THE EXPERIENCES OF WOMEN WHO HAD INTRA-UTERINE FETAL DEATH IN VHEMBE DISTRICT OF LIMPOPO PROVINCE OF SOUTH AFRICA

By

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DECLARATION

I, **Martha Lufuno Kharivhe** hereby declare that the dissertation for the Masters degree in Nursing at University of Venda, entitled **"Experiences of women who had Intra-uterine fetal death in Vhembe District of Limpopo Province of South Africa"** hereby submitted by me, has not been submitted previously for a degree at this or any other university, that this is my own work in design and in execution, and that all reference material contained herein has been duly acknowledged.

Signature..... Date....19.08.2017.....

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DEDICATION

To all women who had IUFD especially those who participated in the study, I dedicate this study for their contribution in making it a success. To my supervisors Dr M Maluleke and Dr NJ Ramakuela who continued to encourage me when I lost hope. To my husband Hendrick for showing understanding, love and support. My children for their assistance during my years of study. I dedicate this study to all hospitals that allowed me to extract information from their maternity records.

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I would like to acknowledge the contribution of the following people, all of whom without them this research would never have taken place.

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- University of Venda Ethics Committee for giving me the opportunity to undertake the study.
- Department of Health of the Limpopo Province for granting me the permission to undertake the research.
- Department of Health Vhembe District for giving me approval to conduct research in the hospitals within the District.
- CEO's, Nursing managers and Nursing staff at maternity ward of the selected hospitals for giving me the opportunity to view their maternity records.
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LIST OF ACRONYMS

- APH – Antepartum haemorrhage
- ANC – Antenatal care
- CMHT – Community Mental Health Teams
- CTG – Cardio tocograph
- EPDS – Edinburgh Postnatal Depression Scale
- IUFD – Intrauterine fetal death
- LB - Live Births
- MDG – Millenium Development Goals
- MH – Mental Health
- OCD – Obsessive compulsive disorder
- PMHP – Perinatal Mental Health Project
- PPIP – Perinatal Problem Identification Programme
- PRAP – Psychosocial Risk Assessment Programme
- PTSD – Post traumatic stress disorder
- Rh – Rhesus factor
- SIDS – Sudden infant death syndrome
- UNPF – United Nations People's Fund
- WHO- World Health Organization

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ABSTRACT

Globally, intrauterine fetal death (IUFD) is a common problem in obstetric nursing science practice and leads to substantial grief reaction with a wide variety of emotions on a grieving woman. The significance of pregnancy and consequences of IUFD differs depending on personal and cultural values.

This study sought to investigate the experiences of women to the loss of the baby and the care that they received from the health professionals before, during and after IUFD in the Vhembe District Limpopo Province of South Africa.

A qualitative, descriptive, explorative and contextual design was used to explore and describe the emotional experiences of women. The study population are women above 18 years who have experienced an IUFD during the year from January 2015 to December 2015. Eight Venda speaking women were sampled through non-random, purposive sampling method. Permission was sought and granted from the University of Venda Higher degrees and Ethics Committee, the Limpopo Province Department of Health, Selected Hospitals Ethics and Research Committees and participants.

Data was collected through in depth individual interviews, recorded using an audio tape recorder and analysed through eight steps as outlined in Tesch open coding method. The results revealed that women had emotional experiences to the loss and the care they received before labour, during delivery and after delivery. Three themes with categories and sub- categories emerged from the analysed data, namely, experiences before labour, during delivery and after delivery.

The study recommends for practice before labour, during delivery and after delivery. Furthermore, an investigation of the experiences of health professionals when caring for a woman who has IUFD.

Keywords: Intrauterine death, Experiences, Health professionals

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DEFINITION OF CONCEPTS

Intra-uterine Fetal Death

WHO, (2015) define IUFD as the death of a foetus prior to complete expulsion from the mother irrespective of duration of pregnancy and without inducing nor terminating the pregnancy.

According to this study, IUFD refers to a baby who has died before birth, fetal heart rate not heard and the woman reporting reduced fetal movements.

Experiences

An exchange of information between the women and the environment, where this information is interpreted as words, feelings or actions that could be heard, understood or observed by another person (Alligood & Marriner-Tomey, 2011).

Experiences in this study are narrations displayed as words or actions by the women who have went through the loss of their baby.

Health professionals

Health care providers who maintain the health of human beings through application of evidence-based medicine by diagnosing, treating and preventing further illness, injury and mental impairment in accordance with the needs of the individuals that they serve (WHO, 2015).

In reference to this study health professionals are the nurses and the doctors who are in contact with women who have lost their babies before birth.

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Intrauterine fetal death (IUFD) is described by Sellers (2009) as the death of the foetus before birth through to eight hours before delivery and it is abortion if the death occurs below 20 weeks' gestation. Similarly, Abizadeh, Kipnis and Carter (2012) agree that IUFD is a miscarriage or spontaneous abortion when death occurs at less than 20 weeks' gestation.

Although people believe IUFD is a loss, some assume it is emotionally less important than other forms of neonatal deaths, regarding it as a bad luck rather than a heartbreak, with solaces such as you can have another (Elizabeth & Stierman, 1987) and (Pullen, Golden & Cacciatore, 2012) later admitted that healthcare providers view IUFD as a medical problem, whereas women view IUFD as a major family tragedy, and ignoring IUFD leads to more emotional pain as compared to women who face the misery that follows naturally. A woman's anguish after the birth is further made difficult by feelings of worry, disappointment and self-blame. The inability to grieve creates many challenges and there are no cultural mentions on how to mourn such a loss (Pullen *et al.*, 2012).

A study by Sutan and Miskam (2012) among the Muslim women to describe the psychosocial impact and social support following IUFD, found that the women experienced psychological difficulties including feelings of confusion, emptiness and anxiety of facing another pregnancy. The significance of pregnancy and consequences of IUFD differs depending on personal and cultural values. Scientific reports on the emotional experiences of women to the loss and care that they receive from health professionals is limited (Sutan & Miskam, 2012).

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Costin and McMurrich (2013) found that when an expectant mother attends antenatal care visits she never expects to hear that her baby's heart is no longer audible. However, if that happens, Hassan, Rothert and Saffran (2013) states that all types of pregnancy loss lead to strong emotional responses and psychological complications, although the responses may vary, they are more intense following later losses or recurrent losses. Any pregnancy loss leads to a substantial grief reaction with a wide variety of emotions, including sadness, feelings of blame, resentment and confusion (Costin & McMurrich, 2013).

A study by Graham, Thompson, Estrada and Yonekura (2016) of no more than 4 weeks postpartum from the IUFD found that women were less depressed after the loss if they already had children, and if they did not blame themselves for the IUFD, or if they received a picture of the foetus or were allowed to see the foetus, and that the women also benefited from the sympathy of the medical staff and by being kept informed of problems as they developed.

The prevalence of IUFD in a society signals the quality of antenatal care (ANC) in that country, Choudhary and Gupta (2014). Worldwide estimations of the fetal deaths occur in nations with dependable data registration (Lawn, Cousens & Zupan, 2015). Royal College of Obstetricians and Gynaecologists, RCOG (2010) states that IUFD rates in developing and underdeveloped countries ranges at 36 per 1000 live-births.

Sub-Saharan Africa and Asia combined contributes (70%) of the IUFD in the world, Choudhary and Gupta (2014) because those regions made slight progress in reducing those deaths (Lawn *et al.*, 2015).

Statistics SA (2012) recorded a total of 8 085 IUFD from 232 718 live-births, (20.7 per 1000 LB) at the Perinatal Problem Identification Programme (PPIP) sentry locations.

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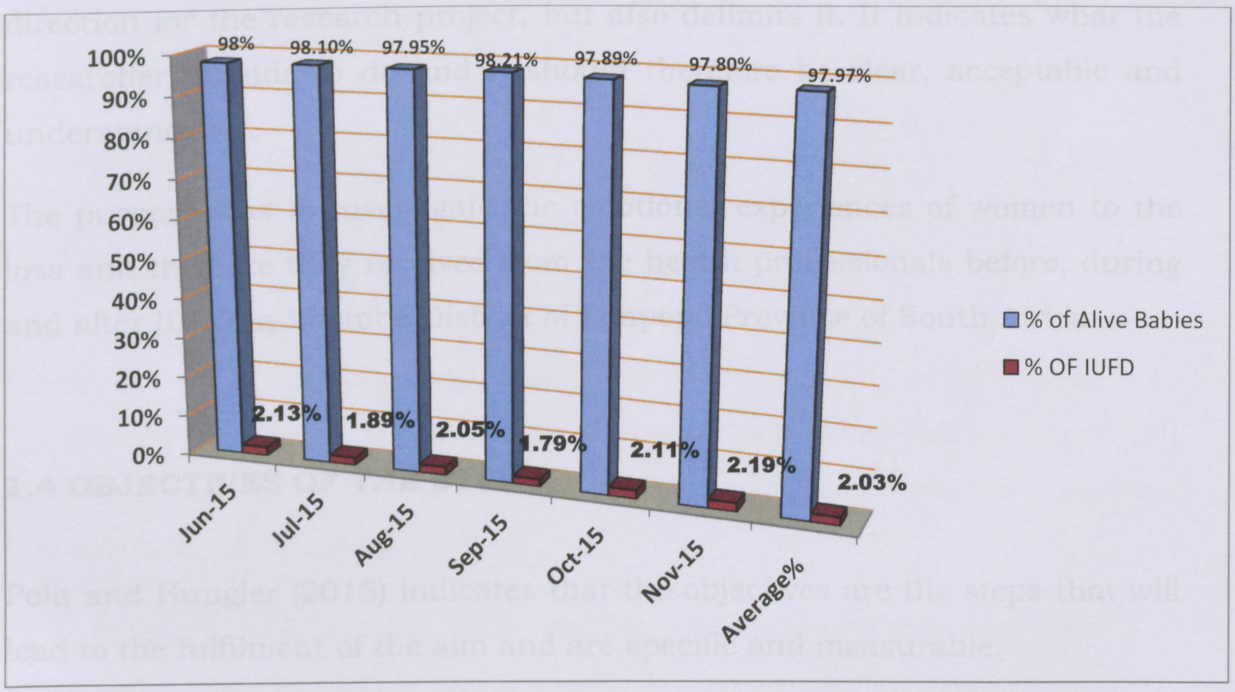
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1.2 PROBLEM STATEMENT

Burns and Grove (2012) describe the problem statement as an area of concern in which there is a gap or situation in need of a solution, improvement, alteration or discrepancy between the way things are and the way they ought to be. Similarly, Brink (2012) define the problem statement as a problem to be studied, should be short and to the point and should also contain three important aspects, namely, the topic, the target group and the setting where the project will be conducted.

The researcher observed from a local hospital register during the months from June 2015 to November 2015 that a total of 34 women were recorded as having IUFD, as compared to 1653 women with live births during the same period. This is indicated in Table 1.

Table 1: Graph chart: 6 months from June 2015 – November 2015



Many researchers in obstetrics and nursing science focus on how to prevent the occurrence of IUFD or how to identify the causal factors related to depression in patients to help them restore their mental health. Yet, considering the emotional experiences of women to the loss and the care

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they received from professionals before, during and after IUFD is limited. For this reason, women who had IUFD were interviewed since their IUFD experience.

IUFD is an emotional trauma and causes major emotional problems in adjustment during bereavement period. Feelings of unpreparedness and denial are commonly expressed (Gausia, Moran, Mohammed, Ryder, Fisher & Koblinsky, 2011). The majority of cases go undetected and are left untreated and only to reach the attention of the professionals after something has gone seriously wrong (Ngozi, 2005). This shows us that maternal and emotional health is a subject of concern.

1.3 PURPOSE OF THE STUDY

Brink (2012) describes the purpose of the research project as showing the direction for the research project, but also delimits it. It indicates what the researcher intends to do and it should therefore be clear, acceptable and understandable.

The purpose was to investigate the emotional experiences of women to the loss and the care they received from the health professionals before, during and after IUFD in Vhembe District of Limpopo Province of South Africa.

1.4 OBJECTIVES OF THE STUDY

Polit and Hungler (2015) indicates that the objectives are the steps that will lead to the fulfilment of the aim and are specific and measurable.

The objectives were:

- To explore the emotional experiences of women who had IUFD to the loss of the baby.

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- To describe the emotional experiences of women who had IUFD regarding the care they received from the health professionals before, during and after delivery.

1.5 RESEARCH QUESTION

Brink (2012) indicates that research questions are questions usually asked after the problem statement has been formulated. The research questions were:

- What are the emotional experiences of women who had IUFD to the loss of the baby in Vhembe District of Limpopo Province of South Africa?
- What are the emotional experiences of women who had IUFD regarding the care that they received from health professionals before, during and after IUFD?

1.6 SIGNIFICANCE OF THE STUDY

According to Brink (2012), the research study should have the potential to contribute to health sciences knowledge in a meaningful way, patients, healthcare professionals and the community should benefit from the findings of the study, the body of science knowledge should be increased from the study, healthcare practice and policies should improve, implemented and cost-effective.

- Women had a plat form to narrate their experiences with the researcher being the sound board.
- Health professionals may receive a reflective information regarding their encounters with grieving women.
- The findings may contribute to the improvement in patient care for women who had IUFD by the information gained.

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- The findings may contribute to the body of knowledge on obstetric and professional care.

1.7 CONCEPTUAL FRAMEWORK

According to Brink (2012) conceptual framework is one that the researcher has developed through identifying and defining concepts and proposing relationships between these concepts, to create a specific way of looking at a particular phenomenon, so the proposed study becomes a logical extension of current knowledge. This study focuses on the women's emotional wellbeing, this is in alignment with King's Interacting Systems Framework, in Alligood and Marriner-Tomey (2011) which include personal, interpersonal and social systems of wellbeing.

1.7.1 Personal systems

Alligood and Marriner-Tomey (2011) regards women, according to this study as entities who are sensible, emotional, and communal beings. The personal systems accumulate selective responses from the environment through the senses. The concepts related to the personal system are self, growth and development, body image, time and space and are discussed below:

Self is achieved when a composite of thoughts and feelings constitute awareness of individual existence, conception of who and what she is. A person's self is the sum total of all she can call her ideas, attitudes, values and commitments. Growth and development encompass processes in people's lives through which they move from a potential for achievement to actualization of self.

Body image refers to the way one perceives both one's body and others' reactions to one's appearance. Time and space is explained by the period that lapsed from one event and another as individually experienced by each

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woman, and the space being the same everywhere, and is well-defined by the physical area known as terrain and by the conducts of those occupying it.

The study ensured the framework as applicable by accepting the participant as an individual who is a rational, sentient social being. To attain mutually set goals, the relationship takes place in an environment that is free from noise, pollution and smell and an atmosphere that is warm and quiet, at a specified period of time.

