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Mothers' Experiences of Stillbirth: A Study in the Accra Metropolis (Socio-Cultural Implications)

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ABSTRACT

Stillbirth is hardly discussed in households especially among women of reproductive age in some of the costal societies in Ghana. In the life of a pregnant woman it is almost a taboo; the expression must not be heard, for fear of being visited or revisited by stillbirth catastrophe. Information on social experiences of those who have had stillbirth in Ghana is lacking. The study explored experiences of mothers who lost their babies during delivery; capturing information on the value system of society, the social expectation and mutuality. Qualitative exploratory design was used to obtain information from fourteen mothers in the Accra metropolis, through purposive sampling, interviewed in English, Ga or Akan languages, using a semi-structured interview guide and analysed through content analysis. Socially, mourning in excess and talking about stillbirth is seen as a potential for sterility and invitation for a recurrence, therefore the mothers were dissuaded from crying. The mothers mourned in unique ways based on their faith and or beliefs. Society in an effort not to further offend the bereaved women avoided them. Although socially, crying and mourning for the stillbirth was discouraged, the mothers couldn't supress it; they mourned in their own ways. Social avoidance, for example spousal neglect were also expressed as painful because it gave the bereaved mothers the impression that because they have "failed" people were not willing to associate with them. Our study has shown for the first time the existence of numerous negative experiences of mothers who have experienced still birth. Social education on stillbirth issues needs to be promoted. Targeted interventions towards enlightening society on prevention and management of stillbirth. Such interventions will lead to reduced stillbirths and educate society on how to treat such individuals.

Keywords: Mothers, Stillbirth, Taboo, Accra Metropolis and Socio-Cultural Implications

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1. INTRODUCTION AND BACKGROUND

Humans need each other in diverse ways and situations of life especially in times of loss. How it be that society apparently shuns the bereaved for various social explanations when this support is vital unto early and total recovery? It is documented that 7178 women worldwide experience the reality of stillbirth on a daily bases. Such a real, painful and damaging experience is further deepened when the the rest of the world believes her stillborn child never existed, which is often socially communicated in various conventional ways (Lancet series, 2015).

This notwithstanding, it is projected that by 2030 a target of 12 or fewer stillbirths per 1000 births will be experienced in every country "The Every New Born Action Plan" (ENAP), however it is projected that 56 countries in Africa and in areas affected by conflict have to put in more than double of the present effort to reach this target (Lancet stillbirth series, 2016).

2. SOCIAL SUPPORT

The interface of everyday support, patterns of family interactions, relationships with friends, people at work and neighbours are crucial for people who are mourning to come into terms with bereavement. Furthermore the input of specialised agencies plus self-help groups cannot be overemphasised. In times of loss when these are deficient the bereaved finds it challenging to maintain a psychological balance. A strong marital or couple relationship has an overwhelming positive outcome; where there is a deep understanding among spouses the grief process is aided and the duration is shorter. It is documented that a strong family and social support tend to promote the ability to cope with grief (Engler and Lasker, 2000; Riches & Dawson 2000, Rich 2000). A notably lower levels of both anxiety and depression was recorded when support from physicians, nurses and family members were forth coming. Mothers of stillborn babies who received high family support in the period after stillbirth had mean anxiety and depression scores that were lower than those of their counterparts who did not. Implying that the most important and impacting form of social support were provided by family members.

Sutan, Amin, Ariffin, Teng, Kamal and Rusli, (2010) in their study of Sixty two (62) respondents assessed depression using Edinburgh Postnatal Depression Scale (EPDS) and self-administered questionnaire; the outcome was that almost all respondents received support from husband after perinatal loss. Three quarters of the participants stated that they received support from their parents, and half of them also received support from friends and siblings. They believe that 'expressing ones feeling' as well as group discussions could help them to cope with and recover faster from their grief. Societal support was very much anticipated by stillbirth bereaved women where the contrary occurs, that situation could be presented as a challenge.

2.1. Social Beliefs and Challenges

In Ghana, there is a traditional view that the spirits of the dead infant will seek a vulnerable new pregnancy, and therefore the taboo of discussing stillbirth and tradition of not performing a burial ceremony for the stillborn baby is perceived as a preventive measure to discourage the spirit stillborn baby from coming back to the same mother, family or society (Van-Otoo & Adusei-Poku, 2010; Gottlieb, 2004; Adetunji, 1996). In sub Saharan Africa hence Ghana, there is a false belief that witchcraft and evil spirits cause stillbirths as well as the traditional view that the spirits of the dead infant will seek a vulnerable new pregnancy or family therefore discussing the stillbirth as a taboo; this is perceived as a preventive measure to discourage the spirit of stillborn baby from coming back to the same mother, family or society. Mothers of stillborn babies are not expected to mourn or have public burials. (Haws, Mashasi, Mrisho, Schellenberg, Darmstadt, and Winch, 2010; Van-Otoo & Adusei-Poku, 2010; Gottlieb, 2004; Adetunji, 1996).

