses can be prevented if all pregnant women received good quality antenatal care, adequate care during delivery and in the
postpartum period. An estimated 5.5 million perinatal losses occur worldwide each year many of which are preventable (Wojcieszek, Boyle & Belizan, 2016:1).

Perinatal losses have a significant burden on health systems as well as on women, families and health care professionals. Perinatal mortality has a deep and long-lasting effect on parents, health care providers and the society at large. Moreover, these deaths have enduring psychosocial consequences for both parents, families and clinicians, with wide-reaching impacts on communities and society. Looking at these statistics, the researcher had observed that the reduction of perinatal mortality was still a global health problem and yet there were no guidelines or interventions available to guide midwifery care in the management of women experiencing perinatal loss. Moreover, a brief summary interventional guideline is now included in the latest DOH 2016 guidelines (DOH, 2016:91), but still excluded in RCMPG 2012 and International ICM 2011.

2.4 THE IMPACT OF PERINATAL LOSS ON BEREAVED WOMEN

The period between 22 weeks’ gestation of intrauterine life to 7 days after birth is the most vulnerable period in the life of a mother. The rate of perinatal loss during this period is higher than any other period of life. It results in various psychological morbidities which last long and may go beyond bereavement care; so, this section will focus on the impact of perinatal loss on bereaved women.

Globally it is estimated that approximately 4.2 women are affected by perinatal losses and are living with depression associated with the loss (Froen, Lawn, Heazell, Flenady, Bernis, Kinney, Blencowe & Leisher, 2016:2). Perinatal loss has been shown to have a substantial psychological impact on women and their families and is associated with post-traumatic stress, depression, anxiety and sleeping disorder (Bamniya, Bhatia, Doshi & Ladda, 2018:1347). Such a loss is frequently attributed to psychological morbidities (Samson, Lee & Lionel, 2015:18) as the affected people go into a state of grief. Morris (2010:1) explains that grief can be described as the intense emotional and physical reactions that someone experiences following the death of a loved one. Furthermore, perinatal loss is a traumatic and painful form of bereavement experienced by the affected mothers and their families (Samson et al., 2015:18), especially from the time the diagnosis is made until the time she gives birth and it
becomes worse when perinatal loss is diagnosed at birth or after delivery. The grieving parents are thought to be psychologically affected probably because, as indicated by Kissane and Parnes (2014:183), their dreams and hopes as an expecting couple were abruptly ended.

The consequences of intense grief due to perinatal loss may include significant relationship issues in couples, depression, anxiety and post-traumatic stress; and these consequences may also occur on subsequent pregnancies (Hutti, Polivka, White, Hill, Clark, Cooke, Clemens & Abell, 2016:42; Wojcieszek et al., 2016:199). In the study conducted by Gopichandran, Subramaniam and Kalsingh (2018:1), the authors concluded that women who experienced perinatal loss suffered from serious forms of grief and guilt and these emotions were aggravated by the insensitivity of healthcare system, healthcare providers and even friends and neighbours. Women’s experiences with midwives during pregnancy and childbirth also have the effect of either empowering and comforting or inflicting lasting damage and emotional trauma (Bowser & Hill, 2010:1). Competent perinatal supportive care rendered to women affected by perinatal loss is therefore considered essential.

Studies have shown that postnatal experiences such as perinatal loss, which do not match or exceed prenatal expectations can have a significant impact on the development of postnatal depression (Lazarus & Rossouw, 2015:102; Byrne & Rosen, 2014:47). Perinatal loss at professional level, provokes negative feelings, including frustration, disappointment, defeat and sadness (da Costa & de Lima, 2005; as quoted by Montero et al., 2011:1407). During perinatal loss women find themselves in a state of distress with feelings of guilt, regret, fear and grief which can be accompanied by frustration or psychological disturbances (Downe, Schmidt, Kingdon, Alexander & Heazell, 2013:3). The RCM (2012:4) reported that the impact of perinatal loss on the women’s emotional well-being during pregnancy is reported to differ from woman to woman, as emotional and social changes take place during pregnancy. The occurrence of perinatal loss events is a very stressful experience as the mother’s expectation of a healthy newborn is disrupted and requires women, fathers and their families to make significant psychological changes and find ways of adapting to this situation, which has deviated from the expected positive outcome of pregnancy (RCM, 2012:4). Perinatal loss is a unique form of death, its occurrence does not evoke the
same feelings of pity and support aroused by other deaths and pain of this kind of loss is often only felt by women and families experiencing it including the bereavement care providers who are present when this event occurs (Kersting & Wagner, 2012:187). It is for these reasons that all women experiencing perinatal loss need proper support and adequate bereavement care, as they are not well prepared for the experiences of perinatal loss and may at times require more information and coping skills to understand this situation.

2.5 THE IMPACT OF PERINATAL LOSS ON MIDWIVES

The original meaning of the word midwife is “being with” woman and “being with” is defined as the provision of emotional, physical, spiritual and psychological support by the midwife as desired by the labouring woman (Kalfoss & Owe, 2015: 979). A midwife is recognised as a responsible and accountable professional whose sole purpose is to work in partnership with women to give necessary support, care and advice during pregnancy, labour and the postpartum period (ICM, 2014:2). Midwives are at the front line of maternal health service provision, interacting with colleagues across primary, secondary and tertiary care services (The State of Midwifery Today, 2011:1); Therefore they are crucial members of public health workforce for health promotion and disease prevention work by improving maternity outcomes and reducing inequalities (RCM, 2014:9). Midwives know how to make public health interventions and many public health initiatives require their input; yet their potential and actual contribution is often overlooked, in policy development, local implementation, as well as in terms of resourcing (RCM, 2014:9).

Midwives as a workforce are expected to provide care to women experiencing perinatal loss, which includes better information and preparation of grieving women, development of specific and relevant grief-therapy interventions (Koopmans, Wilson, Cacciatore & Flenady, 2013:4). Since these perinatal supportive care providers are in the unique position of being in contact not only with women but also with their families as well as with the community at large, they have a specific role to play in promoting wellness in women and their families in collaboration with other multidisciplinary team members and other healthcare professionals. In addition midwives are the most appropriate care providers to supply perinatal supportive care to women during pregnancy, labour, birth and in the postpartum period; yet there is minimal research
on the coping and support needs of midwives caring for women with perinatal loss in South Africa, Eastern Cape and in the NMBHD. It is therefore noted that neither the GMCSA (2015), RCMPG (2012) nor the ICM (2011) provides clear interventions for midwives who provide supportive care to women and their families in the event of perinatal loss. Furthermore, there appears to be inadequate documentation on appropriate interventions and support services for both women and midwives experiencing perinatal loss in the same environments.

On the other hand, midwives, by virtue of being at the forefront of maternity care, bear the responsibility of providing quality care to women experiencing perinatal loss. This role and responsibility are complex and sensitive to the midwives supporting these women as they may be exposed to various traumatic events. Midwives who provide end-of-life and perinatal bereavement care to families are at potential risk for developing stress-related health problems and furthermore the emotional strain associated with end-of-life and perinatal bereavement care not only affects the midwives’ health, but can also affect relationships at home and with co-workers; and can even affect the quality of care provided to women and their families (Zhang & Lane, 2013:1). Working with grieving women and their families is very challenging, difficult and requires a skilled midwife who is trained and specializing in bereavement care (Kersting & Wagner, 2012:187). Therefore, it is important to understand the aspects of midwifery practice that may hold adverse implications for midwives’ psychological health, and which may subsequently impact upon their capacity to provide sensitive maternity care like adequate care to grieving women (Sheen, Spiby & Slade, 2015:579). The latest literature indicates that midwives exposed to perinatal loss events may lead to burnout. In a study done in the USA 35% of midwives exposed to traumatic perinatal experiences and post-traumatic stress experienced moderate to severe symptoms of post-traumatic stress (Beck & Gable, 2012:1), which is further associated with burnout from caring for women with perinatal loss (Sheen et al., 2015:578).

In a systematic review of studies exploring perinatal loss, Shorey, Andre and Lopez (2017:34) found that dealing with perinatal loss in maternity units took an emotional toll on the psychological well-being of healthcare professionals as many midwives reported being ill-prepared for such loss. They experienced of guilt and conflicted
feelings while simultaneously “putting on a brave front” in order to support the parents experiencing perinatal loss. In addition, midwives felt demotivated, overwhelmed and some even experienced the symptoms of secondary traumatic stress disorder (Shorey et al., 2017:34). Caring for families experiencing perinatal loss can make midwives feel vulnerable and can cause considerable stress and anxiety for them (Wallbank & Robertson, 2013:1091). Perinatal loss is seen as an indication of failure as midwives are expected to preserve life and prevent adverse outcomes which in them are resulting in feelings of guilt, helplessness and anxiety (Morake et al., 2016:965). The strong negative emotional regulation or negative problem management of perinatal loss on midwives can impair the wellbeing of the women and may influence their decision-making process, for example, midwives’ negative attitudes at the time of diagnosis, birth, discharge and follow up as well as their approach towards the baby may impair the grieving process of women (Daemers, van Limbeek, Wijnen, Nieuwenhuijze & de Vries, 2017:6). Perinatal loss events affect midwives directly or indirectly and may lead to signs and symptoms of psychological distress.

Most midwives develop stress, anxiety and feelings of self-blame more especially when they see the woman and her family are sad and crying due to perinatal loss. The experience of perinatal loss produces an under-recognised burden on the health and well-being of midwives. According to Ellis et al. (2016:12) midwives identified emotion, knowledge and system based as barriers that prevent them in providing effective care including a lack of time, being emotionally overwhelmed and holding on to the grief. Some felt that they had not received enough education regarding perinatal loss (Ellis et al., 2016:12) and found it challenging and ‘emotionally draining’ to deal with their own ‘shock’ and ‘confusion’ as well as having to provide care to women experiencing perinatal loss.

Andre et al. (2016:61) conducted a study in Norway entitled “Culture of Silence: Midwives’, obstetricians’ and nurses’ experiences with perinatal death”. They reported that midwives expressed denial, anxiety, fear and difficulty in handling the bereaved parents’ emotions and shock, while coping with their own feelings. Some midwives, however, may attempt to protect themselves emotionally from the burden of perinatal loss through maladaptive coping styles, such as self-blame, disengagement and denial (Wallbank & Robertson, 2013:1094). It is difficult for midwives to express their
emotions during the event of a perinatal loss as they are expected to be strong and provide bereavement care to these women while they struggle to cope with their own emotions internally.

Findings from a study done in Southern U.S city by Hutti et al. (2016:18), reported that midwives believed it was critical to assign midwives who were emotionally prepared to care for families experiencing a perinatal loss; and to be sensitive to those midwives who might be feeling too vulnerable to provide bereavement care on a particular day. Being supported by properly trained midwives is extremely important since most women affected by perinatal loss are likely to develop psychological, physical, social, behavioural and emotional morbidities (Ellis et al., 2016:17). Additionally, Martinez-Serrano, Palmar-Santoz, Solis-Munoz, Alvarez-Plaza and Pedraz-Marcos (2018:130) conducted a phenomenological study in Spain, exploring “Midwives’ experiences of delivery care in late foetal death” where midwives viewed perinatal loss as a certain failure in the process of attention, even if there is no link between the perinatal loss and the actions of midwives. These feelings of guilt that were expressed by the midwives affected the provision of bereavement care to bereaved women. Furthermore, these feelings caused midwives to isolate themselves or to withhold their emotions during incidences of perinatal loss.

Based on literature search, to date, although there is a considerable amount of research documenting the incidence of grief associated with perinatal loss, there is a paucity of research focusing on the coping and support needs of midwives caring for women with perinatal loss. Despite the efforts of patient-centred associations worldwide, perinatal loss and its impact on midwives, who are the providers of bereavement care, is still a neglected issue in many countries including South Africa, to the extent that many midwives fail to receive appropriate training on the provision of perinatal bereavement care to families affected by perinatal loss. At present there is no available review that has consolidated findings on the experiences of midwives caring for women with perinatal loss in South Africa, more especially their coping and support needs remain under-explored. This study therefore explored the coping and support needs of midwives caring for women with perinatal loss in the NMBHD.
2.6 PERINATAL BEREAVEMENT CARE FOR WOMEN EXPERIENCING PERINATAL LOSS

Grieving parents need to be emotionally prepared for perinatal loss if it is anticipated, and in cases where a perinatal loss event has been undiagnosed, parents need immediate grief counselling. Supportive perinatal care following perinatal loss is essential to the well-being of women experiencing this loss in the hospital and is beneficial to managing the grief process (Cassidy, 2018:1).

According to Coffey (2016:16), effective, sensitive communication, individualised care and guidance from health professionals in making informed choices about meeting and remembering the child were vital in reducing parents’ trauma associated with perinatal loss. Parents must be prepared emotionally before having contact with the baby and they must be supported during that contact unless it is the parents’ wishes to be left alone. Thereafter, professional follow-up is deemed crucial in order to prevent development of maternal mental health problems (Ryninks, Roberts-Collins, McKenzie-Mchong & Horsch, 2014:1). Emotional preparedness of the bereaved women may be provided by midwives, who make the initial contact with the baby during birth and these midwives are expected to display empathetic emotions during perinatal loss events (McKenna & Rolls, 2011:81); but the training of midwives does not emotionally prepare them for perinatal loss events; for instead they are expected to adjust and cope automatically without any support (McKenna & Rolls, 2011:81). Recommendations for care include better information and preparation of those women and the development of specific, relevant grief-therapy interventions (Koopmans et al., 2013:4).

Parents need quality care which includes deep respect for their individuality and diversity of grief which include respect of cultural backgrounds, religion and respect of the deceased child (Ryninks et al., 2014:1). Interventions for bereaved families following a child’s death have been examined over the last several decades; but there is little high-quality evidence to support any rationale for determining optimal intervention for bereaved parents and siblings (Endo, Yonemoto & Yamato, 2015:590). In addition, the role of support groups after perinatal loss is unclear although benefits, particularly for women, are reported (Flenady, Boyle, Koopmans, Wilson, Stones & Cacciatore, 2014:138). Midwives often provide bereavement care with no evidence to
support optimal interventions, which takes a toll on their psychological health as they lack confidence and support in the interventions. While there is a paucity of guidelines and interventions regarding perinatal bereavement care, a brief summary of postpartum management of perinatal loss has been added in the latest DOH guidelines (2016:91).

Perinatal support interventions are important in improving grief outcomes for bereaved women and their families following perinatal loss. Perinatal bereavement care following perinatal loss involves a multidisciplinary team that is responsible for treating the grieving mothers in order to facilitate the healing process or closure and prepare the grieving women for future pregnancies. Higson (2015:20) conducted a study in UK which supports the latter statement by stating that the positive move is the growing number of Specialist Bereavement Midwives. In smaller hospitals, however, the midwives still lack the necessary experience and proper training (Higson, 2015:20). In support of these statements, ten principles of bereavement care adapted from Hunter, Schott and Kohner (2016:11-12) being used in other countries are outlined below, even though there is no evidence supporting that NMBHD has also adopted these principles.

- Individualised care catering for personal, cultural and religious needs of grieving parents and maintenance of respect and dignity of grieving families needed.

- Sensitive, honest and clear communication with grieving parents tailored to meet individual needs needed.

- Maintaining the autonomy of grieving parents especially decision-making and informed consent.

- Accepting and acknowledging the grieving process of women and their families, its intensity and duration.

- Provision by nursing staff of bereavement care should be by those midwives specifically trained in bereavement care for them to provide not only effective emotional support but also excellent physical care during and after the loss.

- Recognising and meeting the support needs of grieving partners as their grief can be profound.
• Opportunities needing to be provided for all staff members who give supportive care to women before, during and after perinatal loss to develop and update their knowledge and skills and have access to effective support for themselves.

• Respect required for individual wishes and needs for grieving parents and offering of which opportunities to create memories.

• Bodies of babies and foetal remains should always be treated with respect and sensitive disposal options should be discussed with respect.

• Crucial need for good communication between staff and health teams to ensure that staff is aware of parents’ preferences and decisions to avoid repetition.

There is a lack of comprehensive programmes to support and guide midwives caring for women with perinatal loss (Siassakos, Jackson, Gleeson, Chebsey, Ellis & Storey, 2017:161) and the few interventions that exist have had little or no impact, perhaps because they have not been mapped to the actual problems in bereavement care (Heazell, Siassakos, Blencowe, Burden, Bhutta, Cacciatorre et al., 2016:9). Actual problems such as inadequate staff preparation, inadequate training to counsel parents after perinatal loss, inadequate communication between health professionals and parents and insensitive interactions between parents and midwives must be recognised and addressed. The Green-top guideline identified an urgent need for researchers to improve perinatal care and experiences of bereaved parents (Siassakos, Fox, Draycott & Winter, 2010:25).

Women and families affected by perinatal loss should receive appropriate counselling and information regarding investigations done by healthcare workers following the diagnosis of perinatal loss to identify the cause (Sydney Local Health District, 2015:4). Bereavement care training should also be mandatory with annual updates and given the same level of importance as the need to manage obstetric emergencies since both have the potential for equally devastating consequences if managed insensitively. This training could also incorporate other aspects of care, such as how to obtain and preserve good-quality mementos (Coffey, 2016:20). Perinatal loss goes together with grieving and the people who are mostly found in the middle of this loss are the
midwives by virtue of their having to deliver the woman and provide perinatal supportive care afterwards.

Having said this, the researcher sought in this study to investigate coping and support needs of midwives caring for women with perinatal loss in the NMBHD, for the researcher to develop recommendations that would assist midwives to enhance their skills coping and support through incidences of perinatal loss.

2.7 CONCLUSION
This chapter provided a review of literature about the coping and support needs of midwives caring for women with perinatal loss in the NMBHD. The literature review also highlighted the fact that midwives exposed to perinatal loss events experienced the variety of emotions, stress and depression from caring for women with perinatal loss. Furthermore, it was also evident from the literature review that there was a lack of support and coping strategies for midwives caring for women with perinatal loss. Perinatal mortality rates in South Africa have fallen substantially in the past two decades; but while South Africa is still struggling to meet the required target of 10 perinatal deaths per 1000 live births by 2035, more women continue to be traumatised by perinatal loss events. A need for coping and support recommendations that will assist midwives in caring for women with perinatal loss in NMBHD has been noted. The next chapter discusses the research methodology used in this study to investigate coping and support needs for midwives caring for women with perinatal loss in the NMBHD.
CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION
This chapter will discuss the research design and methodology employed in this study. Chapter 1 presented an introduction and overview of the study, which highlighted the literature search, problem statement, research question, purpose and objectives including a brief presentation of the methodology, while chapter 2 presented the literature search process and rationalisation of the study, overview of perinatal loss and impact of perinatal loss on the bereaved women and midwives. In this chapter the researcher will present a detailed description of the research design and methods used to investigate the coping and support needs for midwives caring for women with perinatal loss in the NMBHD.

3.2 RESEARCH OBJECTIVES
The objectives of this study were to:

• explore and describe the facilitative conditions that enable midwives to care for women with perinatal loss in the NMBHD,

• explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in the NMBHD,

• identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD and

• develop coping and support recommendations for midwives caring for women with perinatal loss.

3.3 RESEARCH METHODOLOGY
Research methodology is a science of studying how research is done and is a systematic way to solve a problem by outlining the procedures by which researchers go about their work of describing, explaining and predicting phenomena (Narayana, Varalakshmi, Pullaiah & Sambasiva, 2018:4). This chapter will outline research design, research methods, trustworthiness and ethical considerations.
3.3.1 RESEARCH DESIGN

The research design is an overall formulation of a research problem and it refers to the overall strategy that you choose to integrate the different components of the study in a coherent and logical way (Kabir, 2016:112). Furthermore, design of a study defines the study type (descriptive, correlational, semi-experimental, experimental, review, meta-analytic) and sub-type (e.g., descriptive - longitudinal case study), research question, hypotheses, independent and dependent variables, experimental design, and, if applicable, data collection methods and a statistical analysis plan (Kabir, 2016:112). Research design comprise of three approaches namely, quantitative research design, qualitative research design and mixed methods research design.

In this study the researcher chose and employed a qualitative research design because it was the best design for exploring and describing the coping and support needs of midwives caring for women with perinatal loss in the NMBHD. The research design was then also exploratory and descriptive and will be discussed below.

3.3.1.1 Qualitative research design

A qualitative research design is an emergent, inductive, interpretive and naturalistic approach for the study of people, cases, phenomena, social situations and processes in their natural settings in order to reveal in descriptive terms the, characteristics meanings that people attach to their experiences of the world (Yilmaz, 2013:312). In addition, a qualitative study can be used to answer questions about experience, meaning and perspective, most often from the standpoint of the participant (Hammarberg, Kirkam & de Lacey, 2015:498).

A qualitative research design is a formal method of investigation, with its significance being focused on the individual and the role that circumstances and relationships play in forming ideas and behaviours, at the core of what it means to conduct research with human subjects (Roller & Lavrakas, 2015:1). The values underlying qualitative research include the importance of people’s subjective experiences and meaning-making processes and acquiring a depth of understanding (Leavy, 2017:9). A qualitative research design is used to enhance an understanding of individuals’ cultures, beliefs and values, human experiences and situations (Holloway & Galvin,
2016:3); so in this study the researcher needed the spoken word to provide a deeper meaning and understanding of the cultures, beliefs, values and experiences of midwives caring for women with perinatal loss in the NMBHD hence the use of qualitative research design. The researcher worked with one participant at a time because one-to-one interviews assist a researcher to engage better with the participants and to obtain a more thorough understanding of their experiences. In this regard the researcher was able to gain insight into midwives’ coping and support needs as required for caring for women with perinatal loss.