1.7.2 Interpersonal systems

Furthermore, according to Alligood and Marriner-Tomey (2011), Interpersonal systems are poised as two, three or more personalities interacting in a given situation. Associated with this system are communication, transaction, role, stress and power as discussed below:

Communication was applicable in that information is given from one person to another either directly, through interviews or indirectly through telephone, television or the written word, transaction achieved through interactions in which the women communicate to achieve goals that are valued, goal directed within relationships where two or more women are functioning in roles that are learned, social, complex and situational and achieve a dynamic state. Women needed to interact with their environment to obtain balance for growth, development and performance which involved exchange of information for regulation and control of stressors.

Power referred to the capacity to use resources in organizations to achieve goals, it occurs in all aspects of life and each person has potential power determined by individual resources.

More needed to be explored about the experiences of women who had IUFD, after observing that they were emotionally sad, cried and socially isolated. The findings show that there is a need for communication between the

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healthcare team and the woman, to be clarified if she was allowed to communicate her preferences, and to be offered support and sympathy.

1.7.3 Social systems

Alligood and Marriner-Tomey (2011) state that social systems are "organized boundary systems of social roles, behaviours and practices developed to maintain values and the mechanisms to regulate the practices and rules. Concepts related to social systems are status and decision-making. King (1990) in Alligood and Marriner-Tomey (2011) defines decision-making as a dynamic and systematic process by which goal- directed alternatives are acted upon by individuals or groups to answer a question and attain a goal.

Status indicated the position of an individual in a group accompanied by privilege, duties and obligation. Social systems were applicable since the women, while in hospital, were allowed privileges such as keeping their cellphone, laptop, watching TV, listening to the radio and and to socially interact by allowing friends and family to visit them for support and comfort without restrictions.

1.8 SUMMARY

This chapter introduced the overview of the study. The background, the problem statement, research question and objectives, significance of the study as well as the conceptual framework according to King's interacting systems, where the personal, interpersonal and social systems were discussed. Chapter two present the literature review. Topics covered are the definition, risk factors, emotional aspects and the effect of IUFD on women's health, statistics, bereavement, depression, adjustment and impact of IUFD on quality of life.

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CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Cronin, Ryan and Coughlan (2008) define literature review as an unbiased, thorough summary and critical inquiry of the relevant available research and non- research literature on the topic being studied. Literature review should answer research objectives and indicates the reason why the project is necessary, and outlines the development of information about the topic up to the present time. Gaps are emphasised as they support the current study. If current research is not mentioned, the reader should query when the research was undertaken in case it is out-dated and Fraser, Cooper and Nolte (2010) indicate that literature should be based on the high level of knowledge.

Literature review focused on the definition of IUFD, IUFD as a risk factor for post loss mental health complications, emotional aspects of women after IUFD, IUFD as precursor to strong emotional responses, effect of IUFD on a woman's health. It also discusses neonatal deaths, statistics and possible causes of IUFD, bereavement, complicated grief, maternal health and depression, emotional adjustment to IUFD and impact of IUFD on quality of life.

2.2 DEFINITION OF IUFD

According to Choudhary and Gupta (2014), Intrauterine Fetal death (IUFD), fetal demise, stillbirth and stillborn are interchangeable terms all referring to babies born without any signs of life. WHO, (2015) define IUFD as the

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death of a foetus prior to complete ejection from the mother irrespective of duration of pregnancy and which is not an induced termination of pregnancy. Choudhary and Gupta (2014) describe IUFD as an infant delivered without signs of life after 20 weeks of gestation or a weight of >500g if the gestation is not known and Abizadeh *et al.* (2012) refer to IUFD as a miscarriage or spontaneous abortion, early at 16 weeks and late at 28 weeks gestation. Costin and McMurrich (2013 states that) IUFD result to a woman giving birth to a fresh or macerated stillbirth.

In SA, Sellers (2009) define IUFD as the death of the foetus before birth through to eight hours before delivery, and agrees with Abizadeh *et al.* (2012) that it is abortion if the death occurs below 20 weeks gestation.

2.3 IUFD AS A RISK FACTOR FOR MATERNAL HEALTH COMPLICATIONS

Hughes (2007) indicate that after IUFD, parents often experience painful anguish. Both show the same outline of symptoms but generally a woman's sorrow is far more intense. Hughes (2007) indicate that grief should be sensitively recognized by the health professionals and women should be comforted that their feelings are common and that they could take many months to recover. Strong depression that takes more than six months necessitates psychological management. Indications show that delaying conception for up to a year, allows an easier pregnancy psychologically. Hughes (2007) further indicated that the common practice of encouraging parents to have contact with their dead infant is not evidence based and it might have adverse effects, inducing symptoms of post-traumatic stress disorder (PTSD). A procedure of post deliver follow-up allows women to get appropriate information about the loss, including possible problems and scheduling of another pregnancy. The successive pregnancy could be stressful, and health professionals should diagnose that parents might suffer substantial anxiety.

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Bennet, Shannon, Litz, Brett, Maguen, Shira, Ehrenreich and Jill (2008) state that IUFD is traumatic and places the bereaved at risk for post loss health complications. Various factors (individual, familial, economic, medical cultural and religious) affect long-term emotional reactions to IUFD.

An estimated one in four women experience IUFD during her reproductive years, one in 10 of these losses fall into the category of stillbirth (McMurrich, 2013).

Boots Family Trust (2013) acknowledge that IUFD is a life-altering event and health care providers should concede a woman's past loss, address their concerns during a current pregnancy and identify the probable life-long effect that IUFD might have on women. Obstetricians and midwives also suffer from misery after a perinatal loss, and also carry the pain and memories of the women s' loss and experiences with them for years.

2.4 EMOTIONAL ASPECTS OF WOMEN AFTER IUFD

Hughes (2007) assume that following an outline of what is already known about the emotional effects of IUFD, aspects of management are associated with better outcomes, and that in cultural context, in psychosocial management the women are encouraged to see and handle their foetus, a division between the remedial and cultural models framed the practice in different ways, the moral position of the health care teams counselled women about choices to see or not to see the foetus.

According to Bennet *et al.* (2008), a higher number of pregnancy losses, particularly IUFD are associated with poor health and the need to obtain professional help in dealing with the loss, and partner support is the most important factor. It is important to mourn IUFD, because ignorance impedes the bereavement process, which might then lead to development of pathological, chronic or inappropriate grief responses. People should go

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through all the four phases of grief, namely: shock and numbness; searching and yearning; disorientation and reorganization.

Studies by Aho, Astedt, Kurki, Tarkka and Kaunonen (2009) outline that there is an increased vulnerability of women with IUFD to experience undesirable emotional and social values. There is a critical need to develop appropriate healthcare services for women who had IUFD, including intermediations to develop positive family support. IUFD, Aho *et al.* (2009) is a unique and potentially traumatising experience that can leave mourning parents struggling with a host of mental health difficulties. The exploratory study by Aho *et al.* (2009) examined a cohort of women who experienced IUFD within the precious five years. The results suggested that IUFD is associated with significant distress and diminishing for some women, with greater severity primarily predicted by maladaptive coping skills, low social support and intense emotionality following the IUFD.

Ney (2012)'s research confirmes the presence of symptoms typical of both severe and sustained unhappiness in women who have encountered an IUFD, which are: emotional reactions, inability to function in daily routine, depression, anxiety, loss of appetite, feelings of guilt, anger and sense of failure, suicidal thoughts, somatic complaints, sleep disturbances, loss of energy, psychosomatic complaints, and social difficulties.

2.5 STATISTICS AND POSSIBLE CAUSES OF IUFD

Royal College of Obstetricians & Gynaecologists, RCOG, (2010) recorded that there have been 4037 IUFD, i.e. 1 in 200 babies (5 per 1000 live-births) in the UK, Northern Ireland (3.1) and Scotland (4.6) per 1000 LB.

In Multan, India statistics recorded that there were 1834 live-births and 63 IUFD deliveries i.e. a rate of 34.3 per 1000 LB (Ifnan & Jameel, 2006). According to Lawn *et al.* (2015) IUFD is projected at 4 million babies annually, and most are from low to middle income nations.

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Statistics SA (2012) indicate that the South African average (20.7) per 1000 live-births (LB). The District Health Barometer, (2014/2015) recorded that provincially the lowest rates of IUFD were recorded in Western Cape (17.2) and the highest rates were recorded in Northern Cape (25.5). Limpopo Province recorded (21.4). The rates per Districts in the Limpopo Province are: Vhembe (16.2), Mopani (20.1), Waterberg (21.9), Sekhukhune (22.3) and Capricorn (27.4) respectively per 1000 LB.

Estimations on the numbers of labour related fetal deaths in 2000, Statistics SA (2012), recorded a total of 8 085 fetal deaths weighing from 1000g or more from 232 718 live-births. Fetal deaths (31.5% – 47.5%) are due to avoidable elements, missed chances and significant care, (10.1% – 31.1%) due to institutional problems, both in urban and countryside areas. Fetal deaths owing to oxygen deprivation and birth trauma are assumed to be preventable within the institution in (34.4% - 63.1%) of cases in all areas. Fetal deaths due to elevated blood pressure (hypertension) and per vaginal bleeding before labour commence (antepartum haemorrhage) are believed to be avoidable with prompt management.

According to Sellers (2009), the causes of IUFD beyond 20 weeks may be due to fetal anoxia, or placental inadequacy. Pre-disposing factors for the IUFD includes chronic conditions such as diabetes mellitus, sexually transmitted infections, amniotic fluid infection syndrome, accidents or trauma during pregnancy, antepartum haemorrhage from placental detachment (placenta abraptio), trauma, short cord, uterine rupture, the cord being tied around the fetal neck, decreased liquor volume (oligohydramnios), or Rh discordancy. Some of the causes of IUFD during labour can be due to prolonged labour, malpresentations, anaesthetics, precipitate labour, obstructed labour, maternal death, but some causes are still not known.

Lawn *et al.* (2015) state that maternal problems during labour carry a high risk IUFD, and that poverty is associated with an increased risk. Generally, the foremost causes of fetal deaths are, pre-term births (28%), severe

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contagions (26%), oxygen deprivation (23%), and intrauterine growth retardation (IUGR). Less than (3%) of the 4 million annually of the fetal deaths occur in nations with dependable data registration. Worldwide estimations for oxygen deprivation fetal deaths varied (from 0.7 – 1.2 million). IUFD is a huge and invisible problem, but actually avoidable, where managed care and enhanced information is essential (Lawn *et al.*, 2015).

2.6 BEREAVEMENT

Hull (2011) indicates that childbirth, being one of the most significant milestones in the human life, filled with hope, expectations of joy, fear and faith, yet, for (12%) couples experiencing IUFD each year, this becomes an experience filled with tragedy, mourning and despair.

Elizabeth and Stierman (1987) identified that eighteen women who were interviewed in the months after the IUFD, reported grief and concern. Most of the women reported prickliness, loss of desire, sleeplessness, disordered daily activities, empty emotions and detachment. The reaction of 40 women interviewed shortly after the IUFD occurred, were similar to those reported in the newly widowed. The presence of characteristic grief reactions in women who experienced IUFD, was confirmed.

Hughes (2007) later introduced the practical trait in the management of an IUFD, a counselling service, for women who had IUFD. The service was examined, and women who received the service were compared with women who did not receive the service. Fifty women were assigned indiscriminately to the counselling group and others to the divergence group, who received monotonous hospital care. Assessments carried out at six and 14months thereafter, only two of 16 women in the counselled group showed depressive disorder at six months, as compared to 10 of 19 in the other group, but 14 months later there was no noteworthy alteration between the two groups, when (80%) of women considered have recovered from the depressive

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disorder, but socially secluded women and women whose marital affairs lacked affection were found to have a greater incidence of depression at six months. An early pregnancy (within 6 months after the IUFD) was also associated with a greater prevalence of psychiatric symptoms in the divergence group. The duration of bereavement after IUFD is shortened by support and counselling, particularly for women who are childless or who have a history of major depressive disorder.

Hughes (2007) then mentioned that since women are attached to their pregnancy, loss around the time of birth brings serious suffering and pain. The anguish might last for months, and health care have sought to device practices that mihgt help the recovery, they even advocated that women should have contact with the foetus, believing that it might ease the bereavement, but no efficient confirmation supports this practice, throwing doubt on the therapeutic value of the practice of encouraging contact with the foetus.

Additionally, Gausia *et al.* (2011) later discovered that some bereaved women suffer from long term psychological disorders after an IUFD. They come upon long term psychological moments that include depression, marital tension leading to parting and break-ups. These women suffer prolonged adverse psychological, somatic and social changes, feelings of self blame and disgrace towards the loss. Such women are overwhelmingly miserable, weep and ache for their loss. Poor support leads to partnership failure. These bereft women suffer from a widespread assortment of undesirable social effects such as seclusion from friends and relatives, this makes them even more fervently susceptible, meaning that IUFD is the strongest forecast for postnatal depression.

2.7 COMPLICATED GRIEF

Kersting (2012) mention that usually IUFD is typically sudden and unexpected and the parents had no time to anticipate grief or prepare

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themselves for it. The loss of a child often causes complicated grief reactions that negatively affect psychological and physical wellbeing that generally are associated with a poorer state of mental health. Although the relationship with the infant is not yet built up, grief after IUFD does not differ significantly in intensity with any other loss scenarios. Other studies have demonstrated that grief declines over a period of 2 years after the loss, and that IUFD has shown to have substantial psychological impact in women and their families, and it is associated with post-traumatic stress, depression, anxiety and sleeping disorders.

Complicated grief (prolonged grief disorders) reactions are more disruptive, pervasive and long lasting, maternal trait anxiety included less infant positive affect and lower attention span in the subsequent pregnancies. Kersting (2012) further suggests that there is a prevalence of postnatal depression and is highest in low income developing countries, and these highlight the need for programme managers and policy makers to allocate resources and develop strategies to address postnatal depression and IUFD.

2.8 MATERNAL HEALTH AND DEPRESSION

Ngozi (2005) expressed that depression affects three in 1000 women in their first year after the IUFD. Maternal health problems often present with poor physical health, persistent high risk behaviour including alcohol and substance abuse. Depressed mothers are less likely to care adequately for their own needs and to adhere to prescribed health regiments, leading to increased maternal morbidity and mortality (Ngozi, 2005).

Furthermore, Ngozi (2005) explained that women who are depressed are incapable of handling the tasks of motherhood and they are unable to provide emotional nurturance, protection and stimulation that babies count on. But core features such as fatigue and poor sleep are commonly associated with motherhood itself. Women who are depressed are less likely to care for their own needs, and less likely to seek and receive antenatal or

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postnatal care or to adhere to prescribed health regimens. Postpartum psychosis is the most severe form of maternal depression, with symptoms ranging from hallucinations, paranoia to suicide and infanticide. Because of its severity, postpartum psychosis is handled as a psychiatric emergency.

Studies conducted by Hougaard, Andersen, Kjaer, Hansen, Werge and Lund (2005) demonstrated that IUFD is associated with Post Traumatic Stress Disorders (PTSD). Exposure to perinatal stress result in a general susceptibility to psychopathology, rather than exerting a direct effect on a specific form of psychopathology, and a prenatal environment also forms part in the individual variation in the development of psychopathology.

