

**THE EXPERIENCES OF WOMEN WHO DELIVERED FRESH STILLBIRTHS AT A  
HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE**

**By**

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## **DEDICATION**

This mini-dissertation is dedicated to my late parents, Manana Madumi Andries, Manana Motatjo Elizabeth, my younger sister Pearl Manana, my children Mahlatsi, Tsakani and Nhlamulo, for their continuous love and support throughout my studies.

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To God almighty for giving me strength and courage to complete my studies.

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- Women who delivered fresh stillbirths for granting me the opportunity to interview them.
- The financial assistance of AMREF Health Africa and Limpopo Department of Health towards this research is hereby acknowledged.

## DECLARATION

I declare that **THE EXPERIENCES OF WOMEN WHO DELIVERED FRESH STILLBIRTH AT A HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE**, is my own work and that all the sources that I have used and quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other institution.

.....

05 September 2018

Maswanganyi Tebogo Rosemary

## DEFINITIONS OF CONCEPTS

### **Experience**

In phenomenological research, experience refers to several individuals' meaning of a concept or a phenomenon (de Vos, Strydom, Fouche & Delpont, 2011). In this study experience refers to what the women who delivered fresh stillbirths have come across and encountered at that moment.

### **Woman**

According to Soanes (2013), a woman is an adult female human. In the context of this study, a woman is an adult female between the ages of 18 and 40 who delivered fresh stillbirth.

### **Stillbirth**

A stillbirth is a baby born with no signs of life at or after 28 weeks gestation (Myles, 2010). In this study stillbirth refers to a baby born dead.

### **Fresh Stillbirth**

It is the death of a baby of more than 28 weeks of gestation in utero before 12 hours of delivery with skin intact (Macdorman & Gregory, 2013). In this study a fresh stillbirth is a baby who died 12 hours or less before birth.

## **LIST OF ABBREVIATIONS**

ANC: Antenatal care

FSB: Fresh stillbirth

SDGs: Sustainable Development Goals

## **ABSTRACT**

**Background:** When pregnant women deliver fresh stillbirths, their expectations and happiness are heartlessly substituted by mourning for their loss. The consequences are psychosocial and physiological. Mothers begin to search for answers while feeling guilt and shame; some accept blame for their babies' death. Their experiences are determined by the care they received from healthcare workers during delivery and grieving period. They complain that doctors and nurses care about the fact that the baby has been delivered and do not care about the emotional trauma that the mother is experiencing.

**Objectives:** To identify, explore and describe experiences of women who delivered fresh stillbirths at a public hospital.

**Methods:** A qualitative and descriptive phenomenological study was conducted using an in-depth phenomenological interview technique to collect data. Due to data saturation, nine purposively selected mothers participated. Interviews were conducted in the local language, and field notes were also collected. Interview recordings were transcribed and translated and analysed using open coding thematic analysis.

**Results:** Some women experienced feelings of guilt, sadness, hurt, sense of failure, shock and self-blame. Some needed counselling whereas others were doing fine without it. Some experienced lack of sympathy from healthcare workers.

**Conclusions:** Giving birth to a stillborn baby is a painful experience for women and their families. Healthcare workers should care for such mothers after delivery.

**Keywords:** Stillbirth; postnatal care, phenomenological study design, field notes

## TABLE OF CONTENTS

DEDICATION.....	i
ACKNOWLEDGEMENT.....	ii
DECLARATION.....	iii
DEFINITION OF CONCEPTS.....	iv
LIST OF ABBREVIATIONS.....	v
ABSTRACT.....	vi

### CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND.....	1
1.2 RESEARCH PROBLEM.....	2
1.3 LITERATURE REVIEW.....	3
1.4 PURPOSE OF THE STUDY.....	3
1.5 OBJECTIVES OF THE STUDY.....	3
1.6 RESEARCH QUESTIONS.....	3
1.7 RESEARCH METHODOLOGY.....	3
1.8 SIGNIFICANCE OF THE STUDY.....	4
1.9 OUTLINE OF CHAPTERS.....	5
1.10 CONCLUSION.....	5

### CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION.....	6
-----------------------	---

2.2 CAUSES OF FRESH STILLBIRTH.....	6
2.3 EFFECTS OF FRESH STILLBIRTH ON THE WOMEN.....	7
2.4 EFFECTS OF FRESH STILLBIRTH ON THE FAMILY.....	8
2.5 SUPPORT TO THE WOMEN AND THE FAMILY.....	9
2.6 CONCLUSION.....	11

### CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION.....	12
3.2 RESEARCH METHOD.....	12
3.3 RESEARCH DESIGN.....	13
3.3.1 Study site.....	14
3.3.2 Study population.....	14
3.3.3 Sampling.....	15
3.3.4 Data collection.....	15
3.4 ETHICAL CONSIDERATIONS.....	16
3.4.1 Beneficence.....	16
3.4.2 Respect for human rights.....	17
3.4.3 Justice.....	17
3.4.4 Protecting the rights of the rights of the institutions.....	18
3. 4.5 Scientific integrity.....	18
3.5 DATA ANALYSIS.....	18
3.6 TRUSTWORTHINESS.....	19

3.7 CONCLUSION.....20

CHAPTER 4: FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION.....21

4.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS.....21

4.3 THEMES AND SUB-THEMES.....22

4.3.1 THEME: 1 AN UNEXPECTED LOSS OF UNBORN BABY.....23

4.3.1.1 Sub-theme 1.1 Experience prior loss.....23

4.3.1.2 Sub-theme 1.2 Receiving the news of loss.....24

4.3.2 THEME: 2 COPING WITH LOSS.....25

4.3.2.1 Sub-theme 2.1 Grieving experience.....25

4.3.2.2 Sub-theme 2.2 Lack of support.....26

4.3.2.3 Sub-theme 2.3 Experiencing support.....27

4.3.3 THEME: 3 PERCEIVED CAUSE OF LOSS.....28

4.3.4 THEME: 4 EXPERIENCE OF MATERNAL CARE RENDERED.....29

4.3.4.1 Sub-theme 4.1 Good care practice.....30

4.3.4.2. Sub-theme 4.2 Experience of poor quality care.....30

4.4 CONCLUSION.....31

CHAPTER 5: SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 INTRODUCTIONS.....32

5.2 SUMMARY.....32

5.3 RECOMMENDATIONS.....	33
5.4 STRENGTHS AND LIMITATIONS OF THE STUDY.....	34
5.5 CONCLUSIONS.....	34
LIST OF REFERENCES.....	35

#### LIST OF APPENDICES

APPENDIX 1: ENGLISH INTERVIEW GUIDE.....	38
APPENDIX 2: SEPEDI INTERVIEW GUIDE.....	39
APPENDIX 3: INTERVIEW TRANSCRIPT.....	41
APPENDIX 4: CONSENT FORM (ENGLISH).....	48
APPENDIX 5: CONSENT FORM (SEPEDI).....	50
APPENDIX 6: LETTER REQUESTING PERMISSION FROM LIMPOPO DEPARTMENT OF HEALTH.....	52
APPENDIX 7: LETTER GRANTING PERMISSION FROM LIMPOPO DEPARTMENT OF HEALTH.....	53
APPENDIX 8: ETHICAL CLEARANCE CERTIFICATE.....	54
APPENDIX 9: PROOF OF LANGUAGE EDITING.....	55

#### LIST OF TABLES

Table 4.1 Demographic profiles of the participants.....	22
Table 4.2 Themes and sub-themes.....	22

#### LIST OF FIGURES

Figure 3.1: Map of Waterberg District showing local municipalities.....	14
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# **CHAPTER 1**

## **OVERVIEW OF THE STUDY**

### **1.1 INTRODUCTION AND BACKGROUND**

Fresh stillbirths contribute to a global challenge to meet Sustainable Development Goal 4 which aims at reducing child mortality. According to Myles (2010), when a baby dies during birth, the mother's expectations and happiness are heartlessly replaced by a need to say farewell to the baby and to mourn her loss. The consequences of delivering a fresh stillbirth are psychological, social, spiritual and physiological trauma. Mothers repeatedly search for answers while experiencing feelings of guilt and shame as they sometimes blame themselves (Savin & Major, 2013). The death of a baby during birth does not affect the women and her family alone, but the entire community is also affected.

Experiences of women who delivered fresh stillbirths are determined by the care that they receive from nurses and midwives during and immediately after delivery (Macdorman & Gregory, 2013). Interventions such as strengthening intrapartum monitoring should be done to prevent fresh stillbirths. The general health status of the pregnant women depends largely on the quality of services given by midwives from the high risk antenatal care to labour and delivery. According to Savin and Major (2013), the midwife is regarded as a person with skills to give necessary care of the women throughout the stages of pregnancy. That care includes detection of abnormalities in the mother and the unborn baby. It further includes seeking medical support and the implementation of emergency measures in the absence of medical support.

The provision of good care ensures early detection of diseases and prompts management of such diseases. For this reason, it is important that all pregnancies are monitored by skilled birth attendance in order to ensure quality care; maternity services have to be evaluated at regular intervals, both from the provider and the client perspectives. Macdorman and Gregory (2013) highlight the fact that the provision of client-centred service, where women are able to express their opinions, is good in

improving quality of services. However, sometimes midwives do not take the views and opinions of women regarding what constitutes effective midwifery care into consideration. Only the inputs of midwives and obstetricians are considered in terms of possible changes in the provision of care to women who delivered fresh stillbirths as well as the impact of fresh stillbirths on women, their families and healthcare providers (Scott, 2012). The aim of this study was to explore experiences of women who delivered fresh stillbirths in Thabazimbi Hospital.