Even though different types of qualitative research vary regarding data collection methods and data analysis, they share common characteristics and use similar procedures (Holloway & Galvin, 2016:3). Common elements shared by qualitative research approaches are outlined by Holloway and Galvin (2016:3) as follows:

- Theoretical frameworks are based directly on the data being collected
- Qualitative research is context-bound, meaning researchers must understand that the conditions of participants’ lives or work affects their behaviour.
- Qualitative researchers use the strategies of observing, questioning, listening and absorbing themselves in the real world of the participants.
- Qualitative approaches are linked to the subjective nature of social reality; for they provide insights from the perspective of participants, enabling researchers to see events as their informants do as they explore the insiders’ view.
- Qualitative data is detailed, rich and complex.
- The researcher and participant have a close relationship which is based on a position of absorption in the field and equality as human beings.
- A reflexive approach in qualitative research makes the stance of the researcher explicit.

3.3.1.2 Exploratory research design
An exploratory research design is used to investigate little-known phenomena when a literature search fails to reveal any significant example of prior research (Fitzpatrick, 2012:168) and can help the researcher to fill the gap in knowledge about a new or
under-researched topic or approach the topic from a different perspective to generate new and emerging insights (Leavy, 2014:5). This design helps the researcher to generate questions that describe the phenomena being investigated and seek understanding. Furthermore, an exploratory design probes to gain an in-depth understanding of the circumstances surrounding that behaviour (Silver, Steven, Wrenn & Loudon, 2013:55). This research approach can serve to establish baseline information for future studies (Fitzpatrick, 2012:169). Additionally, an exploratory design requires the researcher to follow his or her instincts and detour into new territory, seeking to inspire new insights, new ideas, clarifications and revelatory observations (Silver et al., 2013:55). The purpose of using an exploratory research design was to investigate and describe the coping and support needs of midwives caring for women with perinatal loss in the NMBHD since there is little-known information regarding this phenomenon.

3.3.1.3 Descriptive research design
A descriptive research design provides a clear picture of a situation as it is naturally happening without manipulation of any of the variables (Schmidt & Brown, 2015:181). This design seeks to elaborate on the phenomenon being studied and is concerned with the circumstances, operations, constructions, and relationships that exist, perceptions held, procedures that are in progress or developments that are evident (Walliman, 2011:10). Furthermore, a descriptive research design is aimed at casting new light on current issues or problems through a process of data collection that enables them to describe the situation more completely. Therefore, a descriptive research design is a scientific method that involves observing and describing the behaviour of a subject without influencing it in any way (Nwokeafor & Ndolo, 2017:16). In this study, a descriptive research design was used to describe in detail the coping and support needs of midwives caring for women with perinatal loss in the NMBHD.

3.3.2 RESEARCH METHODS
Research methods are tools and techniques that are undertaken by the researcher to construct the study and to solve the research problem (Ragab & Arisha, 2018:6). Furthermore, research methods are various steps adopted by the researcher to gather information and facts about the research phenomena and refers to the tools employed
in analysing the collected data (Leavy, 2014:5). The section below presents a description of the tools and techniques that were used to conduct the study.

3.3.2.1 Research population

Research population refers to the entire set of individuals (group) or elements that are at the focus of the research and that meet the sampling criteria (Grove, et al., 2015:250). Furthermore, a population can be the entire group of people to be studied and if the population is relatively small, all its members can be approached and interviewed (Kawamura, 2011:65). Therefore, in this study the research population were all midwives who met the research criteria specified for the research investigation. The NMBHD consists of five MOUs and two referral hospitals where midwives frequently care for women experiencing perinatal loss. The envisaged number of midwives will be presented in table 3.1.

### Table 3.1: Description of population and sample size

<table>
<thead>
<tr>
<th>Maternity unit</th>
<th>No. of facilities</th>
<th>Population of midwives</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOUs</td>
<td>5</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>Hospitals</td>
<td>2</td>
<td>101</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>138</td>
<td>13</td>
</tr>
</tbody>
</table>

3.3.2.2 Sampling and Sample

Sampling refers to the procedure that allows the researcher to study a selected portion of the population which will represent the entire target population (Hartley, 2012:127). Sampling is also called a judgement meaning the researcher is making a judgement about the composition of the sample, selecting participants who he or she believes have either experienced a particular episode or have knowledge that will help to answer the research question (Moule et al., 2014:166). A small adequately representative sample becomes the suitable option to collect data from and obtain the necessary results, since the entire population of interest could never be used at the same time for data collection purposes as the study would be overwhelming and tedious (Brink, van der Walt & van Rensburg, 2012:143). The researcher in qualitative research wishes to obtain information from specific persons who could provide inside
information about the subject being investigated (Schmidt & Brown, 2015:189; Maxwell, 2013:97).

Sampling methods for this study included choosing a sampling technique and determining a sample size. Sampling technique refers to the process through which a sample is extracted from a target population. Sampling technique is divided into two categories i.e. probability or random sampling technique and non-probability or non-random sampling technique. In this study, the sampling technique chosen by the researcher was purposive or judgemental sampling which is a non-probability sampling technique in which the researcher solicits persons with specific characteristics such, to participate in a research study (Johnson & Christensen, 2012: 232). Hence, the researcher selected the participants whom she believed had the most relevant knowledge or information for the phenomenon being investigated, for example, midwives caring for women with perinatal loss (Allen, 2017:1545). The researcher in qualitative research wishes to obtain information from specific persons who could provide inside information about the subject being investigated (Schmidt & Brown, 2014:189). Meaning the population was specifically selected to gather data necessary for addressing the research problem statement or research question. Furthermore, purposive sampling technique aims to sample a group of people (such as midwives) or events with specific characteristics or set of experiences or knowledge regarding the phenomenon being studied. The target population was selected using specific inclusion were:

- Midwives having a minimum of one year’s experience working in the NMBHD.
- Midwives caring for women with perinatal loss.
- Midwives having been permanently working in both MOUs and referral hospitals in NMBHD.

The exclusion criteria, which consists of characteristics that can cause a person or element to be excluded from the target population (Grove et al., 2015:251) were:

- Community service nurse practitioners since they are allocated for only three months in each department.
• Midwives who had personal experience of perinatal loss to avoid triggering emotional reactions when a midwife is narrating the events of perinatal loss.

• Midwives who were working on a rotational basis since rotation duration takes only six months in each department.

Sample size is based on the need to obtain enough information to address the research questions (Moule et al., 2014:168) and qualitative researchers have no specific rules for sample size. The researcher in this study stopped sampling after she had reached data saturation. Data saturation is determined when the themes emerging from the interviews become repetitive and the researcher concludes that no new information is emerging (Brink et al., 2012:141). The sample size was determined by data saturation (Kumar, 2014:229) and sampling stopped after the researcher had interviewed the 11th participant.

The researcher invited all midwives working in the NMBHD to participate in the proposed study by distributing 138 letters explaining the meaning of the title, the purpose, aim and objectives of the study and inclusion and exclusion criteria. Out of 138 letters sent out 130 responses were received from the midwives who agreed to participate in the study. Midwives meeting the inclusion and exclusion criteria were selected among the 130 responses. Then each midwife from selected midwives was telephonically invited to participate in the study; anonymity was assured when writing a report that pseudonyms will be utilised; all midwives were not coerced to participate; and arrangements regarding the date, time and venue of interview appointment were confirmed as their preferences. The envisaged sample size was selected using 10% of the total number of the population as follows, NMBHD consists of 138 midwives working in five MOUS and two high-risk referral hospitals. These five MOUs consists of 37 midwives of which 10 percent of these midwives i.e. 3 midwives meeting the inclusion criteria were selected purposive by the researcher, while the two high-risk referral hospitals consist of 101 midwives and 10 percent of these midwives which is 10 midwives were selected. The three midwives selected from MOUs were selected from three different MOUs and the selected midwives were the most midwives meeting the inclusion criteria, while 5 midwives were selected from each high-risk referral hospital meeting the inclusion criteria. Two of these midwives 1 from MOUs and 1 from
high-risk referral hospital were selected as participants for pilot study. For the main study data saturation was reached at the 11th interview. The total number of the sample size was 13 participants since the findings of the pilot study were used in main study findings.

3.3.2.3. Recruitment

Recruitment of participants for qualitative research is often the most challenging and resource intensive aspect of study (Archibald & Munce, 2016:34). Moreover, according to the Office of the Human Research Protection Programme (OHRPP), identification, initial contact, screening and recruitment of potential human subjects form the foundation of the informed consent process (OHRPP, 2019:1); therefore in this study after the researcher has obtained permission letters from all relevant authorities (DRC, FPGSC [H18-HEA-NUR-017] and ECDoH [EC_201810_016], [See annexures E, F, G and H] to conduct the proposed study in the NMBHD, then permission was also obtained from the NMBHD office (RES KAVE/2018) including permission from the CEO and hospital managers (see annexures D and E). Furthermore, verbal permission was also obtained from other authorities (facility managers and unit managers).

After all the permissions had been granted by all the relevant authorities the researcher started the recruitment process by initially evaluating all the maternity units in the NMBHD, examining the perinatal loss statistics, and excluding all the maternity units that had no history of perinatal loss events. After selection of all labouring units with a history of perinatal loss the researcher visited these units, introduced herself to the unit managers and midwives and explained the purpose of her visit by introducing the research topic, purpose and objectives including the research question. After the introduction, the researcher enquired about the total number of midwives working in each unit and the unit’s organogram. Then the researcher requested the names of all the midwives working in these units and the duty register was provided by the unit manager from which the names of the midwives were extracted. Altogether five MOUs were selected, and two high-risk referral hospitals and the total number of midwives identified from the duty register was 138.
3.3.2.4 Data collection method

Data collection approaches are based on the collection of existing and original data. Original data is generated specifically for the study and existing data is based on information collected by previous researchers or by obtaining information from records and files (Polit & Beck, 2010:339). In this study semi structured one-on-one audio-taped interviews were conducted. All participants were asked the same main questions as follows:

“Now tell me, how is it for you to care for a woman who has lost a baby?”

The researcher also made use of a pre-formulated interview schedule which was used as a guide to direct the progress of the interview. Rationale for the use of the predetermined schedule was to ensure that essential topics that answered the research question and objectives were discussed in each interview (Alharbi, 2017:2466). Moreover, a predetermined interview schedule allows the researcher an opportunity to ask the same questions in different interviews and to be able to compare the results of all the transcribed data. The questions asked for each objective were:

Objective one: Explore and describe the facilitative conditions that enables midwives to care for women with perinatal loss in the NMBHD.

- Now tell me, how is it for you to care for a woman who has lost a baby at birth?

- How does caring for women with perinatal loss make you feel?

- How does it affect your daily life and activities?

- What do you do to cope?

Objective two: Explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in the NMBHD.

- What are some of the difficulties or challenges you experience when caring for woman with perinatal loss?

- Are you able to cope with such challenges?
Objective three: Identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD.

- Do you need any other assistance in helping you cope with such difficulties?
- What strategies are available for you?

Objective four: Develop coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD.

- How would you like to be supported?

3.3.2.5 Data collection process

The data collection process refers to the process of gathering information in a meaningful and reliable manner which includes reviewing of medical records or personnel files, conducting interviews or performing environmental measurements (Porta, 2014:20). In this study the researcher telephonically contacted each midwife to confirm the appointment dates, venue and to schedule a time for interviews as indicated in the completed checklist form.

On the date of the interview each participant was contacted telephonically to be informed that at the time of the interview they must just walk into their chosen venues to maintain confidentiality and privacy. Arrangements were made regarding the chosen venues as most of the participants chose their working areas for interviews; therefore, permission for accessing those venues in those dates was requested prior to the interview date from the unit managers. The researcher prepared the venue which the unit manager had offered to be used for data collection; and made sure that there was a door that could close properly and a ‘DO NOT DISTURB’ sign was placed on the outside of the door to make sure that there were no disturbances during the interviews. A trained DoH psychologist was also invited for those specific dates to be on standby and agreed to be contacted telephonically if her counselling skills were needed. Written informed consent was obtained before conducting the interviews which were conducted on the date and at the time chosen by the participant. The
names of the participants were not revealed to the unit managers to protect the privacy and confidentiality of participants.

Prior to the interview session the researcher greeted each participant and put her/him at ease by having an informal chat before commencing the interviews. When the participant was at ease the researcher started the interviews by introducing the title, aim and objectives of the study to ensure that participants were well-acquainted with the process. Participants were informed that the interviews would be audio-taped, and that field-notes would be taken. Each participant was interviewed separately on different dates. After verbal permission had been granted by each participant the researcher continued the interviews in English and the participants were asked a broader question which was the main study interview question (See annexure A).

During the interviews the researcher used interview strategies such as probing, repeating and confirming (Grove et al., 2013:272) to meet the objectives of the study. Interviews ranged between 15 and 30 minutes depending on the information provided by each participant. To obtain as much information as possible probing questions and unstructured questions were asked, based on the responses of the participants. Data was collected from November 2018 to January 2019 until data saturation for each objective was met on the thirteenth interview. All participants had to respond to one main question and the probing questions that were asked during the interviews. Active interviewing is mutual attentiveness, monitoring and responsiveness. The researcher used the following in the interviews adopted from Kabir and Rashid (2017:96):

- **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 was 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 on something important that was said to gain additional clarity e.g. “So, you say it is very frustrating…”

• **Encouragement**: The researcher encouraged the participants to say more about what was said, for example, “You say you became embarrassed. Why is that?”

• **Reflexive summary**: The participant’s ideas, thoughts and feelings were verbalised to ensure understanding of what the participant had said and to stimulate the participant to give more information.

• **Listening**: The researcher actively listened carefully and attentively to ensure the correct capturing of everything the participant had said. The use of the digital recorder assisted in this regard.

• **Probing**: The purpose of probing is to deepen the response to a question to increase the richness of the data obtained. The researcher used this technique to persuade the participants to give more information, for example, challenging the participant by requesting more information, encouraging, direct questioning, showing understanding and allowing time for elaboration and procuring details.

To capture the interviews the researcher made use of two voice-recorders of good quality to ensure accurate capturing. The rationale for using two voice-recorders to ensure back up when problems like low battery or faulty recorder should arise to ensure data collected is clearly captured. The room was quiet; but the researcher asked the participants to raise their voices slightly to make sure that every word was captured. The two voice recorders were placed in a place in a visible place, closer to the researcher and the participants since recorded audios interviews were permitted by the participant and to ensure that interviews are clearly captured. Participants were reminded not to use actual names but come to a consensus of the manner of identification of the interview for transcription purposes. Moreover, to enhance the collected data, the researcher wrote down some field notes because field notes are among the most fundamental data collection techniques used in qualitative research and are often combined with other data collection methods such as semi-structured interviewing and focus-group research (Sutton & Austin, 2015:227). Therefore, in this
Field notes are known as detailed descriptive accounts of the observations made by the researcher during the interaction with the participants (Monette, Sullivan & De Jong, 2011:238). Moreover, field notes are written records developed within an observational period and continually expanded and revised after the observation has occurred (Hays & Singh, 2012:228). It is important for researchers to record what they have seen, heard, thought or experienced while conducting data collection. These notes may become part of data analysis as they may describe the expression of the participants, change in position and other observations that would not be captured by audio-recordings (Streubert & Carpenter, 2011:43). In this study the researcher documented the field notes about the observation made while responding to the interview schedule including the body language of the participants, their behaviour, body language and facial expressions. Furthermore, the following types of field notes were applied, namely:

- **Descriptive notes**: - observational notes that describe all events observed and actions noted by the researcher during the interview (Monette *et al.*, 2011:238). The researcher observed all the actions, behaviour and movements of the participants and jotted down everything heard and seen during the interview to assist with the interpretations of the responses which enabled the researcher to give a detailed description.

- **Reflexive notes**: - involve the researcher’s picking up on the speaker’s feeling or mood and feeding his/her perceptions back to the participants (Kabir & Rashid, 2017:96). The researcher in this study strove to bracket her feelings and emotions in this context since she had been exposed to perinatal loss by maintaining and keeping of reflective field notes throughout data collection process.

- **Demographic notes**: - provide information about the time, place and date of the field setting where the observation has taken place (Creswell, 2014:194). These written notes included age, gender, name, surname and contact number of each participant, their working area address, years of experience in labouring units, years of exposure to perinatal loss events and academic qualifications.
3.3.2.6 Data analysis

Data analysis is the central step in qualitative research, which is the last step of methodology. Data analysis is the process whereby researchers take the raw data that have been entered into the data matrix and create information that can be used to address the objectives for which the research was undertaken (Kent, 2015:181), including preparing and describing the data. Data analysis in qualitative research is continuous with data collection, hence the possibility to confirm data saturation. Interviews were transcribed within hours of conducting each interview in preparation for data analysis. An experienced independent coder, who was also a nurse, analysed the data. After the researcher and the independent coder had completed their analyses, they met for a consensus discussion to finalise the themes and sub-themes. Responses of participants were categorised, ordered and manipulated through the application of the seven steps of Gale et al. (2013:4-5), framework data analysis.

Framework data analysis is the method of data analysis which gives a systematic, thorough and grounded process for managing data, whilst also allowing the flexibility associated with qualitative enquiry and enables easy retrieval of data (Swallow, Lambert, Santacroces & Macfadeyn, 2011:512). Furthermore, framework analysis involves several inter-related stages that allow for theme-based or case-based analysis or a combination of the two through development of charts that may be read downward (themes) or across (cases). Framework data analysis is also known as thematic analysis or qualitative content analysis (Gale et al., 2013:2); these approaches identify commonalities and differences in qualitative data, before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes; therefore in this study the researcher adopted the seven steps of framework data analysis (Gale et al., 2013: 4-5) and also made an independent coder. A diagrammatic illustration of the seven steps of framework analysis is indicated in Figure 3.1 below and its application is discussed thereafter:
**Figure 3.1 Illustration of adapted seven steps of framework data analysis**

1. **Transcript**
   The recorded data was transcribed verbatim (word for word). The researcher listened to the recordings repeatedly to verify the accuracy of the transcripts and minor corrections were made where necessary. Large margins and adequate line spacing for later coding and making notes were ensured for all the transcribed data. The researcher read the transcripts simultaneously with the audio-taped interviews to check for any errors. Transcribed copies were given to the relevant participants for verification and to research supervisors. After that transcripts were given to the independent coder to familiarize herself with the interviews through reading.

2. **Familiarisation with the interview**
   The researcher became engaged with the details of each transcript to gain a sense of the whole interview before splitting them into sections and identifying repeating themes. Furthermore, all the data transcripts together with the audio-taped recordings were forwarded to the research supervisors, who re-listened to the audio-taped recordings repeatedly and re-read the written transcripts to familiarise themselves with the data. Since the researcher was the one who undertook all the interviews, field notes were collaborated with the audio interviews when transcripts were written. Field notes that had been made immediately following each interview were read alongside each transcript to ensure the context was taken into consideration. All data from all
transcripts was studied. Familiarisation through reading and making notes in this way also helped the researcher to find her way easily around the transcriptions later in the analysis.

**Step 3: Coding**

This process included the coding of repeated narrative patterns in order to identify categories which were further grouped into major themes in the subsequent steps. After the familiarisation stage, interviews were analysed sentence by sentence and page by page. After that paraphrasing, labelling or coding were applied by highlighting each detail of the relevant data or to capture important information relevant to the research objective. Each transcript was given a code to guarantee anonymity and confidentiality of participants. Codes were developed and reshaped as the researcher, the supervisors and independent coder worked through the coding process. Similar codes were grouped together in this study to bring out the essence and meaning of data that had been obtained from the participants.

**Step 4: Developing a work analytic framework**

After the coding of the first few transcripts the researcher compares the categories, she/he has applied and together with the research supervisors agrees on a set of codes to apply to all successive transcripts. Codes were grouped together into labels or categories by using a table where they were clearly presented. Coded data enabled the identification of similarities, differences and consistencies. These were further broken down into smaller units as subthemes prior to final grouping into major themes. This process facilitated the identification of major themes. This forms a working analytical framework if all the transcripts have been coded.

**Step 5: Applying the analytical framework**

A working analytical framework was applied by listing successive transcripts using the existing labels and codes. Each code was assigned an abbreviation for easy identification and written directly into the transcripts. The process initially involved reading each transcript line by line, highlighting key phrases and writing comments in the margins to record preliminary thoughts. Then major themes, sub-themes and categories were carefully developed by considering each line, phrase or paragraph of the coded transcript.
Step 6: Charting data into the framework matrix

A spreadsheet was used by the researcher to generate a matrix and the data were charted into the matrix by summarising the data and by categorising data from each transcript with the help of research supervisors and independent coder. The researcher maintained a balance between reducing data and retaining the original meanings.

Step 7: Interpreting the data

Step seven deals with the interpretation of the themes and sub-themes that emerged from the data transcribed and analysed from the previous six steps of framework data analysis. In this step presentation of the findings related to the responses of the midwives caring for women with perinatal loss in the NMBHD is made. The researcher compared the themes and sub-themes that had emerged from data transcripts and framework analysis against the original transcripts, field notes and audio-recordings to ensure appropriate context. She gradually identified characteristics and differences between the data or mapped connections between categories to explore relationships; and demonstrated transparency at each stage so that the analysis process could be compared with the original data. The transcribed data was interpreted and analysed with the help of research supervisors and the independent coder. Additionally, the discussion of the findings was strengthened and intensified using direct quotations and literature. The three major themes that emerged are presented in Chapter 4 with its associated sub-themes for each theme which emerged during seven steps of framework data analysis.