Gold, Dalton and Schwenk (2007) recommends that soon after IUFD health professionals should increase women's choices about timing, location of delivery and postpartum care, encourage contact with the deceased infant and facilitate provision of photos and memorabilia

On the other hand, Priest, Austin Barnett and Buist (2008) state that recognition of high rates of maternal health morbidity and mortality that affect women during the perinatal period prompted the development of Psychosocial Risk Assessment Programmes (PRAP), which is used for pregnant and postpartum women. Care after IUFD adheres to published guidelines and substantial room for improvement is apparent.

Little research, according to Flynn, Henshaw, O'Mahen, and Forman (2010), exists that guides strategies for screening, follow up and depression referral in obstetric based settings, and recommendations derived were provided as a platform for further research.

Leddy, Lawrence and Schukin (2011) indicate that midwives, obstetricians and gynaecologists view maternal health issues as important topics, however they are not confident in their abilities to diagnose these conditions and are also concerned about the adequacy of their training, thus additional training could prepare them to incorporate maternal health screening into their practices. Health care professionals are in frequent contact with

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women and they could play a role in the screening for maternal illnesses, leading to the prevention of negative health consequences for women resulting from these illnesses.

Stewart and Henshaw (2012) identify maternal health to relate to the various disorders experienced by women during pregnancy and post delivery period. Midwives are identified as having a role to play in screening for and educating about perinatal disorders. A questionnaire survey of midwives was undertaken in two health Districts to examine the level of knowledge they have about the prevalence of these disorders, their experience in dealing with them, whether they felt they had the necessary skills, and what further skills were required. Exploration of midwives' interest in learning more about the disorders and perceptions of their potential role were included to gauge what type of programme should be developed in the future. Results from the data of 266 responses showed that midwives had some knowledge of the prevalence of these disorders and most felt they had a role in management. However, few had had specific training in this area and many identified areas of practice they wished to improve before taking such a role (Stewart & Henshaw, 2012).

A study by Boyle, Vance, Najman and Thearle (2012) documented 194 women following intrauterine fetal death (IUFD). Anxiety and depression were measured immediately from post loss, up to 30 months after. The results showed that bereaved women experienced high rates of psychological distress.

However, Boyle *et al.* (2012), further indicate that there were no serious responses that developed in response to the loss. Bereaved women who were not distressed soon after the IUFD were unlikely to become stressed later, but those who did show distress were likely to remain so even at eight months later.

Boots Family Trust (2013) outlines that lack of awareness around perinatal mental health issues makes it difficult for those affected and their families to spot the symptoms and to recognize when they are unwell. "Illnesses such

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as maternal obsessional compulsive disorder (OCD), post traumatic stress disorder (PTSD), antenatal/postnatal depression, antenatal/postnatal anxiety, puerperal psychosis, phobias (for example, tokophobia, haemophobia, latrophobia, aichmophobia, emetophobia thenatophobia) are relatively unknown by the general public". Literature indicate that women who had IUFD deserve systematic and compassionate support. Their emotional wellbeing was not properly explored, due to time constraints, and lack of perinatal health services and also of the women issues, leading to a situation whereby women not opening up to midwives due to lack of trust between the women and midwives, and lack of teamwork by midwives lead to midwives' inability to form individual relationships with the women.

Walker and Davidson (2014) highlights that women who experience IUFD have extraordinary high rates of depression and anxiety. The suffering is either acute or chronic in form.

2.9 IMPACT OF IUFD ON QUALITY OF LIFE

Women with a previous IUFD, according to Gravensteen, Helgadottir, Jacobsen, Sandset and Ekeberg (2012,) women who received short term interventions share the same level of quality of life, well-being and global depression as women with live births. For women with IUFD the risk of experiencing PTSD is prevalent during the next pregnancies, particularly when the pregnancy occurs soon after the loss. Additionally, measured outcomes of a cohort study concluded that PTSD, Partnership breakdown and depression are the long term sequelae of stillbirth, and increased psychological morbidity in subsequent pregnancies and puerperium.

Statistics by Honikman, Heyningen, Field, Banon and Tomlinson (2012), specify that the prevalence of maternal mental illness is almost (40%) in South Africa. Most of these maternal mental illnesses are experienced by the poor from disadvantaged communities. The common mental disorders are

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prenatal and postpartum depression, anxiety, postpartum blues, and postpartum psychosis. Honikman *et al.* (2012) indicate that there is no routine screening or treatment for maternal mental disorders in South Africa at primary health level.

Research has shown that maternal depression disturbances are implicated in the mother-infant relationships, sub-optimal care leads to detrimental effects on the health of an unborn child. Honikman *et al.* (2012) developed the Perinatal Mental Health Project (PMHP), an intervention that delivered mental health care to pregnant women in a collaborative, step-wise manner making use of existing resources in primary care. According to Honikman *et al.* (2012), ninety per cent of women attending antenatal care in the maternity clinic were offered mental health screening with (95%) uptake, of those screened, (32%) qualified for referral to counselling. Through routine screening and referral, the PMHP model demonstrates the feasibility and acceptability of a stepped care approach to the provision of mental health care at primary level.

2.10 SUMMARY

This literature review covered different aspects of IUFD through different reading materials. IUFD is described in this chapter, it also outlines that maternal health could be positively or negatively affected by birth outcomes, and it contributes to psychological morbidity. IUFD is a risk factor to maternal emotional health complications. The review discusses the emotional aspects for women after IUFD and the ethical position of the staff, whether they advise women about the choice of seeing or not seeing the infant's body. Adjustment to IUFD, its effect and statistics are defined, and that IUFD is a precursor to strong emotional responses such as depression, guilt, anger and confusion. Women who have had IUFD should not ignore the bereavement process, to prevent the development of pathological, chronic or inappropriate grief responses. The duration of grief is shortened by support and counselling.

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The next chapter discusses the research design and methods, the setting and the context, population, sampling, data collection methods and analysis, measures to ensure trustworthiness and ethics related to the study.

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CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter is where research design and methods are well described. The study describe the qualitative approach, the study setting, where the maps show a well defined context, population, samplimg method, data collection, analysis, measures to ensure trustworthiness where credibility, transferability, confirmability and dependability are defined, ethical considerations such as informed consent, privacy, anonymity and confidentiality are applied.

3.2 RESEARCH DESIGN

A research design guides the researcher in planning and implementing the study to achieve the intended goal (Burns & Grove, 2012). Similarly, Research design refers to a set of logical steps taken by the researcher to answer the research question (Brink, 2012). Research design is a systematic plan to study a scientific problem, the study defines the type (descriptive-naturalistic observation, contextual and explorative), data collection methods and the analysis plan. Qualitative, explorative, description and contextual design was adopted.

3.2.1 Qualitative design

Qualitative design needs a more face to face contact with the research population, and the findings cannot be generalised, (Meyer, Naude', Shangase & Van Niekerk, 2011). The researcher observes the person's actions and listens to them. The perception of the person experiencing the

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phenomenon becomes obvious. Qualitative approach does not seek fairness; the researcher seeks complete understanding of the experience. Fraser *et al.* (2010) and Brink (2012) allege that it is for researchers who require to explore, define and encourage thoughtfulness of the individual's experiences such as "pain, grief, hope or care. In these instances, data cannot be numerated, that is where a qualitative approach is proper and appropriate. Furthermore, Polit and Beck (2010) maintain that the findings from the qualitative research are fixed in real life experiences, a probing occurrence in detailed setting, through narratives. All information enables the researcher to identify a clear picture aimed at examining the whole presentation of different sides of the problem.

A qualitative approach was relevant since little was known about the emotional experiences of women who had IUFD to the loss and care they received from health professionals in Vhembe District and the experiences could not be captured in numbers.

3.2.2 Explorative design

Fraser *et al.* (2010) identify the aim of an exploratory approach as to get evidence where knowledge is non-existant, collect new information and to assess if there are any similarities in that information. Similary, Babbie and Mouton (2011) indicate that the exploratory method is vital when the researcher examines a new subject. It reports those subjects where there are high levels of uncertainties about the subject. It is defined by flexibility and not having a formal arrangement. Exploratory research identifies the limits in which the problems, are likely to exist and also identifies the noticeable factors that might be found and are important to the research. Mouton and Marais (2013) report that the exploratory research results in a gain of a more understanding of the circumstances being studied.

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The explorative design was used to gain new insight, discover new ideas and increased knowledge about the emotional experiences of women who had IUFD.

3.2.3 Descriptive design

In a descriptive design, according to Brink (2012) the researcher aims to define the occurrence more precisely within a detailed setting when observing the collected data. The descriptive design documents the behaviour, actions, views, appearances, outlooks, to provide a clear picture that occur in the situation being studied. The aim being to gain more knowledge about the situation and to offer a clear picture of the situation as they occur naturally. Fraser *et al.* (2010) also explain that descriptive research precisely describes the features of persons within that incidence. Descriptive research gives a precise and effective presentation of the issues relevant to the research question.

Descriptive design was used to allow participants to describe their lived emotional experiences to the loss and care they received from health professionals.

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3.2.4 Contextual approach

Contextual studies, according to Burns and Grove (2012) centre on definite occasions in a real-life setting - these real life situations are sometimes referred to as field settings. Research done in real life situations refers to an investigation done in a scenery free from influence. Mouton and Marais (2013) state that the phenomenon is studied for its basic and immediate appropriate importance.

The study focused on in-depth, unstructured interviews which were conducted with women who have had IUFD during the year 2015, selected

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from hospital records in Vhembe District of Limpopo Province of South Africa. Open ended question were asked to the interviewees to find out their lived experiences, emotionally, and socio-economically, that the participant shared in the research study.

3.3 STUDY SETTING

The setting was at participants' homes in Vhembe District of Limpopo Province of South Africa. According to Statistics SA (2012), Limpopo Province has the 4th largest population in South Africa. Limpopo Province is the poorest of all the Provinces in South Africa, with five Districts; Mopani, Vhembe, Capricorn, Waterberg and Greater Sekhukhune. Figure 1 below illustrates the Districts.



Figure 1: Limpopo Province, indicating the five Districts.

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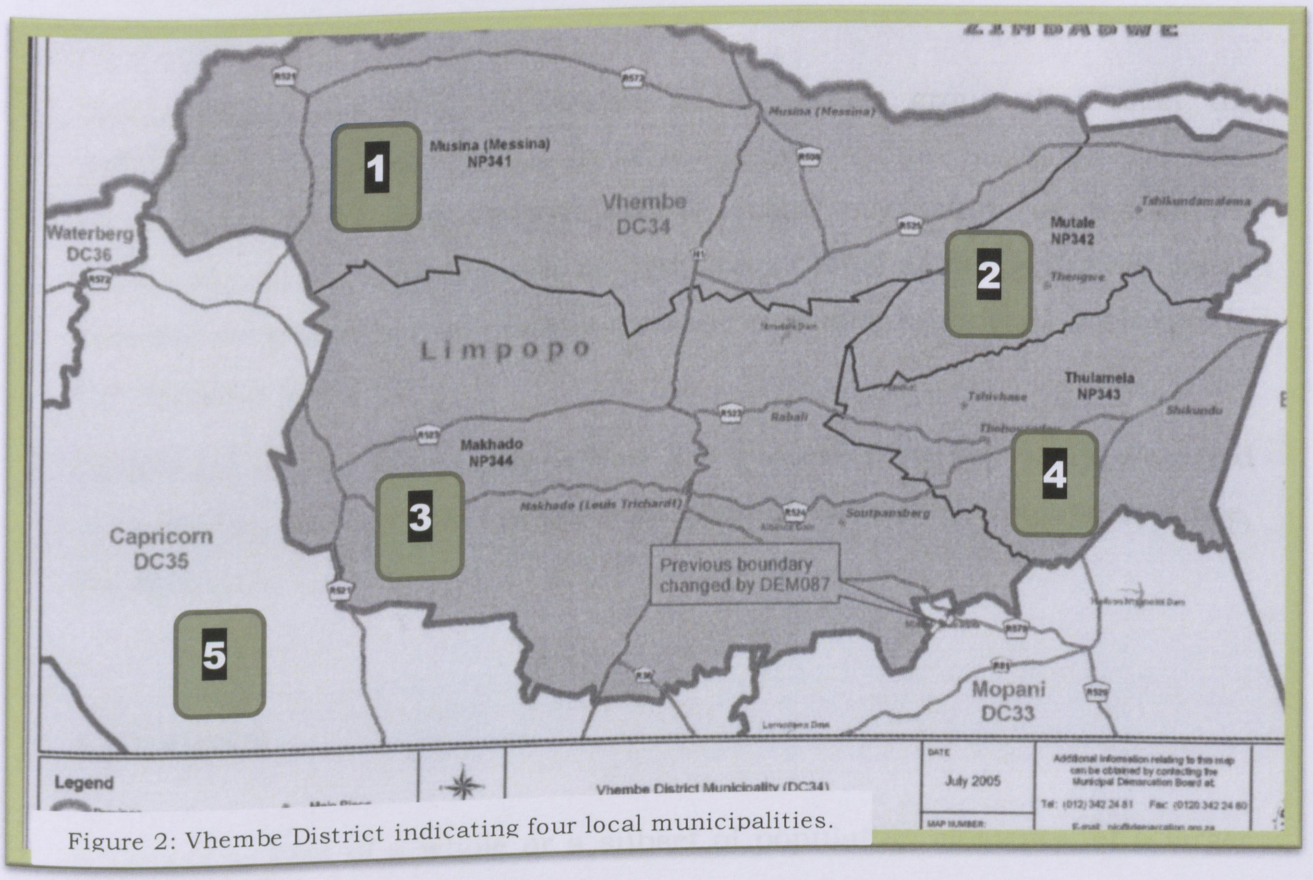


Figure 2: Vhembe District indicating four local municipalities.

Vhembe District is located in the northern part of Limpopo Province and comprises four local municipalities: Musina (1), Makhado (3), Thulamela (4) and Mutale (2) as illustrated in figure 2 above. Vhembe District, has an area of 25 597 km^2, according to Statistics SA (2012) and a population of 1.3 million people. It falls into the second socio-economic quintile. The unemployment rate stands (at 38.7%). There are 113 clinics, 8 Community health centres, 21 Mobile services, 7 District hospitals, 1 Regional hospital and 1 specialised hospital in Vhembe District stillbirth and perinatal mortality rates of 16.1 and 24.6 per 1000 live births respectively, rank Vhembe District the best (due to achieving the`8 lowest rate of emergency caesarean section) in the Province in 2007/8, as in most years' prior, the emergency caesarean section rate (of 23.7%) was the highest in Limpopo Province, and is more than double that of Capricorn District.

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3.4 POPULATION

Brink (2012) describes population as the entire group that meet the standard that the researcher is investigating about. Similarly, De Vos, Strydom, Fouche, and Delport (2011) define population as individuals possessing precise features. Burns and Grove (2012) define population as all possible participants who comply with the sampling criteria for inclusion in the research study.

Conferring to the study, population are women above 18 years who had IUFD during the year 2015 of study in Vhembe District of Limpopo Province, South Africa.