## **1.2 RESEARCH PROBLEM**

The hospital received many complaints through its quality management unit regarding dissatisfaction from mothers who delivered fresh stillbirths in the maternity unit. The mothers' complaints were with regard to lack of support and substandard care given to them during delivery and grieving process. They complained that doctors and nurses seemed to care about the fact that the baby has been delivered and they did not care about the emotional trauma the mother was undergoing. Most of these women were blaming the hospital for the loss of the babies. The Chief Executive Officer (CEO) of the hospital also reported receiving calls from family members and the ward councillor of the area around the hospital showing dissatisfaction with regard to the care given to those women. According to the district health information system, there were 12 fresh stillbirths from the year 2014 out of 2700 deliveries.

Froen, Cacciatore and McClure (2011) indicate that complaints of women who delivered fresh stillbirths affect the hospital negatively as they destroy the image of the hospital. A meeting was held by the quality management team to address the problem with the respective complainants and the responsible nurses but similar complaints continued to be found in the suggestion boxes despite efforts made to address them. This made the researcher to be interested in wanting to explore experiences of women who delivered fresh stillbirths in maternity unit. Experiences of these women may provide understanding of the need for more comprehensive and holistic care.

### **1.3 LITERATURE REVIEW**

According to Polit and Beck (2012), literature review means more than reporting what the researcher has read and understood. It justifies the reason for doing research. Literature review can show that the researcher knows the field and allows her to identify gaps in the topic, and to establish theoretical framework and methodological focus (de Vos, Strydom, Fouche & Delport, 2011).

The study reviewed literature on the following topics which are discussed in detail in Chapter 3: causes of fresh stillbirth, its effects on the women and on the family, and support of the women and family.

### **1.4 PURPOSE OF THE STUDY**

The purpose of the study was to explore and describe experiences of women who delivered fresh stillbirths at a hospital in Waterberg District, Limpopo Province, South Africa.

### **1.5 OBJECTIVES OF THE STUDY**

The objectives of the study were:

- To explore the experiences of women who delivered fresh stillbirths at a hospital.
- To describe the experiences of women who delivered fresh stillbirths at a hospital.

### **1.6 RESEARCH QUESTION**

In this study, the following research question was asked: what are the experiences of women who delivered fresh stillbirths at hospital in Waterberg District, Limpopo Province?

### **1.7 RESEARCH METHODOLOGY**

The researcher adopted a qualitative, exploratory, descriptive and phenomenological design to explore experiences of women who delivered fresh stillbirths at Hospital in Waterberg District, Limpopo Province. Descriptive phenomenology is the most appropriate research design for this study as it emphasises description of human

experience. According to Polit and Beck (2012), descriptive phenomenologist insists on careful description of ordinary conscious experience of everyday life, a description of things as people experience them. The researcher used descriptive phenomenology as she wanted to explore experiences of women who delivered fresh stillbirths.

The researcher used a purposive sampling approach to select the participants. Purposive sampling method is described by Polit and Beck (2012) as the selection of the units of analysis by researchers on their own expert opinion of the population using inclusion and exclusion criteria. The researcher selected only those women who have delivered fresh stillbirths at the hospital.

Saturation of data occurred when additional interviews provided no new information, only redundancy of previously collected data (Burns & Grove, 2013). The researcher interviewed nine participants one by one until data saturation. The data was collected using semi-structured interviews and an interview guide. An audiotape was used to capture data from the participants, and field notes were also taken.

Tesch's open coding method was in data analysis. Trustworthiness was ensured through the principles of credibility, confirmability, dependability and transferability. Ethical clearance was obtained from Turfloop Research and Ethics Committee, and permission to conduct the study was obtained from the provincial Department of Health. Informed consent was obtained from all the participants after explaining the study to them. More information on the research methodology is discussed in Chapter 3.

## **1.8 SIGNIFICANCE OF THE STUDY**

The study may provide information to the hospital. This can lead to development of protocols on the management and care of women who delivered fresh stillbirths, and this can assist in preventing future loss of babies. The study can further help in reducing the number of fresh stillbirths at the hospital, thereby improving the care and satisfaction of women during delivery and after loss of the baby. Provision of care to be rendered

may be individualized based on the women's expectations, thus enhancing the quality of care that is rendered during delivery.

## **1.9 OUTLINE OF THE CHAPTERS**

Chapter 1 briefly discusses the overview of the study, the research problem, the purpose, objectives and the significance of the study.

Chapter 2 covers the literature review in the context of the research undertaken.

Chapter 3 describes the research methodology and study design used.

Chapter 4 discusses the findings in relation to the literature control.

Chapter 5 provides a summary of the results, limitations, recommendations and conclusion in the context of the aims and objectives of the study.

## **1.10 CONCLUSION**

This chapter provided an overview of the study, with focus on the introduction, research problem, literature review, purpose of the study, research question, objectives, methodology, ethical considerations and significance of the study. Chapter 2 reviews literature from studies that have explored experiences of women who delivered fresh stillbirths.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The previous chapter provided an overview of the study, with focus on the introduction, research problem, literature review, purpose of the study, research question, objectives, methodology, ethical considerations and significance of the study.

This chapter discusses literature review, which according to de Vos, Strydom, Fouche and Delport (2011), is a scholarly text that allows the researcher to establish theoretical framework and methodological contributions to a particular topic. The researcher did literature review in order to find gaps which might be there and to get an in-depth knowledge and understanding of the research topic. According to Polit and Beck (2012), literature review means more than reporting what the researcher has read and understood. The researcher reviewed literature that explored the causes of fresh stillbirths, its effects on the women, and on the family. The reviewed literature also described the support with regard to managing women who suffered the loss.

#### **2.2 CAUSES OF FRESH STILLBIRTHS**

The most common causes of fresh stillbirth in South Africa was intrapartum asphyxia (distress of a fetus during labour) and spontaneous preterm labour. According to Cacciatore (2012), poor labour monitoring is one of the causes of fresh stillbirth. Most of the women lose their babies during labour when nurses fail to detect foetal distress, leading to the baby having asphyxia and dying in utero.

According to Scott (2012), babies die due to lack of commitment and dedication by midwives where a woman is left alone during labour without proper monitoring, ending in the death of the baby due to undetected problems. One of the causes of fresh stillbirth, according to Andarge, Berhane and Kebede (2013), is non-cooperation by the women during labour, especially teenagers, where they do not listen to instructions given by midwives, pushing with each contraction when the cervix is not yet fully dilated.

This causes more stress to the baby, resulting in death. In Ethiopia most of the causes of fresh stillbirth is asphyxia. This type of mortality usually occurs among parents have lower levels of wealth and education. However, community members associate this death with evil spirits ((Gebeyhu, Worku & Fantahum, 2013).

According to Cacciatore (2012), rural residency is associated with risk of infant dying in utero and the risk of death increased with gestational age. Older maternal age is associated with risk of stillbirth. Most of the fresh stillbirths were more likely to be delivered by caesarean section or breech. Fresh stillbirths may suggest problems with the care that is available during labour and at delivery.

### **2.3 EFFECTS OF FRESH STILLBIRTHS ON WOMEN**

The effects of delivering a fresh stillbirth differ depending on the women's own coping mechanisms. It is important to remember that women's behaviour in response to the loss can affect her emotionally. Giving birth to a fresh stillbirth can affect the psychological state of their minds which will need therapy to correct it. Shreffler, Hill and Cacciatore (2012) argue that women who remain silent and not verbalise their feelings after delivering a fresh stillbirth are later diagnosed with postpartum depression.

During the birth of a fresh stillborn, some mothers become shocked, numb and want to escape. They most often express the desire for provider sympathy, understanding and psycho education to ease their fears and assuage the immediate effects of their suffering. Mothers felt appreciative when providers engage with them. Women describe enduring guilt, shame, anger and both active and passive thoughts of self-harm (Hughes et al, 2014).

Gebeyhu, Worku and Kebede (2013) indicate that even three years after delivery of a fresh stillbirth, bereaved mothers are twice as likely to report anxious symptoms compared with mothers of live born. Both mothers and fathers experience somatic symptoms in the months and years following delivery of a fresh stillbirth. Recent research suggests that parental grief poses great health risk: being a bereaved parent

has a marked influence on premature mortality that persists for up to 25 years after the child's death (Sibley, Tesfeye, Desta, Frew, Alemu & Stover, 2013).

A study conducted in Scotland found a two-fold mortality risk within the first 15 years after delivery of a fresh stillbirth (Hughes, 2014). Another study based on data from the Jerusalem Perinatal Study found that women who had delivered fresh stillbirths had increased hazard ratio for premature mortality even when controlling for issues related to maternal health such as pre-eclampsia. The increased risk remained strongly associated with coronary heart disease and renal and circulatory disorders (Sibley et al, 2013). Studies have shown higher levels of psychological disorders in women who were pregnant following delivery of fresh stillbirths as compared with pregnant women with no history of loss (Shreffler et al, 2012). However, it has also been reported that pregnancy can have a positive impact on psychological distress following fresh stillbirth delivery.

#### **2.4 EFFECTS OF FRESH STILLBIRTH ON THE FAMILY**

The loss of a baby to a fresh stillbirth can have intergenerational effects. Maternal distress can affect family constellation for surviving children and can carry over into a subsequent pregnancy. The additional burden on suffering parents of taking care of surviving children can be overwhelmingly stressful and confusing (Mills et al, 2014). The consequences of fresh stillbirths are emotional and frustrating. Families are often left searching for answers, internalising feelings of guilt and shame. They usually put a blame on nurses and doctors for failing to save their babies (Branch, Gibson & Silver, 2010). They feel appreciative when providers engage in meaningful acts of actualisation with them. Very young children, usually aged less than two years, may not understand anything more than that their routine has been changed, or they may observe distress of parents (Scott, 2012).

Branch et al (2010) indicated that pre-scholars were more likely to comprehend the loss, but they may be unable to express their emotions verbally. Behavioural changes were not uncommon, and their distress may manifest in excessive clinginess, nocturnal fears, and tantrums. Adolescents may have both emotional reactions which they may or may

not share with others and somatic reactions (Froen et al, 2011). Some withdraw from family, seeking solace in their peers. Others may experience role reversal, a process known as 'parentification'. Most children should be offered an opportunity to participate in death and remembrance rituals alongside their parents (Cacciatore, 2012).