3.3.2.7 Pilot study

A pilot study involves collecting of information (data) from a small sub-sample to test whether the information collection plan for the main study is appropriate or is used to verify that the main study will proceed as planned and that the data-gathering instruments will perform as intended (Sreejesh, Mohapatra & Anusree, 2014:20). The use of a pilot study helps a researcher to minimise any potential errors and risks that may crop up during the main study (Sreejesh et al., 2014:20). Furthermore, a pilot study may also be used to change the main study research design, if the pilot study results are not appropriate (Sreejesh et al., 2014:20). In this study the pilot study was conducted after obtaining all relevant letters granting the researcher the permission to
conduct the research study in the NMBHD in November 2018. The aim of conducting the pilot study was to investigate and identify any potential risk factors and to identify whether the main study could proceed as planned.

Two participants were extracted from the predetermined study population following the recruitment process adopted for this study and semi-structured one-to-one audio-taped interviews were conducted following the pre-formulated interview schedule. The interviews were conducted in a public hospital in the same context and manner as in the main study. The results of the pilot study were forwarded electronically to the supervisor and co-supervisors for review. No major potential issues were identified other than the interview skill of the researcher that needed attention. These recommendations were mainly because the researcher was not an experienced interviewer and therefore at time asked leading or questions that were not clearly understood and not enough probing questions asked. After the relevant changes were made then the researcher started data collection process for the main study. Those two interviews from pilot study were included in the main study seeing that there were no methodology changes needed (Vosloo, 2014:4).

### 3.3.2.8 Role of the researcher

Being a specializing midwife in one of the labouring units of NMBHD, with experience of being exposed to perinatal loss events conducting the interviews was challenging, physically, emotionally and psychologically as the responses of the midwives were stimulating the emotions of the researcher. Moreover, the researcher experience difficulties since the interviews were conversational in nature and combined with the task of the researcher being the research instrument through which data was being collected. Above all the researcher avoided imposing his/her own beliefs in the interpretation of data. Bracketing of the researchers’ opinion and experiences was maintained throughout in order to establish the rapport with the midwives.

### 3.4 TRUSTWORTHINESS

Lincoln and Guba’s Model of trustworthiness was adapted in this study to ensure that the results of the study would present solely the data and the findings of interviewed participants, which were the midwives caring for women with perinatal loss (Polit &
Beck, 2018: 69). Lincoln and Guba’s Model proposes four criteria, namely credibility, transferability, dependability and confirmability which were applied as follows.

3.4.1 Credibility
Credibility refers to confidence of having accuracy or truthfulness of the findings including accurate interpretation that the researcher makes from the analysis of data (Rees, 2016:32; Polit & Beck, 2010:585). Moreover, credibility refers to the accuracy and truthfulness of the research findings and answers the questions of how the researcher has confidently establish the findings throughout the design, analysis and interpretation of the study and its data (Riazi, 2016:68). In this study the researcher used the following strategies to conform to credibility namely:

- **Triangulation**: Triangulation, also known as crystallisation, refers to the linking of findings from the disparate sources of data, for example, interviews, observations and documents (Riazi, 2016:68). Furthermore, triangulation is a basic aspect of data collection that also shapes the action process of data analysis (DePoy & Gitlin, 2011:279). For this study the researcher used different approaches like semi-structured interviews, an audio-tape recorder and reflective field notes as methods of data collection which were forwarded to the research supervisors and independent coder so that the same conclusion was reached.

- **Member checks**: Member checks refers to the technique in which the researcher check an assumption or an understanding with one or more participant (DePoy & Gitlin, 2011:280). After the completion of the interview, researcher discussed the data with each participant before leaving the field to verify the accuracy of information gathered during one-to-one audio-taped, semi-structured interviews. Moreover, checking the findings and interpretations with the participants helped the researcher to confirm whether the captured transcripts were indeed reflecting their opinions. After data had been transcribed verbatim, each transcript was given back to each participant to confirm the accuracy of data.

- **Peer debriefings**: The researcher purposely involves peers in the analytical process or a group of peers to review the collected data and emerging the findings to observe if same conclusion is reached (DePoy & Gitlin, 2011:279).
In this study, research supervisors and independent coder was utilized for the purpose of peer debriefing and thus attempt to reach the same conclusion.

- **Reflectivity**: Research reflects on research activities and sought to rule out any perceived bias (Riazi, 2016:68). In this study the researcher examines the degree to which the adopted research methodology and activities fits the data.

### 3.4.2 Transferability

Transferability refers to the extent to which findings can be transferred to another setting or group by correlating it with the external validity (Polit & Beck, 2010:511). The researcher enhanced the transferability of the study by providing thick descriptions of the research process; highlighted the context of the study and provided a detailed and precise description of the data so that readers might determine whether transferability would be appropriate to other settings. In this study transferability was reached by adopting the following methods:

- **Thick description**: Thick description refers to the collection and provision of extensive description of research contents (Brink *et al.*, 2012: 173). Thick descriptions are essential to inquiry because it forces the researcher to pay attention to details, great and small so that one sees the group in its entirely (Buckelew & Fishman, 2011:99). For the purpose of this study, all concepts used, and methodology were clarified using relevant sources.

- **Prolonged engagement**: Prolonged engagement refers to enough time invested by the researcher to establish trust with the participants and eventually learn about the culture, climate, and socialization process inherent in human nature and phenomena under investigation (Erford, 2015:102). The researcher visited participants at each of the five MOUs and two high-risk referral hospital where midwives are working. During this visit participants were granted an opportunity to ask questions and clarify uncertainty. During the interviews the researcher ensured that that the interviews were given prolonged time while gathering quality data until data saturation was achieved.
3.4.3 Dependability
In dependability the researcher demonstrates that the proposed study reflects procedures and decisions that can be seen, evaluated and trusted by other researchers (Tight, 2017:35). To ensure that the data collected was interpreted as perceived by the participants, the researcher has described the research design and its implementation including approaches adopted to undertake such research design to obtain the needed answers. Also, the operational detail of data gathered was addressed to indicate what was done in the field.

3.4.4 Confirmability
Confirmability refers to the extent to which the findings can be judged as accurate based on the data collected and not on subjective views or interpretation of the researcher (Tight, 2017:25). In this study to ensure confirmability by using triangulation (see 3.4.1 discussion) to reduce the effect of the researcher bias. The researcher also adopted reflexivity technique in bracketing her own experience of the problem being investigated in order to prevent bias and manipulation of results. Corroboration of the collected data (transcripts and field notes) to confirm whether findings were consistent with the collected data and consensus was reached on the major themes, sub-themes and categories and the effectiveness of the process of inquiry undertaken was evaluated by use of independent coder and the research supervisors.

3.5 ETHICAL CONSIDERATIONS
Qualitative research seeks to engage with relatively unorganized forms of data, whether produced through observation, interviewing or the analysis of documents (Hammersley & Traianou, 2012:1). The acquiring of such data may require the researcher to be close to or to have a long-term relationship with the participants. The characteristics of qualitative research draw attention to the need for such close relationships, especially if perceptions or experiences of participants are to be understood adequately and if the full relevant range of their activities are to be documented (Hammersley & Traianou, 2012:1); therefore these attributes of qualitative research require consideration when it comes to reasoning about ethical issues (Hammersley & Traianou, 2012:1). In this study the researcher adopted the principles of the Belmont Report which insists on a profound respect for the voluntary nature of research participation, true informed consent and ethical responsibilities of
the researcher to ensure human welfare (Hulley et al., 2013:225), to prevent any ethical controversies that may arise through the close relationship formed through the researcher’s direct contact with the participants. The principles of the Belmont Report namely, principles of respect for persons, beneficence and justice, were upheld together with the principle of anonymity, confidentiality and privacy.

3.5.1 Principle of Respect for Persons
In order to uphold the principle of respect for persons, the researcher provided information to all the midwives, explaining the purpose and objectives of the study, including the data collection process. All the participants were therefore given an opportunity to make an informed decision regarding their participation in the study which was voluntary without coercion from the researcher. Furthermore, participants were allowed the right to withdraw from the study at any time and to ask for clarification if the purpose of the study and questionnaires were unclear (Grove et al., 2014:108).

3.5.2 Principle of Beneficence
Grove et al. (2014:108) define the principle of beneficence as protection from discomfort and direct harm. It is described as an obligation to do good and to prevent harm to the study participants. The researcher of this study is closely linked to the participants as she is working in one of the labouring units in the NMBHD; so the researcher maintained neutrality throughout the data collection process by allowing each participant to abstain from responding to questions that might be experienced as personal or disturbing and excluded all midwives who had a personal experience of perinatal loss to avoid emotional reactions triggered by memories of perinatal loss events. A trained counsellor was organised to be on standby to assist for referral of participants, who during the interviews were likely to experience trauma when recalling perinatal events. The skills of the trained counsellor were not required in any of the interviews as all of them were completed without incidence.

3.5.3 Principle of Justice
Justice refers to the balance between receiving the benefits of research and bearing its burdens (Fink, 2013:92). The participant’s identity (name, surname and contact details) was required as part of selection checklist to assist the researcher in identifying the participants when scheduling the interview appointments in cases
where work contact details had been issued and in implementation of purposeful sampling; but this information was kept confidential by the researcher and not shared with the research supervisors. All participants were given the information letter consisting of the research title, purpose, objectives and the scheduled interview protocol.

The identity of participants was not revealed to other stakeholders including the research supervisors and the researcher maintained the principle of anonymity by using pseudonyms when writing the rapport and confidentiality throughout the data collection and data-analysis process and the same main interview question was addressed to all participants. Since the researcher collected the information from the midwives by completion of checklists and by interviewing them using an audiotape and field notes, the real identification of participant was excluded; each interview and transcript was coded, and audio taped. Each transcript was coded as Participant A, B, C up to Participant M and each question and responses were number from 1-150 depending on the duration of each interview and this kind of information was shared with the research supervisors and the independent coder.

3.5.4 Anonymity, Confidentiality and privacy
Confidentiality entails keeping all information reserved and not divulging personal information or the identity of participants which is known only to the researchers whereas privacy in research refers to the principle of controlling the personal information collected from participants without unduly disclosing this information to others (Alderson & Morrow, 2011:30). In this study, therefore, the names of the participants and the names of the labouring units where the participants were working were kept confidential and private, known only to the researcher. Furthermore, during data-analysis pseudonyms of the transcribed data were conducted to keep each participant’s identity anonymous.

3.6 CONCLUSION
In this chapter the research design and research methods, including the data collection process, data analysis, trustworthiness and ethical considerations followed by the researcher were fully described. Trustworthiness and ethical principles maintained in
this study were discussed. Interpretation of research findings and discussion of findings using extensive literature search will be discussed in the following chapter.
CHAPTER 4
DATA ANALYSIS AND PRESENTATION OF RESULTS

4.1 INTRODUCTION
Chapter 4 represents a detailed analysis of the collected data and the presentation of the findings related to the responses of midwives of the Nelson Mandela Bay Health District (NMBHD), regarding their coping and support needs when caring for women with perinatal loss. In this study midwives were given an opportunity to share their experiences in their own words regarding their coping and support needs when caring for these women. The use of a preformulated interview schedule guided the data collection tool which helped in collection of data using a digital recorder and field notes. The data collected for this study was analysed using seven steps of the framework data analysis.

Qualitative data analysis encompasses a structured process that looks across the collected data to identify and construct analytic themes and ultimately turns these themes into findings that help the researcher to answer the research questions (Ravitch & Carl, 2016:1). In addition, qualitative data analysis is the intentional systematic scrutiny of data that occurs throughout the research process, which involves data organisation, analysis of recorded data, analysing each written transcript and presentation of analysed data. In chapter four the researcher reports on the data-analysis process, results and the discussion thereof. Literature will be used to support the findings.

4.2 DEMOGRAPHIC PROFILE OF THE PARTICIPANTS
The population that participated in this study is described by gender, age, years of experience in labouring units, years of experience with perinatal loss events and designated work areas. Thirteen midwives were interviewed for this study. Their ages ranged from 31 to 51 years and they were all females. Their work experience ranged from 2 to 16 years in labouring units where perinatal loss events frequently take place. Furthermore, these midwives were registered with SANC and they possessed a range of qualifications. Five midwives had a diploma in General Nursing Science (GNS) (Psychiatry, Community and Midwifery), four had a degree in nursing and four had an
Honours Degree in Advanced Midwifery and Neonatal Science. Altogether 23% of the midwives were working in MOUs, 38.4% were working in labour wards and 38.4% were working in High Care Obstetric Units (HCOUs) in NMBHD. Table 4.1 below presents the demographic profile of the participants.

Table 4.1: The demographic profile of the participants

<table>
<thead>
<tr>
<th>NO</th>
<th>AGE</th>
<th>GENDER</th>
<th>UNITS</th>
<th>QUALIFICATION</th>
<th>WORK EXP AS A MIDWIFE</th>
<th>WORK EXP IN UNIT</th>
<th>PROFESSIONAL QUALIFICATION</th>
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<tr>
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<td>31-40</td>
<td>F</td>
<td>HCOU</td>
<td>DEGREE</td>
<td>6-10</td>
<td>2-5</td>
<td>PN</td>
</tr>
<tr>
<td>2.</td>
<td>41-50</td>
<td>F</td>
<td>MOU</td>
<td>HONS</td>
<td>16-20</td>
<td>16</td>
<td>MID SPEC</td>
</tr>
<tr>
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<td>41-50</td>
<td>F</td>
<td>MOU</td>
<td>DIPLO</td>
<td>11-15</td>
<td>11-15</td>
<td>PN</td>
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<td>4.</td>
<td>41-50</td>
<td>F</td>
<td>LW</td>
<td>DIPLO</td>
<td>↑21</td>
<td>↑16</td>
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<td>5.</td>
<td>41-50</td>
<td>F</td>
<td>LW</td>
<td>HONS</td>
<td>11-15</td>
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<td>F</td>
<td>LW</td>
<td>DIPLO</td>
<td>16-20</td>
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<td>MS</td>
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<td>DEGREE</td>
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<tr>
<td>10.</td>
<td>&gt;51</td>
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4.2.1 Gender
Only females took part in the study. This is understandable from a historical perspective as midwifery is the first holistic profession in the world in which care has always been a women-centred phenomenon (Barnawi, Richter & Habib, 2013: 114). A gender imbalance has always been noted within the midwifery setting and in the nursing profession in general even though midwifery is no longer an exclusive non-standardised female practice. Furthermore, gender did not have any significance in this study as the midwives did not perceive gender as a problem factor in their coping and support needs when caring for women with perinatal loss.

4.2.2 Age
Midwives who participated in this study were between the ages of 38 years and 59 years. Findings of this study indicate that 7 (53.8%) of midwives participating were between 41 years and 50 years; 5 (38.4%) were above the age of 50 years while 1 (7.6%) was between 31 and 40 years old. Hence the participants were mostly older midwives. However, because of their experience they are expected to mentor the junior midwives but no significant noted in terms of the age and years of experience in relation to the support needs. They all shared same experiences and similar support needs.

4.2.3 Years of experience of midwives in labouring units
The midwives had at least 6 years of work experience and at most 21 years of working experience in labouring units. Most of these midwives, 4 (30.7%), had more than 21 years in the midwifery setting; another 3 (23%) had 6-10 years; 3 (23%) had 11 to 15 years while the last 3 (23%) had 16-20 years of experience in labouring units. This meant that most midwives participating in this study had more than 10 years of working experience and may possibly have had several exposures to perinatal loss events. The midwives with more than 10 years of experience amounted to 10 (76.9%), meaning that most midwives participating in this study were very experienced midwives employed in labouring units of NMBHD.

4.2.4 Midwives’ years of experience of exposure to perinatal loss
The midwives participating in this study had a minimum of 2 years and the maximum of 16 years of exposure to perinatal loss experiences. The midwives who were most
experienced in exposure to perinatal loss, 3 (23%), had more than 16 years’ experience of exposure to perinatal loss; another 3 (23%) had 11 to 15 years of experience, while another 3 (23%) had from 6 to 10 years of experience to this type of exposure and the majority of midwives 4 (30.7%) who participated in this study had between 2 and 5 years of experience of perinatal loss exposure. Altogether, 46.1% of the midwives had been in service for more than 10 years, meaning that the midwives had long-term exposure to perinatal events and could assist the researcher in obtaining deeper information and thus understanding of the coping and support needs of midwives caring for women with perinatal loss in the NMBHD.

4.2.5 Midwives’ area of work
More of the midwives who participated in this study, 5 (38.4%), were allocated to the labour wards and 5 (38, 4%), were allocated in high care wards for maternity in the areas with a high turnover of patients. The minority of 3 (23%) were allocated in Midwife Obstetric units. The area of work was included to ensure that the information given by the midwives was not influenced by the area where midwives were working.

4.2.6 Midwives’ academic and professional qualification
The academic and professional qualifications of the midwives participating in this study varied between 5 (38.4%) midwives who had a diploma; 4 (30.7%) with Honours and 4 (30.7%) midwives with the normal degree in nursing. The majority of 9 (69.4%) midwives who participated in this study were experienced midwives while only 4 (30.7%) of these midwives had a post-basic qualification. Advanced midwives are expected to have advanced skills in managing obstetric emergencies including perinatal loss. Furthermore, advanced midwives are expected to mentor even the experienced midwives in case where advanced skills are needed; yet in this study different categories of midwives taking care of women with perinatal loss did not appear to influence in the findings of this study as perinatal loss is overwhelming to all healthcare professionals involved.

4.3 THEMES AND SUB-THEMES
In this section the themes and sub-themes that emerged from the data will be discussed. The themes and sub-themes are presented in Table 4.2.
### Table 4.2 Themes and Sub-Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<td>1. Midwives rely on their own coping mechanisms to deal with perinatal loss.</td>
<td>1.1 Informal peer-debriefing helps with perinatal loss events.</td>
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<td>1.2 Family support assists with coping with perinatal loss events.</td>
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<td>1.3 Prayer as a means of coping with perinatal loss events.</td>
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<td>1.4 Relaxation techniques as a means of coping</td>
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<td>1.5 Coping by suppressing feelings during perinatal loss events.</td>
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<td>1.6 Follow-up care with women after perinatal loss gives closure.</td>
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<td>2. Midwives reported how management influenced the way they coped with perinatal loss events.</td>
<td>2.1 Limited support from management during perinatal loss</td>
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<td>2.2 Lack of private rooms for grieving women</td>
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<td>2.3 Time constraints in provision of bereavement care.</td>
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<td>2.4 Lack of protocols regarding management of perinatal loss</td>
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<td>2.5 Staff shortage expressed as a challenge in management of women with perinatal loss</td>
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<td>3. Midwives expressed the need for psychological and emotional support.</td>
<td>3.1: Poor provision of EAP services</td>
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<td>3.2: Confusion over the process of EAP referral</td>
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<td>3.3: EAP Act in interests of the public not the employee.</td>
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<td>3.4: No feedback given from EAPs leading to negative attitudes of midwives</td>
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<td>3.5: Shortage of staff prevents midwives from accessing EAPs</td>
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<td>3.6: Referral to specialist (Psychological counselling i.e. EAP)</td>
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4.3.1 Theme 1: Midwives rely on their own coping mechanisms to deal with perinatal loss

The challenges faced by midwives in the provision of extensive and holistic bereavement care and support, as expressed by midwives in this study, is the experience of overwhelming emotions, self-blame, feelings of guilt, stress and depression. When midwives identify with the women’s situation it results in them adopting their own coping mechanisms to manage their experiences, while on the other hand it indicates coping and support needs which are not being dealt with by their working institutions.

In this study the first theme highlighted the fact that midwives were relying on their own coping mechanisms to manage their experiences of perinatal loss. One needs to have a clear understanding of the meaning of “coping mechanisms” in this section in order to understand findings of this study. A coping mechanism refers to strategies used to deal with stressful situations and control or reduce the effects they have (Orzechowska, Zajaczkowska, Talarowska & Gatecki, 2013:1050:1). These mechanisms help individuals view the stressful situation more clearly and change the perception of stress by giving them tools to deal with the situation effectively or make it a precious ally for future use in their work. Moreover, coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to master, reduce, tolerate or minimise stressful events (Kumar, 2011:150). According to the Transactional Model of Stress and Coping, the “actual strategies” of coping efforts of dealing with the triggered emotions to mediate the primary and secondary appraisals in this study were ascertained by exploring how the midwives managed perinatal loss in their daily activities and work environment” (Glanz, Rimer & Viswanath, 2015:226). In addition, coping mechanisms are the remedial actions taken by a person whose survival is endangered (Dinda, Edwards & Mikkonen, 2017:11) and that midwives had adopted in order to manage their experiences of perinatal loss, were mentioned by most participants during the interviews.

The findings of this study are therefore coherent with existing literature. Since midwives found that their emotional involvement in caring for women with perinatal loss had resulted in their holding on to memories of the perinatal event and failing to handle the loss, therefore ending up adopting their own coping mechanisms.
Midwives put in practice different mechanisms, attitudes and behaviours in order to avoid dealing with their emotional aspects to reduce their anguish (Montero et al., 2011: 1408).

In the process of giving the required support to women experiencing perinatal loss, midwives attempt to conceal their own disappointments, frustrations and sadness when things go wrong by adopting their own coping strategies to conceal their true feelings (England & Morgan, 2012: 112). This finding coincides with a study done by Montero et al. (2011:1140) which indicated that, during perinatal loss situations, professionals are obliged to use defence mechanisms. The use of coping mechanisms in order to adapt in response to stress is required and coping mechanisms are different for each individual and are an individual's own way of dealing with stressful situations. In this context therefore, six sub-themes (See table 4.2) supporting theme 1, as "coping mechanism used by midwives" are presented.