3.5 SAMPLE

A sample is part of a whole or a subset of population elements, of a larger set carefully chosen by the researcher to partake in a research study and contains the elements of an inquiry from a defined population, (Brink, 2012; Polit & Beck, 2010). The sample is a representative of the target population that form part of the study.

Ten women who had intra-uterine fetal deaths during the year 2015 from January to December 2015 in Vhembe District were sampled to participate in the study.

3.5.1 Sampling method

According to Burns and Grove (2012) sampling is a method whereby a sample is selected, that represents the target or a larger population. Sampling criteria is then designed and indicated, where the researcher follows that sampling standards. Brink (2012) indicate that sampling means that the decision of the researcher with regard to the subjects is

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characteristic of the study phenomenon, or knowledgeable about the situation at hand, and that this kind of sampling is used when the number of participants' is not known earlier, the number of the participants is only reached at the point of saturation, when no newer information surfaces from the participants.

A non-probability, purposive sampling was used to select participants. The names of women who experienced IUFD were retrived from the selected hospitals records. A total number of 46 names of women with full contact details were found. All the names were written in pieces of papers then put in a container. Ten papers were picked and recruited those women to participate in the study.

3.5.2. Inclusion criteria

Inclusion criteria specify population characteristics and those characteristics must be present for an element to be included in the study (Burns & Grove, 2012).

Inclusion criteria are Venda speaking women above 18 years who had IUFD, from three months after IUFD has occurred, irrespective of parity, during the year 2015 of study at selected hospitals in Vhembe District of Limpopo Province, South Africa.

3.6 DATA COLLECTION METHOD

Burns and Grove (2012) state that data collection is a process identifying the respondents and the precise, systemic gathering of information relevant to the research purpose, the specific objectives or research. Data collection details how the research instrument was chosen, designed, tested and applied. This applies particularly to questionnaires, interview schedules or observation checklist. Fraser *et al.* (2010) recommend that the reader should

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consider whether these aspects are appropriate to answer the research questions, considering the various instruments, strengths and limitations.

An in depth individual interview was used to collect data. This was a one-to-one interview between the researcher and the participants. The interviews were conducted in the privacy of their own homes at their convenient time. The language used was the participants' own language, Tshivenda. An audiotape was used to record interviews and data was later transcribed verbatim for analysis purposes (Appendix 8 on pg. 75). The interview was directed by the following two broad questions which was followed by probing.

- *Please tell me the story of your emotional experiences to IUFD*
- *Kindly share with me your experiences of the care you recieved from health professionals before labour, during delivery and after delivery.*

These broad questions made it possible for the researcher to get a better understanding of the emotional experiences to the loss and care they received from health professionals before labour, during delivery and after delivery as narrated by women who had IUFD.

The researcher was equipped with interviewing, listening and communication skills, listened attentively while observing the non-verbal cues, perceived the body movements, facial expression, fidgeting and the quality of the tone of the voice, and identified information about participants' experiences, by probing, clarifying, and linking information. The information given were summarised to the participant in the participants' own words to clarify what was being said, and to be clarified on statements that were un-understandable to avoid assumptions. The researcher was respectful, calm, relaxed and as natural as possible towards the participants, keeping the purpose of the study to remain on track.

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3.7 DATA ANALYSIS

Data analysis means categorising, ordering, using data and describing them in meaningful terms, Brink (2012). The aim of analysing data is to sort data obtained during data collection and organising it in a manner that themes and sub-themes that surface from the data are able to address the research problem. Simlarly, Data analysis should be clarified, including discussions and explanations in statistical terms, Fraser *et al.* (2010).

Data analysis adopted Tesch's eight steps of data analysis, Creswell (2010) as follws:

- Sense of the whole made: All transcripts were read through and notes were taken as ideas came to mind.
- Document picked: The shortest document was selected from the transcribed interviews, and this was done for several participants, thereafter, transcripts were read to find the underlying meaning.
- Topics listed: After completing step 2, a list of all topics was put together, then topics were divided into columns of major topics, unique topics and left- overs (cannot be grouped).
- Back to Data: From the list of topics, each topic was assigned an abbreviated and identifiable code. Then from the abbreviated list of topics and wrote data segments next to that code.
- Topics described: From the topics, the most descriptive words were found and turned into themes or categories. Topics that related together were grouped together thus reducing the list of themes.
- Categories abbreviated: The abbreviations were finalised for each category and alphabetised the codes.
- Data assembled: Data was assembled according to each theme in one place, a preliminary analysis was done using a cut and paste method.
- Data recorded: Here the data was then interpreted, reported and recorded the research findings into tables covering each theme, category and sub-category.

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3.8 MEASURES TO ENSURE TRUSTWORTHINESS

According to Polit and Beck (2010) trustworthiness of a research study is important to evaluating its worth. It refers to a degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, Confirmability and authenticity. Brink (2012) also defined trustworthiness as the employment of procedures to ensure accuracy of findings.

Measures to ensure trustworthiness were considered through credibility; transferability, confofirmability and dependability. Each is discussed below.

3.8.1 Credibility (Truth Value)

Patton (2005) indicate that credibility depends less on sample size than on the richness of the information gathered as well as on analytical abilities of the researcher. Brink (2012) indicates credibility as the confidence in truth of the data and the interpretation thereof.

Credibility was ensured by using the following: Investing sufficient time during data collection to have a detailed understanding of the situation under study, thereby increasing reliability. Time spent with each participant was about an hour during data collection.

Rapport with the participants was developed, an appointment was set telephonically and full information was given to participants about the study.

The researcher observed participants as they were being interviewed, observing elements relevant to the problem, issues such as the mood, grooming and gestures. After interviews were conducted, the researcher summarised what the participants said to ensure that information captured by the researcher is exactly what the participants desired to share.

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3.8.2 Transferability (Applicability)

Transferability refers to the ability to apply the findings on other context or other participants (Brink, 2012). The findings of the study will only be transferable if a similar study is done in a population whose geographical background and characteristics are the same as the population studied. The researcher cannot specify the transferability of the findings, s/he can only provide sufficient information that can be used by the reader to determine whether the findings are applicable to the new situation.

The study ensured transferability by appropriately describing the background information of participants. The context and setting were described to allow others to assess how transferable the findings are. A non-random, purposive sampling was chosen to select participants who fit the described criteria.

3.8.3 Confirmability (Neutrality)

Confirmability refers to the degree to which the findings are a function solely of the participants and conditions of research, not biases, motivations and perspectives. It refers to the degree to which the researcher could demonstrate the neutrality of the research interpretations through a confirmability audit. This is achieved by providing an audit trail consisting of raw data, analysis notes, reconstruction and synthesis products, process notes, personal notes and preliminary developmental information (Brink, 2012).

To ensure confirmability or neutrality the findings are a function solely of the participants and conditions of research, not biases, motivations and perspectives by presenting raw data, analysis notes, personal notes and preliminary developmental information. Confirmability was ensured by playing the recorded interviews to verify what the participants have said.

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3.8.4 Dependability (Consistency)

Brink (2012) commented that dependability refers to provision of evidence such that if the study were to be repeated with similar participants in similar context, its findings will be similar. Creswell (2010) state that qualitative reliability should be consistent throughout different researchers and projects.

Dependability was confirmed by allowing a cross-checking of codes, known as intercoder agreement by other researchers, to see if other researchers coded the same as the researcher. Field notes and audio recorder were preserved.

3.9 ETHICAL CONSIDERATIONS

Ethics are a set of moral principles which are suggested by an individual or group (De Vos *et al.*, 2011); (Kotze, 2008) describes ethics as a good action with an attached sense of excellence. The research's ethical implications are considered, with discussions of how dilemmas were resolved. Obtaining ethical approval is reported and the possibility of harm to the participant is discussed, including physical or emotional trauma or lowered self-esteem.

Ethical clearance was obtained from University of Venda Research Ethics Committee (Appendix 2 on pg. 67). Permission to conduct research was granted by Limpopo Provincial Department of Health and Vhembe District Department of Health (Appendix 3 and 4 on pgs. 68 and 69) respectively. The participants' privacy, anonymity, confidentiality and informed consent were ensured.

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3.9.1 Informed Consent

Informed consent is an agreement by a prospective subject to participate voluntarily in a study after the participant has assimilated information about the study (Burns & Grove, 2012); (Meyer *et al.,* 2011) and the participants understand the aims, objectives, data collection methods, duration and participation needed from them.

Informed consent was obtained after participantst were given full information (Appendix 6 on pg. 72) about the study and signed a consent form refer to sample of the consent form (Appendix 7 on pg. 73). Their particulars were drawn from the hospital records with permission from the hospital authorities as well as from the Department of health at District and provincial level, and University of Venda Research Ethics Committee. Participants gave consent upon their own free will without coercion, harassment, manipulation or any form of remuneration.

3.9.2 Privacy

Burns and Grove (2012) define privacy as the freedom of the participant to determine the time, circumstances and extent to which private information will be shared.

Participants' attitudes, opinions, beliefs, medical records and identity were not being shared with people who were not involved with the research project. Information was kept away from any intruder or unauthorised persons, and all interviews were done in privacy in their own homes and upon the participants' own free will, in their own language and without intimidation from fellow family or community members. Participants were also assured that whatever they said would never be used against them or to embarrass them. It was explained why an audio recorder was used and why field notes were taken.

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3.9.3 Anonymity and Confidentiality

Burns and Grove (2012) define confidentiality as the management of private data in research in such a way that only the researcher knows the subject's identities and could link them with their responses. According to Meyer *et al.* (2011) confidentiality means that the information obtained through the research should not be made available to other people.

Information which was gathered was not shared with anyone outside the research team, such as close friends, family members or any other unauthorised persons. When reporting the collected data, no names or identities of the participants were included, coding and psuedonyms were used while names of participants were kept safe.

Institutions are not identifiable or linked by participants' response, where a participant named an institution, seven questions marks (???????) were used to protect the name of the institution. Data were kept privately in such a way that only the researcher was able to access and link participants' response with the names of the institution.

3.10 RISKS

Meyer *et al.* (2011) comment that in all research projects, the possible benefits of the research must be weighed against the possible risks and harm that may result from the research. Risks may include physical, emotional and economical risks.

No risks were anticipated towards participants and the research initially. The risk of a relapse was strictly monitored and controlled, the researcher is a trained psychiatric nurse able to recognise signs of a relapse and intervene accordingly and appropriately in case of a relapse or unpleasant circumstances.

Contact was maintained to find out how the women were coping up to three months after the interviews, with positive results. Counselling skills were

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used to help the women through telephonic conversations and all the women reported that they were fine. Participants were interviewed from three months after the loss, because by then most of the women have adapted to their own coping threshold.

3.11 SUMMARY

The chapter describes the study research methodolgy, were the qualitative explorative, descriptive and contextual design was detailed.

The study setting, population, sampling and sample, data collection, analysis, measures to ensure trustworthiness and ethical measures were discussed in detail.

The next chapter discusses sample description, discussion of research findings and interpretation of the results by using tables to highlight the themes, categories and sub-categories.

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CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The chapter gives detailed information of the findings obtained from collected and analysed data on the emotional experiences of women who had IUFD to the loss and care they received from the health care professionals in Vhembe District of Limpopo Province of South Africa. The sample description, identified themes, categories and sub-categories emerged during the interviews and are presented in this chapter in detail.

4.2. SAMPLE DESCRIPTION

The sample, as described under the research design in chapter 3, consisted of women who had intra–uterine fetal deaths from different hospitals in the Vhembe District, and a sample size dependant on data saturation. Ten (10) women were recruited for interviews, whose ages ranged between 18 to 42 years, had IUFD during the year from January 2015 to December 2015. Eight conseted and participated in the study. Two women declined. At the time the IUFD occurred, three women were pregnant for the first time (primiparous) and five were women who had already delivered previously (multiparous).

4.3 DISCUSSION OF RESEARCH FINDINGS

Data was analysed using Tesch's eight steps of data analysis (in Creswell, 2010). Three themes were identified from the analysed data, namely, experiences before labour, experiences during labour and experiences after

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delivery. Presentation of the data is done according to themes and discussed separately.

4.3.1 THEME 1: EMOTIONAL EXPERIENCES BEFORE LABOUR

Table 2 indicate the theme, category and sub-category

Table 2: Theme 1: Emotional experiences before labour

Theme	Category	Sub – category
Emotional experiences before labour	Forewarning	-Stillness -No Fetal movements -Feeling nothing for four days -Reduced fetal movements -Painful umbilicus
	Communicated with the baby	-Ate food -Drank plenty of water -Nudged and turned from side to side -Isolated
	Curbed their worries	-Baby is turning -Baby is just tired -Baby is big
	Protected self and loved ones	-They are not serious -Requested more time -Did not tell relatives
	Professional diagnosis	-Abrupt -Silence -All talking to each other
	Emotional	-Devastated -Hurt -Anxious -Distressed

DISCUSSION

The analysed data revealed that participants expressed a lot and varied experiences before labour. This theme emerged from data indicating that all women had a signal about the death of a baby before labour, secondly emotionally they experienced loss. The following are the categories identified from the theme: Forewarning, communicated with the baby, curbed their worries, and protected self and loved ones, Professional diagnosis and emotional response. Following is the discussion of each category.

Forewarning

All women in this study, before receiving the news that their baby was in danger in utero, experienced a forewarning such stillness, no fetal movements, painful imbilicus, just turned over and feeling nothing the whole day. Following quotes depict how participants experienced forewarning.

"...I used to wake up at night because the baby moved, but I slept all that night and woke early and the first thing I felt was the stillness in my stomach...

"...I did not feel anything at the time, by month end August I started to feel that there were no fetal movements..."

"...my umbilicus was painful....my baby was still... "

"When I wokeup in the morning I felt no movements... he just turned over to my other side of my stomach..."

"... I spent the whole day alone trying to feel that there were indeed no any movements, of which I felt nothing, but I knew that when I went to the clinic because I had a problem that I did not feel the baby kicks like the other days, and at the clinic they did tell me that they could not hear anything..."

A woman's own understanding of the pattern of movement is one method

used to identify an unborn baby at risk. In (5% - 10%) of all pregnancies there is decreased fetal movement. These babies are at risk of illness or death (Froen, Tveit, Saastad and Bordahl, 2008). Similarly, Trulsson and Radestad (2014) agrees that (50%) of women whose babies died in utero had recognised gradually decrease of fetal movements.

In a follow-up of 314 women 3 years after IUFD, (23%) said they had had a "very strong" feeling that the baby was dead before the professional diagnosis was made (Malm, Lindgren & Radestad, 2011). Similarly, Ezechi, Kalu and Nwokoro (2011), indicate that in diagnosing IUFD, signs and symptoms of pregnancy subside. Diagnosis is based on the absence of fetal heart tones, lack of uterine growth or ultrasound studies during prenatal examinations. In later stages of pregnancy, a woman may be aware of changes in the fetal movement (kicks) or that the movements have ceased.