## **2.5 SUPPORT TO THE WOMEN AND FAMILY**

Nurses can assist women who have experienced fresh stillbirth by forming a support group to share the stress of coping with the loss. This may help to relieve some of the stress and existential loneliness so prevalent in working with traumatic grief (Branch et al, 2010). It is critically important to address the response of communities to women who experience fresh stillbirth, particularly those who experienced repeated loss. The national focus on Sustainable Development Goals 4 and 5 along with national, regional and local information, education, and communication campaigns that increased public understanding of the social and biological causes and preventability of fresh stillbirths may help decrease the blame and stigmatisation of women. Such campaigns may also help enhance the value of women as persons, mothers and community members and lead to women's improved self-care and health-care seeking and avoidance of potentially harmful behaviours (Andarge et al, 2013).

According to Shreffler (2012), nurses taking care of women with history of previous fresh stillbirths can likewise emphasise these messages, and encourage women to notify them in the event of any unusual feeling. They can also provide bereavement support and counsel women about the best and safest time to conceive again, if desired, and ways to prevent conception in the interim.

Psychosocial support by nurses significantly improves a family's outcomes after delivery of a fresh stillbirth (Cacciatore, 2012). However, studies suggest that nurses may be avoidant, feel helpless and guilty, or may experience a sense of failure when a woman delivers a fresh stillbirth. These emotional states resulted in the perception that the nurses lacked care or concern for the family (Branch et al, 2010). Nurses mitigated some of the long-term negative outcomes for parents by spending extra time with

grieving parents, facilitating the gathering of much needed memories, validating their emotional expressions, and enabling the family to make informed decisions about their baby's body. Families were allowed to mourn in a way that was consistent with their cultural beliefs and values (Froen et al, 2011).

To be attuned with a family means to be fully present and deeply self-aware. It is vital that nurses maintain awareness of their own feelings toward a fresh stillbirth. Being an attuned provider improved sensitivity toward the grieving family. Trust was established through honest and open communication and a willingness to witness suffering. Macdorman and Gregory (2013) maintain that nurses tend to regard the way they organise maternity care as the best way, ignoring the interests of the very women for whom the services were planned. A client-centred service had to be provided through identifying what women want and need.

Women who experienced loss of the baby as fresh stillbirths were usually blamed by their families for the loss. Some were divorced, and so in fear, the women shifted the blame to the nurses. The midwife is regarded as a person with skills to give the necessary support to women throughout the stages of delivery. The responsibility of a nurse is to take foremost role in the relief of pain and caring for the women. Fresh stillbirth is often a misunderstood and painful loss. Women and families struggle to cope with the immediate and long lasting effects of a baby's death, which can last for years and sometimes decades.

Fresh stillbirths also affect nurses and leave a feeling of guilt in them (Ellis et al, 2016). Consequently, it was becoming more important to listen to women who use maternity services to ascertain how they perceived the services that they receive from nurses. The role of positive interaction between women and nurses were critical in improving client compliance (Scott, 2012). There was a need to document the views of women with recent experience of care. According to Macdorman and Gregory (2013), mothers complained that they rarely had an opportunity to see, hold or take photographs of their fresh stillborn babies. Instead, they were whisked away and disposed. Most of the

mothers who did not see and hold their babies regret lost opportunities of contact. Most of the women who got enough support and counselling coped well with the loss and were able to accept what happened, and this also prevented complaints regarding the kind of care they received from nurses (Cacciatore, 2012).

## **2.6 CONCLUSION**

Chapter 2 discussed the literature review in order to gain insight on the findings of other researchers on experiences of women who delivered fresh stillbirths. The researcher reviewed literature that explores the causes of fresh stillbirths, its effects on women, on the family. The reviewed literature also describes the support with regard to managing women who suffered the loss. Chapter 3 will focus on the research methodology that has been used in the study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The previous chapter reviewed literature that explores the causes of fresh stillbirths, its effects on women, and on the family. The literature also describes the support with regard to managing women who suffered the loss.

The purpose of this chapter is to describe the research methodology used in this study. According to Polit and Beck (2012), methodology is defined as a way of obtaining, organising and analysing data. In this chapter, the research design, study site, population, sampling, data collection, data analysis, measures to ensure trustworthiness and ethical considerations are discussed in detail.

#### **3.2 RESEARCH METHOD**

The qualitative approach was used because it is deemed more appropriate to explore experiences of women who delivered fresh stillbirths. According to Polit and Beck (2012), qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. Researchers use qualitative approaches to explore the behaviour, perspectives and experiences of people that they study.

The qualitative approach is a way of gaining insight by discovering meaning (Burns & Grove, 2013). The approach emphasises the dynamic holistic individual aspects of human experience, and attempts to capture those aspects within the context of those experiencing them.

Qualitative methods are used to describe and promote understanding of human perspectives such as pain, grief, hope or caring (Polit & Beck, 2012). An accurate description of information provided by women was done in order to discover the

meaning that they attach to the effects and support of women who delivered fresh stillbirths.

Polit and Beck (2012) indicate that some of the characteristics of the qualitative approach are as follows:

- Qualitative research requires researchers to become intensely involved, often remaining in the field for lengthy periods of time. As such the researcher physically goes to the people.
- It requires the researcher to become the research instrument, for data collection and analysis. As such data is collected by the researcher i.e. (conducting the interviews and doing participant observation) rather than giving them pamphlets with questions to complete on their own.
- It tends to be holistic, striving for an understanding of the whole. That is why with this endeavour, the researcher is mainly interested in exploring experiences of women who delivered fresh stillbirths in maternity.
- It involves using different methods where the researcher interviews, observes and participates while collecting data.

The researcher studied people in their natural settings and tried to understand how they live, talk and behave and concluded that this approach was well suited to achieve the goal of the study.

### **3.3 RESEARCH DESIGN**

The researcher used a descriptive design that allowed women's experiences to be studied in terms of their own experiences during delivery in the maternity ward (Burns & Grove, 2013). The researcher explored experiences of women who delivered fresh stillbirths using the descriptive design. According to Polit and Beck (2012), descriptive phenomenologists insist on observing people in their everyday life, how they live and interact with others, and of things as people experience them.

### 3.3.1 Study site

The hospital where the study was conducted is in Thabazimbi Local Municipality, which is located in the South western part of Limpopo Province. The municipality shares the border with Botswana. The hospital is one of the 2014 revitalised hospitals in Limpopo Province and provides health service to nine clinics and one health centre. The hospital has 120 approved beds, and has many wards such as medical, surgical, paediatric unit, outpatient department, casualty and maternity wards. The study took place in a maternity which has 24 approved beds. The maternity has a labour ward with 4 labour rooms, a nursery with five beds, a post-natal with 22 beds, an antenatal care with eight beds and a ward for premature babies (kangaroo mother care) with four beds. The map is attached as Fig 3.1. (Yes! Media, 2018)

**Figure 3.1 Map of Waterberg District showing municipalities**



### 3.3.2 Study population

Population refers to a group about which the information is gathered and a conclusion is drawn. It should be clearly defined in respect of person, place and time as well as other factors relevant to the study (Polit & Beck, 2012). The target population of this study

was all women who delivered fresh stillbirths at a particular hospital in Waterberg District from 2014 up to date. According to the district health information system, there were 12 fresh stillbirths from the year 2014 out of 2700 deliveries.

### **3.3.3 Sampling**

Sampling is the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made. The researcher used a purposive sampling approach to select the participants. The purposive sampling method is described by Polit and Beck (2012) as the selection of units of analysis by researchers on their own expert opinion of the population using inclusion and exclusion criteria. The researcher selected only those women who have delivered fresh stillbirths at the hospital.

According to Polit and Beck (2012), qualitative researchers do not specify the sample size, instead they collect data until data saturation has occurred. A sample of nine women who delivered fresh stillbirths was obtained. Saturation of data occurs when additional interviews provide no new information, but only redundancy of previously collected data (Burns & Grove, 2013). The researcher interviewed all available participants one by one until data saturation.

- **Inclusion criteria**

All women who delivered fresh stillbirths at the hospital from 2014 to 2016.

- **Exclusion criteria**

Women who delivered fresh stillbirths but had puerperal psychosis.

### **3.3.4 Data collection**

An in-depth phenomenological interview was conducted to collect data until saturation was reached. The participants were interviewed in their language which is Sepedi. Participants were interviewed at the clinic, others were interviewed at the hospital for privacy. There were other participants who were interviewed at their homes since they couldn't manage to go to the health facilities due to transport problem. An interview is

defined as a conversation with the purpose of gaining an understanding of the perspective of the person being interviewed (Fox & Bayat, 2012).

The researcher used an interview guide with a central question and some probing questions. The central question was “please tell me about your experiences of giving birth to a fresh stillbirth”. The Interview guide also collected biographical information of the participants. It is attached as Appendix 1. The women were interviewed in their own language which is Sepedi (see Appendix 2 for Sepedi translation). Each interview with the women who delivered FSB was at least 30-45 minutes long. With the participants’ permission, the interviews were audiotaped in a conducive environment, free from distractions and noise. Observations and field notes were made as part of the data collection methods as suggested by Hughes et al (2014). The researcher used observation and field notes to remark on some of the non-verbal activities during the interview.

### **3.4 ETHICAL CONSIDERATION**

According to Polit and Beck (2012), ethics refers to a system of moral values that is concerned with the degree to which the research procedures adhere to professional, legal and social obligations of the study participants. There are primary ethical principles on which ethical standards of ethical conduct of research are based, as discussed below: beneficence, respect for human rights, justice, protecting the rights of the institution and scientific integrity.

#### **3.4.1 Beneficence**

Brink et.al (2012) describe beneficence as an ethical principle that emphasises on minimising harm and maximising benefits to the participants. A research study should contribute to social value and improve the wellbeing of society. The participants must not be subject to any form of harm, either physical or psychological. Dealing with psychological harm in qualitative research requires sensitivity on the part of researchers, due to in-depth exploration of inquiry into personal issues that may unearth deep seated fears, guilt and anxieties (Polit & Beck, 2012).