4.3.1.1 Sub-theme 1.1: Informal peer-debriefing helps with perinatal loss events

In this study the participants stated that an informal peer-debriefing process assisted them in dealing with their experiences of perinatal loss events. The participants expressed their thoughts regarding such informal peer-debriefing as follows:

“Discussion within the team after the perinatal loss incident helps” … (Participant 1 0081, female, 38 years).

“Talking to colleagues after the perinatal events relieves the stress” … (Participant 4 0024, female, 49 years).

“Talking with colleagues as a way of coping after perinatal loss relieves the stress” … (Participant 7 0015, female, 47 years).

It is clear from the above quotations that perinatal loss is a stressful event for the participants. One of their ways of coping with such stress is to discuss the event with colleagues in what could be termed “informal peer-debriefing”, which helps to relieve the stress. The concept of informal peer-debriefing refers to the discussion between two or more midwives in which aspects of a performance are explored and analysed
with the aim of gaining insights that impact on the quality of future clinical practice (Cheng, Morse, Rudolph, Arab, Runnacles & Eppich, 2016:32). Hutti et al. (2016:18) also argue that midwives who have experienced perinatal loss need to share their experiences with their peers. According to Jonas-Sampson et al. (2013:6), nurses found the support of colleagues to be helpful to them as they navigated their way through grief. They found discussing their experiences after their shift as therapeutic. The participants expressed the fact that debriefing with peers was also an important method of evaluating any incidents that had taken place:

“...if there’s an incident on our group, we will have like a team discussion you know, and just to talk about it. You know, as a means of coping so that you can get it out of your system, and then you know see, is it this something that we could improve on, is it something that we can do differently. If there’s nothing, if it’s something that really that was out of our hands”... (Participant 1 0081, female, 38 years).

“What is there is sort of a meeting where cases like these will be discussed and we identify gaps to prevent the incident”... (Participant 13 0024, female, 58 years).

The participants referred to team discussions. They linked coping to these discussions. Shore (2014:117) stated that debriefing after significant events could also improve patient outcomes, assist with identifying training needs, identify process snags and improve staff morale and sickness rates. Lastly, debriefing and feedback allow for the reflective observations, abstract conceptualisation and active experimentation of components of the learning cycle and to reflect on their practice to improve future performance (Burns, 2015:118). Moreover, Walpole (2011:75) highlights the fact that a desire to discuss such situations with peers may stem from a need to unburden and reduce the stress being experienced following a challenging situation, the need for and provision of non-judgemental listening and the possible restoration of self-esteem (Walpole, 2011:75).

4.3.1.2 Sub-theme 1.2: Family support assists with coping with a perinatal loss event
Midwives reported that they often rely on their families for support to cope with perinatal loss events, especially in cases where there was no opportunity for informal
peer-debriefing. Family is a socially constructed and culturally defined concept and the ideological underpinning of the definition of family has traditionally been defined as a unit composed of a mother, father and their children (Kabuto & Martens, 2014:1). The participants expressed the support they received from their family members as follows:

“By talking about it with my family and I speak with my colleague” (Participant 4 0023, female, 49 years).

“I talk with my husband about the perinatal loss event that has occurred at work as we share everything, it helps me to debrief.” (Participant 9 0023, female, 58 years).

“Now, when I come home, I share, I must talk about it even if I’m gonna take an hour, even if I’m talking to someone who’s not familiar with the environment where I’m working.” (Participant 13 0023, female, 58 years).

The midwives indicated that they relied on family support because family plays a central role in their well-being. Talking about their experiences was important to the midwives. They referred to the need to debrief and the need to share their experiences. Family offers identity, love, care, provision of protection and above all it can be a great source of support (Daly, Bray, Bruckauf, Byrne, Margaria, Pechik & Samms-Vaughan, 2015:5). Furthermore, family members share similar characteristics like enjoying spending time together, effective communication, appreciation, commitment, coping skills, values and convictions all of which is beneficial in helping midwives to deal better with perinatal loss (Daly et al., 2015:5).

Tracy, Thorogood, Pincombe and Pairman (2011:201) indicate that midwives need the support of their family when dealing with perinatal loss events. Moreover, relying on support from outside the workplace, in this case family support, can also play a crucial role in the ability of nurses or midwives to cope (Ramalisa, du Plessis & Koen, 2018:5). Stressful events alter the dynamic balance of the family, hence the importance of the family unit having a good coping strategy (Martinez-Montilla, Amador-Marin & Guerra-Martin, 2017:592).
4.3.1.3 Sub-theme 1.3: Prayer as a means of coping with perinatal loss events

Many midwives reported that prayer was helpful in coping with their experiences of perinatal loss. They expressed their feelings regarding the benefits of prayer during their professional lives as follows:

“Prayer heals, you feel a relief once you pray because prayer heals…” (Participant 4 0024, female, 49 years).

“Praying helps to cope because every hard situation when I feel my heart is heavy…” (Participant 7 0013, female, 47 years).

“There are times when you feel helpless due to the rate of perinatal loss, we just pray about it and continue like nothing happened …” (Participant 11 0022, female, 59 years).

From the above quotations, prayer was one of the tools that the participants used to cope with the challenge of perinatal loss. They expressed feeling a sense of relief after prayer and that in situations of helplessness they would resort to prayer. They also described prayer as having healing properties. Prayer or spirituality is a religious practice where people express their being-in-the-world, their hopes and fears, their worries and desires (Immink, 2016:4). Religious beliefs and practices may help people to cope better with stressful life circumstances, give meaning and hope (Bonelli, Dew, Koenig, Rosmarin & Vosegh, 2012:1). Furthermore, referring to religious beliefs, Koenig (2012:7) states that these have “the potential to influence the cognitive appraisal of negative life events in a way that makes them less distressing”. The religious coping mechanisms of prayer have been shown to be effective in reducing stress (Davis, 2017:1).

The abovementioned findings correspond with the findings of Kumar (2011:147), Mohamed and El-Hafez (2015:47) and Akbar, Elahi, Mohammadi and Koshknab (2016:61) who acknowledge that nursing students seek spiritual support by performing prayers during periods of stress. Moreover, the study conducted by Ramalisa et al. (2018:5) discovered that several nurse participants had emphasised spirituality as a method of coping. This statement is supported by Roostae et al. (2016:5332), who
indicated that most studies, which have examined the relationship between religions and coping with stressful situations, have pointed out that the role of religion as a way to deal with stress is called "religious coping". In general, religion plays an active role in preventing and reducing mental disorders, such as anxiety, stress, and depression and religious coping can be considered as an instrument to control those stresses created in a working environment, like prayer and fasting (Roostaee et al., 2016:5330). The midwives participating in this study clearly found their spiritual life provided a sense of relief from the negative life events of perinatal loss. A similar source of relief used by the midwives was relaxation techniques.

4.3.1.4 Sub-theme 1.4: Relaxation techniques as a means of coping with perinatal loss events

Several midwives who reported that they found it difficult to cope with the events of perinatal loss identified relaxation techniques as a means of coping when they were faced with such situations. Relaxation techniques include any method, process, or activity, that helps a person to relax, to attain a state of increased calmness to reduce levels of pain, anxiety, stress or anger (Ronen, 2011:141). They expressed their feelings about the need for opportunities to relax and to reduce stress related to perinatal loss events as follows:

“…there should be a proper wellness, ehhh mmnc relaxing facility for midwives and I would go as far as to say…because we work with different kinds of situations everyday… And you can have a loss in both either a mother or baby which is both traumatic.” (Participant 1 0091, female, 39)

“We got a lot of stress involve, so I must try to break the stress at home by a relaxing techniques and things like that” (Participant 5 0039, female, 49 years).

“Uhmm, team building and end year parties, to go out though there’s no time, helps in relaxation and reduces the stress of perinatal loss” (Participant 7 0035, female, 47 years).

The participants felt that they needed opportunities to relax in response to the stressful situations they encounter, particularly perinatal loss. Relaxation techniques such as
meditation and deep breathing and somatic techniques such as yoga and Tai Chi which incorporate exercise with relaxation are the two main categories of mind-body therapies (MBTs) and techniques designed to enhance the mind’s capacity to affect bodily and symptoms (Chopra et al., 2015:161). Taking deep and clearing thoughts before seeing a client may help the midwife to be fully present when engaged in clinical care (Anderson, Rooks & Barroso, 2017:250). In a study of nursing students, Yazdani, Rezaei and Pahlavanzadeh (2010:213) reported that stress management practices such as yoga relaxation, progressive muscle relaxation, breathing exercises, meditation and mental imagery had been shown to be effective in the reduction of the stress and anxiety.

In the present study the participants stated that relaxation techniques had assisted them to cope with and relieved stressed caused by perinatal loss events. Similarly, participants in a study conducted by Mehrabi, Azadi, Pahlavanzadeh and Meghdadi (2012:423) found 8 weeks of yoga exercise could make a significant difference to intensive care nurses. This response of participants in this regard has therefore motivated the use of relaxation techniques as a coping mechanism method that will assist midwives in coping with perinatal loss events in a working environment.

4.3.1.5 Sub-theme 1.5: Coping by suppressing feelings during perinatal loss events
Midwives reported that they found it difficult to cope with perinatal loss events that occurred when they were on duty and they expressed that they suppressed their feelings during such events. Participants in this study described how they set aside their emotions during perinatal loss events.

“You yourself as a professional nurse, is very difficult because you cannot really show your emotions because you need to be strong for this person” (Participant 1 0012, female, 39 years).

“I learned very early on nursing not to get too emotional invested cause you not gonna survive” (Participant 3 0024, female, 48 years).
“It let you think further but emotionally state is, emotionally you put your feet, you stop your emotional side here and you go home and do your own life with your own” (Participant, 5 0021, female, 49 years).

The process of dealing with the emotions of women during perinatal loss events by midwives, while simultaneously managing their own emotions, can be very challenging to midwives. Hence, at times they choose to suppress their feelings as a coping mechanism, which is the conscious effort to push something out of awareness and when it is used over and over the brain begins to do this automatically (Griggs, 2010:13). On the other hand, Pistorello, Hayes, Costello, Simpson, Begin, Rosen and Pearlstein (2015:416) define suppression of emotions as stopping or controlling unwanted thoughts or emotions. Suppression of feelings is temporary and is described as a “maladaptive emotion regulation strategy” used when individuals choose not to explore their reaction to a certain situation in depth (Subic-Wrana, Beutel, Brahler, Stobel-Richter, Knebel, Lane & Wiltink, 2014:2).

Midwives are more able to exercise autonomy in how they control their emotions and emotion management is driven by a desire to make a difference based on the idea of caring and service (Marshall, Raynor & Nolte, 2014:9); but perinatal loss events may undermine midwives’ autonomy in controlling their emotions leading to their suppressing their feelings as a coping mechanism in order to help the women and their families through the grieving process. These results are supported by Jones and Smythe (2015:21) who found in their studies that midwives confirmed that although the loss was not theirs, their own sense of loss was intense and deeply personal, meaning that the midwife was involved intimately with the loss; yet the loss is not hers to grieve over openly. Suppression of emotions has long been suspected to have a role in health; but empirical work has yielded mixed findings (Chapman, Fiscella, Kawachi, Duberstein & Meuning, 2013:1). Midwives frequently managed their emotions at work in order, firstly, to present a positive, calm and communicative demeanour and, secondly, to protect themselves from the adverse effects of the emotional intensity of birth (Rayment, 2011:138). In a study by Williamson (2016:48), one participant reported that even if the mother had accepted that the baby had died, when the baby comes out the mother she becomes more emotional, and it becomes even more difficult for the midwife because the mother is crying and the midwife also
wants to cry; but cannot cry in front of the mother. Instead the midwife must be strong, and this is a challenge to her.

4.3.1.6 Sub-theme 1.6: Follow-up care with women after perinatal loss gives closure

Midwives in this study expressed the fact that follow-up appointments with women after perinatal loss events helped to give a sense of what could be described as closure. Contacting women following perinatal loss events at a later stage or during fixed appointments to check the progress of the woman through bereavement care has been described by midwives as a way of giving closure.

“It doesn’t sit well with you until you come back again and then you talk with the woman about it as the time goes on you just get better” (Participant, 8 0089, female, 48 years).

“Tomorrow if I come and my patient is still here, I will go to her and tell her if you need help I’m there you can phone me or just call me if you need help, talking with her after perinatal loss make me feel better” (Participant 9 0023, female, 58 years).

“And what also make me feel better is to do a follow up on the woman, if they are discharged or transferred out of the unit as we are not the disposing unit, ehhh I would still follow up, I will go to the post-natal wards and I will make sure to follow up just to see if the woman is fine. I will still ask them every time I see them “Are you okay”, do you think you need anything, do you need to know anything. I followed one up to home and then I was, when I was…we ended up being people who are seeing each other even now outside my work place and I was happy to see that she has accepted it and she’s moving on and she is now able to talk to me because I said to her next time let it be a planned pregnancy” (Participant 13 0023, female, 58 years).

The participants expressed the need to make contact with the women after their loss. This could be in the labour unit or the postnatal ward or via the phone or in the form of home visits. Follow-up refers to the controlled activities undertaken during and following the construction and implementation phases for new development (Morrison-Saunders & Arts, 2012:118). Midwives have a responsibility of providing follow-up care to all women from conception until the completion of puerperium period as stated in the Scope of Practice of Registered Midwives from SANC, DOH guidelines 2016 and
in the Royal College of Physicians of Ireland (2013:12). Follow-up encompasses a broad spectrum of activities from regular site inspections and surveillance through compliance statements, to a very formal, systematic process of monitoring and audits (Morrison-Saunders & Arts, 2012:118).

Midwives in this study expressed the fact that they achieved a sense of closure after perinatal loss events through follow-up appointments with the women after these events. Fenstermacher and Hupcey (2019:16) state that there is a need for healthcare professionals to follow up with women after a perinatal loss and this is of benefit to the women; but there is a paucity of literature showing that midwives also have a need for follow-up with the women and to reach out and thereby receive some form of closure for themselves. Some midwives expressed emotions of disappointment and hurt at not receiving an opportunity to meet with women following perinatal loss events as follows.

“…But for us it is very difficult to follow up to see whether that person actual went to the psychologist and whether she get necessary attendance and help, that she, she needed” (Participant 1 0069, female, 39 years).

“…She’s emotional, she’s crying but you can’t even stay with her you have to rush out and go and attend to other administration duties that also need your attention. What I’m actually trying to say is that the setup is not conducive. I think it’s ideal for the patient to realise that this sister trying to understand what I’m going through she’s trying to make things better for me. At times you are so busy you can’t even take a photograph for them or even call a relative. Then, like when you are at home you start thinking this is gonna be the way that we nurse this patient, then you will have to come back and say mama I really forgot to do this and that and that, meanwhile if there was enough staff and enough resources those services were going to be rendered easily”... (Participant 6 oo13, female, 49 years).

Participants expressed the need to facilitate follow-up visits with the woman following perinatal loss. This could provide opportunity for them to discuss the issues or to address the questions a woman may be having relating to the loss and their wishes. Jones and Smythe (2015:21) describe the process poignantly stating that each step
of the way the midwife steers her way between providing situation-sensitive care to the woman and her family, and coping with her own intense, overwhelming feelings that are necessarily hidden and unspoken. There is no map to follow on this journey but rather a sense of finding your way”. It is of the utmost importance to offer follow-up support and referral for ongoing counselling of women and their families following their discharge from hospital; yet frequently midwives are not given the opportunity of following up with the women after the perinatal loss events and in some institutions counselling is rendered by a psychologist not midwives.

4.3.2. Theme 2: Midwives expressed how management influenced the way they coped with perinatal loss events

Midwives have an important role to play in the provision of bereavement care for women who have lost their babies during the perinatal period. They are expected to provide healing and support. In Theme 2 midwives expressed their feelings about how management influenced the way they coped with perinatal loss events. The hospital system was frequently a cause of work-related stress. Work-related stress refers to the roles, tasks and demands of a specific job within an organisation that bring about stress (Harrington, 2013:273). It can be defined as a pattern of reactions that occur when workers are presented with work demands that are not matched to their knowledge, skills or abilities and which challenge their ability to cope (Pramanick & Ganguly, 2010:170). Work-related stress consists of the physical, mental and emotional reactions that occur when workers perceive that the demands of their work exceeds their abilities or resources to cope (The State of Queensland, 2019:3). The four sub-themes supporting Theme 2 (See Table 4.2) were expressed as follows,

4.3.2.1 Sub-theme 2.1: Limited support from management during perinatal loss

Midwives expressed their concern about not receiving support from management during the perinatal loss events. In this study the midwives expressed their anger and frustration at the inadequate or lack of support from management in relation with perinatal loss.

“...there’s no support personal that I can see from the department in helping us in managing things like that” (Participant, 10083, female, 39 years).
“This is an ongoing process moss and you don’t get any support, oookay, there are managers which are you know they feel, they feel sorry for you but that’s it, it ends there, there’s nothing they are doing moss. You must just carry on with your work, it’s over, next page life must go on” (Participant, 2 0029, female, 48 years).

“I’ve never seen any support but sometimes you have to just adjust to the situation on your own” (Participant 4 0018, female, 49 years).

Support refers to the everyday help and reassurance that management, doctors and healthcare superiors provide in the workplace (Leach, 2015:7). At times support can refer to passive support such as listening without offering opinions and suggestions to active support such as advocacy, suggestions and verbal commitment (Jeffreys, 2012:288). Inadequate or lack of support suggests a lack of guidance in decision-making and/or lack of positive feedback given by superiors. The results of this study correlate with the findings of the study conducted by Bremnes, Wiig, Abeid and Darj (2018:3) which reported that midwives also experienced a loss of motivation at work due to limited support from their superiors, something that contributed to their feelings of demoralisation. These authors further reported that they felt that they had no advocate in their leaders and that the leaders always were on the patient’s side in conflicts (Bremnes et al., 2018:3). These results are also supported by the results of the study conducted by Chokwe and Wright (2013:4) in which participants had frequently mentioned the lack of appreciation and support from management.

Midwifery care requires a high level of emotional work since caring for childbearing women and especially those who have lost their babies during childbirth can result in overwhelming emotions for both the affected women and the midwife providing supportive care. Ngoatle (2015:50) reported that the midwives expressed their grievance about supervisors that did not show any support in cases of maternal death and lack of support is often coupled with a lack of appreciation of the midwives’ good and hard work. Furthermore, in this study midwives have reported that during perinatal loss they receive little or no support from their superiors and management.

Inadequate support for midwives as expressed by midwives has resulted in experiences of negative emotions (from guilt, sadness, anger to depression. Also, the
A study conducted by Calvert and Benn (2016:106) highlighted the fact that the emotional needs of the midwife were not considered by management and that psychological debriefing or professional supervision was not available except for those in a management position. Additionally, a Bogren and Erlandsson (2018:8) indicated that if there was inadequate support for midwives, to strengthen their self-confidence through education and through continuous professional and economic development, little could be achieved in terms of improving quality care of women from conception and until childbirth.

Professional nursing organisations embrace practices that support healthcare providers in difficult situations like perinatal loss events (Tamburri, 2017:369). Providing healthcare employees with support at the organisational level during such an emotionally distressing time is mutually beneficial to both the providers involved and the institution (Helo & Moulton, 2017:779). Furthermore, the manager, advanced practice nurse and educator must be aware that, since staff members will often look up to them for their support, they should be modelling respectful, compassionate and blame-free interactions (Tamburri, 2017:371). Midwives in this study highlighted the need for empathic and emotional support from their managers which included change of attitude when handling perinatal loss, ending the blaming culture and improving the environmental atmosphere as follows.

“It is difficult in the sense that the blame for these losses is put on the midwives, instead of getting support in our workplace, our actions and management is being questioned and the doctors and management we are being treated differently and we tend to lose confidence or our self-image when managing such women because of the type of treatment we get” (Participant 6 007-009, female, 49 years).

“One morning, I went home with tears because that happened early hours of the morning and I was like bombarded by the night supervisor to write an incident and she wanted a full incident cause there was no incident form I got it in labour ward” (Participant 12 0037, female, 59 years).

“It affects you because you come to work and you are angry, no support, support makes a big difference like I said on our level here at work there’s a support but you
go home you are angry, you come again same thing happen you are angry the next thing you think about is “I want to leave this place you know,”, I want to go to a better place because people don’t care about our feelings, I mean I feel people don’t care about you it’s like you run the ward for the government next thing something happen and people stress you as if now you are responsible for what happens” (Participant 60037, female, 49 years).

The midwives in the above quotes feel that they are being blamed by management in situations where there is perinatal loss. This is not an ideal situation and it adds to the trauma of an already difficult situation. It is critical that midwives and doctors who work with bereaved families have appropriate emotional support themselves (Hunter, Schott, Henley and Kohner, 2016: 385-387). Support during these often very distressing situations can help avoid undue pressure building up on staff and help them to continue delivering high-quality care. Based on these findings it is clear to the researcher that midwives in the NMBHD have been given independence in decision-making and taking the initiative in the provision of quality care in midwifery practice to the extent that the fact that they are lacking skills in provision of bereavement care is overlooked; yet these midwives are the ones who are being blamed when perinatal loss events occur and they are not given support. Midwives have identify the type of support needed from management, namely, acknowledging their emotions during these situations by expressing empathy, and a positive attitude, referral for psychological and emotional support and provision of resources, protocol and guidance that will direct the care they provide to grieving women. They suffer in silence; yet they continue providing midwifery care with heavy and burdened hearts while they ensure quality midwifery care for all childbearing women. This is an ongoing problem and through it all midwives must maintain professionalism by conducting midwifery practice or themselves in a manner that promotes the good image of midwifery as a profession.