Communicated with the baby

This study revealed that the feeling of motionlessness in the stomach and lack of kicks from the baby when a woman was expecting movements were perceived as unusual behaviour. Therefore, women actively sought contact with the baby by attempting different means of communication in a form of eating food, drank cold water, moved side to side in bed, isolating themselves to have time with the baby and took a bath to establish contact, but no response came from the baby. Their attempts are depicted by the following quotes.

"...I then ate food thinking that my baby will move as usual..."

"..... drank plenty of water...they had said I should drink cold water, still the baby never responded"

"..... nudged and turned from side to side, still there was no response, and there always used to be a movement..."

"I woke up in the morning and I couldn't feel the fetal movements, I went to

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the Tshitanga (outside hut used as a kitchen) and stayed there until late, then I went to wash myself, still I could not feel any movements..."

In Norway, a study found that approximately half the women who had IUFD had waited 24 hrs or more and a third of the women waited more than 48 hours without feeling baby movements and kicks before they contacted the healthcare services (Holm Tveit, Saastad, Stray-Pedersen, Bordahl, Flenady & Frets, 2009).

Curbed their worries

This study found that women normalised the lack of babies' movement by curbing their worry for their babies. They developed their own explanation such as the baby is turning, the baby is tired, and there is not much space to move around. They thought the baby was safe. Their thoughts are encapsulated in the following verbatim responses:

"I thought that maybe the baby was just turning, I ended up just staying but there were no more pains...."

"...On arriving at the clinic they checked me, and the nurse told me she couldn't feel anything, I told myself that the baby is just tired..."

"... I thought since it was too big, there was no enough space to move and it has settled into a correct position nothing is wrong..."

Despite contradictious evidence concerning normal fetal movements during the third trimester Myles textbook for midwives (2015) states that fetal movement normally decreases from gestational week 32 based on decreased space in the uterus, and women should be advised that this is the case. The possibility that the women in this study had been advised that the baby would move less towards the end of the pregnancy and also that it had been difficult for them to distinguish decreased movement from lack of movement cannot be ruled out.

Protected self and loved ones

Although women in this study became increasingly worried that something serious might have happened to this baby, they distanced themselves from the worst scenario- that the baby had died. They tried to protect themselves and their loved ones from the insight that their baby's life was in danger by thinking the health professionals were not serious, requesting more time and not telling relatives. This is substantiated by the following responses:

"...When they first told me that my baby is dead, I thought they were not serious... , but it did pain me because I was unable to phone my mother, I was unable to tell her on the phone, she was told by the nurses, because I did not know how to tell her and I was crying unable to talk..."

"...I told the doctor that before he could do anything, he must give me the whole day so that I could be sure that there is no longer any kicks, the doctor agreed and I spent the whole day trying to feel that there were indeed no any movements, of which I felt nothing..."

"...I didn't tell my relatives anything, it was my own secret. It was painful, but not yet time, I held on, just walking around without telling anyone...."

The loss of a baby is the most devastating of all losses (Bowlby, 1988) the emotional coping patterns of the women in this study can be explained as a reaction to the threat of a forthcoming traumatic event (Kleber & Brom, 1992).

Health professional diagnosis

Research findings indicated that the first professional signs that 'things have gone wrong' occurred during ultrasound scan. Some woman related how health care professionals were abrupt in manner when informing them that their baby had died. Participants said:

"...I went for my 28-week scan and the doctor mumbled something and

walked out of the room. I didn't know what he said so I asked the nurse, and she said 'your baby is dead...".

Similarly, Simmons, Singh, Maconochie, Doyle and Green (2016) reported that blunt disclosures from medical personnel during routine ultrasound scans, as well as lack of sympathy and compassion from professionals.

Futhermore, during the study women reported that verbal communication with the staff ceased during the examination, but that body language of staff showed that something was wrong with the fetus. Following quotes depict how participants experienced the non verbal languge of health professionals.

"...they didn't say anything. Everybody was totally silent, and I asked, 'What's going on, what's happening?' They didn't say anything so I thought it could be serious, and they were all talking to each other but not to me. Obviously if you're lying there and you're having a baby and they don't tell you anything, then you imagine all kinds of things..."

".....At the examination room the nurses there were communicating with each other without involving me in the discussion."

"...The silence worried me, it would have been better if the nurses at the clinic had talked during the examination, explaining what they saw or what was puzzling them, I was supposed to have been told at the clinic that the baby is dead."

Other studies (Malacrida, 1999) have reported blunt disclosures from medical staff during routine ultrasound scans, as well as lack of sympathy and compassion from professionals (Simmons *et al*, 2016). It is apparent that training for medical personnel in the emotional and caring aspect of 'breaking bad news' during routine scans needs to be re-examined. While advances in ultrasound imaging have advantages for women, providing early indications of abnormality, the ultrasound scan is, paradoxically, the most explicit example of the way in which the body is rendered an object of

specialist knowledge and inspection. The image that explains the medical status of the event also manifests the total objectification of women's personal experience.

Emotional Response

The findings have shown that women placed emotion at the center of their meanings which provides a powerful indicator of how they have constructed their emotional experiences. Their emotions involved devastation, self-blame, and anxiety. This is substantiated by the following responses:

"When they showed me there was no heartbeat I was devastated... It was like some-one had ripped out my heart, my heart broke and it's never gone back right."

"I couldn't believe it, I felt angry, but the anger was directed at myself thinking I had done something wrong, that maybe there must have been something that I had done for this to happen."

"... I felt uncontrolled anxiety after the doctor told me of my baby's death."

" ... I felt very distressed, as if my heart was ripped apart."

These descriptions are consistent with Hassan *et al.* (2013)'s affirmations that all types of pregnancy loss lead to strong emotional responses and psychological complications, although the responses vary, they are more intense following later losses or recurrent losses. Any pregnancy loss leads to a substantial grief reaction with a wide variety of emotions, including sadness, feelings of blame, resentment and confusion. Similarly, Gausia *et al.* (2011) when argued that women who lost their unborn babies were often profoundly sad, cried and yearned for their lost child. While, Malm *et al.* (2011) found that (8%) stated they were sad, hurt, or angry about the way they had been informed of the diagnosis. Health professionals need more data to understand to what extent dissatisfaction can be prevented, for

example, by being alert when examining the child's vital status and by continuously giving unambiguous information about their actions and findings. Sensing that one's baby may be dead and receiving the diagnosis are, in themselves, highly distressful; it stands to reason that these women are extremely vulnerable.

On the other hand, Ney (2012)'s research confirmes the presence of symptoms typical of both severe and sustained unhappiness in women who have encountered an IUFD, which are: emotional reactions, inability to function in daily routine, depression, anxiety, loss of appetite, feelings of guilt, anger and sense of failure, suicidal thoughts, somatic complaints, sleep disturbances, loss of energy, psychosomatic complaints, and social difficulties.

4.3.2 THEME 2: EXPERIENCES DURING LABOUR

Table 3 below present the theme, category and sub-category

Table 3: Theme 2: Experiences during delivery

Theme	Category	Sub Category
Experiences during delivery	Marginalised	-Delivery not acknowledged -Gave birth on the floor -Delivered on a sofa, door openned -Being ignored
	Acknowledged	-Accepted in the sorrowness -Sympathised with me

DISCUSSION

The analysed data indicated how women experienced the care from health professional during giving birth. Two categories emerged from the data, namely, marginalised and acknowledged. Each category is discussed below.

Marginalised and Negativity

Although health professionals cannot be expected to understand the needs of bereaved women unless they are equipped with relevant knowledge and skills, study participants argue that communication between health professionals and women is equally important, and professional staff need to listen to the concerns of the woman. Marginalisation and negativity actions during professional encounters emerged from women's narratives:

"...my baby was not cleaned or dressed... my baby's body was treated differently from other deceased persons... I felt that the nature and extent of my grief had not been recognized, and that the trauma incurred through my experience had not been acknowledged".

"...I had severe pains then another patient called a nurse on my behalf and the nurse said i should go where nurses are." She cried for about 3 minutes. *"It was difficult for me to walk since I had a drip, and a urine catheter..., when I arrived there the nurse told me she is still helping another patient ... I gave birth on the floor, ...and my baby was picked up by a linen... I was not treated like other patients who were to give birth to alive babies..."*

"...I went to the nurse to be checked, after checking me she said something talking to another nurse, I could not hear what she said and they then told me to go back to my bed, I told them that I couldn't, I was unable to go back there... They told me to sit on the sofa. The pain became worse, I felt something on my waist and finally I delivered right there on the sofa... the door was open..."

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"...I had this deep down feeling that something was wrong, all the time I asked I was being ignored... the outcome could have been not so tragic that I'm still angry at the hospital..."

These experiences not only reveal a failure by health professionals to convey reassurance, they also overlook, and so fail to acknowledge, emotional aspects of the loss. In the interaction between professional and patient, the patient often has difficulty making the voice of the life-world heard, because it is the professional who dominates the interaction (Hydén, 2012). Similarly, Layder (2016) points out that a professional is able to define a patient's state of health in terms of a body of medical knowledge based on scientific evidence. The patient, on the other hand, usually has to take the professional's word for it, accept advice, and comply with instructions. Greenhalgh and Hurwitz (2016) suggest that the core clinical skills of listening, questioning, explaining, and interpreting may provide a way of mediating between the very different linguistic and imaginative worlds of patients and health professionals.

On the otherhand, Hakosalo (2013) claims that power techniques are used to make the body docile so that it can be subjected, used, transformed, and improved. Through this perspective, the woman who has suffered a pregnancy loss is a 'blip' on the production line. Her medical and personal needs become invisible, since there is no place for her, or her lost baby, in the rationalized processes of production to which medicine is now subordinated.

Acknowledged

Some women expressed that they had been acknowledged, supported and accepted in their sorrow by the health care professionals. These women felt that the midwives were standing by them, they were suitably attentive during the delivery, they sympathized, and that the women were received in a warm and caring fashion as individuals. Participants said:

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"...the nurses there were fantastic... they cared, they stood by me in my pain and sorrow... I was not alone in the sorrow-ness..."

"...at the hospital I was admitted, the nurses treated me so well there, checking me daily. My bed was next to the nurse' station and they used to come and speak with me and I was not allowed to have my cellphone as they said it could aggravate my condition if I could happen to receive bad news."

"I was treated fairly when I had to choose a nurse who could assist me since I knew she felt sympathy for me as she knew my situation..."

Graham, Thompson, Estrada and Yonekura (2007) found that grieving women were further helped by the sympathy and support of the healthcare staff. Similarly, the Boots Family Trust (2013) claim that women who are suffering from losses such as in IUFD do deserve efficient and sympathetic support from health staff.

According to Cacciatore in Totten (2013), most of the women who had IUFD had grievances with how the healthcare providers handled the situation. The women needed more care, and Cacciatore in Totten (2013) explained that in addition to forming trusting relationships, is informing the woman of the procedures, pathophysiology and the psychology of what the process entails. To develop a strong, trusting relationship with the patient, the nurse should focus on the cognitive, emotional and psychomotor areas of patient centred care emphasized in psychoeducation, the woman should be helped through the physical process, by evaluating post-delivery and providing support (Temple & Smith, 2014).

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4.3.3 THEME 3: EXPERIENCES AFTER DELIVERY

Table 4 below present the themes, categories and sub-categories.

Table 4: Theme 3: Experiences after delivery

Theme	Category	Sub-Category
Experiences after delivery	Felt tortured	-Cries of babies -Left the hospital undischarged -crying day and night -Kept with women whose babies are alive -requested to be discharged -Opened wounds -lost baby and file too
	Psychologist intervention	-In-effective psychological intervention -Not refered to psychologist

DISCUSSION

Data revealed the agony some women experienced after delivery. Two themes emerged namely, felt tortured and psychological intervention. Each is discussed below.

Felt tortured

Some women recited that they felt tortured in staying at the hospital hearing the cries of newborn babies, kept with women who had babies, unable to bear the trauma and wounds opened. These resulted in them leaving the hospital un-discharged, requesting premature discharge and crying day

night. These feelings are encapsulated in the following verbatim narrations:

"...I requested to be discharged as soon as possible, to avoid listening to babies' cries, I could not bear the trauma...did not like it at all..."

"...I left the hospital undischarged, I couldn't stay when I could hear babies crying all over, it affected me badly..."

"...I used to cry day and night, I was unable to bear the cries of the new-borns while mine was lifeless, it did not make me feel well."

"...I was kept with women who had given birth because looking at the women nursing their babies and the babies crying was painful...I did not like that setup at all."

These descriptions are in consistent with Gold, Dalton and Schwenk (2007) when they indicate that the healthcare professionals should increase womens' choices about timing, location of delivery as well as post delivery care. Similarly, this study is consistent with the findings of a study by Ney (2012) who claimed that women develop social difficulties, induced separation, difficulty leaving the house and a continuing decrease in social contacts. In a hospital setting this will be confirmed by noticing that the women isolate themselves, are seen crying and wanted to go home.

One woman narrated her agony as follows:

"My wounds were opened when three months later when I was starting to admit the situation, the hospital phoned me and said that I have left a baby at the hospital who is supposed to be buried at home. We had signed papers for incineration. It was on a Friday afternoon, the whole weekend I was crying... waited until on a Monday, then the baby was taken and buried here at home. This experience was very cruel, my crying was renewed."

Another one expressed how she felt when she went for followup care:

"...I felt annoyed and disturbed ...I lost the baby and the file too...I went back

to (hospital) *on the 12th of October for an appointment, they said I should go to OPD to fetch my file, I did not get my file... I was then sent to look for my file at maternity, lucky enough I found the nurse who assisted me on my delivery and I told them to look for my file, it was never found, I opened a new one... I was told I could never be assisted without my previous notes, I told them that my file disappeared here, I never took my file home. They phoned maternity, I was told to return to maternity, I felt that I was not being treated fairly, I felt annoyed and left without assistance..."*

Psychological intervention

Some women expressed their experience of psychologist intervention. Some women indicate that the psychologist did not help and the other one reported that she did not receive psychological care at all. Participants said:

"...I was taken to the psychologist on Tuesday, but what the psychologist said to me or how I answered to him I couldn't even remember... When I came back home I found that they had buried the baby...I could not comprehend what the psychologist said or how I responded towards what was being said, the conversation had no lasting impressions since my heart was still sore..."

"...Another thing I could say is that the psychologist should at least see me after I have already finished with my family, maybe after 2 weeks after I have accepted it on my own way, because really what the psychologist said to me it did not help me in any way, that's why I did not even go back and honour my appointment..."

"The psychologist saw me on the 14th [the following day] *in the morning, I was given a date to come back, I was not happy with what I was being asked because it was not the things that could heal me."*

"I saw the psychologist only once, and what he told me did not help me in any way... I did not go back."

"...I was not referred to a psychologist, I was discharged and came back

home...I believe had I recieved the psychologist intervention, I would have handled the death of my unborn baby better..."