Stillbirth leaves the mother with many challenges, such as ill health, grief, sadness, and the problem of coping with community perceptions; a wide range of negative social consequences follows the occurrence. Such social challenges ranges from avoidance of society members to deteriorating relationships and the consequential isolation in the lives of the bereaved. The isolation occurs in friends, extended family members, and others in their social networks, making the mothers more emotionally vulnerable (Kilguli et.al, 2016; de Montigny, Beaudet, Dumas, 1999). Furthermore family support and relationships gets deteriorated as presented by Chandra, and to follow up, these women are left alone to the harsh traditional judgment and being branded as unproductive in society, (Kilguli et.al, 2016; Tharyan, Muliyil, Abraham (2002); Patel, Rodrigues, DeSouza, (2000). While these social consequences have been quite well studied in developed countries, there is considerably less information about these from developing countries, (Gauzia, Moran, Ali, Ryder, Fisher, & Koblinsky, 2011).

In the presentation of Gauzia and colleagues, although the Asian traditional customs frowns on married women talking against their husband or marital family members to others, the contrary was reported in their study; "Psychological and social consequences among mothers suffering from perinatal loss" in Bangladesh. A high rate of report on deteriorating relationships and withdrawal of support from members of the marital family and a higher frequency of report on worsening spousal relationship. A defective relationship occurs because the bereaved woman is seen as a blockade to propagating the family lineage.

The socio-cultural ideology of 'continuity', women are expected to produce a child for the family to continue the lineage therefore the marital family tend to blame the women for not producing a healthy child to continue the lineage (Hsu, Tseng, & Kuo, 2002) and so families and society contend with the bereaved mother. Likewise sub-Saharan Africa where a great social meaning is attached to childbearing.

Higher levels of marital dissatisfaction have been presented beyond expectation. Marital relationship worsens where there is an apparent imbalance in the degree of grief among spouses, for instance, when one parent is no longer feeling sad, the other spouse may interpret it as insensitivity or not feeling the loss. (Gold, Sen, and Hayward, 2010). Turton and Hughes (2009), predicted that the risk of marital breakdown could be four times higher among women with stillbirth compared with women who had live birth in their Swedish study that followed a cohort of women for 7 years after perinatal loss. These negative social consequences is comparatively higher in the bereaved women than in women with live babies. Information on experiences of mothers who have experienced still birth is lacking in West Africa. In view of this, we sought to explore the experiences of mothers who have experienced still birth in Accra Metropolis.

2.2 Data collection Materials and Methods

An exploratory qualitative study was conducted in Accra through purposive sampling. Nineteen mothers who were in a postnatal period between 6 weeks and 24 weeks (6 months) post stillbirth delivery were recruited at Korle-bu Teaching Hospital. In reference to the antenatal document their mental health status was established to be devoid of psychiatric symptoms that could confound the findings. In addition women who were deaf and or dumb, women who cannot speak English, Ga and Twi as well as those below eighteen years were excluded from the study. The primary researcher's who work with the midwives on duty at the maternity ward and the Post Natal Clinic, helped to establish rapport and also gain the confidence of the mothers who lost their babies. As a backup method of recruitment approach, a book was left with the midwives to document the contact addresses of potential participants. The intention of recruitment was declared to potential participants and detailed residential address and telephone numbers were obtained from those who showed interest.

An in-depth interview approach involving semi structured interview guide prepared in English and made up of open-ended questions was used to obtain data. The interview guide used, sought for information such as personal profile and some obstetric information, information about the process of delivery, the state of the service delivery point, support available from service providers. A pilot interview on three (3) bereaved women helped to ensure reliability of the tool; unclear questions or those that did not elicit the expected answers were reviewed for clarity and efficiency.
The Institutional Review Board of the Noguchi Memorial Institute for Medical Research gave ethical clearance (NMIMR_IRB_CPN_21/12/13). Formal permission to recruit was obtained from the administration of the Korle-bu Teaching Hospital. The objectives of the study were explained to the respondents and their informed consent was obtained before soliciting information on the scheduled date. A counsellor was available to provide support in case data collection adversely affects any participant.

Venue for Data collection, predominantly the homes was decided by the participants. The interview lasted between 35 to 90 minutes. Information elicited was digitally recorded with the fourteen participants' consent. In the process, non-verbal messages and objective pieces of information observed were recorded into a field note book, which subsequently helped to enrich the results. Where the response to the questions indicated participant does not understand the question, clarification was given.