“They don’t need to do things like sending us away for debriefing or counselling but by virtue of them showing that they care and support us will really help especial if they can be there for us in the ground level instead of coming and scrutinize the file and tell us you didn’t do this and that and that and why was this not monitored knowing there’s nobody available to monitor that” (Participant 60039, female, 49 years).
“To the institution to talk about this with the staff or the midwives to feel free and to feel being supported it will be very nice”. (Participant 7 0037, female, 47 years).

“Attitude of managers should change also in order for us, to support us as midwives working on the floor”. (Participant 12 0047, female, 59 years).

The midwives in the above quotes expressed how the attitude and the actions taken by the management in situations when there is perinatal loss impact on their coping mechanism, as they view their emotions being not treated as a priority. In view of the above quotes’ midwives are expressing emotions of burnout, as these actions from management aggravate the trauma of an already difficult situation. Receiving support around the time of a death is vital to someone’s adaptation to challenging circumstances and ability to cope (Stephen & Macduff, 2012:2); yet, since support from the managers was perceived to be non-existent the participants explained that working in the maternity ward, especially the labour ward, with poor or lack of management support made it more difficult to cope with the demands of the job adequately (Matlala & Lumadi, 2017:51). These findings correlate with the findings of the study conducted by Ullström, Andreen, Sachs, Hansson and Øvretveit (2014:328) which found that many informants reported insufficient or no support from their closest manager or any hospital representative and even though most were supported by colleagues and family, the results highlighted a need for support and understanding from their managers or employer.

According to Chimwaza, Chipeta, Ngwira, Kamwendo, Taulo, Bradley and McAuliffe (2014:3), the rationale for the health professionals to leave their profession was frequently due to poor support from management. Participants believed that managers had a responsibility to ensure the wellness of the employee through provision of managerial support following adverse events (Matlala & Lumadi, 2017:52). Based on these findings, participants from this study suggested the need for an improvement of managerial support during perinatal loss events, especially a change in attitude of management when handling perinatal loss, empathetic support during perinatal loss events, prioritising the emotions of the midwives before demanding written incident
reports, provision of protocols and guidelines guiding midwives on management of perinatal loss and provision of bereavement care. The findings of Martínez-Serrano, Palmar-Santos, Solís-Muñoz, Álvarez-Plaza and Pedraz-Marcos (2018:130) also reported that midwives demanded protocols that facilitated the bereavement process without forgetting the importance of personalized care.

4.3.2.2 Sub-theme 2.2 Lack of private rooms for grieving women

In this study the midwives expressed the lack of private rooms in hospitals for grieving women. These women had to share rooms immediately after the loss with other women, who were in labour or had delivered healthy babies. The midwives felt guilty about this situation.

“But now we have a mother and then there are mothers with other babies which makes it more traumatic for that mother as well as me as nurse that I’m nursing her because at some point you actually don’t you don’t know what to say because of she becomes more emotional because of she lost a child now and yet we are having a lot of mothers still coming in delivering and giving birth to healthy babies so there are quite you know a few challenges” (Participant 1 0028, female, 39 years).

Participant 1 expressed the lack of private rooms for grieving women as the cause of traumatic experience for midwives. This environmental condition is also exposing the woman in more trauma of witnessing another woman enjoying motherhood while grieving to the loss.

“…the unit where I’m working a grieving woman is lying next to a happy woman. So, now you’ve done grieving counselling, you’ve given moral support, she has stopped crying and she’s also assisting herself to understand that she’s loss the baby and then the woman next to her is got alive baby, she’s got a bouncing baby boy and then during visiting times the whole family of the other one will come, and they start celebrating next to this one who’s lost the baby…the problem is the space we do not have anywhere to place them, if we could have a ward that is mainly ehhh for them then I think it would be so much better…” (Participant 13 0017, female, 58 years).
The midwives felt frustrated by the infrastructural constraints of their labour wards that did not cater for women undergoing perinatal loss. They expressed the sense of injustice and the lack of compassion that the layout of the ward appeared to communicate to the grieving women and their families. In this study as expressed by midwives, a private room is a room which gives privacy to grieving women and their families and protects them from hearing labouring women who have delivered live healthy babies. A private room is described as a place for patients to recuperate in private with the necessary medical staff and supported by visits from family, friends, colleagues and clergy during assigned visiting hours (Gregerman, 2010:1).

The participants expressed feelings of being in an ethical dilemma as the purpose of midwifery education is to promote safe midwifery practice and quality midwifery care for women and their families (ICM, 2013:2); yet they found the environment where grieving women were being nursed following perinatal loss was not conducive to supporting women through the grieving process. Midwives’ professional and ethical practice requires them to create and maintain an environment conducive to ethical practice and to accept and assume accountability and responsibility for their actions and omissions within the legal and ethical parameters of a dynamic healthcare environment as stipulated in the South African Nursing Act R36935 (SANC, 2013:14).

Midwifery care promotes, protects and supports women’s human, reproductive and sexual health and rights; and it respects ethnical and cultural diversity as it is based on the ethical principles of justice, equity and respect for human dignity (ICM, 2014:2); therefore it is the duty of the midwife to ensure the safety of the patient and protection of the patient’s rights while maintaining confidentiality (ICM, 2014:2).

Sutan and Miskam (2012:7) conducted a study on the psychosocial impact of perinatal loss among Muslim women. They reported that the participants recognized the difficulty in providing privacy in government hospital; but the women felt that they really wanted it when faced with the trauma of losing a baby and also reported that they were disturbed with the crying of the other babies in the surrounding wards. The Irish National Standards of Bereavement Care Following Pregnancy Loss and Perinatal Death reported that hospitals did have systems in place to ensure that bereavement care and end-of-life care for babies was central to the mission of the hospital and was
organised around the needs of babies and their families (O’Farrell, 2016:618). The nursing profession develops its practitioners to become ethical agents who will advocate the well-being of the patients and their families with compassion, commitment, confidence, competence and a deep sense of moral awareness (Pera & van Tonder, Oosthuizen & van der Wal, 2015:3). Therefore, the application of ethics in midwifery care is that midwives provide care to pregnant women from conception until the end of puerperium phase even during the grieving process (Beneficence), if grieving women are entitled to a safe environment, surely the same applies to midwives who are entitled to a safe working environment (Justice) and lastly midwives are legally bound to ensure the protection of the rights of the grieving women (Advocacy); yet the working environment of these midwives forces them to work against these ethical principles leading to stress and feelings of guilt.

One of the strategies that provide healing in healthcare organisation is provision of a harmonious environment, which is free of noise, clean and safe and an integral part of the infrastructure. Midwives perceive their work environment as posing threat to the aging midwifery care as newly qualified midwives prefer to work in other settings other than in midwifery and not understood by many within the institution (Matlala & Lumadi, 2017:51).

American Association of Critical Care Nurses (AACCN) stated that nurses must be valued and committed partners in making policy, directing and evaluating clinical care and leading organisation operations (2016:21). Therefore, in order to fulfil their role as advocates, nurse must be involved in decision-making about patient care; but same applies to midwives who were participants in this study who were advocating for women who experienced perinatal loss to be nursed in an environment that was free of the noise of live crying babies. Safe and calm work environments are imperative to the well-being of patients which requires systems, structures and cultures that support communication, collaboration, decision-making, staffing, recognition and leadership (AACC, 2016:10). These findings are like the findings of the study conducted by Sereshti, Nahidi, Simbar, Ahmadi, Bakhtiari and Zayeri (2016:2011), who that reported inadequate facilities were highlighted by their participants. One participant for example who was a 46-year-old woman who had had eight recurrent miscarriages claimed that her roommate who had gave birth to a live baby was happy and laughing with her
relatives and looking for a name for the child in the same room while she was mourning her loss.

According to Peters, Lisy, Riitano, Jordan and Aromataris (2015:275), parents may be distressed when the birthing suite or delivery ward is not set up or equipped to support parents in the time between learning that their baby has died at birth; and exposure to the cry of newborn babies and other parents can be highly distressing. Kingdon, O’Donnell, Givens and Turner (2015:10), also reported that participants complained about sub-standard care which included lack of facilities for women after having given birth to their stillborn because they felt their needs were not being met when they were placed in wards with other women who had just given birth successfully. Based on these findings participants in this study suggested a change in hospital infrastructure or environment to accommodate the needs of women experiencing perinatal loss in order to prevent the need for midwives to switch from feelings of sadness to a happiness needed for parents celebrating the birth of their live babies.

4.3.2.3 Sub-theme 2.3: Time constraints in provision of bereavement care
The midwives in this study who were caring for women with perinatal loss expressed the problem of challenges regarding time constraints in the provision of bereavement care.

“…we so busy here, we so short-staffed we don’t even have time to talk with them, you know, that patient who lost the baby you know is one of the eight patient you looking after, you rushing through them you don’t have time, you only have time at home to process” (Participant 3 0088, female, 48 years).

“…you are running and rushing, then to all our high-risk patient once they deliver an IUD (Intra-uterine death), she’s emotional, she’s crying but you can’t even stay with her you have to rush out and go and attend to other administration duties that also need your attention.” (Participant 6 0013, female, 49 years).

“The mother’s life is not, just maybe is still heartbroken at that moment but you as a nurse you must continue with the other patients, patients that need your help. So, you can’t dwell on that one mother…. ” (Participant 11 0018, female, 59 years).
Participant 6 also expressed the fact that staff were encouraged to make footprints of the baby’s feet; but that only happened about 10% of the time, whereas 90% of the time they were struggling to meet the grieving women’s needs. Hence, the participants described their work as a constant “rushing” to attend to the labouring women or to administrative duties due to time constraints. There was a sense of not being able to attend properly to any of their demands.

The findings of this study are supported by Williamson (2016:36), who reported that midwives have a responsibility to look after the mothers who are experiencing perinatal loss as well as those who give birth to live babies; but owing to the high turnover of patients, midwives have less time to focus and support mothers going through perinatal loss. They are expected to be competent in addressing perinatal loss events and bereavement care as they are at the forefront in the provision of midwifery care; but high patient turnover, limited training in bereavement care, high litigation rates and environmental factors interfere with the provision of adequate bereavement care (DOH, 2019:9). Time constraints led to high levels of stress experienced by midwives as they find difficulties in balancing their work, meaning the care of the grieving woman, against the care of other women in their units. Additionally, Ball, Murrells, Rafferty, Morrow and Griffiths (2013:116) reported that 86% of nurses had reported that one or more activity had been left undone due to lack of time on their previous shift, especially comforting or talking with patients. The midwives in this study reported that owing to their responsibility of caring for too many patients at the same time, they did not have time to provide adequate bereavement care to these grieving women.

4.3.2.4 Sub-theme 2.4: Lack of protocols regarding management of perinatal loss

Since midwives are at the frontline of providing midwifery care to all pregnant women from conception, intrapartum until the end of the puerperium phase, they are the closest healthcare providers to grieving women following perinatal loss. In this study they reported that their responsibility of providing immediate grief counselling without proper protocols was leaving them with negative emotions which they reported to the
researcher in the interviews, expressing their emotions regarding effects of providing grief counselling without proper protocols as follows.

“Our department to be more involved in assisting the midwives you know, ehhh getting proper protocols in place you know if this one doesn’t work what is our next step, how do we deal” (Participant 1 00113, female, 39 years).

“And, we also need more protocols for example which will help in knowing whatever extra-mile you need to walk with the patient through this situation and know that you are being supported by the protocol on it” (Participant 6 0013, female, 49 years).

“It’s because I was never given you know, a proper guide on how to do it or to carry on it. It’s only when by reading on my own by only literature that you know I’m start you know thinking that I am doing what is supposed to be done and for them I, because I don’t get feedback, I don’t know if I’m saying the good thing or the right thing to them” (Participant 10 0035, female, 58 years).

In admitting to a lack of guidance in management of women with perinatal loss midwives expressed the need for availability of proper protocols that will guide the care they provide to women with perinatal loss as well as their lack of confidence in the provision of immediate grief counselling due to lack of proper guidance on how to care for women with perinatal loss. These findings correlate with the results of the study conducted Ellis et al. (2016:15) which reported that healthcare professionals often lack confidence in their personal ability to provide good quality care for parents and unfortunately hospital protocols and processes seem to create barriers to providing holistic and individualised care during perinatal loss events. Many midwives may feel unprepared and inexperienced in this complex level of midwifery care regardless of their previous midwifery experience (Jones & Smythe, 2015: 17). In this study results showed that midwives had minimal knowledge in the management of women experiencing perinatal loss and that they required support from their organisation through being provided with proper protocols for management of women with perinatal loss.
According to the study conducted by Hutti et al. (2016:18), it was reported that in some obstetric units’ nurses received specialised unit-based training beyond their basic educational preparation to provide care to women and their partners. Many bereavement care studies have already indicated that bereavement care requires a specialised healthcare professional who has acquired skills in bereavement care to facilitate the appropriate care in each institution and availability of resources (see Montero et al., 2011:1410; O’Farrell, 2016). Furthermore, midwifery care must have practice guidelines and protocols that exist for clinical and administration purposes which midwives are expected to adhere to and that these resources must be reviewed regularly inter-professionally (RANZCOG, 2017:11). As in other studies midwives in this study explained the problems occurring in their working conditions hence their suggesting the need for more resources to assist them in management of women experiencing perinatal loss.

4.3.2.5 Sub-theme 2.5: Staff shortages expressed as a challenge in management of women with perinatal loss

Midwives expressed how shortage of staff become a challenge when managing women with perinatal loss. These midwives stated that high patient turnover and poor nurse-patient ratio result in a workload that deterred them from rendering quality when managing women with perinatal loss as follows:

“It is because they are running away from the main problems like shortage of staff and shortage of resources which can use to manage these women in cases of emergencies” (Participant 6 0011, female, 49 years).

“I think the main problem is shortage of staff because we have that feeling of not being there for our patient if you have to attend on your own self at the time that you are supposed to look at them”. (Participant 10 0033, female, 58 years).

“I think ehhh, let me talk about Eastern Cape, I think we all have entertained the issue of staff shortage, that we accepted that we are short, we are short staffed and we are not doing anything about it because if we can be assisted on that so much can be
Midwives expressed shortage of staff as the issue that was overlooked by management as being the main problem in management of women with perinatal loss. The results of the study conducted by Bremnes et al. (2018:3) reported that all the participating midwives reported a substantially higher patient/nurse ratio than the one recommended at the hospital meaning that two midwives could be responsible for up to 60 women in different stages of labour per shift when delivery frequency was at its highest. These results are like the findings of Bhaga (2010:71) which indicated that among the 22 (64.70%) participants who believed that their workload was very high and that they were unable to cope with its demands, 17 participants also believed that some nurses were suffering from burnout and becoming physically and emotionally exhausted. Bhaga (2010:72) examined the relationship between staff shortage in the maternity unit and stress being experienced by the nursing staff and the results revealed that among the 23 (67.65%) participants who had commented that there was a staff shortage in their unit which forced them to work extra shifts, 22 also believed that more nurses than other healthcare professionals were affected by stress. Matlala and Lumadi (2019:5), also reported that shortage of midwives seemed to have a major impact on the delivery of service and the unpleasant working conditions of midwives and midwives emphasised the negative impact of the shortage on their daily working experience. The shortage of staff or midwives is the major problem worldwide; but its impact on midwives is not recognised, hence midwives in this study suggesting availability of extra staff as one of the resources that will improve their coping with perinatal loss events.

4.3.3 Theme 3: Midwives expressed the need for psychological and emotional support

The midwives in this study expressed the need for psychological and emotional support during perinatal loss events. Psychological support refers to the provision of support and validation to the staff (e.g. counselling) in order to prevent individuals from becoming from experiencing a range of emotion and facing burnout (Thomas, Davison & Rance, 2013:79). However, emotional support refers to the quality of a person’s
relationships with others including empathy, caring, companionship, love and trust (Aldwin, Igarashi, Gilmer & Levenson, 2018:312; Aldwin & Gilmer, 2013:247).

The unanticipated and sudden end of a pregnancy can be a devastating and traumatic experience and can result in high levels of psychological morbidity (Pistorello, Hayes, Costello, Simpson, Begin, Rosen & Pearlstín, 2015:6). In particular, our findings suggest that education and support in nursing practice could be enhanced by supporting nurses to attend workshops and seminars on the topic of perinatal loss and bereavement care; incorporating discussions on supporting families, patients, colleagues, and oneself in bereavement care during orientation to the unit and ongoing education; debriefing after perinatal loss; and providing staff with a bereavement mentor (Jonas-Simpson et al., 2013:9). Furthermore, it is indicated that midwifery educators and employers should provide relief care, education on coping with death experiences and counselling after traumatic experiences in order to maintain the well-being of midwives (Muliira & Bezuidenhout 2015:74). Midwives are expected to provide psychological support to women experiencing perinatal loss since they are with the women during this phase; yet those same midwives become overwhelmed by the experiences of perinatal loss events and struggle to provide this care as they expressed their limitation in training and guidance of managing women with perinatal loss. Additionally, based on these midwives’ expressions of concern it can be concluded that there is a lack of psychological or emotional support for midwives caring for women with perinatal loss in the NMBHD including lack of support from management. Continued exposure to perinatal loss events with no psychological or emotional support may well lead to psychological morbidity and burnout which will later affect the grieving women negatively.

In a study by Williamson (2016:50), the midwives reported that after delivering a patient who had a miscarriage, they found themselves thinking about the event afterwards and some would go home unable to stop thinking about the event and the patient. Therefore, midwives identified a number of emotional, knowledge and system-based barriers in providing effective care which included being emotionally overwhelmed and the need for coping strategies such as avoidance and lack of knowledge of cultural and social differences around the grieving process (Ellis et al., 2016:12). Lastly, women experiencing perinatal loss are more likely to suffer
psychological problems in the future if they do not receive adequate professional support, therefore it is recommended that all staff who come into contact with women during perinatal loss should be trained in how to care for them (Montacute & Bunn, 2016:4). Therefore, the six sub-themes supporting Theme 3, as indicated in table 4.2 will be discussed as follow,

4.3.3.1 Sub-theme 3.1: Midwives perceive the EAP services as being inadequate
Since midwives are at the frontline of providing immediate care to women experiencing perinatal loss, they are bound to experience secondary traumatic symptoms and will need psychological support. In this study some of the midwives commented that in their institution there were Employee Assistance Programme (EAP) services available for them when they needed psychological and emotional support; but they felt that the provision of the EAP services was inadequate or non-existent.

“We have an EAP system in place but really, it’s not sufficient for what we sometimes deal with here and is in district offices”. (Participant 1 0042, female, 39 years).

“If you not coping in private (hospital) you can phone, and they will hook you up with the psychologist and someone phones and talk to you and follows up with you. There’s nothing here, no one talks about it here” (Participant 3 0058, female, 48 years).

The midwives felt the EAP services were not sufficient for their needs. They felt that EAP in the private sector was better than the public sector and that it is not discussed openly. Findings of this study indicated that some of the participants were aware of EAP services in their organisation while others showed no understanding of available EAPs, which correlates with the findings of the study conducted by Mugari (2011:91). Her study revealed that 45% of participants had not been exposed to EAP information sessions whereas 40% had. EAPs are a set of services designed to improve and/ or maintain the productivity and healthy functioning of the workplace and aim to address organisational productivity and help employees identify and resolve both work and non-work-related personal issues (Bajorek, 2016:4). Manganyi’s study (2015:76) found that a minority of participants (36%) had reported that EAP services were being provided in their departments while most participants (64%) had reported that EAP
services were not being provided in their department. Lastly, Dipela (2016:83) reported that there were a significant number of employees (38%) who were not aware of the EAP services whereas the majority (57%) of employees were aware of EAP. Midwifery care, according to the literature is reported as incurring a high level of emotional stress since caring for childbearing women and specially those who have lost their babies during childbirth can result in overwhelming emotions, self-blame, feelings of guilt and depression. It is therefore important for each institution to provide EAP services for its employees. Bhaga (2010:101) argues that participants in higher job positions utilise the EAP services much more than the participants in the lower job positions and it would seem that the nursing staff in the lower ranks do not utilise EAP because they are not aware of the service or they do not understand its role.

The study conducted by Rakepa in department of education in Free state (2012:65) showed that most participants had rated the services provided by the EAP as poor (41%), and very poor constituting a total of 52%, while very good, good and adequate had a total of 48%. In addition, Kenny (2014:102), reported that there was poor utilisation of the EAP among the nursing staff in the maternity unit described in his study, and the following are the comments from the participants regarding their trust in the EAP: staff is afraid to use the EAP, the EAP is believed to report to management about your problems and the managers and supervisors gossip about what is discussed at EAP, even though these participants had not used EAP services. They all indicated a lack of trust in EAP (Kenny, 2014:103). Furthermore, ensuring the confidentiality of those employees who make use of the service should, consequently, be guaranteed otherwise the assumption is that most employees believe that only the offsite model helps to ensure their confidentiality (Rakepa, 2012:118). The midwife who made use of EAP in this study did not find the service to be helpful. She expressed this as follows:

“…To help you to heal, I didn’t get that in my case, maybe in somebody else’s case I don’t know” (Participant 8 0062, female, 48 years).