Hughes (2007) agrees with this suggestion, in a study where fifty families were assigned randomly to their psychotherapy group and others to a comparative group, who received only the monotonous hospital attention. Evaluations were done at six and 14 months after the incident, the results showed that in the (70%) of the women who were studied, only two of 16 women in the counselled group showed mental disorders at six months, while 10 of 19 in the other group were diagnosed with the mental disorders. The duration of bereavement reaction after IUFD tends to be noticeably reduced by support and counselling, particularly for women who are childless or who have a history of major depressive disorder and have received proper management.

4.4 SUMMARY

The chapter described the sample in detail. Data was collected and analysed in a step-wise format as outlined by Tech's eight steps of data analysis. Three themes emerged from the research findings: experiences before labour; experiences during labour; experiences after delivery. Experiences before labour included forewarning, communicated with the baby, curbed their worries, and protected themselves, professional diagnosis and emotional responses. Experiences during delivery include marginalised and negativity, and acknowledged. Experiences after delivery included feeling tortured and psychological interventions.

The next chapter is the conclusion, summary of the research findings, recommendations, future research and challenges encountered by the researcher during the study.

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CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter concludes the study about the emotional experiences of women who had IUFD. The chapter includes the risks, limitations, interpretation of the research findings, recommendations and further research.

5.2 RESEARCH DESIGN AND METHOD

A qualitative research design was used to have a systematic description on the emotional experiences of the women who had IUFD. Non-probability sampling and a purposive technique was used. Eight women who had IUFD were sampled. Interviews were conducted in the privacy of their homes participants were interviewed through in depth interviews to explore their emotional experiences. They were given time to describe their lived emotional experiences until at a point of data saturation. Data was transcribed verbatim and qualitatively analysed using Tesch's method then interpreted as themes, categories and sub categories.

5.3 SUMMARY OF THE RESEARCH FINDINGS

The research study identified three themes, namely, experiences before labour, experiences during labour and experiences after labour.

5.3.1 Experiences before labour

The findings revealed that women before receiving the news that their baby was in danger in utero, experienced a forewarning such stillness, no fetal

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movements, painful imbilicus, just turned over and feeling nothing the whole day.

The feeling of motionlessness in the stomach and lack of kicks from the baby when the woman was expecting movements were perceived as unusual behaviour. As a result, women actively sought contact with the baby by attempting different means of communication in a form of eating food, drank cold water, moved side to side in bed, isolating themselves to have time with the baby and took a bath to establish contact, but no response came from the baby.

This study women normalised the lack of babies' movement by curbing their worry for their babies. They developed their own explanation such as the baby is turning, the baby is tired, and there is not much space to move around.

Although women became increasingly worried that something serious might have happened to this baby, they distanced themselves from the worst scenario that the baby had died. They tried to protect themselves and their loved ones from the insight that their baby's life was in danger by thinking the health professionals were not serious, requesting more time and not telling relatives.

Women indicated that the first professional signs that 'things have gone wrong' occurred during ultrasound scan. Health care professionals were abrupt in manner when informing them that their baby had died.

Some women placed emotion at the center of their meanings which provides a powerful indicator of how they have constructed their emotional experiences. Their emotions involved devastated, self-blame, and anxious.

5.3.2 Experiences during labour

Marginalisation and negativity actions during professional encounters emerged from several women's narratives.

During the study, very few women expressed that they had been acknowledged, supported and accepted in their sorrow by the health care professionals.

5.3.3 Experiences after delivery

Data revealed the agony some women experienced after delivery. Some women recited that they felt tortured in staying at the hospital hearing the cries of newborn babies, kept with women who had babies, unable to bear the trauma and wounds opened. These resulted in them leaving the hospital un- discharged, requesting premature discharge and crying day and night.

Some women expressed their experience of psychologist intervention. Some women indicated that the psychologist did not help and the others reported that they did not receive psychological care at all.

5.4 RECOMMENDATIONS BY THE RESEARCHER

The following recommendations are made based on the study findings.

5.4.1 Practice

- **Before labour**

The study results revealed that women before professional diagnosis, they experienced a forewarning that their baby was in danger in utero. Upon experiencing the forewarnings, they did not seek professional care, instead

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they attempted to communicate with the baby, curbed their worries, normalised the situation and protected themselves.

The possibility cannot be ruled out that the women in this study had been advised that the baby would move less towards the end of the pregnancy and it had been difficult for them to distinguish decreased movement from lack of movement.

A reccommendation is made that health professionals need to advise pregnant women during their routine check up to be on watch out for the warning signs that their un- born babies are in danger and seek professional help immediately. This supported by Lawn *et al.* (2015) when stating that IUFD is a huge and invisible problem, but actually avoidable, where managed care and enhanced information is essential.

- **During delivery**

Study women were vocal about the feeling of marginalisation and negativity actions during their encounters with the health professionals.

It is acknowledged that health professionals cannot be expected to understand the needs of bereaved women unless they are equipped with relevant knowledge and skills.

This study recommends that communication between health professionals and women be done throughout. Secondly, health professionals need to listen to the concerns of a grieving woman.

- **After delivery**

The study findings report that the psychologist intervention was not helpful during their pains and tears. This study recommends that the psychologist practioner should tailor make their interventions according to the needs of individual grieving woman. Similarly, Hughes (2007), recommend that since women are attached to their pregnancy, loss around the time of birth brings

serious suffering and pain. The anguish might last for months, and health care have sought to device practices that might help the recovery.

5.4.2 Future research

Future research is recommended on:

Investigation of the experiences of health professionals when caring for a women who has IUFD.

5.5 CHALLENGES ENCOUNTERED BY THE RESEARCHER DURING THE STUDY

The researcher experienced the following challenges:

- Initially four hospitals where intended for the research project in the Vhembe District, which ended with three hospitals giving permission to conduct the research project. In one hospital, the CEO required that the researcher submit the hard copy of the research proposal through her email address, which was not the case with the other hospitals and the researcher felt discomfort in continuing with the hospital and no further communication was done. In another hospital the research committee required that permission from the District office must be submitted even when there is permission from the provincial office and to make a presentation of the proposal to all hospital staff, it was done but other two hospitals never required the researcher to bring permission from the District office.
- Some women were difficult to follow up since they did not have stable addresses and the cellphone numbers that they supplied on admission went into voicemail or just silence. Some of the women who have had the IUFD no longer stayed in the addresses that they supplied at the time of admission, the researcher relied exclusively on

the admission book at maternity ward, when contacting them using the cellphone numbers that they supplied on admission, only to find that the woman has relocated to Johannesburg and would not return until maybe Christmas time.

- IUFD is kept a secret in most families, details such as the cellphone numbers that the women provided at the time of their admission to hospital was solely relied upon, when those numbers are wrongly typed, the information is lost and the woman could never be traced, and addresses that are given were mostly incomplete.

5.6 SUMMARY

This is the last chapter of this dissertation. It gives the summary of the research design and research findings. The reccommedations based on the findings are given, namely, practice and research. The challenges encounterd by the study researcher were also described.

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APPENDICES

Appendix 1: Language editing

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To whom it may concern.

I hereby confirm that I edited the Master's thesis of

Martha Lufuno Kharivhe

Title:

The experiences of women who had intra-uterine fetal death at Selected Hospitals in the Vhembe District of the Limpopo Province of South Africa

in January 2017

I wish this student well in their endeavours.

Catherine Hutchings

Catherine Hutchings

Appendix 2: Approval by University Research Ethics Committee

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms ML Kharivhe

Student No:
11592482

PROJECT TITLE: Experiences of women who have had intra-uterine fetal death (IUFD) at selected hospitals in the Vhembe District Limpopo Province of South Africa.

PROJECT NO: SHS/15/PDC/14/0408

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr M Maluleke	University of Venda	Supervisor
Dr NJ Ramakuela	University of Venda	Co-Supervisor
Ms ML Kharivhe	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: August 2015
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

University of Venda
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Appendix 3: Approval by the Department of Health Limpopo Province

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila 015 2936210 Ref:4/2/2

Kharivhe ML
University of Venda
Private Bag X5050
Thohoyandou
0950

Greetings,

RE: Experiences of woman who have had intra-uterine fetal death (IUFD) at selected hospitals in the Vhembe District , Limpopo Province of 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.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy 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.

Your cooperation will be highly appreciated.

Head of Department

06/11/2015
Date

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

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Appendix 4: Approval by the Department of Health Vhembe District

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
VHEMBE DISTRICT

Ref: 10/1/1/1/1
Enq: Sirwali NR
Date: 08/01/2016

To: KHARIVHE ML

SUBJECT: REQUEST FOR PERMISSION TO CONDUCT RESEARCH.

1. The above matter has reference.
2. Vhembe district hereby approves your request to conduct research in the identified Hospitals within Vhembe district.
3. Kindly note that during your stay you will be obliged to adhere to the norms and standards of the department as enshrined in those facilities or Hospitals. The conditions as set by provincial office are also endorsed.
4. District wishes you a good study in its facilities and all of the best.

.....
Acing District Executive Manager

07/01/2016
Date

Private Bag X5009 THOHOYANDOU 0950
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015)962 1001/2/3/4/5/6
Fax (015) 962 2373/ (015)9622274/ 4623.

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Appendix 5: Sample letter asking permission to conduct research

University of Venda
Private Bag x5050
Thohoyandou
0950
26 August 2015
Tel No. (015) 962 8000

Limpopo Provincial Department of Health
Private Bag x9302
Polokwane
0700
Tel (015) 516 9302

To: Head of Department

Subject: Request for permission to conduct research

I, Martha Lufuno Kharivhe am a Professional nurse working at Louis Trichardt Memorial Hospital and a Masters Degree in nursing student at University of Venda, request permission to conduct research at selected Hospital in Limpopo Province.

The title of the study is **"Experiences of women who had IUFD in Vhembe District of Limpopo Province of South Africa."**

Purpose of the Study

The purpose is to explore and to describe the experiences of women who had IUFD in Vhembe District of Limpopo Province of South Africa.

Significance of the Study

The findings could help inform discussions around programme interventions and policies to address maternal health following IUFD. The research could improve patient care of women who had IUFD.

The knowledge gained could stimulate interest to conduct further research in IUFD and also enable hospitals to identify any gaps regarding quality of life in a woman who had IUFD.

Supervisor: Dr Mary Maluleke

Co-Supervisor: Dr NJ Ramakuela

Appendix 6: Participant information sheet

Title: Experiences of women who had IUFD at selected Hospitals in Vhembe District of Limpopo Province of South Africa.

The purpose of the research study is to explore the experiences of women who had IUFD in Vhembe District of Limpopo Province of South Africa.

The objectives of this study were:

- To explore the experiences of women who had IUFD.
- To make recommendations based on the findings from women who had IUFD.

Significance of the Study

The findings could help inform discussions around programme interventions and policies to address maternal psychological health and welfare following perinatal loss. It could assist in the nursing practice by improving the lives of women who have had intrauterine death, address their turmoil, influence curriculum and lead to formulation of policies that could improve patient care.

The knowledge gained could stimulate interest to conduct further research in intrauterine death and also enable Hospitals to identify any gaps regarding quality of life in a woman who had IUFD.

What are the risks?

There are no risks anticipated towards participants and research. The researcher is a psychiatric nurse who could haveintervene appropriately in case of a relapse or unpleasant circumstances.

What are the benefits?

Proper implementation of patient care, thereby preserving the dignity in women after IUFD

Contact: Supervisor: Dr Mary Maluleke

Co-Supervisor: Dr NJ Ramakuela

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Appendix 7: Sample of Consent Form

Research Topic: "**Experiences of women who had IUFD in Vhembe District of Limpopo Province of South Africa."**

Dear Participants

The Researcher is a Masters Degree in nursing student conducting research on the experiences of women who had IUFD in Vhembe District of Limpopo Province, South Africa. The researcher requests your participation in the study. The study and its procedures have been approved by the University's Research Committee, Hospitals Research Committee, Vhembe District Department of Health and the Ethics Research Committee of the Provincial Department of Health Limpopo Province.

Your participation in the study is totally voluntary and you are free to withdraw from the study any time without experiencing any difficulties or harassments, and no remunerations will be paid for your participation. The researcher will obtain the necessary information from you as a participant through interview which will be conducted in a private place. The data will be stored in a secure place where anyone that is not connected with this research will be prohibited. The participants' identity will not be linked to the collected data as your names will not appear on the research documents or the research report.

As far as the researcher knows, there are no risks to this study. You will not benefit directly from this study, but the hospital, the communities and the government will benefit from the research findings.

.....

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I have read and understood the contents of this consent form. I understand that I am not compelled to participate in the study and that I can withdraw from the study whenever I want.

Participant Signature.....

Date.....

The researcher has explained the information that appears in the consent form to the respondent, according to their opinion, the subject understood the contents of this

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Appendix 8: Transcripts

PARTICIPANT 01 (P1)

Pseudonym: P1 - Participant 01

Researcher: R

Another Patient: P

R: "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and also a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in the Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language.

Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research.

P1: "mmm." She agreed and signed the consent form.

R: People experience different feelings, that's why we need to know how it affects you, in order to see if there is an improvement that need to be implemented, what I discover it does not mean that so and so said what, myself I write down where we are having shortfalls, what you say could help someone who could be in this same situation, leading to a change in the way that we are doing things at present, but I will not force or coerce you into talking. You may ask me if there are any questions.

P1: Exclamation: "Hai!"

R: "Hmmm. When did it happen?"

P1: She remained quiet for about 3 minutes, looking down. "It happened on the 5th of March around 8pm. I can't, I won't, you see, you went there, just like when the nurses told me to go to hospital. Hayi! I dn't like talking about it, even if I could explain, I'll be left feeling not well. Just like if I go to the clinic and I see the Nurses who helped me, or when I find that someone has lost a child, it all come back."

R: "Mmmm."

P1: "Even if I could tell you here, I will be left with a problem, I will be left feeling so painful, just like when I go to the clinic, when I arrive there and see the people who helped me on that day, it comes back, even if I could hear that somebody has lost a child, the feelings come back. That is why I do not want to spend time being alone or without anyone to speak to."

R: "Hmmm."

P1: "Since I started vomiting, I didn't feel anything."

R: "When and for how long did you start vomiting?"

P1: "It was only on that day."

R: "Mmmm."

P1: "I went to the clinic, there the nurses checked me, and told me that they couldn't feel the heartbeat. They called an ambulance which took me to the hospital, at the hospital I was taken to the sonar where the doctor told me he couldn't see the baby's heartbeat. I was then given medication. The doctor called me and told me he will insert a pill per vaginal, then later on I started feeling contractions. Then it was time for the visitors, I didn't tell my relatives anything, it was my own secret. It was painful, but not yet time, I held on, just walking around without telling anyone, then later on I asked another patient to call a nurse for me. I felt I should tell those at home, but I couldn't, I just kept it a secret. I was feeling slight pains, I didn't tell anyone, I just held on until I asked for a nurse."

R: "Mmmm."