In this study, the participants were informed about possible harm and benefits of the study. Since the study was more about personal experiences which might have risen emotional distress, arrangement was made with the hospital psychologist in case the participants needed counselling during and after the interviews.

### **3.4.2 Respect for human rights**

This involves the right to self-determination and the right to full disclosure which are the major elements of informed consent.

- **Right to self determination**

According to Polit and Beck (2012), participants are autonomous and capable of controlling their own activities. Thus, they have the right to decide to take part in a study voluntarily without coercion or penalty for refusal. In this study the participants were informed that their participation is voluntarily and that they were free to withdraw or refuse to respond to any question without any penalty.

- **The right to full disclosure**

According to Polit and Beck (2012), the participants have the right to make informed voluntary decisions concerning their participation in a study. This requires full disclosure by the researcher. In this study, full description of the nature of the study, including the participants' right to refuse to participate or to withdraw from the study at any given time. Expectations were clearly explained to the participants and they were encouraged to ask questions to enhance clarification and to obtain more information about the study.

- **Informed consent**

According to Brink et al. (2012), informed consent is the right of the participants to decide on their own whether or not they want to participate in the study without fear of being victimised. In this study the researcher ensured that the participants were informed about the nature of the study, and were requested to sign a consent form similar to the one attached as Appendix 5.

### **3.4.3 Justice**

The principle of justice involves participants' rights to fair treatment and privacy.

- **Rights to fair treatment**

According to Polit and Beck (2012), the selection of participants should be based on the research requirements and not the vulnerability or compromised position of certain persons for knowledge advancement. The participants who choose to decline from participating in the study should be treated in a non-prejudicial manner. In this study, the participants were purposively selected on the basis of the experience of the topic of the study.

- **Right to privacy**

According to Polit and Beck (2012), a research study that focuses on human beings intrudes into personal lives. As such, the researcher has to ensure that the research is not more intrusive than it ought to be. The researcher assessed the physical area to ensure privacy for the participants. Interviews were conducted in a private room away from distracters. The purpose of the study was explained to the participants to exclude exploitation so that they could take informed decisions before signing the consent form, see Appendix 4 & 5.

### **3.4.4 Protecting the rights of the institution**

Permission to collect data was requested and obtained from the Limpopo Department of Health. The letter asking for permission is attached as Appendix 6 and the one granting permission as Appendix 7. The researcher kept the names of the institution anonymous by requesting the participants not to mention the names of the nurses and the facility.

### **3.4.5 Scientific integrity of the research**

Ethical clearance was obtained from Turfloop Research Ethics Committee (TREC). The researcher is a professional nurse and adheres to the ethical principles of the profession governed by the South African Nursing Council. Ethical clearance has been attached as Appendix 8.

## **3.5 DATA ANALYSIS**

According to Grove, Burns and Gray (2013), data analysis is a process of examining and interpreting data in order to get the meaning and gain understanding. The

researcher translated the transcripts from Sepedi into English. The English transcripts were then written in a tabular form for easier coding (see Appendix 3). The researcher played and replayed the audio recorder to listen to the responses. The transcript were read and re-read to get more understanding of the interview. The researcher used Tesch's open coding process (Creswell, 2013) which suggests the following steps:

1. Read all the transcript carefully to get a sense of the whole and write down notes as ideas come to mind.
2. Pick one interview document at a time and go through it to establish what it is about, while continuing to write notes in the margins as ideas come to mind.
3. Write a list of topics based on the ideas from each transcript and group similar topics together.
4. Use topics as codes and write each next to the appropriate section of the transcript.
5. Find the most descriptive wording for the topics and turn them into categories.
6. Write codes alphabetically.

The researcher then developed themes and sub-themes as they emerged from data analysis. The transcripts were sent to an independent coder with expertise in analysing qualitative research and knowledge of the topic at hand. A meeting with the independent coder was held to discuss and compare the themes and to reach consensus.

### **3.6 TRUSTWORTHINESS**

According to Polit and Beck (2012), trustworthiness of the study refers to the degree of confidence that qualitative researchers have in the study. There are four aspects to be considered when dealing with trustworthiness in qualitative research, namely, credibility, transferability, dependability, and conformability, all of which will be applied in this study.

- **Credibility**

It refers to confidence in the research findings and the criteria that one can use to establish them (Polit and Beck, 2012). Credibility was ensured by prolonged

engagement with the women who delivered fresh stillbirths. To enhance credibility, the researcher spent some time with each participant on the day of the interview, explaining the purpose of the study as well the interview procedure so as to establish rapport. After the interview, the researcher sent the transcript to an independent coder for verification and then had a meeting with him/her to compare, discuss and agree on the codes.

- **Transferability**

According to Polit and Beck (2010), transferability is the extent to which findings can be applied to other settings. To ensure transferability, the researcher used dense or thick description, which refers to rich and thorough descriptions of the settings, participants and observation (Polit & Beck, 2012). The researcher triangulated multiple resources of data from different sources. A clear and detailed demographic description was provided of the selected sample in order to transfer the findings to a context.

- **Dependability**

Dependability is the stability and conditions of the data over time (Polit & Beck, 2012). Dependability was enhanced by reporting the processes within the study in detail, thereby enabling future researchers to repeat the work. All the research processes were outlined for future references. Conformability was enhanced by keeping the transcript, audiotapes and notes for five years as proof of evidence.

- **Conformability**

Conformability is a measure of the extent to which findings are affected by personal interests and biases (Polit & Beck, 2012). Transcripts were sent to an independent coder for analysis, and consensus was reached between the researcher and independent coder.

### **3.7 CONCLUSION**

This chapter discussed the research methodology that was followed when conducting this study, the site of the study, population, sampling, data collection, data analysis, measures to ensure trustworthiness and ethical considerations. Chapter 4 will discuss the findings of the study and literature control.

## **CHAPTER 4 FINDINGS AND LITERATURE CONTROL**

### **4.1 INTRODUCTION**

The previous chapter discussed the research methodology that was followed when conducting this study, the site of the study, population, sampling, data collection, data analysis, measures to ensure trustworthiness and ethical considerations. This chapter discusses the findings and literature control to support the study findings. Polit and Beck (2012) describe literature control as a method of clarifying the findings and putting them into context. These findings emerged during data analysis using Tesch's open coding qualitative data analysis method as described by Creswell (2013). The following themes emerged from data analysis. An unexpected loss of unborn babies, coping with loss, experience of maternal care rendered and perceived causes of loss.

### **4.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS**

The study sample comprises nine participants with one participant between 15 and 19 years old, three between 20 and 24, two between 25 and 29, one between 30 and 34 and one between 35 and 39 years old. Out of all nine participants, three were primiparous and six multiparous. All participants attended antenatal care, and only one had a medical history of hypertension. Only three of the participants were employed, and six were unemployed and unmarried. According to the Department of Health Guidelines for Maternal Care (South Africa, 2016), hypertensive disorders some of the most common direct causes of perinatal morbidity, including fresh stillbirth. Women at risk of delivering fresh stillbirths as a result of hypertension are teenagers and women of age 35 years and above. Table 4.1 summarizes the demographic profile of the participants.

**Table 4.1: Demographic profile of the participants**

AGE	PARITY	MARITAL STATUS	MEDICAL HISTORY	EMPLOYMENT STATUS	BOOKING STATUS
15 -19	Primiparous	Unmarried	None	Unemployed	Booked
20-24	Multiparous	Married	None	Unemployed	Booked
20-24	Primiparous	Unmarried	None	Unemployed	Booked
20-24	Primiparous	Unmarried	Hypertension	Unemployed	Booked
25-29	Multiparous	Married	None	Employed	Booked
25-29	Multiparous	Married	None	Unemployed	Booked
30-34	Multiparous	Married	None	Employed	Booked
35-39	Multiparous	Unmarried	None	Employed	Booked

### 4.3 THEMES AND SUB-THEMES

As summarized in Table 4.2, data analysis yielded four themes and seven sub-themes. Themes in qualitative data analysis are theoretical relationships that emerge after the researchers have spent extensive time examining data, categorizing and sorting elements into groups to look for patterns (Burns & Grove, 2013).

**Table 4.2: Themes associated with the experience of women who delivered fresh stillbirth**

Themes	Subthemes
1. An unexpected loss of unborn baby	1.1 Experience prior loss 1.2 Receiving the news of loss
2. Coping with loss	2.1 Grieving Experience 2.2 Lack of support 2.3 Experience of support
3. Perceived cause of loss	
4. Experience of maternal care rendered	4.1 Good care practice 4.2 Experiences of poor quality care

### **4.3.1 Theme 1: An unexpected loss of unborn baby**

Most women who had an unexpected loss of unborn babies seek opinions in different places to confirm whether they are in true labour or not before they go to the hospital. The findings reveal that the women had different experiences related to the loss of their babies. The following sub-themes have emerged under this theme.

#### **4.3.1.1 Subtheme: Experience prior to loss**

Prior to loss of a baby, women experience signs and symptoms that alert them to seek medical attention. Some women start by consulting in different places to seek opinions or clarity on what they are feeling. These experiences may start from home or clinics until they end up in a hospital where they receive news of loss of the baby. The statement below reveals their experiences prior loss.

Participant 6 said:

*“I was feeling pains in my tummy, they started at school on a Thursday, when I got home I told mama that I was feeling pains on my tummy. They first took me to church and after that, that’s was when I went to the hospital.”*

Participant 4 added:

*“I went to the private doctor for a check-up as I was not feeling well. The doctor checked me and told me that my pregnancy is in trouble. He gave me the referral letter and told me to go to the hospital.”*

Participant 9 added:

*“Before I came here I went to a local clinic. I was told that I can expect a child anytime within ten days, then before ten days when I visited the clinic and I was told that they couldn’t hear the fetal heart and then transferred me to the hospital.”*

The participants consulted different places to check the wellbeing of the baby before they could go to the hospital. In a study done in Mumbai, most women reported to start consulting their traditional healers or priests to find out if they are going to deliver normal babies and to find out if there are complications related to pregnancy (John, Saxena & Kumar, 2017).