EAPs were therefore considered to be an employee benefit as well as a means of improving employees’ (and therefore by extension the employer is) productivity through reducing personal problems that could negatively affect an employee’s job
performance (Kenny, 2014:86). On the other hand, however, the findings of the study conducted by Kenny (2014:104) reported that some participants had been impressed with the EAP services and the EAP staff. Furthermore, Donaldson’s (2018:75) indicated that therapists had rated their participants as improved regardless of which session model they were assigned to. It also found that most participants who had resolved their issue had also completed their entire session model; but even when participants had not completed their entire session model, they did improve. Based on these findings the researcher would suggest that EAPs do help employees to heal or improve; however, in this study there is limited information to support this statement since among the midwives who participated in this study only one midwife had experienced an EAP consultation.

4.3.3.2. Sub-theme 3.2: Confusion over the process of EAP referral
Some of the midwives further complained that there was no self-referral rule for EAP because if as a midwife when one sought psychological consultation one would have to wait for one’s manager to refer one to EAP.

“It’s not a self-referral, you know everything you have to report, let’s say to the Operational manager (OM) and then it’s only when you reported that she will organise referral to EAP ”... (Participant 8 0034, female, 48 years).

Participant 7 also implied that referral was required in order to access EAP.

“Referral to the EAP at some stage will be very good, you can talk then somebody will listen.” (Participant 7 0029, female, 47 years).

Participant 8 was under the impression that the operational manager had to refer the employee to the EAP services; but this demonstrates a degree of confusion regarding the way EAPs function. In some circumstances self-referral can result in better continuity of care, speedier diagnoses, and improved timely access to healthcare services; yet self-referral is often criticised because it can result in a conflict of interests (Beck & DuMoulin, 2013:33). In this study self-referral refers to the midwives’ act of self-referral for EAPs while lack of self-referral refers to the absence or limited use of self-referral.
These findings are supported by Letsoale (2016: v) who stated that supervisors and shop stewards were aware of their role of identifying, supporting and referring employees who needed help to EAP. Furthermore, the findings of the study conducted by Letsoale (2016:A-65), indicated that, 70% of participants (managers) had affirmed to the question, 57% had cited health problems as their reason for referral and all the participants had cited more than one problem with absenteeism being the highest at 45% followed by substance abuse at 35%. Additionally, the study conducted by Manganyi (2015:107) had revealed that 75% (n=3) of the managers had never referred the employees to EAP whereas 25% (n=1) reported that employees had been referred due to absenteeism, aggressive behaviour, low performance and financial problems. Findings of the study conducted by Manganyi revealed that 75% (n=3) of the employees had been referred by their supervisor to EAP whereas 25% (n=1) had referred themselves.

The findings indicated that the utilisation of the EAP services among the nursing staff in that maternity unit had been very poor; for only 6 (17.65%) of the participants had utilised the services of the EAP, while an astounding 28 (82.35%) participants indicated that they had not utilised the EAP services (Bhaga, 2010:100).

Among the 6 (17.65%) participants who had utilised the EAP services, 3 of the participants had been referred by their supervisors to the EAP, while the other 3 of the participants had been self-referral (Bhaga, 2010:101). These findings of Bhaga (2010:101), indicate that EAPs have an open-door policy even though the results of this study suggest otherwise; for many employees are unaware that they are allowed to access the EAP without being referred by supervisors, which implies that employees do not understand the related policies and procedures (Rakepa, 2012:110). As much as the policy states that the employee has a responsibility to seek EAP assistance when identifying problems in her or his work environment, it has been noted that frequently the referral is not made directly to the EAP, but through the unit supervisor. In this study the only midwife who had received EAP consultation reported that no feedback had been given by the EAP facilitator which had led to her feeling acutely unhappy with the EAP process.
“I will not go back there because there was no feedback, so I will take it, as if it’s no use going there as if now, they just wanted that information” (Participant 8 0058, female, 48 years).

Participant 8 felt very despondent after using the EAP service and felt very strongly that she would not use the service again. Feedback often occurs after a response or when information is provided about the specific task at hand (Norlin, 2014:11). In addition, feedback can be regarded as providing information relating to the performance of the receiver with the goal to improve performance (Dobbelaer, Prins & van Dongen, 2013:99). The findings of Dipela (2016:85) revealed that among 17% of participants who had received EAP services, 2% indicated that they would never visit the EAP again, whereas 74% of indicated that they might consider visiting EAP if possible, in future. Based on these findings, the researcher has noted that the EAP service being rendered does not seem meet the expectation of the employees. Furthermore, Rajin (2012:64) reported that 50% of the participants in his study had received feedback from EAP whereas 39% indicated that they had not received any feedback from the EAP practitioners. These findings also reveal that the EAP feedback procedure is possibly not understood by the employee as the feedback is given directly to supervisors who referred the employees. Some of the supervisors that had participated in other studies also reported that no feedback had been given. It is reported that anecdotal feedback had been given to the Human Resources (HR) managers which was the way through which they were able to find out what employees thought of the EAP services and this was offered as some form of organisational evaluation (Kinder & Roberts, 2016:13). Feedback aims to develop performance to a higher level by dealing with underperformance in a constructive way (Hardavella, Aamli-Gaagnat, Saad, Rousalova & Sreter, 2017:328).

4.3.3.3 Sub-theme 3.3: Shortages of staff prevent midwives from accessing EAPs
Since shortages of staff in healthcare are a known problem in South Africa, employers have a responsibility to improve employee performance and consequently institutional productivity by promoting both healthier individuals and healthier work environments (Mugari, Mtapuri & Rangongo, 2014:257). Midwives in this study reported, however,
that they were unable to seek EAP services due to shortage of staff. Quotations from some of the participants follow.

“…there’s so much in the unit to take care off, so escaping and getting time for me to get for me to get to go to the EAP, it looks as if I’m depriving now my patients the care that they need because we are very few I am not able now to run away and to get me ehhh briefed or whatever or to get me taken care off”. (Participant 10 0029, female, 58 years).

“Because now I would like when I got perinatal loss to go quickly and assistance, support system for myself so that I’m in a good position to start grief counselling for my patients and who is going to work on my place because there are still other patients that are under my care. [But] if I move out of the unit there will be grossly short of staff…” (Participant 13 0039, female, 58 years).

According to UNFPA (2015:14), midwives make up to 36% of the midwifery workforce across 73 countries. 23 (67.65%) participants agreed that the staff shortage in their unit forces them to work extra shifts and only 2 (5.88%) participants disagreed that staff shortage forces them to work extra shifts. Many nurses find shift work difficult when they must cover for absent colleagues (Bhaga, 2010:72). Findings of the study conducted by Pugh, Twigg, Martin and Rai (2013:498), reported that shortage of midwives is due to lack of societal and professional recognition, lack of adequate education, as well as limits to providing antenatal and intrapartum care. South Africa, like many other countries faces a shortage of highly skilled healthcare professionals including midwives (Onobanjo, 2013:2). Furthermore, Staff shortage puts pressure on the nursing staff to fulfil their work and family roles effectively and often forced to work extra shifts and overtime which makes them physically and emotionally exhausted (Bhaga, 2010:83). However, midwives from this study reported that shortage of staff lead to guilty feelings as they are unable to go and seek EAP services during perinatal loss events with fear of leaving women alone and unattended.

4.3.3.4 Sub-theme 3.4: Referral to a specialist for counselling
Adverse event may or may not be preventable (in this case perinatal loss), if preventable it can be considered as a result of an individual or a system error (Austin,
Smythe & Jull, 2016:19) which may result to secondary traumatic symptoms to midwives. Secondary traumatic symptoms referred to are feelings of sorrow, anxiety, insecurity, resentment, guilt, rage, feeling of failure (Montero et al., 2011:2010). The provision of psychological and emotional support has been highlighted as a necessary intervention needed by midwives following the exposure to perinatal loss events as discussed under theme 3. Even though the existing EAP services in some organization is not known or inaccessible yet midwives have suggested the referral for specialist will help them cope with perinatal loss,

“If we have something like this that is free for nursing staff or midwives to go to. If you had a very bad situation at your work cause you can go there may be on that premises, you can have your psychologist or psychiatry that maybe visit once or twice a week and have your sessions with them, on a routine basis but at the same time you are also looking at your total wellbeing” (Participant 1 0099, female, 39 years).

"What can be done, I think if they can be, what you call this, psychologist who will come and address these women or the staff, give them a support you know, moral support you know, emotional physical and give us a talk you know after all this, maybe if, even if its once a month maybe it will relieve the stress and depression” (Participant 2 0039, female, 48 years).

“Referral to the EAP at some stage will be very good, you can talk then somebody will listen” (Participant 7 0029, female, 47 years).

Employer responsibility and liability for their employees’ psychological well-being is becoming more recognisable. According to Helo and Moulton (2017:779), employees may benefit from time off from work and confidential psychological services, which may encourage health professionals to seek counselling. EAP is the short-term designed counselling resource that relies on referral and networking to provide greater support in minimising the impact of everyday life on job performance and improving an employee’s quality of life (Ramotshere Moiloa Local Municipality, 2015:3). This referral system is organised by employees on a voluntary basis or by the employee manager when an employee’s work performance has declined or the basic code of
The role of psychologists serves to facilitate responses to issues and problems at work by serving as advisors. Von Schantz-Enoksson (2018:58) reported that the use of an adopted coping mechanism might help midwives to carry on working which is the way of surviving struggle; but these coping methods are not enough; and therefore structures for psychological first aid and clear pathways need to be implemented. Furthermore, midwives experiencing both organisational and occupational episodes of work-related psychological distress due to the insalubrious, emotionally arduous and traumatic work environment they endure will require effective interventions of support for them to enjoy a psychologically safe professional journey (Pezaro & Clyne, 2016:1). Additionally, Pezaro and Clyne (2016:11), noted that midwives valued support which was non-judgemental and confidential, as some midwives feel unable to express themselves, stigmatised, yet feel required to cope, suggesting a need for a confidential online intervention designed to support midwives in work-related psychological distress situations. Expert participants also agreed that midwives in distress should be offered information designed to inform them where they can access alternative help and support (Pezaro & Clyne, 2016:9).

Midwifery needs to follow the example of other helping professions and acknowledge secondary trauma as professional risk and investigate its nature and prevalence in midwives and this should be a prerequisite for the development of an evidence base for education and professional supervision and for finding new means to manage the costs of being with a grieving woman or midwife who is no longer able to cope with her responsibilities e.g. by offering psychological support for midwives (Leinweber & Rowe, 2010:85). In addition, the nature and organisation of midwifery work needs to be considered in the development of prevention or management interventions to reduce the psychological impact of work-related stress in a midwifery setting (Creedy, Sidebotham, Gamble, Pallant & Fenwick, 2017:6). Midwives experiencing severe burnout may require temporary leave of absence, psychiatric evaluation and treatment for major depression and other comorbid diagnoses, as well as a supportive return-to-work programme that fosters autonomy, teamwork and work satisfaction (Creedy et al., 2017:6).
4.4 CONCLUSION

Midwives working in labouring units in the NMBHD are experiencing stressful situations on daily basis. In this study midwives have expressed how perinatal loss events have affected them emotionally, physically and psychologically. Furthermore, these midwives have highlighted the main issues that aggravate their ability to cope with perinatal loss which has been discussed in three themes that emerged i.e. Theme 1, Theme 2 and Theme 3. These stressors place a great demand on midwives’ coping ability. Midwives in this study further suggested different measures that could assist midwives in coping better with perinatal loss events and reduce maladaptive coping mechanisms; therefore it is necessary for management to plan and implement the recommendations suggested by midwives which will assist them in coping during perinatal loss events as discussed in Chapter 5.
CHAPTER 5

DEVELOPMENT OF RECOMMENDATIONS FOR THE SUPPORT OF MIDWIVES TO COPE WITH CARING FOR WOMEN WITH PERINATAL LOSS

5.1 INTRODUCTION
The previous chapter of this study presented and discussed the findings of the study that related to the coping and support needs for midwives caring for women with perinatal loss in the NMBHD. The discussion was guided by the three themes and a range of sub-themes that emerged from the interviews with the midwives. This chapter entails the development of recommendations from the data analysis results.

5.2 BACKGROUND TO THE DEVELOPMENT OF THE RECOMMENDATIONS
Midwives are part of the multidisciplinary team in labouring units and have the bulk of the obstetrical and midwifery responsibilities. The responsibilities being referred to include provision of perinatal care and support to grieving women who have lost their babies at birth and to their families. The care referred to in this study is focused mainly on the grieving women and not on the midwife. By virtue of midwives being present in the event of perinatal loss or caring for a woman who experienced perinatal loss, midwives are compelled to be involved and are bound to experience deep emotions. Furthermore, there is little formal support available for midwives caring for women with perinatal loss in NMBHD and South Africa at large.

The NMBHD has high levels of perinatal loss, for example, from 2011 to 2012 NMBHD was the third district in Eastern Cape Province with the highest inpatient early neonatal deaths (17.2%) which was above the prescribed average in South Africa (Day, et al., 2013:53). Since 2013 no improvement in this trend has been noted and the NMBHD now has the highest average inpatient early neonatal losses in the Eastern Cape Province.

Owing to above, the aim of this study was to obtain a deeper understanding of coping and support needs of midwives caring for women with perinatal loss in the NMBHD. From the findings obtained from the midwives, recommendations were developed that could support midwives to cope with caring for women with perinatal loss in the
The study adopted a qualitative, explorative and descriptive design to respond to the research questions and the objectives. The theoretical framework underpinning the design and methodology was the Transactional Model of Stress and Coping (TMSC) (Glanz et al., 2015:228). The TMSC was developed with the understanding that stressful experiences are constituents of person/environment transactions whereby the impact of an external stressor is mediated by the person’s appraisal of the stressor and the psychological, social and material resources at his/her disposal. Hence, the findings showed that midwives rely on their own coping mechanisms in order to deal with perinatal loss, and they expressed how management influenced the way they coped with perinatal events, and the need for psychological and emotional support. The findings that emerged from the data analysis were used to develop the recommendations needed for supporting midwives with coping with caring for women with perinatal loss.

5.3 RATIONALE FOR THE DEVELOPMENT OF RECOMMENDATIONS

Developing the recommendations was one of the objectives of the study. In view of the results from data analysis of this study, it is evident to the researcher that even though midwives rely on their own mechanisms, they still need some support and assistance to better cope with perinatal loss. The challenges faced by midwives in the provision of extensive and holistic bereavement care and support, as expressed by midwives in this study, included a range of emotions, self-blame, feelings of guilt, stress and depression leading them to rely on their own mechanisms of coping. The use of coping mechanisms in order to adapt to stress varies for each individual and are an individual’s own way of dealing with stressful situations.

In addition, midwives expressed their feelings about how management influenced the way they coped with perinatal loss events. The hospital system was frequently a cause of work-related stress. Work-related stress refers to the roles, tasks and demands of a specific job within an organisation that bring about stress (Harrington, 2013:273). Work-related stress consists of the physical, mental and emotional reactions that occur when workers perceive that the demands of their work exceeds their abilities or resources to cope (The State of Queensland, 2019:3).
On the other hand, the midwives in this study expressed the need for psychological and emotional support during perinatal loss events. All healthcare professionals, midwives included, require support in their care for women with perinatal loss, and this includes knowing where and how to seek their own support and the ability to develop resilience to ensure the longevity of their career and to avoid burnout (Matheson, Robertson, Elliot, Iversen & Murchie, 2016:e507). In this study, midwives in the NMBHD expressed the need for that support.

These factors were the driving force which inspired the researcher to develop the recommendations that are now presented in this chapter and guided by the theoretical framework adopted for the study. The TMSC was developed with the understanding that stressful experiences are constituents of person/environment transactions whereby the impact of an external stressor is mediated by the person’s appraisal of the stressor and the psychological, social and material resources at his/her disposal.

In this study, the researcher sought to develop coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD as was stipulated by the last objective: To develop coping and support recommendations for midwives caring for women with perinatal loss in the NMBHD. The primary interview question from which the data was elicited from the participants was:

*Now tell me, how is it for you to care for a woman who has lost a baby?*

In listening and subsequently analysing the responses of the midwives to this question and other interview questions the researcher was able to identify and describe the support needs for midwives caring for women with perinatal loss in the NMBHD. The TMSC model guiding this objective concerned coping in the face of a challenging situation. The midwives indicated a strong reliance on their own coping mechanisms to deal with perinatal loss. They further expressed how management influenced the way they coped with perinatal events and the need for psychological and emotional support. In terms of the TMSC, this objective focuses on emotional regulation/adaptation. The midwife participants indicated what they needed to assist them in coping with the care they provided to women with perinatal loss. They described experiencing stressful situations daily. They expressed how perinatal loss
events affected them emotionally, physically and psychologically. Furthermore, they highlighted the main issues that influence their ability to cope with perinatal loss. These stressors place a great demand on midwives’ coping ability and for them to better cope with perinatal loss and reduce maladaptive coping mechanisms, recommendations that could enhance the wellbeing of the midwives during perinatal loss have been developed.

5.4 PROCESS OF DEVELOPMENT OF THE RECOMMENDATIONS
The AGREE II tool was adapted for use as a systematic process of developing the recommendations for midwifery practice as it relates to perinatal loss. The Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument was originally developed to provide an understanding of the quality of a set of clinical guidelines. The tool has undergone a rigorous process of validation and is viewed across the globe as the benchmark for the evaluation of guidelines (National Collaborating Centre for Methods and Tools, 2013:1). This study did not seek to develop guidelines, however, the AGREE II tool, in an adapted format, was considered a suitable means of developing recommendations in a systematic manner. Out of the six domains of the AGREE II tool five domains were used for this study. In addition, out of the 23 items used for guideline development (as used in the AGREE II tool), 13 were used for this study to develop the needed recommendations.

5.4.1 RECOMMENDATIONS FOR THE SUPPORT OF MIDWIVES TO COPE WITH CARING FOR WOMEN WITH PERINATAL LOSS

Three recommendations were developed for this study using the adapted version of the AGREE II tool and these are presented below:

**Recommendation 1:** Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss.

**Recommendation 2:** Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss.
**Recommendation 3**: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.

All three recommendations are presented in tabular format to demonstrate how the Agree II Tool was used to develop each recommendation (see Table 5.1, Table 5.2 and Table 5.3).

**5.4.1.1 Recommendation 1**: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss.

**Purpose**: The purpose of Recommendation 1 is to encourage teamwork among midwives so that they assist one another during times of perinatal loss. It seeks to enhance peer support, whereby midwives provide emotional support to their peers as well as facilitating spiritual support during times of perinatal loss.

**Table 5.1**: Recommendation 1: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss

<table>
<thead>
<tr>
<th>Domains and Items of the adapted AGREE II tool used for the evidence-based recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 1</strong>: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss</td>
</tr>
<tr>
<td><strong>Domain 1. Scope and Purpose</strong></td>
</tr>
<tr>
<td>1. The overall objective(s) of <strong>Recommendation 1</strong> are specifically described.</td>
</tr>
</tbody>
</table>

The objectives of **Recommendation 1** seek to:

- Encourage teamwork among midwives so that they assist one another during times of perinatal loss.
- Enhance peer support, whereby midwives provide emotional support to their peers during times of perinatal loss.
- Facilitate spiritual support for midwives as derived from peers during times of perinatal loss.
2. The population (patients, public, etc.) to whom Recommendation 1 is meant to apply is specifically described.

- The population to whom Recommendation 1 is meant to apply are hospital managers, unit managers and midwives who are based in labouring units in the NMBHD.

**Domain 2. Stakeholder Involvement**

3. The views and preferences of the target population (patients, public, etc.) have been sought.

- The views were sought from practicing midwives in labouring units, who provide care for women with perinatal loss in the NMBHD.

4. The target users of the recommendation are clearly defined.

- The target users are the hospital managers, the unit managers and the midwives themselves who are based in labouring units in the NMBHD.

**Domain 3. Rigour of Development**

5. The methods for formulating the recommendations are clearly described.

- An adapted version of the AGREE II tool was used to develop Recommendation 1.

6. There is an explicit link between the recommendation and the supporting evidence.

Supporting evidence was provided for each recommendation.

- The participants expressed the need for support from their colleagues and the sense of teamwork during perinatal loss events. A Sierra Leone study highlighted the importance of teamwork and the role of leadership in encouraging teamwork. The midwives in their study worked as a team and provided support for one another emotionally when there were both losses, and successes in the labouring unit (Ngongo, Christie, Holden, Ford, & Pett, 2013:1232-1233).
The participants emphasised the role of their peers in providing emotional support in situations where there was perinatal loss. Favrod et al. (2018:10) suggest the importance of introducing a "peer support system" for midwives as a form of social support, with a view to protecting midwives from being susceptible to mental health challenges.

The participants emphasised the importance of spirituality and prayer in coping with perinatal loss events. In a study by Kalu, Coughlan, and Larkin (2018:6), all the participants highlighted the positive effects of midwives' spiritual support and how this had a positive influence on the abilities of the women to cope with their loss. Furthermore, Crowther and Hall (2015:173) highlight the importance of spirituality in midwifery practice and argue that the role of spirituality should not simply be policy driven but be allowed to play a more prominent role.

**Domain 4. Clarity of Presentation**

7. The recommendations are specific and unambiguous.

**Recommendation 1** is clearly presented in a specific and detailed manner.

8. The different options for management of the health issue are clearly presented.

**Recommendation 1** presents the different options for management, namely, to equip unit managers with the skills needed to facilitate peer support, teamwork, and spiritual support among their staff. Management should seek to create a workplace environment whereby these forms of support are promoted in order to increase the well-being of their staff.