3. DATA ANALYSIS

A qualitative Content analysis was used to analyse the data. The recorded interview was listened to over and over again and transcribed word-to-word. After reading the transcripts at least three times, significant statements were identified line by line, without making any assumptions. The data was compared between researcher and another transcriber for similarities and also to determine differences in the codes. Data reduction was obtained through the use of Nvivo version 7.0. Codes and groupings were formed as nodes. The loaded software also helped for easy access to quotations needed to support the findings. A table was generated to display the codes after which the codes were sorted according to the groupings. The final step, interpretation of findings was done and conclusion was drawn based on the frame of reference defined by the research questions to categorize the data identified to enable description of the experiences of the mothers.

The conclusion was taken back to participants for accuracy and representativeness review. Intercoder comparison was done on categories identified in the analysis of the data and no major discrepancy identified but rather additional information was obtained, as in one participant who eventually explained that no indication was given her when she was being referred. Also an in-depth literature review further helped to confirm these categories.

4. RESULTS

The fourteen women interviewed in their own environs predominantly, were at least six weeks post-delivery. These women were hairdressers, teachers, traders, housewives, a laboratory technician, a student, a seamstress, a caterer, a police officer and one was unemployed.

4.1 Beliefs Attached to Stillbirth

This conveys the socio-cultural and faith stance surrounding stillbirth. As the participants expressed what they know and what they were told during their bereavement period, socio cultural and religious beliefs emerged. Mourning stillbirth was seen to either promote sterility or recurring stillbirth. The women were therefore encouraged not to mourn. The sources of this strong belief was based on individuals' social background, furthermore even professionals nurses shared the same belief and applied it to desist the women from crying. As part of the various reports, mothers with stillbirth were not acknowledged as mothers thus instances of maternal devaluation was reported. Stillbirth is believed to have supernatural association; some believed it was the doing of God while others explained it could be through evil forces. Among the Muslims taking pictures of the dead is not allowed however there is a positive observation; the Muslim always takes custody of their dead babies and disposed them off on their own, which promotes value of the baby.

Infertility

Fertility is reduced when one mourns the stillborn; the myth that the woman will become infertile made society dissuade the women from mourning. Additionally they explained that stillborn baby is a stranger, on transit therefore mourning or talking much about the stillborn because it welcomes recurrence, this is evident by the participants' narration.

> ***Adjoa**: I cried and one midwife told me that if I cry too much it will affect my womb and it will trouble my future. So then I stopped crying but anytime I remember my eye wells with tears.*
>
> ***Freda**: yes they say when you weep, your delivery will delay or you will not give birth again.*
>
> ***Rita**: they think it is a dead baby so" you don't know him, we don't miss him; it is you we know so don't even talk about him" you see and this does not help situations.*

Non-acknowledgement of motherhood

A woman, who goes through labour but comes home without a live child is not acknowledged as a mother; she is seen as barren. This is evident by the avoidance of the use of congratulatory expressions used for woman after delivery. Some Ghanaian customary rites were withheld from the mothers.

> **Rita:** *I was thinking they should call me to congratulate me for carrying the baby up to full term because it was a matured baby before but because it's a dead baby so they feel I have failed, [sounding very emotional]. I have failed so there was nothing like congratulations.*
>
> **Freda:** *you are not acknowledged as such [as a mother], usually when one delivers based on the sex of the baby a male of female fowl is slaughtered for the woman but because the baby didn't come home that was not done.*

Faith

Christians and Muslims have various beliefs surrounding stillbirth. The Muslims believe the source could be a spiritual issue. Also among the Muslim, it is believed that pictures of the dead must not be taken therefore some participants who underwent a General Anaesthesia at the time of delivery did not get the chance to see how their babies looked like, had this to say:

> ***Isha**: They think if you are tempted by the devil, it [stillbirth] can follow you to where ever you go, you can lose your babies but if you are Godly the devil can't do it to you, God will help you.*
>
> ***Halima**: yes I know that God gave to me and he has taken back but some people often say that it was an attack from someone or.*
>
> ***Ramatu**: Through birth it came and God has taken back. So I don't have anything to do….they say it is wrong; you don't take the picture of a dead person as a Muslim.*

Furthermore the spiritual inclination promoted prayer sessions expecting a divine intervention; in support of the belief of supernatural influence concerning the occurrence of stillbirth this was evidenced by the excerpts from Shola and Adom respectively.

….we called so many pastors they prayed for me. And also I went to church, I was given anointing oil to practice, I was having that faith that God can do something, but nothing happened, ahh!

> *…….. I was saying God, this is what they are saying but I will be excluded, I will get an angel as a nurse or a doctor over there. Truly, truly when I went God provided good nurses for me.*

Disposal of the Dead

The reports from the participants did not present the value of having a good burial services therefore to the disposal of the dead babies; they allowed the hospital to take care of them, not knowing how it will be disposed of.