In another study done by Hughes et al. (2014), women who had stillbirths reported to have undergone all antenatal care check-ups and to have done all the medical tests. During the check-ups, they were told that everything looks fine. They felt disappointed when they received the news that the baby is no longer alive.

#### **4.3.1.2 Subtheme: Receiving the news of loss**

Most of the women who deliver fresh stillbirth are not aware of the fact that their baby is no longer alive until the nurses break the news by telling them about the loss of the baby. They reacted differently to the news depending on an individual's coping mechanism.

Participant 9 said:

*“It was very painful I even thought that maybe is a joke, I was having doubt in my heart until the doctor confirm it by sonar. I don't know how I can explain the kind of pain I was feeling at that moment, it was so painful I cried a lot. It affected me a lot since this was my second loss, I didn't expect another loss.”*

Participant 1 added:

*“It was the most painful experience I got in my life, I went to the hospital expecting to deliver a live baby but my baby died there. It hurt me a lot because this baby was a boy and I wanted a baby boy.”*

Ellis et al. (2016) revealed that women experience shock, a feeling of being paralysed, speechlessness, escape and denial. The situation of giving birth to a fresh stillbirth is very painful and women find it difficult to comprehend what has happened. Women describe the time immediately after they learned their baby was dead as unreal and numbing. They had feelings of anger and sorrow. Peters et al. (2015) also supported the findings by explaining that receiving news of stillbirth by a woman as an emotionally and physiologically painful and traumatic event that occurs suddenly and often without warning.

### **4.3.2 Theme 2: Coping with loss**

The findings reveal that the women had different experiences related to coping with the loss due to stillbirth. The following sub-themes emerged under this theme:

#### **4.3.2.1 Subtheme: Grieving experience**

Burden et al (2016) define grief as a normal affective response of a person to a significant loss, and includes sadness, irritability, disturbed sleep and loss of appetite. Grieving is a feeling of sadness and sorrow following the death of a loved one. Women who had suffered loss due to a fresh stillbirth have different experiences with regard to mourning and expressing feelings of sadness. This is confirmed by the following statement:

Participant 5 said:

*“The most pain that I got is when other babies are crying and when others are breastfeeding their babies, it made me feel bad and sad. I felt like I was stupid and I cried during the night.”*

Participant 9 added:

*“I felt ashamed and humiliated especially as it was the second time. I didn’t know how I will face my church members as they were so ready to welcome me and the baby when I come back from the hospital.”*

Participant 1 added:

*“I wasn’t sleeping and eating well, I cried most of the time when I was alone.”*

Women who had fresh stillbirths had significantly higher rates of psychological and emotional disorders, including depression (both self-reported and clinical), general anxiety disorder, social phobia, agoraphobia, anger, negative cognition appraisals such as sense of failure and long-term guilt and other post-traumatic stress disorders. They frequently reported guilt and disturbing images, thoughts and feelings that interfered with their normal behavior. Many blamed themselves for the baby’s death, citing their “body failure”. Women were embarrassed and guilty of their post pregnant bodies as they did not have the baby.

According to Kelly and Trinidad (2012), the weeks following stillbirth, women experience sadness, irritability, guilt or somatic symptoms. The high prevalence of feelings of depression and anxiety suggests that these are normal reactions. One study found a correlation between guilt-proneness, shame-proneness and grief intensity. Several women reported that hearing noises of the bustling activity and other birth around them added to their suffering.

According to Peters et al. (2015), many women perceived themselves as failures at the role of mother. Grief and sometimes depressive symptoms are a common experience following stillbirth, and should be viewed as normal. Unique individual experiences of grief, loss and other emotions such as anger can be acknowledged as valid and natural by nurses and doctors. Scott (2012) indicates that grief should be sympathetically acknowledged by nurses and doctors, and women should be reassured that their feelings are normal and recovery may take many months.

#### **4.3.2.2 Subtheme: Lack of support**

Some women received lack of support from nurses when going through this painful experience. Lack of support means not caring and not showing sympathy to women suffering the loss of stillbirth. Kelly and Trinidad (2012) describe lack of support as lack of understanding or support from family and friends, and as one of the most painful experiences to the woman who lost a baby. Lack of support is evidenced by the statement below.

Participant 3 said:

*“I was not treated well because they say I come from North West Province. She would speak in the presence of other patients that I killed a child.”*

Participant 7 added:

*“Nurses were blaming me as if I am the one that caused the death of my baby. They said I didn’t listen to the movement of the baby.”*

Peters et al. (2015) indicate that women may be further distressed by nurses who appear disengaged or do not take time to provide information support and empathetic care. Women may feel neglected or blamed by nurses who seem insensitive or judgmental regarding their emotions or actions. Women may experience potentially avoidable and unexplained delays in receiving information about the death of the baby negatively.

According to Ellis et al. (2016), women with stillbirths may feel that their care is not appropriately prioritised by nurses. Some women waited extended periods of time for a doctor to confirm the stillbirth, and others felt that they did not receive appropriate medical care from nurses because their baby was dead. Women thought they were not given priority or that they were not considered important once the baby was dead.

#### **4.3.2.3 Subtheme: Experience of support**

Support is when women receive care and sympathy from both the family and healthcare workers in order to feel for the women, thereby assisting and comforting her. Women would appreciate a healthcare system ready to provide emotional support following stillbirth and discharge from the hospital (Ellis et al, 2016).

Participant 1 said:

*“On discharge they sent me to the psychologist for counselling”.*

Participant 4 had a different view about counselling: *“ I didn’t go for counselling I counselled myself and I am fine”.*

Participant 6 added:

*“If people are kind to you it makes you forget about the problem you are experiencing, the nurses comforted me with good words. Doctor was also sympathetic”.*

Women who have experienced loss should be offered psychological counselling routinely and is often found useful by those who seek it, others may cope without counselling (Burden et al, 2016).

Women require sensitive and genuinely empathetic care from nurses and doctors as well as clear, carefully worded information and guidance. Women may appreciate when

nurses give them the option to have friend or family members present to provide support while in hospital. Women may also appreciate it when nurses show emotion and empathy towards their experiences. Nurses who sympathetically acknowledge women's sorrow and who are warm, attentive and caring are found to be sources of great support (Peters et al, 2015). According to Kingdom et al. (2015), women described their appreciation for nurses who provided strong emotional support by taking time to talk to the family and staying with them. Nurses who gave permission to cry, who used humour appropriately and who seemed to go out of their way to spend extra time with the family were viewed as particularly supportive.

Many women felt that their nurses had given them special attention. Bereaved women were most appreciative of actions that demonstrated emotional support from nurses and showed attention to the physical needs of the women. Women revealed that believing in God, comfort and counseling from sympathetic nurses were sources of strength (Kelly & Trinidad, 2012; Kiguli et al, 2015).

#### **4.3.3 Theme 3: Perceived cause of loss**

Perceived causes result from what happened that may have been thought to have contributed to the stillbirth. The findings reveal different perceptions with regard to the cause of loss both from the women. The following sub-themes have emerged under this theme.

According to the Department of Health Saving Mothers Report (South Africa, 2016), hypertension is among the top five causes of both maternal and perinatal death. Most of the women who suffer hypertension during pregnancy ended up delivering stillbirth either fresh or macerated due to placental insufficiency causing hypoxia. In a study done in Uganda, maternal conditions associated with stillbirth in low and middle- income settings include hypertension, diabetes and maternal infections (e.g. syphilis, malaria, HIV, maternal under nutrition, obesity and smoking). An estimated 40,000 stillbirth occur each year in Uganda. Due to these causes, the country has the highest number of

stillbirth in the world. Women reported the use of traditional herbs during pregnancy which contribute to the causes of stillbirth (Kiguli et al, 2015).

Women who delivered stillbirths have their own perceptions regarding their loss. These perceptions differ depending on how they have been treated during delivery and how they view the whole process of pregnancy that might have contributed to stillbirth up to delivery.

Participant 1 said:

*“They kept me in the ward when I was feeling pains, they did not attend to me, and so after a day they told me the baby’s fetal heart has disappeared.”*

Participant 5 added:

*“I think is witchcraft related because there were some people who were complaining that how can I be pregnant while they were not pregnant.”*

Participant 9 added:

*“I think it’s because the baby was big, the baby weighed around 4kg something.”*

Most stillbirths occur due to lack of commitment and dedication by nurses, where the woman is left alone during labour without proper monitoring, ending in death of the baby due to undetected problems. In another study, women reported that there was only one nurse and many women during delivery. Some nurses had gone to rest. By the time the nurse came from where she had gone to deliver another baby, she found that the women had already delivered alone and the baby is dead. One of the women reported that she had a complicated delivery where the baby was bigger. She was taken for caesarian section where the baby died during the procedure. Witchcraft was commonly emphasized by women (Scott, 2012; Kiguli et al, 2015).

#### **4.3.4 Theme 4: Experience of maternal care rendered**

Maternal care rendered to women may differ depending on how they view the care that they received during that time. Experience may differ in such a way that what some view as a good practice, to others it may not. The following findings reveal that women

had different experiences with regard to maternal care rendered to them. The following emerged under this theme.

#### **4.3.4.1 Subtheme: Good care practice**

In healthcare good care practice refers to the care that meet the set standard of a health facility and satisfies the customers who are the recipient of that care. Providing quality patient care is referred to as good care practice (Mills et al, 2014).