9. Key recommendations are easily identifiable.

**Recommendation 1** was clearly presented using the domain table with 13 items originally used for the AGREE II guidelines instrument.

**Domain 5. Applicability**

10. The recommendations describe facilitators and barriers to its application.

**Recommendation 1** describes the facilitators and barriers to its application:
• The training for unit managers can be presented as professional development which could be provided to all labour ward and neonatal unit managers in the province.

• Team building is critical to any workplace in which there is regular exposure to adversity. Opportunities for team building should occur on a regular basis.

• Many labour wards have scarce material and infrastructural resources and hence the greatest resource is essentially the midwives themselves. Team building has the potential to draw on this “natural resource” which can be used to assist midwives to cope with perinatal loss events.

• It is critical that hospital and unit managers listen to the experiences of the midwives so that they are constantly aware of the working conditions in which they work and can therefore respond appropriately to them.

• It is important that unit managers acknowledge or be made aware of the role of spirituality in midwifery care and that its practice be encouraged.

11. The recommendation provides advice and/or tools on how the recommendations can be put into practice.

Advice on how the Recommendation 1 could be implemented was included:

• Unit managers should be trained on how to support midwives and to facilitate peer support among midwives who have been exposed to a perinatal loss event.

• There should be regular team building exercises among midwives especially regarding the challenges encountered during perinatal loss events.

• Midwives should also be consulted on regular basis regarding their experiences of perinatal loss events or any traumatic event in the labour unit.

• Unit managers should encourage spirituality in its various forms to be practiced and that all religions and spiritualties be respected among staff and patients.

12. The potential resource implications of applying the recommendations have been considered.

All potential resource implications are included:
• There are few resource implications as such regarding Recommendation 1. The main challenge is the need for time to allow for peer support, team building and spiritual support. There will be certain costs involved with regard to unit manager training.

13. The recommendation presents monitoring and/or auditing criteria.

**Recommendation 1** presents monitoring and audit criteria:
• Staff satisfaction surveys to be conducted annually following implementation of the recommendation to assess the effectiveness, weaknesses and strengths of the implemented recommendation.

### 5.4.1.2 Recommendation 2: Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss.

**Purpose:** Recommendation 2 seeks to develop protocols regarding what to do during perinatal loss events and make them accessible to midwives. It aims to address the issue of staff shortages to eliminate time-constraints in the provision of bereavement care and to allow follow up opportunities for midwives to attend to women who have experienced perinatal loss. In addition, it seeks to ensure the availability of a private room(s) for grieving women and for midwives experiencing secondary traumatic stress disorders. And it seeks to explore the introduction of a bereavement support midwife or a bereavement specialist team in the labouring unit.

**Table 5.2: Recommendation 2:** Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss.

<table>
<thead>
<tr>
<th>Domains and Items of the adapted AGREE II tool used for the evidence-based recommendations</th>
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<tbody>
<tr>
<td><strong>Recommendation 2:</strong> Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss</td>
</tr>
<tr>
<td><strong>Domain 1. Scope and Purpose</strong></td>
</tr>
<tr>
<td>1. The overall objective(s) of the recommendation is (are) specifically described.</td>
</tr>
</tbody>
</table>
The objectives of **Recommendation 2** seek to:

- Eliminate staff shortage issues to reduce time constraints in provision of bereavement care.
- Encourage follow-up services for bereaved women to be conducted by midwives for closure.
- Provision of private rooms for grieving women.

2. The population (patients, public, etc.) to whom the recommendation is meant to apply is specifically described.

- The population to whom **Recommendation 2** is meant to apply are the hospital managers, the unit managers and the midwives who are based in labouring units in the NMBHD.

**Domain 2. Stakeholder Involvement**

3. The views and preferences of the target population (patients, public, etc.) have been sought.

- The views were sought from practicing midwives in labouring units, who provide care for women with perinatal loss in the NMBHD.

4. The target users of the recommendation are clearly defined.

- The target users are the hospital managers, the unit managers and the midwives themselves who are based in labouring units in the NMBHD.

**Domain 3. Rigour of Development**

5. The methods for formulating the recommendations are clearly described.

- A modified version of the AGREE II tool was used to develop **Recommendation 2**.

6. There is an explicit link between the recommendations and the supporting evidence.

Supporting evidence was provided for **Recommendation 2**:

- The participants complained that there were no guidelines or protocols at the labouring units in the NMBHD. Hence, developing and implementing
protocols that will provide guidance for midwives during perinatal loss events is critical (Martinez-Serrano et al., 2018:130). Ngongo et al. (2013:1231) found that when staff followed the unit’s protocols it enhanced the teamwork and reduced the friction between midwives and doctors.

- The participants complained of staff shortages and that they did not have sufficient time due to other work commitments to spend time with those women who had perinatal loss. This appears to be a global phenomenon with Crowther and Hall (2015:174) stating that owing to “fragmentation and task-orientated care” there is a lack of time for midwives to provide holistic care to their patients. This was supported in Kalu et al.’s (2018:74) study where midwives indicated that providing effective support was challenging because of “fragmentation of patients’ care and a lack of continuity of care due to staff shortages”. The midwives stated that managers needed “to facilitate continuity of care” to assist midwives to support bereaved parents.

- The participants found it upsetting and stressful that women with perinatal loss and their families had to remain in an environment where other women had given birth to healthy babies. Provision of private rooms for bereaved women and their families during perinatal loss promotes coping among midwives and reduces experiences of secondary traumatic disorders. Midwives in Kalu et al.’s (2018:74) study also highlighted the lack of privacy for staff for the purposes of debriefing.

- Participants did not specifically suggest that labouring units need midwives who specialise in bereavement care; however, literature suggests that this is helpful. In the UK, most labouring units have a designated Bereavement Support Midwife who is required to provide support to the women and her family (Kenworthy & Kirkham, 2011:1), which could help ease the pressure from the other midwives.

**Domain 4. Clarity of Presentation**

7. The recommendations are specific and unambiguous.

**Recommendation 2** is clearly presented in a specific and detailed manner.

8. The different options for management of the health issue are clearly presented.
**Recommendation 2** presents the different options for management, namely, to develop a protocol for midwives in the event of a perinatal loss. Management to seek to address the problem of staff shortages. Management will also need to seek creative ways of facilitating the continuum of care in the light of staff shortages. Management will also need to identify suitable midwifery staff to take on the role of “bereavement support midwife”.

<table>
<thead>
<tr>
<th>Domain 5. Applicability</th>
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<tbody>
<tr>
<td>10. The recommendation describes facilitators and barriers to its application.</td>
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</table>

**Recommendation 2** describes facilitators and barriers to its application:

- Support and understanding from the DoH and management will be a major facilitator for achieving Recommendation 2.
- One of the barriers to Recommendation 2 is staff shortages that prevent midwives having sufficient time to provide care to women with perinatal loss.
- Another barrier is infrastructural related and concerns the identification and provision of private wards for women with perinatal loss and for midwives who need debriefing.
- A less obvious barrier could be the attitudes of management and medical doctors towards the needs of midwives providing care after perinatal loss events. Further research is required in this regard.

<table>
<thead>
<tr>
<th>11. The recommendations provide advice and/or tools on how the recommendations can be put into practice.</th>
</tr>
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<tbody>
<tr>
<td>- Management are to develop and implement protocols that will provide proper guidance of midwives throughout the bereavement care.</td>
</tr>
<tr>
<td>- Unit managers should organise in-service training programmes or organise induction workshops that will facilitate the implementation of the developed bereavement care protocols.</td>
</tr>
</tbody>
</table>
• Unit managers together with hospital managers, human resource officers and trade unions organisations to motivate the need for skilled staff and organising adequate resources including provision of private rooms for bereaved women away from labouring units.
• Midwives should be consulted and be involved in decision making and implementation of support systems including well-managed shift systems.
• To promote change by encouraging management to acknowledge that exposure of midwives to perinatal loss is stressful and overwhelming.
• Communication platforms need to be created for managers to listen to the concerns and needs of the midwives.
• The identification and training of two or three advanced midwives to provide bereavement care in the labouring unit.

12. The potential resource implications of applying the recommendations have been considered.

All potential resources included:
• The main resource implication regarding Recommendation 2 is the need for an increase in staff in the labouring unit to address the problem of staff shortages. There will be certain costs involved with regard to training of advanced midwives in bereavement care.

13. The recommendation presents monitoring and/or auditing criteria.

Recommendation 2 presents monitoring and auditing criteria:
• Staff satisfaction surveys to be conducted annually following implementation of the recommendation to assess the effectiveness, weakness and strength of the implemented support systems.

5.4.1.3 Recommendation 3: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.
**Purpose:** Recommendation 3 seeks to inform midwives of EAP services and promote self-referral to address the challenges of caring for women with perinatal loss. It also aims to provide debriefing and counselling opportunities after a perinatal loss event and to facilitate regular group therapy for midwives.

**Table 5.3:** Recommendation 3: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.

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<thead>
<tr>
<th>Domains and Items of the adapted AGREE II tool used for the evidence-based recommendations</th>
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</tr>
</tbody>
</table>

**Domain 1. Scope and Purpose**

1. The overall objective(s) of the recommendation is (are) specifically described.

The objectives of **Recommendation 3** seek to:

- Inform midwives of EAP services and promote self-referral to address the challenges of caring for women with perinatal loss.
- Provide debriefing and counselling opportunities after a perinatal loss event.
- Facilitate group therapy for midwives on a regular basis.

2. The population (patients, public, etc.) to whom the recommendation is meant to apply is specifically described.

- The population to whom **Recommendation 3** is meant to apply are the hospital managers, the unit managers and the midwives who are based in labouring units in the NMBHD.

**Domain 2. Stakeholder Involvement**

3. The views and preferences of the target population (patients, public, etc.) have been sought.

- The views were sought from practicing midwives in labouring units, who provide care for women with perinatal loss in the NMBHD.
4. The target users of the recommendations are clearly defined.
   • The target users are the midwives who are based in labouring units in the NMBHD, HR managers who must develop and facilitate these support systems, EAP staff who will facilitate the EAP services for midwives working in labouring units in the NMBHD.

Domain 3. Rigour of Development

5. The methods for formulating the recommendations are clearly described.
   • An adapted version of the AGREE II tool was used to develop the recommendations.

6. There is an explicit link between the recommendations and the supporting evidence.
   • The participants did not appear to be aware of EAP services or its processes, or to make use of EAP after perinatal loss events. Literature shows that employees in South Africa are frequently not aware of EAP or do not make use of its services (Dipela, 2016; Manganyi, 2015). Not all the midwives in this study understood that self-referral to EAP is an acceptable practice and this is a common misconception among employees.
   • The participants in this study felt strongly that there was a need for debriefing after perinatal loss events. In Kalu et al.’s (2018:74) study, all the midwife participants felt that there was a need for formal debriefing and counselling by professionals to enhance the wellbeing of midwives.
   • The participants expressed the need for psychological support and that frequently perinatal loss was not spoken about. Hence, group therapy would be beneficial to the midwives. According to a literature review on burnout and nurses by de Oliveira, de Alcantara Sousa, Gadelha, and do Nascimento (2019:64), globally group interventions are the most frequently used to address burnout among nurses and are shown to be effective.

Domain 4. Clarity of Presentation

7. The recommendations are specific and unambiguous.

Recommendation 3 is clearly presented in a specific and detailed manner.
8. The different options for management of the health issue are clearly presented.

**Recommendation 3** presents the different options for management, namely, to create a culture of EAP utilisation. Management should seek to put in place opportunities for early debriefing and counselling in the labouring units. It should put in place structures that will lead to regular group sessions for midwives to assist with coping in the light of perinatal loss events.

9. Key recommendations are easily identifiable.

**Recommendation 3** is clearly presented using the domain table with 13 items originally used for the AGREE II guidelines instrument.

**Domain 5. Applicability**

10. The recommendations describe facilitators and barriers to its application.

Each recommendation described facilitators and barriers to its application:

- The EAP system is already in place so it is easier to enhance its utilisation. However, a barrier is that it is not designed specifically for supporting midwives providing support to mothers experiencing perinatal loss. Making the counsellors more sensitive their needs may prove more challenging.
- There may be cost implications to providing counselling services by professionals over and above the EAP services.
- Clear communication from management to midwives to inform and encourage them about the various methods of utilising the EAP will help facilitate its utilisation.

11. The recommendations provide advice and/or tools on how the recommendations can be put into practice.

Advice on how the recommendations could be implemented was included.

- Encourage management to acknowledge the need for midwives to receive psychological and emotional support after perinatal loss events.
- Management and EAP co-ordinators are expected to implement plan that outline the schedule and actions of the EAP to promote awareness of EAP to the midwives.
• Management and EAP co-ordinators are expected to inform midwives about the various methods of utilising the EAP, such as self-referral, supervisory referral and referrals by a colleague to prepare midwives for seeking assistance from EAP when debriefing is needed.
• Management and EAP co-ordinators are expected to strengthen the existing EAP services by ensuring: Accessibility; Feasibility; Open door policy
• Maintaining continuous trust-relationships between midwives and EAP co-ordinators.
• Give feedback to the midwives after consultations.

12. The potential resource implications of applying the recommendations have been considered.

All potential resources were included.

13. The guideline presents monitoring and/or auditing criteria.

**Recommendation 3** presents monitoring and audit criteria:

• Staff satisfaction survey to be conducted annually following implementation of the recommendation to assess the effectiveness, weakness and strength of the implemented recommendation.

### 5.5 CONCLUSION

Findings of this study brought suggestions that assisted the researcher in developing recommendations that will facilitate coping and support needs for midwives caring for women with perinatal loss. Three recommendations were made: Recommendation 1: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss; Recommendation 2: Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss; and Recommendation 3: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss. The following chapter provides the conclusions, limitations and recommendations from the findings.
CHAPTER 6
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION
The previous chapter presented the developed recommendations of the study based on the analysis and discussion of qualitative data under chapter 4. This chapter will draw conclusions regarding the study, as well as describing the limitations of the study, and summarize the developed recommendations. The chapter will also make recommendations regarding future midwifery research regarding perinatal loss. The purpose of the study was to understand the coping and support needs of midwives caring for women with perinatal loss in the NMBHD. The conclusions of the study discussions will be based on the research findings discussed in chapter 4 and will be in response to the research objectives as formulated in chapter 1 section 1.5

6.2 CONCLUSIONS OF THE STUDY
The discussion of the research process was guided by the objectives of the study, which were to:

• explore and describe the facilitative conditions that enable midwives to care for women with perinatal loss in the NMBHD.

• explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in the NMBHD.

• identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD; and

• develop coping and support recommendations for midwives caring for women with perinatal loss.

6.3 ATTAINMENT OF THE RESEARCH OBJECTIVES
In this study to attain the research objectives one, two and three, a qualitative, exploratory and descriptive research design was utilized to conduct this empirical research study. The population consisted of 138 midwives. A purposive non-random sampling technique was used to select the sample of the study. The sample of the study was then selected using a set of inclusion criteria which were listed as follows:
• Midwives having a minimum of one year’s experience working in the NMBHD.
• Midwives caring for women with perinatal loss.
• Midwives having been permanently working in both MOUs and referral hospitals in NMBHD.

The exclusion criteria were:
• Community service nurse practitioners since they are allocated for only three months in each department.
• Midwives who had personal experience of perinatal loss to avoid triggering emotional reactions when a midwife is narrating the events of perinatal loss.
• Midwives who were working on a rotational basis since rotation duration takes only six months in each department.

Data was collected using a semi-structured one-to-one audio-taped interviews. Data saturation was reached at participant thirteen, making a total sample of 13 for the study. Preformulated interview schedule protocol with questions prepared to gather answers for each objective as discussed in Chapter 3 from page 39 was used for each interview. Responses of each participant was captured utilizing two high quality audio-taped recordings and written field notes to ensure accuracy of findings. Findings were then analysed utilizing the seven steps of Framework Data Analysis as described in chapter 3.

Three main themes emerged from the data analysis were:

• Midwives rely on their own coping mechanisms to deal with perinatal loss.
• Midwives reported how management influenced the way they coped with perinatal loss events.
• Midwives expressed the need for psychological and emotional support.
The findings were presented by describing the biographical characteristics of the participants and the emerging three major themes and seventeen associated sub-themes. Objective four was attain by developing recommendations, namely:

**Recommendation 1:** Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss.

**Recommendation 2:** Provide formal support systems in the labour unit to assist midwives to care for women with perinatal loss.

**Recommendation 3:** Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.

6.3.1 **Objective one: Explore and describe the facilitative conditions that enable midwives to care for women with perinatal loss in the NMBHD.**

Findings of the study revealed that there are limited coping strategies in the midwifery healthcare setting to assist midwives during exposure to perinatal loss events. This midwifery setting caused the midwives to adopt their own coping mechanisms as the facilitative conditions that enable them to care for women with perinatal loss in the NMBHD. The ability for them to control their own emotions triggered by exposure to perinatal loss empowered them to care for women with perinatal loss.

Midwives highlighted that a lack of debriefing opportunities in their labouring units resulted in them relying on family support as a coping mechanism which assists them with coping with perinatal loss. Family is important for every individual and for this reason, midwives expect family members to support them in times of difficulties (Dartey et al., 2019: 132). In this study family support has been acknowledged as one of the facilitative conditions adopted by midwives which assisted them with perinatal loss events while caring for women with perinatal loss. Caring for women with perinatal loss is intense, difficult and stressful as reported by midwives in Theme 1 (chapter 4) and requires support hence midwives are relying on their own family support. Family support enables midwives to debrief, to share their feeling and emotions and facilitates their coping mechanisms.
The concept of "being-with" the woman is not just a physical locality, but an emotional journey travelled together where the loss of a baby is navigated personally and privately by each midwife in contrast to the journey travelled when there is a live baby (Jones & Smythe, 2015:21). Each step of the way, the midwife steers her way between providing situation sensitive care to the woman and her family, and coping with her own intense, sometimes overwhelming feelings that are largely hidden and unspoken (Jones & Smythe, 2015:21) and there is no map to follow on this journey but rather a sense of finding your way. Since midwives often have to hide their emotions, informal peer-debriefing with colleagues helps midwives with perinatal loss events. Moreover, informal peer-debriefing has been reported as a helpful facilitative condition which enables the midwives to review the incident and maternal record to find gaps and views of other people, which help them to deal with perinatal loss events and enable them to care for women experiencing perinatal loss.

6.3.2 Objective two: Explore and describe the inhibitory conditions that prevent midwives from caring for women with perinatal loss in NMBHD.

Several inhibitory factors that prevent midwives from caring for women with perinatal loss were outlined by midwives. Factors being referred to were expressed as management barriers that influenced the way midwives coped with perinatal loss, namely, inadequate or lack of management support, lack of private rooms for grieving women, time constraints in the provision of bereavement care, lack of protocols regarding management of perinatal loss and staff shortages expressed as a challenge in management of women with perinatal loss.

Inadequate or lack of management support during perinatal loss events has been highlighted as one of the inhibitory conditions that influence the way midwives cope with perinatal loss. The midwives experienced limited support from management after the loss, however, support and appreciating an employee’s work is a potentially powerful motivator of employee performance (Ngoatle, 2015:49). This lack of support led to negative feelings like feelings of guilt and self-blame for the occurrence of perinatal loss which make it difficult for midwives to care for these women during these situations. Participants mentioned that hospital management was not doing enough to assist midwives with caring for patients who experience a perinatal loss and expressed that although they were eager to make changes, their lack of counselling rendered
them incapable of changing the situation. Therefore, it is recommended that managers implement strategies that will support midwives caring for women with perinatal loss.

Lack of private rooms for grieving women was also acknowledged as an inhibitory condition that prevented midwives from caring for women with perinatal loss. This situation placed the midwives who provided immediate grief counselling for these women in an ethical dilemma as these women were forced to share the room with women who had delivered live babies. Midwifery care promotes, protects and supports women’s human, reproductive and sexual health and rights; and respects ethnical and cultural diversity as it is based on the ethical principles of justice, equity and respect for human dignity; therefore it is the duty of the midwife to ensure the safety of the patient and protection of the patient’s rights while maintaining confidentiality (ICM, 2014:2). Women faced with the trauma of losing a baby, reported that they were disturbed with the crying of the other babies in the surrounding wards (Sutan & Miskam, 2012:7). This situation makes it difficult for midwives to provide bereavement care to women after perinatal loss events.

Similarly, time-constraints in provision of bereavement care was acknowledged as one of the inhibitory conditions that prevented midwives from caring for women with perinatal loss. In this study, time constraints were associated with shortages of staff and high turnover of patients, which prevented midwives from caring for women with perinatal loss. Some participants expressed that even though they were short-staffed, they were interested in spending more time with their patients, however, they claimed that because of the high turn-over of patients this was proving to be impossible. It recommended that management to provide adequate resources which include proper employment of skilled staff that will encourage midwives to spend more time with the grieving woman following perinatal loss events.

6.3.3 Objective three: Identify and describe support needs for midwives caring for women with perinatal loss in the NMBHD
Objective three was achieved as all participants shared their own support needs for caring for women with perinatal loss. A literature control was used to support these identified needs and these needs were highlighted as: provision of coping mechanisms for midwives caring for women with perinatal loss in the NMBHD; improve managerial
factors that prevent midwives from caring for women with perinatal loss and midwives expressed the need for psychological and emotional support.