> ***Adom**: So my husband came and they asked him whether he wants to take the baby home or hospital will take care of it? He said the hospital should take care of it. So they said there is something supposed to be paid, so after he paid those things they took him.*
>
> ***Adjeley:** I was still lying down when they showed it to me they showed me and asked whether we would want to bury it ourselves but my brother asked them to take care of that.*
>
> ***Ayekai:** And when I asked my husband, when you paid money for the burial, did you see the baby? He said no and that the child is already dead.*
>
> **Rita:** *The response my mother in law particularly gave was; "We were expecting a live baby and now the baby is dead what do you want us to do with it? You can do whatever you want with it"*

5. DISCUSSION

The prevailing norms and beliefs that form social control in this study were explained as; too much crying or mourning promotes infertility. This social belief was confirmed when the participants stated that even nurses used this information to dissuade them from crying. Prolonged grieving and its accompanying stressfulness could physiologically influence the hormonal level; an imbalance which could eventually affect their reproductive cycle therefore their fertility. This projection is upheld by Sander and Bruce (1997) cited by Franche (2001); women who grieve intensely find it more difficult to conceive than those who grieve less. Religion is important to many people; it often lighten the burden of uncertainties in life thereby it serving as an emotional support in time of loss (Kavanaugh & Hershberger 2005). The report revealed that a Supreme Being was in charge of all that happens and has the ability to replace their loss; therefore they must submit to him.

A clear connotation that they have dissociated from the lost babies and were expecting their living and or subsequent babies in their current world. Prayers organized to supernaturally change the situation supports this assumption. The prayer sessions psychologically prolonged the duration for the woman to prepare and accept the situation of child loss. The "God factor" was presented by all participating women despite their religious affiliation further more they derived strength from the scriptures. Cacciatore and Bushfield, (2007) saw spirituality emerging as a strong theme for many bereaved women in their study, also concomitant to the findings of Pilkington (2006); the participants reached out to God for strength, were able to pull through their pain.

Contrary report from Modiba and Nolte (2007); where participants demonstrated anger against God; asking why they lost their babies, the current participants' faith in the Supreme Being rather strengthened and comforted them. Also the faith in seeing these babies in the hereafter gave more relief. Congratulatory rituals and acknowledgement of motherhood is not available to stillborn mothers as reported by some participants. There the expected acknowledgement is not forthcoming there is a duplicated the grief pain the victims, here they experience a dual loss: loss of a child and loss of acknowledgement of motherhood. Devaluation of the life lost was implied when the babies were disposed of without any burial rites however the absence of rites is at variance with Muslim burial practices. The Muslims took custody of their babies and gave them the required burial ceremony in recognition that a life has passed on. This is line with the Swedish practice of taking the dead baby home for burial ceremony; which promotes psychological health, (Trulsson & Radestad, 2004).

6. SUMMARY AND CONCLUSION

Social belief that crying and overly engrossed about the stillborn is as result of the local worldview that the still baby is an evil visitor to the family for that reason, talking more about stillbirth means an invitation of a recurrence or leaving behind the catastrophe of rendering the woman sterile. The client perception of the service providers (another aspect of the study) presented that Devaluation of the baby begun at the health institution, through the community as well as the unconscious action of some parents of the baby. Spousal rejection is a form of devaluation of the mothers. In relation to Roy, (1971) metaparadigm of nursing, Grief in the life of the bereaved is an aspect of the internal environment of the individual. The severity of grief, the duration as well as the personality of the individual, in addition to the support available determines the health state of this individual. These women's external environment; hospital setting, the service providers and all those around them who were expected to form support to propel them back or keep them within the health continuum however this was found to be inadequate. Our study reveals the existence of numerous negative experiences of mothers who have experienced still birth. Social education on stillbirth issues needs to be improved. Targeted interventions must be directed to society on prevention and management of stillbirth. Such interventions will lead to reduced stillbirths and educate society on how to treat such individuals.

7. RECOMMENDATION

Counselling and support must begin at the hospital through to the community. Social education is recommended to augment the effort of Health service personnel in addition organising talks, open forum, distribution of information leaflets can be a good beginning. There is the need for Review of social and psychological service provision within the Ghana Health Services. Further studies should be conducted on Social perception of stillbirth, the mental health of stillbirth mothers as well as the knowledge and practice of Service Providers on stillbirth

8. STRENGTH AND LIMITATIONS

8.1 Strength

The willingness of the participants to share their experience as well as the academic and professional background of the authors; helped to facilitate the study; Midwifery and psychology Trained counsellors.

8.2 Limitation

Interviewed 2 participants at the hospital setting.

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