Participant 9 said:

*“The thing that helped me during my loss is that they sent me to a psychologist for counseling, I thought it is done in private hospitals only, but I was happy about that.”*

Participant 2 added:

*“The nurses were really helpful, they were trying to help me. The nurses who were assisting me could see that I was in pain and they assisted me when I was struggling to raise my legs.”*

Participant 7 added:

*“The doctor that helped me treated me well, everything was done well, and the doctor explained everything to me. When I started feeling pains and crying, he gave me an injection for pain and tell me that the baby will come out soon.”*

In a study conducted by Kelly and Trinidad (2012), only few women were given referrals for counselling; most women sought counselling or treatment on their own. The majority of the women reported benefiting from the counselling.

#### **4.3.4.2 Subtheme: Experiences of poor quality care**

Women experience poor quality care during their stay in a healthcare facility. These may be directly or indirectly related to the care rendered to them. Other experiences of poor quality may be health worker-related or administrative-related, but they have an impact in the quality of care rendered. The following statements reveal the poor quality experienced.

Participant 1 said:

*“Yes they left me alone for many hours, they just put a CTG monitor to monitor the baby, and I could even feel when the fetal heart was slowing down.”*

Participant 6 added:

*“They placed me in one room with those mothers who are having live babies and breastfeeding, I preferred to be in a quiet room where I can be alone without disturbance, I felt sad when I hear babies crying.”*

According to Kelly and Trinidad (2012), in most healthcare institutions, the typical labour and delivery environment is not designed to support women during stillbirth. Delivery rooms are not typically set up to provide space or privacy for women who have lost a child before or during delivery. Several women reported that hearing noises of other bustling activities and other birth around them added to their suffering. One woman reported being transferred to the geriatric ward where the staff thought she would have more quietness and privacy.

Substandard care included lack of facilities for women after having given birth to their stillborn. They felt their needs were not being met when placed on wards with other women who had just given birth (Kingdom et al, 2015). Perceptions of poor quality and experiences of care, including disrespectful treatment, have also been found to influence women’s decision of whether or not to seek care. The most common experiences of poor quality of care described by women entailed feeling ignored or neglected (Kiguli et al, 2015).

#### **4.4 CONCLUSION**

This chapter focused on research findings and literature control. The findings were categorised according to the main themes and sub-themes, namely: an unexpected loss of unborn baby, coping with loss, experience of maternal care rendered and perceived cause of loss. Chapter 5 focuses on summary, limitation, conclusion and recommendations of the study.

## **CHAPTER 5**

### **SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS**

#### **5.1 INTRODUCTION**

The previous chapter focused on the research findings and literature control. The findings were categorized according to the main themes and sub-themes, namely: experience prior loss, breaking the news of loss, grieving experience, lack of support, and experience of support, good care practice and experience of poor quality care.

In this chapter, the conclusion of the study, limitations of the study and recommendations based on the research objectives were made. The main aim of the study was to explore experiences of women who delivered fresh stillbirths at a hospital in Waterberg District, Limpopo Province. Qualitative research method employing phenomenology was used.

- The objectives of the study were to identify, explore and describe the experiences of women who delivered fresh stillbirths at a public hospital.

The objectives of the study were met since all the participants were able to explain their experience in terms of delivering fresh stillbirths (see chapter 4), the kind of pain they experienced, how they managed to cope with the loss and the kind of support they received from nurses and doctors. In terms of support, some participants were happy to be sent for psychological counselling while others were coping without counselling.

#### **5.2 SUMMARY**

This chapter focuses on making conclusions on the objectives of the study and recommendations on the findings of the analysis of qualitative data. The researcher summarised the findings of the study. The study generated four themes from data because of recurring regularities. The themes were discussed through literature control. The experiences of women who delivered fresh stillbirths reflected on the emerged themes.

Some women experienced feelings of guilt, sadness, hurt, sense of failure, shock and self-blame. Some needed counselling whereas others were fine without it. Some experienced lack of sympathy from nurses. They had an experience of lack of support and of being neglected by nurses. Regardless of all the challenges that women experienced during the fresh stillbirth, some women appreciated the kind of care they received from nurses and were satisfied despite their loss. Some women explained that the pain of delivering fresh stillbirths is too much and cannot be compared to anything. The care that women received from nurses during delivery and grieving period determines their experiences (negative or positive). A lot of sympathy is needed when caring for these women due to the pain of delivery and of loss they had. The total support by nurses will help the women to heal during the grieving period.

### **5.3 RECOMMENDATIONS**

The following recommendations were made:

#### **Practice**

- Only doctors with passion of working with women should be allocated in maternity. This will have a positive impact in terms of caring for women and their loss.
- There must be an improved staff attitude: nurses and doctors must treat all women well regardless of whether she has lost a baby or not.
- Regular monitoring of patients should be done at all times in order to detect complications earlier.
- Bereavement support should be recommended to those women who delivered fresh stillbirths, and psychological counseling should be done in agreement with the women.
- Consistent service should be offered without discrimination. All women should be treated equally regardless of race or ethnicity.
- There must be a separate room where women who need to grieve can be sent to, for space to grieve alone without disturbance.
- Grieving women should not be placed in the same room with those with live babies as it is traumatic for them to see and hear babies crying.

## **Education**

- The nursing education curriculum should also emphasize care of a woman who has lost a baby as much as it emphasizes the care of those with live babies in order to prevent neglect of women who lost their babies.

## **Research**

- Further research is needed to explore experiences of women who delivered fresh stillbirths in order to find out experiences of their families and to find out the kind of support which might be helpful to them during period of mourning.

## **5.4 STRENGTHS AND LIMITATIONS OF THE STUDY**

- **Strengths**

The researcher interviewed all women who took part in the study in their own language which is Sepedi. This enabled them to express themselves in their own language, thereby giving all the information needed.

- **Limitations**

Women were not interviewed at their homes but at the hospital and some at their nearest clinics. This was done as an agreement between them and the researcher in order to get privacy at the healthcare institution and to avoid disturbances at home.

## **5.5 CONCLUSION**

This chapter outlined the conclusion, limitations and recommendations of the study. Key findings were presented on the lived experiences of the participants as emerged from the study. It is advised that implementation of the recommendations from the study will have some implications for the improvement of care rendered to women who delivered fresh stillbirths and to prevent further complaints by women and their families.

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## APPENDIX 1: ENGLISH INTERVIEW GUIDE

### SECTION A

#### SOCIO DERMOGRAPHIC DATA

PARTICIPANT ID:

AGE	PARITY	MARITAL STATUS	MEDICAL HISTORY	EMPLOMENT STATUS	BOOKING STATUS
<19	Primiparous	Married	Diabetes	Employed	Booked
20-24	Multiparous	Unmarried	Hypertension	Unemployed	Unbooked
25-29			Other chronic disease		
30-35			Previous C/Section		
35-39					
>40					

### SECTION B

#### RESEARCH QUESTIONS

##### 1. Main Question

**Please tell me about your experiences of giving birth to a stillborn child**

##### 2. Follow –up questions

- How can you describe your relationship with midwives?
- How can you describe the treatment that you received from midwives during delivery?
- How did you feel when you hear that the baby is not alive?
- How did the death of your baby affect you?
- Please share with us any other information that you believe will be helpful in this research?
- In your opinion, what do you wish should be improved in this hospita

## APPENDIX 2: SEPEDI INTERVIEW GUIDE

### TSELA YEO DIPOTSISHO DI TLO TSAMAYAGO

#### KAROLO A

#### BOITSIBISHO

#### NOMORO YA BOINGWADISO YA MOTSEA KAROLO:

MENGWAGA	MAEMO A TSA PELEGO	MAEMO A GO NYALWA	MAEMO A GO NYALWA	MAEMO A GO BEREKA	SEKALO SA BAEMANA
<19	Ke mpa ya mathomo	O nyetswe	O nyetswe	O a bereka	O thomile sekalo
20-24	Ke mpa ya bobedi	Ga wa nyalwa	Ga wa nyalwa	Ga o bereke	Ga se o thome sekalo
25-29					
30-34					
35-39					
>40					

#### KAROLO YA B

#### DIPOTSISHISHO TSA DINYAKISHISHO

##### 1. Potsisho kgolo

Ke kgopela o mpotse ka maitemogelo a gago a go belega ngwana o a hlokofetsego

## 2. Dipotsisho tsa go latela

- O ka hlalosa bjang kamano ya gago le bashomi ba ka mo
- O ka hlalosa bjang hlokomelo yeo o e humanego go baoki ba go belegisha ge o belega
- O ikwela bjang ge o ekwa gore ngwana ga a sa phela/ o hlokofetse
- Go hlokofala ga ngwana wa gago o go amile bjang
- Ke kgopela o mphe maele a ka gonang go thusa go dinyakishisho tse
- Go ya ka wena ke se sefe se ka fetolwa goba go konofatswa ka sepetlele se

**APPENDIX 3: TRANSCRIPT OF THE WOMEN WHO DELIVERED FRESH STILLBIRTH AT A HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE.**

**RESPONDENT 2**

Researcher	My first question is tell me about your experience of giving birth to a fresh stillborn child
Respondent 2	I didn't want to think about the experience I got the time I gave birth to a stillborn because it was very painful, but I will try. I experienced pains and I knew that I was due. I called the ambulance; I was brought to the hospital and got admitted. I was checked until the around nine o'clock I think. The pains were severe around seven o'clock to eight o'clock but the doctor was still busy with other patients and around nine o'clock that's when she came in. First thing, it felt so different I don't know how but I was having a, what can I say... a short breath. It felt too heavy than any other pregnancies, the pain, I cannot say it was severe but I couldn't I didn't have that energy it was like I was tired before time that's how I felt until the moment when they came in because they had to take me through all those tests and take me in but I didn't have that energy and it felt like I was lazy or I was not cooperating but that's how I felt but I couldn't
Researcher	You just felt that you have failed yourself. Ok.
Respondent 2	If only I was strong because I remember when I left home telling my daughter that I don't even know how to breathe. When I breathe I felt like I was just taking all the air and was not giving her enough. I hated myself, I felt that I would have done better than I did or maybe if I had reported earlier but I wasn't sick I was alright. Maybe if I had come earlier but the pains were not severe that I could come to the hospital. I just felt that I failed there
Researcher	Ok I understand the way you feel. So you were thinking that if you had booked early, if you had been strong enough maybe the baby would have survived right, those were your feelings?
Respondent 2	That's how I feel
Researcher	Ok, how did the death of the child affect your family members?
Respondent 2	I had to be strong for them because these two boys were hoping to get their little sister, who they felt maybe she would clean because since they are boys I send them around a girl would help with the dishes and some of the things I used to send them. So I called them because their father was already here at the hospital I just didn't know where he was exactly. I then called my older daughter and told her what happened and then she said when they come back from school she would tell them what happened. The older didn't cry and the youngest one cried and cried.
Researcher	The older one was the one who was crying?
Respondent 2	He didn't cry
Researcher	Who was crying?
Respondent 2	The last one
Researcher	The last one was crying?
Respondent 2	Yes
Researcher	Did you show them the baby?
Respondent 2	Yes, the day before the burial