P1: "I had severe pains then another patient called a nurse on my behalf and the nurse said I should go where the nurses are." she cried for about 3 minutes. "It was difficult for me to walk since I was inserted a drip, and a urine catheter, I went, when I arrived there the nurse told me she was still helping another patient who was going to theatre, I replied that because my baby is no longer alive I'm not supposed to be given a bed (to deliver on)." I gave birth on the floor, my baby was not cleaned or dressed, and my baby was picked up by a linen, my baby's body was treated differently from other deceased persons. I felt that the nature and extent of my grief had not been recognized, and that the trauma incurred through my experience had not been acknowledged. I was not treated like other patients who were to give birth to alive babies. I will never forget that nurse. I told her that she had hurt me. It shows that she is not at peace, I realise that there could be many who have been treated in this way. Maybe they (nurses) are forced because there are no other places of employment.

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P1: "I then went to sleep. During visitors' time, my mother in law and relatives came and everything was explained to them about the proceedings. They took the baby for burial. I was still at the hospital for the monitoring of Bp as it was still elevated."

R: "Where you taken to the psychologist?"

P1: "Yes, I could not comprehend what the psychologist said or how I responded towards what was being said, the conversation had no lasting impressions since my heart was still sore."

R: "So when where you discharged?"

P1: "I was discharged the following day after I was seen by the doctor who told me to follow up at the clinic for the hypertensives. I am still doing my follow ups at the clinic."

R: "Do you have any other illnesses that you take medications except for the Hypertensives?"

P1: "No, I do not have other illnesses."

R: "Where are you working?"

P1: "I am unemployed."

R: "What standard did you pass at school?"

P1: "I passed standard 7."

R: "Do you have anything else that you could tell me that could improve in our hospitals in the treatment of the women who have gone through what you went through?"

P1: "Nurses should have sympathy, because it hurts if even though the baby is no longer alive, it shouldn't be handled that way, it is not right."

R: "I understand however that do not refrain from taking care of your health. I am very pleased with the time that you have given me and for you to tell

me your experiences, this will help when other women who have also went through your situation, to improve in their care. Farewell."

P1: "Farewell." End of Interview.

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PARTICIPANT 02 (P2)

Pseudonym: P2 - Participant 02

Researcher: R

R: "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and also a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language."

P2: "Mmmm."

R: "Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research."

P2: "Mmmm." She agreed and signed the consent form.

P2: "I did not have any problems, I was treated well by the nurses including those at the ??????? clinic, they know that I could shout them, even when I arrive they would say that that woman who shouts is here."

R: "Ok, explain to me what happened when you first heard the news that the baby's heart beat is not heard."

P2: "The nurses checked me and thereafter they called an ambulance to take me to ???????. On arrival I was taken to a sonar machine by the doctor, who then said he could not see anything, When the doctor showed me that there was no heartbeat I was devastated, it was like someone had ripped out my heart, my heart broke and it's never gone back right. I told the doctor that before he could do anything, he must give me the whole day so that I could be sure that there is no longer any kicks, the doctor agreed and I spent the whole day trying to feel that there were indeed no any movements, of which I felt nothing, but I knew that when I went to the clinic because I had a problem that night, I did not feel the baby kicks like the other days, I just turned over to my other side of my stomach, I turned from side to side, still there was no response, and there always used to be a movement. When I woke up in the morning I felt no movements, I then ate food thinking that my baby will move as usual and I also drank plenty of water, at the clinic they had said I should drink cold water if I did not feel anything, but still the baby never responded. I then went to the clinic, they checked me and told me that they could not hear anything, that's' why they called an ambulance to take me to the hospital. I was then given medication the following day, which was given to me hourly, and I was also being monitored even by the student nurses, and I was also given food. Myself there is nothing I could complain about."

R: "When you reflect upon the whole things that happened, and as you say you have been treated well, what, according to you, could you say for other women who could find themselves in the situation that you have been through, what could make them to recover well and appreciate the care that they receive?"

P2: "According to me, it was when I was well received, and heard, even heard when I told the doctor not to do anything, but to leave me for a day."

R: "Where do you work?

P2: "I work at a white man's farm picking *naartjies.*

R: "Is there anything that you could think of as being the cause of this demise?"

P2: "No, because I stopped working when I was 5 months pregnant before anybody could notice that I was pregnant, avoiding my work which required bending and stretching all the time."

R: "Thank you for the time that you gave me to hear your story and all your experiences. Farewell."

P2: "Farewell."

End of Interview.

PARTICIPANT 03 (P3)

Pseudonym: P3 – Participant 03

Researcher: R

R: "Aa!" Greetings

P3: "Aa!" Greetings

R: "How are you."

P3: "I am fine and how are you."

R: "I am also fine."

R: "Are you vho-P3?"

P3: "Yes, that's' me."

R: "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and also a student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, unknowingly. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language."

P3: "Mmmm."

R: "Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research."

P3: She agreed and signed the consent form. "Since when I was just 3 months pregnant I attended antenatal clinic and things were going well until when I was around 8 months pregnant when I went for check- up, on arrival they found that my Bp was elevated, and there they inserted me a drip and a catheter, and an ambulance was called for me to take me to hospital. At the ???????hospital I was admitted. The nurses treated me so well there, checking me daily, my bed was next to the nurse' station and they used to come and speak to me and I was also given food without salt, and I was not allowed to have my cellphone as they said it could aggravate my condition if I could happen to receive bad news. The nurses there were fantastic, they cared, they stood by me in my pain and sorrow, I was not alone in the sorrow-ness. I was then discharged after a week with a return date for Tuesday. When I went back on Tuesday still I was told that I had an elevated Bp and I was told that I am being admitted again. Around those days when I was being checked, I was told by the nurses that they could not feel my baby's heart rate, it was on a Friday. I stayed there the whole weekend until I was checked again on Monday by the doctor, the doctor mumbled something and walked out of the room. I didn't know what he said so I asked the nurse, and she said "your baby is dead".

R:"How did you feel?"

P3: "I felt very distressed, as if my heart was ripped apart." She paused for about one minute. "I was then given medication to start contractions. During that night I felt pains, when I was checked I was told that there is not yet dilatation and I told them that it is better that they take me for caesarean section if there is no dilatation. I was then inserted a pill per vaginal, it then happened that I delivered. I was listened to when I asked to be assisted by the nurse whom I have asked not to go, and she did wait for

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me until I delivered and it was already very late for her, she then knocked off afterwards. She treated me very well."

R: "So the following day did you go home?"

P3: "No, I was told that they are still monitoring my Bp."

R: "Where you taken to the psychologist?"

P3: "Yes, I was taken to the psychologist on Tuesday, but what the psychologist said to me or how I answered to him I couldn't even remember. When I came back home I found that they had buried the baby."

R: "Tell me, in your opinion, what could you say to me, that could make you to think that all went well, or things that you think might need improvement in the care that might leave a woman to say that she has been treated fairly."

P3: "I felt that I was treated fairly when I had to choose a nurse who could assist me since I knew she felt sympathy for me as she knew my situation. Another thing I could say is that the psychologist should at least see me after I have already finished with my family, maybe after two weeks after I have accepted it on my own way, because really what the psychologist said to me it did not help me in any way, that's why I did not even go back and honour my appointment."

R: "So your Bp was it able to get under control?"

P3: "I did not go back to the clinic, I couldn't because everytime I went there I'm told my Bp is still elevated, until I just stopped going back to the clinic."

R: "It is not okay that you should stop your check –ups. If you are feeling unwell, go to the clinic, so, do you have any plans of having another baby?"

P3: "Not now, I'm still taking some time."

R: "Who do you stay with?"

P3: "I stay with my husband and my mother in law."

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R: "And your schooling, are you finished?"

P3: "Yes, I have passed grade 12, I was at FET in Thohoyandou."

R: "And now?"

P3: "Presently I have stopped."

R: "I advise you to finish your school, so that tomorrow you find yourself better empowered."

P3: "Yes, I will."

R: "Thank you for the time you have given me for this interview, farewell

P3: "Farewell."

End of interview.

PARTICIPANT 04 (P4)

Pseudonym: P4 – Participant 04

Researcher: R

We met at the gate.

R: "Aa!" curtsying. Greetings

P4: "Aa!" curtsying. Greetings to you too

R: "How are you?"

P4: "I am fine and how are you?"

R: "I am also fine. Are you vho-P4?"

P4: "Yes, I am."

R: She took me inside her house, iron roofed looks big, and she ushered me into the dining room. We sat in sofas, she sat on the other sofa next to me. "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your

own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language."

P4: "Mmmm."

R: "Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research.".

P4: She agreed and signed the consent form. "Yes, I used to feel pains ever since I was 7 months pregnant and going to the clinic for antenatal follow ups. When I was 9 months pregnant, on a Thursday, I felt nothing, no pains, no movements. I then went to the clinic. When I arrived I was checked by the nurse, who then said that maybe their machines are not working well, she called another nurse, and she also said that she couldn't feel anything.

P4: They called an ambulance to take me to the hospital and there I was admitted. They checked me on the sonar machine, then the doctor said that he could not see the heart rate on the sonar machine.

R: "How did that make you feel?"

P4: "I couldn't believe it, I felt angry, but the anger was directed at myself thinking I had done something wrong, that maybe there must have been something that I had done for this to happen."

He then told me that I would be given a pill the following day."

R: "Was the pill diluted in the bottle?"

P4: "Yes, it was a pill diluted in a bottle, I was able to go and take the medication every hour, then around 4.am I went to the nurse to be checked, and after checking me they didn't say anything. Everybody was totally silent, and I asked, 'what's going on, what's happening? They didn't say anything,

so I thought it could be serious. The nurses were talking to each other but not to me, I could not know what they said and they then told me to go back to my bed, obviously if you are lying there and you're having a baby and they don't tell you anything, you imagine all kinds of things, I told them that I couldn't, I was unable to go back there. They told me to sit on the sofa. The pain became worse, I felt something on my waist and finally I delivered right there on the sofa."

R: "Was there any privacy?

P4: She cried. "No, the door was open, a certain woman and her daughter were coming through."

R: "Mmmm."

P4: "I had this deep down feeling that something was wrong, all the time I asked I was being ignored... the outcome could have been not so tragic that I'm still angry at the hospital. They came and took the baby, they asked if I could see the baby and I replied yes, I saw the baby and they then took the baby away. I waited for my relatives to come so they could do funeral arrangements, the baby was buried but I was told to wait until Tuesday since on Monday it was a holiday. I was then discharged on Tuesday."

R: "When you were discharged were you seen by the psychologist?"

P4: "No, I did not see a psychologist."

R: "Up till today?"

P4: "Yes, I did not see a psychologist."

R: "For you to be able to accept your loss, how was that possible?"

P4: "There is a woman that I attend church with, she is the one who used to sympathise with me here at home."

R: "Would you be able to see a psychologist if I could make arrangements?"

P4: "No, up to now, I am okay, I do not have a problem."

R: "Are you working?"

P4: "Yes, I work at a crèche."

R: "Which standard did you pass at school?"

P4: "I passed standard 9."

R: "Which age of children do you work with at crèche?"

P4: "I work with children who are 2 to 5 years."

R: "Are you able to work well with children?"

P4: "Yes, I prefer working with these very little ones, I like it when I am able to hold them."

R: "Could you, in your opinion, tell me anything that could improve the quality of patient care that we give to women who have gone through what you went through?"

P4: "I feel that nurses should explain explicitly things that concern me, because if she could just say something which leaves me not understanding what she (the nurse) has said, I end up not knowing what is happening."

R: "Mhhm, in other words, you are saying that if nurses are able to explain everything in a way that a woman could understand, could leave a woman feeling that she has been treated fairly."

P4: "Yes, because if they talk about me and I'm left not knowing what they are saying, I'm left feeling not justly treated."

R: "Vho-P4, thank you for the time that we have spent together, and you being able to tell me your experiences, and I also thank you for welcoming me. What you have told me is of much importance, and will help others who might find themselves in the same situation. Farewell. If there is anything that you would like to know, you have my numbers, do not hesitate to call me."

P4: "Farewell." End of interview.

PARTICIPANT 05 (P5)

Pseudonym: P5 – Participant 05

Researcher: R

R: "Aa, Good morning." (Speaking to her mom)

Her mother: "Good morning to you too!"

R: "My name is professional nurse Kharivhe Lufuno, I work at Louis Trichardt Memorial Hospital, and a Masters Degree student at University of Venda. I am doing research. I have come to P5 concerning a research that I am doing, me and P5 will talk in privacy, what we talk about is never supposed to be known by any other person, " smiling", if it was a sunny day I was going to sit down with her under a tree."

Her mother: "It is fine, sit with her here in the dining room, I will go to the bedroom."

R: "Ok, P5 how are you?"

P5: "I am fine."

R: "Since you have heard me identifying myself to your mother, are you allowing me to ask you questions? I have an audio recorder which will record everything that we will be talking about here, if ever there is something which you will not want to be recorded, tell me to stop the recording, but everything that we will talk about here will never be disclosed to anyone, it is between the two of us".

P5: "Yes"

R: "I am researching about women who came to hospital and gave birth to a child who did not survive, however the woman knew that she will give birth

to a dead baby, since the woman was told at the clinic that the fetal heart is not heard, and was sent for further management at the hospital and the doctors confirmed that after they have done some investigations."

P5: "Yes, that is what happened in my case."

R: "Please sign here for me, this is to let us know that you have allowed me to do this research, and that everything that we have said is between us, no one else who is not part of this research will know."

P5: (she signs)

R: "So, I do understand that a woman could be affected by what has happened, I do not know how it may have affected you, or how the management that you have received was enough or maybe you think that the management should have been like this or that, I would like you to tell me how you should have wanted to be treated."

P5: "Oh, I went back to ??????? on the 12th of October for an appointment, they said I should go to OPD to fetch my file, I did not get my file, I was then sent to look for my file at maternity, lucky enough I found the nurse who assisted me on my delivery and I told them to look for my file , it was never found, I opened a new one, I was told I could never be assisted without my previous notes, I told them that my file disappeared here, I never took my file home. They phoned maternity, I was told to return to maternity, I felt that I was not being treated fairly, I felt annoyed and left without assistance. I felt annoyed and disturbed, I lost my baby and now my file too?"

R: "What is it that they wanted to do on the said date in October?"

P5: "I don't know, I was just told to come for a check-up, I didn't know what the check-up was for."

R: "Hmmm, so you left without having been assisted?"

P5: "Yes, I left because what where they going to do since they never found my bed letter."

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R: "Mmm, this now is another issue of the missing bed letter, was the baby your first child?"

P5: "Yes, it was my first child."

R: "What happened?"

P5: "I also do not know what happened, initially at the clinic they gave me a date of the 26th August, on that same date I was writing my trial examination, and again on the 28th I was writing Mathematics, I did not feel anything at the time, by month end August I started to feel that there were no fetal movements, my umbilicus was painful, I thought that maybe the baby was just turning, I ended up just staying but there were no more pains, my baby was still. Around 01h00 to 02h00 in the morning I went to the clinic. At the examination room the nurses there were communicating with each other without involving me in the discussion, they then sent me to *???????*hospital without telling me what was wrong."

R: "When arriving at *???????*hospital*?*"

P5: At *???????* hospital I was told that they are not hearing the fetal heart, and they told me there is a possibility that I could give birth to a baby who could be either alive or dead, by 15hoo I then gave birth to a dead child."