Midwives need support during perinatal loss events, especially from both their peers and their managers to assist them in coping with care of women with perinatal loss and to prevent them from adopting their own coping mechanisms. Hence, it is important for the maternity units’ managers to promote unity among midwives in their units and to provide adequate resources.

Managerial factors that prevent midwives from caring for women with perinatal loss need to be resolved and improved as these factors are acknowledged as having an influence on how midwives cope with perinatal loss. Furthermore, some of the midwives experience a range of emotions and stress and anxiety and have expressed the need for psychological and emotional support. Therefore, the provision of psychological and emotional support by strengthening the existing EAP Services or developing a new program that will assist midwives with coping with the care they provide for women with perinatal loss recommended

6.3.4 Develop coping and support recommendations for midwives caring for women with perinatal loss.

The coping and support recommendation were developed that could help midwives to cope better when caring for women with perinatal loss and were outline in chapter 5. Three main recommendations developed for this study were guided by the three major themes and seventeen sub-themes which emerged from data analysis as:

- **Recommendation one**: Facilitate various forms of peer assistance to prepare and support midwives caring for women with perinatal loss.
- **Recommendation two**: Provide formal support systems in the labour unit so that midwives can carry out their clinical duties for women with perinatal loss.
- **Recommendation three**: Strengthen existing EAPs and provide unit-based psychological and emotional support in order to accommodate the needs of midwives caring for women with perinatal loss.
The expected outcome of the developed recommendations was to enhance the coping of midwives when caring for women with perinatal loss in the NMBHD. These recommendations can assist the management of each labouring unit in initiating support structures and programs to assist midwives when caring for women with perinatal loss. Therefore, recommendations that will promote a positive relationship between managers and midwives caring for women with perinatal loss and facilitate the coping mechanisms of midwives were developed which include, clinical midwifery practice, nursing education and nursing research.

6.4 MIDWIFERY OR NURSING RESEARCH

Regarding future research and based on the findings of this study the researcher recommended the following midwifery related research that should take place:

- A similar research study should be conducted investigating the perceptions of women experiencing perinatal loss in the NMBHD.
- Research on the role of leadership processes, such as managerial support, can assist in furthering what is known about the influence of leader behaviours in shaping and improving the midwifery work environment.
- A similar research study can be conducted investigating the existing Employee Assistant Programs in the NMBHD. To establish the degree of awareness regarding its existence, its effectiveness and its role among midwives.
- Future studies should be conducted which compare the provision of EAP services between public and private facilities since the private facilities are generally well resourced.
- Studies can be done in establishing a model for women-midwife ratios to determine how many midwives and are needed in maternity units to render continuous support during childbirth.
- Studies can be done to determine attitudes of nursing managers when investigating the adverse events such as perinatal loss.
- Extensive research should be conducted regarding emotional and psychological support required by midwives in order to empower them to care for women experiencing perinatal loss.
6.5 CLINICAL MIDWIFERY PRACTICE

- Enhancing immediate debriefing with colleagues within the first 24hrs after the exposure to perinatal loss event to promote midwives’ coping mechanisms when caring for women with perinatal loss in the NMBHD.

- Enhancing the supportive skills of managers will be an effective strategy to promote coping and support needs of midwives caring for women with perinatal loss in the NMBHD.

- Provision of private rooms for women experiencing perinatal loss which is free from the cry of a baby and away from labouring women or women with live babies, will facilitate coping mechanisms of midwives when caring for women with perinatal loss in the NMBHD.

- Create an environment that will be encourage the grieving women to be supported by her family members immediately following perinatal loss as this will prevent midwives from feelings of guilt when leaving the woman alone when needed to care of other women.

- Devise a strategy that will ensure a midwife-women ratio so that midwives will be able to provide immediate grief counselling and perinatal care for women with perinatal loss in the NMBHD.

- Availability of evidence-based policies and guidelines with clear steps to be followed by midwives when managing women with perinatal loss in the NMBHD.

- Nursing managers to facilitate the EAP services for midwives caring for women with perinatal loss in the NMBHD.

- Facilitate in-service training for all midwives to raise awareness regarding the existing EAPs in the NMBHD.

- Strengthen the existing EAP service to cater for the needs of midwives caring for women with perinatal loss in the NMBHD.

- Nursing managers to inform the midwives about the referral procedures of EAP facilitator.

- Give feedback where necessary to the midwives that have utilized assistance of EAP.

- Ensure that EAP service is easily accessible and transparent for all personnel.
• Ensure that the EAP facilitators are equipped with necessary skills in provision of psychological and emotional support for midwives caring for women with perinatal loss in the NMBHD.

• EAP coordinators to maintain professional confidentiality of the service rendered for midwives.

• Facilitate perinatal loss and bereavement care peer teaching in labouring units by ensuring provision of coaching and mentoring of junior midwives from experienced midwives regarding perinatal loss events.

6.6 NURSING EDUCATION

• Incorporating perinatal loss and bereavement care education in the undergraduate curriculum to provide students with transformative knowledge that will prepare them for these adverse events in clinical midwifery care.

• Bereavement counselling should therefore be included in the undergraduate curriculum to prepare the midwifery students with communication and counselling techniques.

• Management of perinatal loss and bereavement care should be included in detail in the Guidelines for maternity care in South Africa, ICM standards and in The Royal College Practice Guidelines for Midwives to raise awareness to all midwives.

6.7 LIMITATIONS

The limitations of the study were as follows:

• Limited availability of South African literature on the study theme was noted. Therefore, comparison of the findings with similar contexts was challenging at times.

• Research results of this qualitative study related to the NMBHD midwives where the study was conducted. Therefore, the results obtained cannot be generalized to other midwives in the area.

6.8 CONCLUSION

The objectives of the study were to explore and describe the facilitative conditions that enable midwives to care for women with perinatal loss in NMBHD, to explore and describe the inhibitory conditions that prevent midwives from caring for women with
perinatal loss in NMBHD, to identify and describe support needs for midwives caring for women with perinatal loss in NMBHD and to develop coping and support recommendations for midwives caring for women with perinatal loss. A qualitative exploratory, descriptive research design was used to answer the research question. Experiences of midwives regarding caring for women with perinatal loss in the NMBHD provided crucial insights on how midwives caring for women with perinatal loss in the NMBHD are coping. It is hoped that the necessary measures will be put in place to facilitate coping and support needs for midwives caring for women with perinatal loss in the NMBHD. The researcher has made recommendations based on the findings of the study to the relevant professionals and institutions and the report will be disseminated to them and articles will be written.
7. REFERENCES


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ANNEXURE A
PERMISSION LETTER TO THE DEPARTMENT OF HEALTH
Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON COPING AND SUPPORT NEEDS OF MIDWIVES CARING FOR WOMEN WITH PERINATAL LOSS IN THE NELSON MANDELA BAY HEALTH DISTRICT.

I, Yekiswa V. Kave, am a Master’s student at the Nelson Mandela University in Port Elizabeth. I plan to do research on a topic with the title: Coping and support needs for midwives caring for women with perinatal loss in the Nelson Mandela Bay Health District.

This project will be conducted under the supervision of Mr. BSI. Sonti (NMU, Port Elizabeth) and co-supervisor Doctor D. Morton (NMU, Port Elizabeth).

The objectives of the study will be:

• To explore and describe the facilitative conditions of midwives caring for women with perinatal loss in NMBHD.
• To explore and describe the inhibitory conditions of midwives caring for women with perinatal loss
• To identity and describe support needs for midwives caring for women with perinatal loss
• To develop coping and support recommendations for midwives caring for women with perinatal loss.

The researcher will conduct one-to-one audio-taped semi-structured interviews on midwives that will meet the inclusion criteria of the research and who will give voluntary consent to participate in this research. The role of institution is voluntary, and you may decide to withdraw the institution’s participation at any time without penalty. Only staff members who have signed will participate in the project. Furthermore, all information obtained will be treated in strictest confidence. The participants’ names will not be identifiable and used in any written reports and participants may withdraw from the study at any time without penalty.

I have provided you with a copy of my proposal which includes a copy of a consent form to be used in the research process, as well as a copy of the approval letter from the Nelson Mandela University Research Ethics Committee (Human). I am hereby seeking your consent to conduct research your District and to be able to approach your staff to take part in my study.

For further information, please do not hesitate to contact my supervisor, Mr. BSI. Sonti (NMU, Port Elizabeth) at Israel.Sonti@mandela.ac.za or my co-supervisor, Doctor D. Morton (NMU, Port Elizabeth) at (David.Morton@mandela.ac.za) or the researcher on 0836609069 or s213386585@mandela.ac.za.

Yours sincerely,

Ms. Yekiswa V. Kave (Researcher)
ANNEXURE B
LETTER TO THE MIDWIVES REQUESTING THEIR PARTICIPATION
Dear Participants,

**RE: INVITATION TO PARTICIPATE IN THE STUDY**

I, Yekiswa V. Kave, am a Master’s student at the Nelson Mandela University in Port Elizabeth. I plan to do research on a topic with the title: Coping and support needs for midwives caring for women with perinatal loss in the Nelson Mandela Bay Health District.

This project will be conducted under the supervision of Mr. BSI. Sonti (NMU, Port Elizabeth) and co-supervisor Doctor D. Morton (NMU, Port Elizabeth). The objectives of the study will be:

- To explore and describe the facilitative conditions of midwives caring for women with perinatal loss in NMBHD.
- To explore and describe the inhibitory conditions of midwives caring for women with perinatal loss
- To identity and describe support needs for midwives caring for women with perinatal loss
- To develop coping and support recommendations for midwives caring for women with perinatal loss.

The researcher will conduct one-to-one audio-taped semi-structured interviews on midwives that will meet the inclusion criteria of the study and who will give voluntary
consent to participate in this research. The inclusion criteria for this research study will be:

• Midwives with a minimum of one year of experience working in NMBHD.
• Midwives who have cared for women with perinatal loss.
• Midwives who are permanently working in MOUs and referral hospitals maternity units in NMBHD

The exclusion criteria shall be:

• Community service nurse practitioners.
• Midwives who have personal experience of perinatal loss.
• Midwives working on a rotational basis.

I am hereby seeking your consent to take part in my study. If you meet the required inclusion criteria and willing to voluntary participate in this study, kindly complete the attached checklist.

For further information, please do not hesitate to contact my supervisor, Mr. BSI. Sonti (NMU, Port Elizabeth) at Israel.Sonti@mandela.ac.za or my co-supervisor, Doctor D. Morton (NMU, Port Elizabeth) at David.Morton@mandela.ac.za or the researcher on 0836609069 or s213386585@mandela.ac.za.

Yours sincerely,

Ms. Yekiswa V. Kave (Researcher)
**ANNEXURE C**

**INFORMED CONSENT FORM**

<table>
<thead>
<tr>
<th>RESEARCHER’S DETAILS</th>
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<tbody>
<tr>
<td><strong>Title of the research project</strong></td>
<td>Coping and support needs for midwives caring for women with perinatal loss in Nelson Mandela Bay Health District</td>
</tr>
<tr>
<td><strong>Reference number</strong></td>
<td>213386585</td>
</tr>
<tr>
<td><strong>Principal investigator</strong></td>
<td>Yekiswa Victoria Kave</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>Department of Health, Private Bag x11951, Spondo Road, Zwide</td>
</tr>
<tr>
<td><strong>Postal Code</strong></td>
<td>6005</td>
</tr>
<tr>
<td><strong>Contact telephone number</strong></td>
<td>041 406 4252</td>
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<tr>
<th>1. DECLARATION BY OR ON BEHALF OF PARTICIPANT</th>
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<tbody>
<tr>
<td>I, the participant and the undersigned</td>
<td>(full names)</td>
</tr>
<tr>
<td>ID number</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
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<tr>
<td>I, in my capacity as (parent or guardian)</td>
<td></td>
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<tr>
<td>of the participant (full names)</td>
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<tr>
<td>ID number</td>
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<td>Address (of participant)</td>
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<tr>
<th>A1 HEREBY CONFIRM AS FOLLOWS:</th>
<th>Initial</th>
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<tbody>
<tr>
<td>I, the participant, was invited to participate in the above-mentioned research project</td>
<td></td>
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<tr>
<td>that is being undertaken by Yekiswa Victoria Kave</td>
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</table>
2. THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:

<table>
<thead>
<tr>
<th>2.1 Aim:</th>
<th>The purpose of this study is to explore and describe coping and support needs for midwives caring for women with perinatal loss in Nelson Mandela Bay Health District. Based on the findings from the study, the researcher will develop coping and support recommendations for midwives caring for women with perinatal loss.</th>
</tr>
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<tr>
<td>2.2 Procedures:</td>
<td>I understand that I need to answer a questionnaire that I will be asked in a semi-structured one-to-one audio-taped interview. I understand that open ended questionnaire will be asked about my coping and support needs for caring for women with perinatal loss in Nelson Mandela Bay Health District. I understand that the researcher will make use of field notes. I will require about 40 minutes to respond to the question and my contact details will be obtained from the checklist form that I will sign if I give my consent to participate in this proposed study. I will be given an individual number in order to keep my information confidential.</td>
</tr>
<tr>
<td>2.3 Risks:</td>
<td>None</td>
</tr>
<tr>
<td>2.4 Possible benefits:</td>
<td>There is no direct benefit to you for taking part in this study; but the findings of the study will be utilized to assist midwives with coping and support recommendations when caring for women with</td>
</tr>
</tbody>
</table>
2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the researcher and supervisors and I will be given an individual number in order to keep your information confidential.

2.6 Access to findings: Only the researcher and supervisors will have access to the data and findings of this study.

Voluntary participation / refusal / discontinuation:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>My participation is voluntary</td>
<td></td>
</tr>
<tr>
<td>My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle</td>
<td>TRUE</td>
</tr>
</tbody>
</table>

3. The information above was explained to me/the participant by:

Yekiswa Victoria Kave

<table>
<thead>
<tr>
<th>Afrikaans</th>
<th>English</th>
<th>Xhosa</th>
<th>Other</th>
</tr>
</thead>
</table>

and I am in command of this language, or it was satisfactorily translated to me by

(name of translator)

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 myself.

A.2 I hereby voluntarily consent to participate in the above-mentioned project:
4. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I, (name of interviewer) 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)

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) By (name of translator)

4. I have detached Section D and handed it to the participant YES NO

Signed/At On 20

Signature of interviewer Signature of witness:
Full name of witness:

5. DECLARATION BY TRANSLATOR (WHEN APPLICABLE)

I, (full names)

ID number

Qualifications and/or

Current employment

confirm that I:

1. Translated the contents of this document from English into (language)
2. Also translated questions posed by (name of participant) as well as the answers given by the investigator/representative;

3. Conveyed a factually correct version of what was related to me.

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
Signature of witness:

Full name of witness:

6. 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 arises as a result of the research, or
- you require any further information with regard to the study, or
- the following occurs

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

Kindly contact at telephone number
ANNEXURE D

THE INTERVIEWINGSCHEDULE

The researcher will obtain permission from the participant. Researcher will greet and introduce herself to the participants and give a brief overview of the study, then obtain the participants permission to participate in the study.

1. Main question
Now tell me, how is it for you to care for a woman who has lost a baby?

2. Probing questions
• How does it make you feel?
• How does it affect your daily life and activities?
• What are some of the difficulties or challenges you experience with caring for women with perinatal loss?
• Are you able to cope under such difficulties or challenges?
• What do you do to cope with it?
• Do you need any other assistance in helping you to cope with such difficulties?
• What strategies are available for you?
• How would you like to be supported?

3. Conclusion
Thank you so much for sharing your experiences with me. Is there anything you would like to add? Thank you once again.
Dear Participant,

Thank you for agreeing to participate in this study, kindly complete the following questionnaire. The privacy and confidentiality of your information is assured.

**Instructions:**

Please indicate your choice with x

Please answer all questions

**SECTION A: BIOGRAPHICAL DATA**

1. Age in years

   | 20 – 30 |
   | 31 – 40 |
   | 41 – 50 |
   | 51 and above |

2. Gender

   | Female |
   | Male |
3. Work experience as a midwife in years

<table>
<thead>
<tr>
<th>Years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5 years</td>
<td></td>
</tr>
<tr>
<td>6 years - 10 years</td>
<td></td>
</tr>
<tr>
<td>11 years - 15 years</td>
<td></td>
</tr>
<tr>
<td>16 years - 20 years</td>
<td></td>
</tr>
<tr>
<td>21 years and above</td>
<td></td>
</tr>
</tbody>
</table>

4. In which of the following units are you working at?

<table>
<thead>
<tr>
<th>Unit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying-in antenatal ward</td>
<td></td>
</tr>
<tr>
<td>Midwifery obstetric unit (MOU)</td>
<td></td>
</tr>
<tr>
<td>Labour ward</td>
<td></td>
</tr>
<tr>
<td>High-care obstetric unit</td>
<td></td>
</tr>
<tr>
<td>Post-natal clinic</td>
<td></td>
</tr>
<tr>
<td>Post-natal/Gynae ward</td>
<td></td>
</tr>
</tbody>
</table>

5. Work experience in this unit in months and years

<table>
<thead>
<tr>
<th>Years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 2 years</td>
<td></td>
</tr>
<tr>
<td>2 - 5 years</td>
<td></td>
</tr>
<tr>
<td>6 -10 years</td>
<td></td>
</tr>
<tr>
<td>11 - 15 years</td>
<td></td>
</tr>
<tr>
<td>16 years and more</td>
<td></td>
</tr>
</tbody>
</table>

6. Academic Qualification

<table>
<thead>
<tr>
<th>Qualification</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td></td>
</tr>
<tr>
<td>BCur degree</td>
<td></td>
</tr>
<tr>
<td>Honour’s degree</td>
<td></td>
</tr>
<tr>
<td>Master’s degree</td>
<td></td>
</tr>
</tbody>
</table>
7. Professional qualifications

- Generalist midwife
- Midwife Specialist
- Professional Nurse
- Enrolled midwife
- Other

8. Please indicate in writing your most suitable preferences.

| Date of Interview | 
| Time of Interview | 
| Venue of Interview | 

9. Name and Surname: .................................................................

10. Contact number: .................................................................
ANNEXURE F

REC- H FORM AND APPROVAL LETTER
Outcomes of Research/Project Proposal:

Qualification: 65000 Master of Nursing

Coping and Support Needs for Midwives Caring for Women with Perinatal Loss in the Nelson Mandela Bay Health District

Please be advised that your final research proposal was approved by the Faculty Postgraduate Studies Committee (FPGSC).

FPGSC granted ethics approval. The ethics clearance reference number is H18-HEA-NUR-017 and is valid for three years.

We wish you well with the study/project.

Kind regards,

Ms M Afrikaner
Faculty Postgraduate Studies Committee (FPGSC) Secretariat
Faculty of Health Sciences
ANNEXURE G

NATIONAL HEALTH RESEARCH DATABASE APPROVAL LETTER
RE: Coping and support needs for midwives caring for women with perinatal loss in the Nelson Mandela bay Health District. (EC_201810_016)

Ms Y.V Kave

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted amended protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE
REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON COPING AND SUPPORT NEEDS FOR MIDWIVES CARING FOR WOMEN WITH PERINATAL LOSS IN THE NELSON MANDELA BAY HEALTH DISTRICT

In response to your application for permission to conduct the above research, permission is hereby granted with the following proviso:

- Health service delivery should not be disrupted under any circumstances.
- Timely appointments must be made with the relevant persons prior to commencement of interviews/visits.
- All required data should be collected by the Researcher or a designated fieldworker (whose name should be forwarded to the relevant Sub District Coordinators prior to data collection). The Sub District Coordinators Messrs. Mzulu – 083 378 1942, Koll – 060 563 1225 and Reuters – 060 557 9732 should be contacted before your visit and this letter is to be presented when visiting the facilities.

The Nelson Mandela Bay Health District, as the research site, will expect a copy of the final research report when the study is completed. If the duration of the research period is required to be extended, the District Office (District Manager) should be informed accordingly.

This Office would like to wish you well in your research study.

Yours faithfully,

[Signature]

DR L P MAYEKISO
CLINICAL GOVERNANCE MANAGER – NMBHD
Ms YV Kawsu
84 Garaya Str
NDB Motherwell
Port Elizabeth
6211

Re: PERMISSION TO CONDUCT RESEARCH – “COPING AND SUPPORT NEEDS FOR MIDWIVES CARING FOR WOMEN WITH PERINATAL LOSS IN THE NELSON MANDELA BAY HEALTH DISTRICT” [EC_201918_016].

NME ETIQUETTES CLEARANCE NUMBER: N2019-04316-016. STUDENT NUMBER: 203110605

1. With reference to your letter dated 7 December 2018 regarding the aforementioned matter, permission is officially granted – as specified in the following reasons:

2. It is noted that consent for research was granted by NMU Post graduate Ethical committee, Eastern Cape Department of Health as well as Nelson Mandela Bay Health District.

3. A copy of the consent to conduct research has been forwarded to the Clinical Manager, Dr. B. Mahase, Nursing Service Manager, Mrs. A. Guezen, the Area Manager, Mrs. E. Cisagco, the Area Manager PO3 Ilse Bhanga.

4. Prior arrangements must be made via the Nursing Service Manager or Area Manager to conduct research.

5. Arrangements must be made with the nursing manager on call.

6. Service delivery must at no time be disrupted due to the research process.

7. All ethical rules should always be adhered to.

8. We wish you well with your studies and hope to receive feedback of your findings as promised.

Regards

Mrs MP Klassen

CEO – Lithembu Provincial Hospital
Together, moving the health system forward

Final production line: 0301 201

Website: www.Finalproduction.line