Researcher	Before the burial?
Respondent 2	They also took pictures, we have it, and they want it there
Researcher	Ok then what happened
Respondent 2	It's like I gave up on myself before time, because I couldn't breathe I remember I asked them and then they gave me oxygen and I told them I felt pain. I felt pain coming from where my heart is and that was when they said the situation was very serious, they checked me and they realized there was a problem, I thought that water was coming out but then they realized it was a cord that's when they took me in.
Researcher	Ok, do you mean that you didn't have enough energy...?
Respondent 2	Yes, I had short breath, I couldn't breathe even when they said move this side so that... it was very heavy. It's like the baby was too big, it's like I was.
Researcher	But when you came to the hospital did you have these pains
Respondent 2	I had pains; it felt like I could give birth at any time. It was normal pains but at the time I got to the hospital and the doctor had to start by checking me, check my pressure and measurements. It's like I had given up. You know when one feels like they have given up, when there is nothing you can do, feeling like everything can be done for you. That it is why I'm saying it was so heavy. Breathing was a problem for me, to move as well especially when they were pushing me "Saying come on don't be slow look she's coming", but then I had no strength.
Researcher	Ok, and then after they told you the baby is no longer alive, how did you feel?
Respondent 2	The thing is they told me that the baby was no longer alive after we had left the theater. I wanted to ask but as I have told you that I didn't have strength or anything, I heard that I didn't hear a cry, but as I said that I had a pain in my heart, I think i kept fainting from but, the thing is I can't explain to you that, it is as thou my trouble with breathing because I was in need of air even when I was still in theatre I told them I even remember the doctor saying its fine since you can't say anything just make the sound mmh instead. I also had trouble speaking. My problem was that I had a sharp pain in my heart, I had failure to breathe and I felt like my heart would stop pumping. Then he told me to make pumping like movements with my hands. So he would see through the movements that I was with them, I could feel, and I remember moving and I think I saw them busy with the child even though I never heard a cry.
Researcher	You didn't hear your baby crying.
Respondent 2	I didn't
Researcher	You said they operated you
Respondent 2	Yes they did
Researcher	So was it the one where you made to sleep or they just paralyzed your legs?
Respondent 2	They made me sleep.
Researcher	Totally?
Respondent 2	Yes, they made me sleep and then they had that cloth placed like this as they were busy with me. I remember when I said "I can't breathe anymore", my problem was air.
Researcher	During the operation you were able to see everything?
Respondent 2	No, I couldn't see, I could hear.
Researcher	But you could hear?
Respondent 2	I was able to hear that one doctor was standing just next to me like right here. I

	remember when I said to him that I lost my sense of feeling; I think he then injected me at some point I think I felt like it was a bit quite for a moment like for a short time I was not around anymore but at the time I regained consciousness I think he called me but I didn't hear him. He then said to me, please if you cannot say yes just make movements so that I can see that you are with us and can hear us".
Researcher	Ok so how did you find out the child died?
Respondent 2	After I was taken to the ward
Researcher	When you were already at the ward?
Respondent 2	Yes, when I was being taken to the ward
Researcher	U said they didn't show you the baby in theatre, why
Respondent 2	Yes they didn't, It can be the condition I was in as well because like I mentioned to you before that I had problems breathing and had pains. Maybe I don't know they thought maybe somehow I could also die as well but I don't know I just think so I'm not sure. Maybe they saw that my condition was so bad that if they tell me something would happen to me I don't know but I remember when they were taking me to the ward, they told me we have bandages and then they told me that your baby had passed away and then I told them can I please see her and they showed me there and there as she held her because I couldn't.
Researcher	Ok, they brought the baby to you when in the ward and then what happened
Respondent 2	Yes the nurse that I said was assisting me had the child wrapped and was carrying her, so she showed me
Researcher	So you saw the child?
Respondent 2	Yes I did
Researcher	Did you hold her?
Respondent 2	No I didn't
Researcher	Why didn't you hold the baby? Did u ever asked the nurse to hand you the baby so you can hold it yourself?
Respondent 2	I had no strength
Researcher	Oh you had no strength, ok, alright, but now how did you feel when you heard that the baby was not alive
Respondent 2	I just cried
Researcher	Ok that time, how can you describe your relationship with the midwives who have been helping you
Respondent2	The nurses were helpful to me, it was just the doctor in particular who seemed a bit preoccupied, and it was as though I was wasting his time like there were other people waiting but I couldn't help it. but the midwives that were present there it's just that I cannot remember their names they were helping me, when they would ask me to move I would say can I just hold your hand so that I can try to move, you understand? But they would try to assist. I wanted to move my body but I couldn't, it felt like I was in need of air, it was like the blood stopped flowing, it felt like I was not well but I just couldn't. The only thing that I could lift up was my head.
Researcher	Ok, and then according to you, when there were busy helping you, how can you explain the kind of treatment that the sisters/ midwives were giving you. How did you find it?
Respondent 2	The midwives were really helpful, they were trying to help me The midwives who were assisting me they could see that I wanted but I would tell them that I was

	struggling the weight was unbearable, she is too big, I could also tell that she is too heavy. In actual fact I did feel that she was too heavy for me, it's like it was time but the weight I felt from her with the pregnancy I couldn't move anything hence I said to you I felt numb it was like my legs... You know after giving birth when they inject you know that you can feel your body but you can't move your legs. That is how I was feeling
Researcher	You felt like you had cramps?
Respondent 2	Yes, because I remember asking one to lift my foot up so I could be able to move this side and then I ask the other one that please when I turn like this, dragging myself with that nighty so I can turn to the side that she wanted, do you understand me? But I couldn't.
Researcher	According to you, what do you think should have been done that would have made things better?
Respondent 2	In my view in as much as I don't know the processes and procedures of the hospital but I think if you are in labour the doctors should afford you the time and attention you deserve than those people who are supposed to do the reports. I feel that the paper work is more important than us because she didn't know my condition, she didn't see me early in the morning when I got here, the nurse that admitted me and put me there did the paper work maybe for hand over. In my opinion she should have been the one who came because she is a doctor not a midwife, maybe she would have seen those other precautions and the other stuff because I think a doctor is on an upper level than the midwives but she just walked through those wards whereby I feel the people didn't need her at the time because they just needed to have their blood taken, to sign and check if they are better. I don't understand why the doctors don't start with those that are in the process of giving birth.
Researcher	Ok, if I understand you well, you are saying why the doctors don't concentrate too much on you who are in labour than those who are in pain?
Respondent 2	No they are in pain, the pain is the same is just that you are almost there, and nobody knows what will happen. Do you understand? The midwife will not deliver my child before the doctor checks me first. What if at that time maybe the child's head was coming out? If she has not come in the morning when her shift started she would be busy with patients in the wards. Isn't it you start in the ward and when the time to deliver comes you leave the ward and you are taken to the labour room.
Researcher	Were you taken to the labour room?
Respondent 2	Yes, so why don't they start with someone in the labour room, so that when there are busy with their rounds they are sure about what is going on with everything even about the time. Why is it not like that, she came in at that time when she had to check me and found that this is an emergency I must be taken to the operation.
Researcher	And then at that time how was the baby?
Respondent 2	You know when i was feeling the pains that were when she wanted to check those centimeters that tell you how far. And then the time she said I should turn I don't know what she still wanted to do to me, that is when I felt like there was water coming out because you would be feeling something cold. At the time I said "I think she's coming" that's when she found the <i>cord</i> . So I sometimes feel that at the time she was doing vaginal examination maybe it was her that broke the membranes, because she didn't know what was going on, that is how I feel,

	because immediately after she inserted the finger and took it out she said there is cord prolapse before putting it back in, and then that's when she said to me I shouldn't sleep, but rather bend over, she continued with her finger inside me until...so I don't know , I can't say it's her that damaged it, I don't know, I don't know anything, but had she came on time maybe we could have seen how far or how long it would have taken me, isn't it I don't know those measurements, so at the time she came to check and the time it was coming out when I was supposed to deliver the baby, the cord was already out. So I don't know in other words if it's her, I don't know if she's the one who caused cord prolapse. I can't say it's her I don't know
Researcher	You had a <i>cord</i> prolapse?
Respondent 2	Yes
Researcher	Ok so they wheeled to theater?
Responded	Yes, that's when they held it so that it cannot come out until I got to the theater
Researcher	How long did it take for you to be taken from the labour room to the theater?
Respondent 2	She did it immediately to theater; because I even signed the papers, I think... they asked me if I gave consent to operation? I was not feeling well, that is why I said I felt like my body was numb, I felt like I was also losing my life because of the breathing problem and because I was unable to do anything, it's like you are alive and dead at the same time.
Researcher	Ok yes, I understand. Ok you had cord prolapse, then you were taken to theater for caesarean section as an emergency. After they have shown you that the baby died, what else did they do to you?
Respondent 2	Nothing
Researcher	Did you go for counselling?
Respondent 2	I went there later
Researcher	Later when?
Respondent 2	It was on a Monday, because I gave birth on the 9 <sup>th</sup> it was a Wednesday; Thursday; Friday, then on Friday it was when I asked to go bury my daughter because I remember I was supposed to have buried her on Friday but because I was still struggling there was no way I could have been discharged.,
Researcher	Ok I understand
Respondent 2	I was just given that opportunity to go bury. An appointment with the psychologist had already been made for Monday. The psychologist called me on the same Friday even disappointed that why was I discharged before we could have a session. I responded that I had to leave because I don't stay in Limpopo I am from Brits
Researcher	So you only saw the psychologist on Monday?
Respondent 2	Yes on Monday it was the 14 <sup>th</sup> .
Researcher	After your session with the psychologist, how did you feel?
Respondent 2	I felt peaceful, I was at peace. I accepted immediately
Researcher	Ok you accepted everything. Do you mean that the counseling that you got from the psychologist was helpful?
Respondent 2	Yes, It was like that heavy bag I was carrying was taken off of me.
Researcher	Ok I understand you, so can you please share any other information that you believe will be helpful in this research, any information, isn't it that you have got an experience.
Respondent 2	It's just that things are not done in the same way. But during delivery of my last