R: "Hmmm, so how did that make you feel?"

P5: "It did not make me feel well, I requested to be discharged as soon as possible, to avoid listening to babies cries, I could not bear the trauma, it affected me and that is why I wanted to go back home, I did not like it at all, but they did not want me to go back home because my blood pressure was elevated."

R: "So, it means that you have left before you were discharged?"

P5: "Yes, I left the hospital undischarged, I couldn't stay when I could hear babies crying all over, it affected me badly."

R: "So, who did you tell here at home?"

P5: "I told my mother, I phoned her while I was still in the hospital."

R: "Hmmm, the father of the baby, does he know?"

P5: "Yes."

R: "Are you still in love?"

P5: "Yes, we are."

R: "When you left, where you not seen by the psychologist?"

P5: "The psychologist saw me on the 14th (the following day) in the morning, I was given a date to come back, I was not happy with what I was being asked because it were not the things that could heal me."

R: "What was it that was bothering you?"

P5: "The silence worried me, it would have been better if the nurses at the clinic had talked during the examination, explaining what they saw or what was puzzling them, I was supposed to have been told at the clinic that the baby is dead."

R: "The clinic is not in a position to tell you before some investigations which are only done at the hospital, the clinic does not have the final diagnosis, that is why they have sent you to the hospital."

P5: "Ohh!"

R: "How do you feel now?"

P5: "When I see a child I still feel pain in my heart."

R: "I would like to assist you, these things do happen in life, never think you are alone, is your father around?"

P5: "No, he died about five years ago."

R: "Is there anything that you might be thinking that could have lead to what happened?"

P5: "No."

R: "Did you enjoy the pregnancy?"

P5: "Yes, even though I was still at high school I did like the idea that I was going to have a child."

R: "Any future plans, like whether you would like to conceive again?"

P5: "Yes, I would like to conceive again but I do not have any interest in going back to hospital, what are they going to do since they didn't find my bed letter?"

R: "There are many people out there who have also come across what has happened to you, many, it is only that I could not tell you their names, and others even go to the extent of keeping it a secret, you might feel it only happened to you (the IUFD), I would wish that you make plans for your future, and accept what has happened."

P5: "Yes, now that I have passed my grade 12 I intend registering at FET for my future career."

R: "Yes, that is acceptable, do you have any sisters?"

P5: "I have a younger sister and two brothers."

R: "Who is the one that you feel comfortable tell about yourself?"

P5: "My mother."

R: "Ok. Your mother, do not hide away your feelings from her, if also you are not feeling well, go to the hospital, through the clinic, even those that gave you a hard time when looking for the bed letter, things change and you might find the person is no longer working there, nevertheless, who told you that the fetal heart is no longer heard."

P5: "A white Doctor."

R: "Did the psychologist see you?

P5: "I saw the psychologist only ones, and what he told me did not help me in any way."

R: "What did he tell you?

P5: "How could he ask me whether from my mother who else is having a child, it did not help me in any way, I did not go back."

R: "Maybe he first wanted to gain your confidence, who knows, but since you do have my cellphone numbers, you could phone me if there are things that you would like to let me know."

P5: "Mmm!"

R: "Is there anything else that you could tell me, or any questions that you might have?"

P5: (shook her head)

R: "Thank you, you do have my numbers, do not be afraid to contact me. Call your mother so that I could say goodbye to her."

P5: (She called her mother and I thanked them both for inviting me to their home and for the time that we spent together).

R: "Farewell! and I thank you for the time that we had."

P5: "Farewell." End of Interview.

PARTICIPANT 06 (P6)

Pseudonym: P6 – Participant 06

Researcher: R

R: I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me and also tell me if we could continue our conversation in Tshivenda language. No names will be used when disseminating the results of this research. Are you agreeing with me?

"P6: "Yes!" She agreed to the telephonic conversation.

R: "People experience different feelings, that's why we need to know how it affects you, in order to see if there is an improvement that need to be implemented, what I discover it does not mean that so and so said what, myself I write down where we are having shortfalls, what you say could help someone who could be in this same situation, leading to a change in the way

that we are doing things at present, but I will not force or coerce you into talking. You may ask me if there are any questions. "

P6: "It happened while I was at home, after I haven't felt baby movements for four days. I went to the clinic, on arrival I was checked, thereafter they told me they couldn't hear anything, and they gave me a letter to take to hospital, I went to ???????hospital they told me to wait for the doctor who will use an ultrasound."

R: "Mmmm!"

P6: "There I was checked and they told me they couldn't see anything. They told me to wait for the Doctor to check me using a sonar (ultrasound), after checking me he told me he couldn't see the fetal movements."

R: "How did you feel?"

P6: "I felt uncontrolled anxiety after the doctor told me of my baby's death, then they told me they will give me medication to induce labour. I was given the medication the following day, I took the medication, and I went into labour the whole day until I delivered in the early hours the following day, it was on Saturday the 30th of April. They told me that the mortuary is closed until the 2nd of May since it was on a weekend and a holiday combined."

R: "Were you taken to a psychologist?"

P6: "Yes, I was referred to the psychologist on the 3rd before I was discharged."

R: "From what transpired, to be able to accept this and to move forward with your life, how did you achieve that?"

P6: "It was my mom who was able to sympathise with me, and my friend who used to read bible verses, I could only say that the support that I received from home and my in laws was impressive."

R: "In your opinion, what then could we do to improve the care that the women receive in our hospitals when they meet these situations?"

P6: "I appreciate the care that I have received from the nurses when they communicated nicely with, encouraging and sympathising with me. There were also student nurses who also treated me well. Other things I could just say I did not like it when I was kept with women who had given birth because looking at the women nursing their babies and the babies' crying was painful. I did not like that setup at all."

R: "Where would you have preferred to stay?"

P6: :"I could have preferred to stay where there were no babies or where the women there have not yet delivered, as long as there was no baby in sight. I used to cry day and night, I was unable to bear the cries of the new-borns while mine was lifeless, it did not make me feel well."

R: "What else would you tell me?"

P6: "I appreciate the morning prayers, those nurses are gifted and they encouraged me."

R: "Are you working or schooling?"

P6: "I have passed grade 12, I am in college now."

R: "That's good, I appreciate you having the positive plans in life, and I thank the time that you have allowed me to speak about your situation. Farewell."

P6: "Farewell."

End of the interview.



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PARTICIPANT 07 (P7)

Pseudonym: P7 – Participant 07

Researcher: R

R: "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language.

P7: "Mmmm."

R: "Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research."

P7: She agreed and signed the consent form.

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R: "People experience different feelings, that's why we need to know how it affects you, in order to see if there is an improvement that need to be implemented, what I discover it does not mean that so and so said what, myself I write down where we are having shortfalls, what you say could help someone who could be in this same situation, leading to a change in the way that we are doing things at present, but I will not force or coerce you into talking. You may ask me if there are any questions.

P7: "I used to wake up at night because the baby moved, but I slept all that night and when I woke up early in the morning, the first thing I felt was the stillness in my stomach, I couldn't feel the fetal movements, I went to the tshitanga (outside hut used like a kitchen) and stayed there until late, then I went to wash myself, still I could not feel any movements, I felt pain on my waist, I slept again and woke up around 19h00 in the evening and asked them to call transport to go to the clinic, and it came and take me to the clinic."

R: "Mmmm!"

P7: "On arriving at ??????? clinic they checked me, and the nurse told me she couldn't feel anything, I told myself that the baby is just tired. I prayed, asking for strength, I thought since it was too big, there was not enough space to move and it has settled into a correct position, nothing is wrong. An ambulance was called."

R: "Who did you tell first on realising this?"

P7: "I told my husband. I told him when I arrive at the hospital I will tell him after they have checked me again."

R: "On arrival at the hospital I was checked by two nurses, and they didn't tell me anything, but the machine did not have a sound, I was taken to the doctor, the doctor checked me using an ultrasound (sonar), and he told me he couldn't see anything, he explained to me in a reassuring way."

P7: "I asked if they could remove the baby by operation, and he (the doctor) said that there is no need for an operation as the baby could be delivered normally. When I was checked again, the waters broke."

R: "What was the succession child?"

P7: "It was my sixth child, I did not have labour pains, I just felt slight pains around my waist, I was told that I was not supposed to deliver right there, and I told then I couldn't move. It became difficult because I still have not yet delivered by the next day on Friday morning, until the students arrived, they applied fundal pressure, and it was very painful."

R: "Mmmm!"

P7: "The doctor had given me two injections, the male students applied fundal pressure and I delivered after an episiotomy, indeed they succeeded in delivering the baby since the doctor was no longer there and I was left with a junior nurse the previous night until the students arrived."

R: "Mmmm!"

P7: "My husband phoned and I explained to him that the foetus has already been collected, he came during the visiting hours at 13h00 and left at 14h00. I stayed in hospital until Tuesday, my Bp elevated as I was stressed, I took my belongings because I was in the same cubicle as other women who were still awaiting delivery, when they are being monitored it is painful. The doctor came and plead with me to spend just one more night. The following day by 07h00 my husband had already arrived, but we finished around 16h00. We were taken from pillar to post, without a thought that I still haven't taken food."

R: "Mmmm!"

P7: "My things were delaying at the nurses until I explained to a certain young man. I have persevered because I needed help, I was taken to the psychologist on a Tuesday. The psychologist asked me how many people I stay with, and I told him they are five, my husband and four other children.

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And he said do I suffer from any other sicknesses, and I told him sugar diabetes, at the clinic I attended high risk ANC, the doctor even said that after delivery I should close.

R: "Mmmm!"

P7: "Night Nurses there in the hospital don't treat patients well, I was sutured an episiotomy, when she finished she inserted her hand, the way she handled me was not okay. Patients are beaten by the nurses, a young nurse beating up a woman older than her."

R: "How could we improve?"

P7: "Seniors should go to maternity ward unannounced, they have to go there and see for themselves what is happening there. Nurses yell and laugh at the patients. There should also not be long stays in the hospitals, because long stays give rise to other illnesses, women who have lost their babies (IUFD) should stay separated from the women who have given birth, even alone. I appreciate 'Taki' in all nurses there, nurses should take care of the patients."

R: "Are you working?"

P7: "Yes, self-employment, me and my husband manufacture bricks, burn them, after they are drying we sell them."

R: "Which highest standard did you pass at school?"

P7: "I only attended up to standard 3, because of my father who wouldn't pay school fees, me and my sisters were out of school, he never thought that one day we would take care of him if we were educated."

R: "Thank you very much for the time we have spent together for this interview, I appreciate it. Farewell."

P7: "Farewell."

End of the interview

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PARTICIPANT 08 (P8)

Pseudonym: P8 – Participant 08

Researcher: R

R: "I am professional nurse Kharivhe Lufuno, I work at Memorial hospital in Louis Trichardt and a Masters Degree student at University of Venda. I do follow up on women who have delivered in the hospitals in Vhembe District and things did not go well, that as health workers and also under the fellowship of the university, we need to find out how did things go from when you first heard that the fetal heart rate is not felt, until you delivered, up until today and how is your health. Since many women experience different feelings, it's vital to know how you feel, to identify if there are things that we need to improve in our hospitals, what you could say could help someone who finds herself in the same situation that you have went through, it could happen that there might be some shortcomings in our management, no one knows. All this I would like you to tell me upon your own free will, without force, and that I am recording all this conversation using my audio recorder, if there are things that you won't like me to record, you could tell me to stop the recorder or you could stop using this button, and also tell me if we could continue our conversation in Tshivenda language."

P8: "Mmmm."

R: "Please sign this consent form to show that I have explained and that you understand and agree with me. No names will be used when disseminating the results of this research."

She agreed and signed the consent form.

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R: "People experience different feelings, that's why we need to know how it affects you, in oder to see if there is an improvement that need to be implemented, what I discover it does not mean that so and so said what, myself I write down where we are having shortfalls, what you say could help someone who could be in this same situation, leading to a change in the way that we are doing things at present, but I will not force or coerce you into talking. You may ask me if there are any questions.

P8: "When I first attended antenatal clinic I was 4 months pregnant, my Bp used to be elevated, and I was told to reduce salt intake, I stopped taking salty foods. On the 17.12.2015 I went to the clinic when I spent the night without feeling the fetal movements, at the clinic they told me the baby is still okay, and to sleep on my left side. I went to bed again."

R: "Mmmm!"

P8: "On Saturday the 26th, I had a headache around 19h00, I went to the clinic at???????, after the nurses have checked me they sent me to hospital. Around 03h00 the following day they checked me on a sonar (ultrasound). I was due for delivery on the 28th. I was inserted a drip, and given medication and I took it throughout even whilst I was with my visitors.

R: "Mmmm!"

P8: "I felt labour pains the whole night and delivered 04h00 to 05h00 (05h55) the next day on the 28th.

R: "Mmmm!"

P8: "When they first told me that my baby is dead I thought they were not serious, but then I accepted thinking that maybe God had other plans for me, but it did pain me because I was unable to phone my mother, I was unable to tell her on the phone, she was told by the nurses, because I did not know how to tell her, I was crying and unable to talk.

R: "Mmmm!"

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P8: "On Monday I was discharged and came back home, having left the baby at the hospital since I was not told anything.

R: "Mmmm!"

P8: "My wounds were opened when three months later when I was starting to admit the situation, the hospital phoned me and said I have left a baby at the hospital who is supposed to be buried at home. We had signed the papers for incineration. It was on a Friday afternoon, the whole weekend I was crying, I waited until on a Monday, then the baby was taken and buried here at home." This experience was very cruel, my crying was renewed."

R: "Mmmm!"

P8: "There was nothing wrong except that I felt sad and without having a live baby. They were supposed to have told me how things are handled concerning burials, they never told us, and we signed papers for incineration. We told them we prefer incineration, and they sent us to social workers, and signed the papers, we were never told that we were not supposed to leave the baby."

R: "Who gave you support?"

P8: "The person who supported me is my brother and my mother, my sisters where unsupportive, they were always prying on me (she said, crying)."

R: "Where you referred to a psychologist?"

P8: "No, I was not referred to a psychologist, I was discharged and came back home. I believe had I received the psychologist intervention, I would have handled the death of my unborn baby better."

R: "Could I make arrangements for you to see a psychologist?"

P8: "No, I feel okay now."

R: "Are you at school?"

P8: "Yes, I'm in grade 11."

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R: "Where is the baby's father?"

P8: "We have separated when he accused me of killing his child."

R: "What then do your sisters say?"

P8: "My elder sister is already married and stays in her house, my other sister I am staying with her here at home has a 7 months old baby, and there is no more problem because I even take care of her child."

R: "In your opinion what could you tell me that could improve the care that women receive in our hospitals?"

P8: "My problem was when I had to relieve the experience which I had already accepted, if only I was told while still at the hospital how it is handled, I could have accepted it then, currently when I see the grave here at home I feel sad."

R: "Thank you for the time that you have given me to conduct this interview, what you said will help other people who find themselves in this situation, thank you and farewell."

P8: "Farewell."

End of the interview.

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