	born what happened is, I remember the last time, it didn't even take me long to give birth to him, there is this machine that they tie you with
Researcher	The CTG
Respondent 2	Yes that one
Researcher	Yes CTG machine
Respondent 2	In my view, for my third born, I think it helped me. I feel like the same process that took place then should have been done now including the doctors being there.
Researcher	Do you mean that at this hospital you were not placed on a CTG machine? Did you see others on the CTG machine?
Respondent	I didn't
Researcher	So you just feel that they should have used the same machine
Respondent	That process I went through the last time, because it's not the first time. My second born is asthmatic, when I gave birth to him I didn't have anything, it was almost just like this situation. I didn't have any problem breathing but I had a problem giving birth, but because the doctors were there they helped me and I gave birth to him. Even though he was not crying, just having the doctors there, they managed to help me until he would. I remember there were these midwives there. The midwives for me are so important. There was this other midwife who was a Christian she even prayed and that's when my son coughed and he started crying. But the doctors were there because the midwives would be there assisting saying "give me this" and the doctor is there physically doing everything. It just makes it easier to get everything you need.
Researcher	So that was in your previous pregnancy?
Respondent 2	Yes. That was on my second one and he survived even if he is asthmatic. I don't know if it was because of the problem we encountered for that short period of time but he is alive.
Researcher	So if I understand you well, you mean that if you received the same or similar kind of care maybe it would have helped you.
Respondent 2	Maybe it would have helped.
Researcher	So in your opinion, what is it that you think can be done that can help other women to prevent loss of babies
Respondent	I think they must allocate doctors with passion of working with women, this profession does not need somebody who seems like doesn't want to work with people, you can't tell if she is afraid or not, you can't tell if she is just lazy or not, the way she is too soft.
Researcher	The doctor?
Respondent 2	Yes.
Researcher	She is too soft?
Researcher	Are you planning to have another baby?
Respondent 2	I was supposed to tie my tubes. I already did Pap smear they booked for me in Mokopane then I had a problem with my husband or rather the father of my children. I then went there sneaking forgetting that God can see me. Then I found out he wants another child, he is crying for that one and if I cannot give him, he will go. So I decided if that is the case I'd rather have him go because I don't want. Because that is what is in his heart even if he understands that it is impossible but because I knew that it was coming from his own heart and I was not willing and I am not even blaming him and I decided that I cannot stay with him because I knew that the relationship would be sour. He has this small scar that he doesn't want it

	to heal.
Researcher	Ok you have said a lot. Let me say thank you very much for coming and answering everything. Is there anything you want to tell me that maybe I didn't ask you?
Respondent 2	No.
Researcher	Alright, thank you very much.

**APPENDIX 4: ENGLISH CONSENT FORM**

Statement concerning participation in a Research Study

Name of Study: **EXPERIENCES OF WOMEN WHO DELIVERED FRESH STILLBIRTHS AT A HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA.** I have read /heard the information on experiences of pregnant women admitted in the maternity ward. The aims and objectives of the study were provided and I was given the opportunity to ask questions and adequate time to rethink the issue. The aims and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence in the care that I am supposed to receive at the hospital. I know that this study has been approved by the CEO. I am fully aware that the results of this study will be used for scientific purposes and may be published.

I hereby give consent to participate in this study.

.....  
.....

Name of participant

Signature of participant

.....  
.....

.....

Place

Date

Witness

---

Statement by the Researcher

I provided verbal and written information regarding this study

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

.....  
.....

Name of Researcher                      Signature                      Date                      Place

**APPENDIX 5: SEPEDI CONSENT FORM**

**LETLAKALA LA GO DUMELELA GO TSEA KAROLO KA GARE GA DINYAKISHISHO**

Taba mabapi le go tsea karolo ka gare ga dinyakishisho

Hlogo ya dinyakishisho: **MAITEMOGOLO A BASADI BAO BA BELEGENG BANA BA BA HLOKOFETSEGO**

Ke badile le go kw aka tsebisho ya basadi bao ba belegeng bana ba ba hlokofetsego ba amogetswe ka mo go begelwang ka gona. Bohlokwa le maikemishetso a dinyakishisho ke a filwe, gape ke filwe sebaka sa go botsisha dipotsisho le nako ya go nagana ka taba ye. Ga ka gapeletswa go tsea karolo ka tsela ye ngwe le ye ngwe.

Ke kwishisha gore go tsea karolo ka gare ga dinyakishisho tse ke ka go nyaka gaka, gape nka tlogela go tsea karolo nako ye ngwe le ye ngwe g eke nyaka ntle le go fa mabaka. Seo se ka se amane le tsela yeo ke swanetsego go humana hlokomelo mo sepetlele. Ke tseba gore dinyakishisho tse di dumeletswa ke “Nursing Research Ethics Committee”. Ken a le maitemogelo a gore dipoelo tsa dinyakishisho tse di ka phatlalatswa, tsa ba tsa shomishwa go baithuti ba bangwe goba dinyakishisho.

Ke fa n aka tumelo ya go tsea karolo ka gare ga dinyakishisho

.....  
.....

Leina la motsea karolo

.....  
.....

Lefelo

Letsatsi

Hlatse



Taba ka monyakishishi

Ke hlaloseditse bat sea karolo ka gare ga dinyakishisho tse ka molomo le ka go ngwala

Ke dumela go tlo araba dipotsisho tse di ka tlogo mabapi le dinyakishisho tse ka nako e talgo

Ke tlo tswara dinyakishisho tse go ya ka mo ke dumeletsego

**APPENDIX 6: LETTER REQUESTING PERMSSION FROM LIMPOPO DEPARTMENT OF HEALTH**

Limpopo Department of Health

Private Bag X 9302

Polokwane

0700

Dear Sir/Madam

**RE: REQUEST TO CONDUCT A RESEARCH STUDY**

I wish to request permission to conduct the research study at Thabazimbi Hospital. I am currently doing Masters degree in Public Health with the University of Limpopo. My research title is **'Experiences of women who delivered fresh stillbirths at a hospital in Waterberg District, Limpopo Province, South Africa'**.

I have decided to do the above study as there is a lot of complaints and dissatisfaction by the public regarding care during birth.

The aim of my study is to explore experiences of women who delivered fresh stillbirth at Thabazimbi Hospital.

In my study I will interview women who delivered in the maternity ward. The findings of the study will be provided to you in a report reflecting the combined outcome of the participants' inputs.

I have obtained ethical clearance to conduct the study from the University of Limpopo. Please refer to the attached research proposal for more detail

Kind regards

Researcher: T.R MASWANGANYI

Date.....

Supervisor: Dr MATLALA S.F

# APPENDIX 7: LETTER GRANTING PERMISSION FROM LIMPOPO DEPARTMENT OF HEALTH



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

## DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650)

Ref:4/2/2

Maswanganyi TR  
University of Limpopo  
Private Bag X1106  
Sovenga  
0727

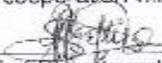
Greetings,

**RE: The experiences of woman who delivered fresh still births at a Hospital in Waterberg District, Limpopo Province, South Africa**

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
  - Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
  - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
  - The above approval is valid for a 3 year period.
  - If the proposal has been amended, a new approval should be sought from the Department of Health.
  - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

  
Head of Department

Date

15/09/2016

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700  
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

## APPENDIX 8: ETHICAL CLEARANCE CERTIFICATE



**University of Limpopo**  
Department of Research Administration and Development  
Private Bag X1106, Sovenga, 0727, South Africa  
Tel: (015) 268 2212, Fax: (015) 268 2306, Email: noko.monene@ul.ac.za

### TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

**MEETING:** 05 July 2016

**PROJECT NUMBER:** TREC/83/2016: PG

**PROJECT:**

**Title:** The experiences of women who delivered fresh still births at a Hospital in Waterberg District, Limpopo Province, South Africa  
**Researcher:** Ms TR Maswanganyi  
**Supervisor:** Mr SF Matlala  
**Co-Supervisor:** N/A  
**School:** Health Care Sciences  
**Degree:** Masters in Public Health

  
**PROF. TAB MASHEGO**  
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

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

**Note:**

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

## APPENDIX 9: PROOF OF LANGUAGE EDITING

Enq. Kubayi SJ  
Email. kubayij@yahoo.com  
Cell No. 079 484 8449

Po Box 29  
Khomanani  
0933  
12 January 2018

### TO WHOM IT MAY CONCERN

This is to certify that the mini-dissertation entitled 'Experiences of women who delivered fresh stillbirths at a hospital in Waterberg District, Limpopo Province by Maswanganyi Tebogo Rosemary (Student Number 201518333) has been edited, and that unless further tampered with, I am content that all grammatical errors have been eliminated.

Yours faithfully



Dr SJ Kubayi (DLitt et Phil)

Senior Lecturer (Department of Translation Studies and Linguistics – UL)