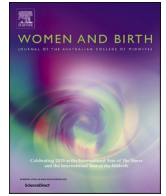




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Original research

# An exploration of women's lived experiences of care and support following perinatal death in South-Western Nigeria: A hermeneutic phenomenological study

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## ARTICLE INFO

## Keywords:

Perinatal death  
Mothers  
Support  
Care  
Sub-Saharan Africa  
Bereavement care

## ABSTRACT

**Background:** Perinatal death results in long-lasting intense grief for bereaved mothers with a potential to negatively impact on their short- and long-term outcomes and quality of life if inadequately supported in coping with and managing their experience.

**Aim:** This study aimed at exploring the lived experience of women, of care and support following perinatal death in South-Western, Nigeria.

**Methods:** A qualitative methodology using Heideggerian phenomenology was used. Fourteen women who had experienced perinatal death in South-Western Nigeria within the last (5) five years were interviewed, and Van Manen's approach to hermeneutic phenomenology was used in data analysis.

**Findings:** Four main themes were identified: "they did not tell me the baby died", "response of health care professionals after the baby died", "moving on from hospital", and "support from family". The physical health status of mothers determined how they were informed of perinatal death. Health care professionals were distant, rude, nonempathetic and did not offer emotional support, in some cases. Mothers were given opportunity to see and hold their babies. There was no routine follow-up support in the community, besides a postnatal check-up appointment offered to all mothers regardless of their birth outcome. Family provided emotional support for mothers on discharge.

**Conclusion:** This study was the first to explore the lived experience of women of the care and support following perinatal death in South-Western, Nigeria. There is a need for healthcare systems to review bereavement care and support provisions for women who experience perinatal death.

## Introduction

Perinatal death (stillbirth and neonatal death) is prevalent globally, with 2.3 million neonatal deaths within the first 28 days of life and 1.9 million stillbirths occurring in 2021 [34,35]. Most occur in low and middle-income countries (LMIC), with South Asian and sub-Saharan African countries carrying the highest global burden, and Nigeria ranking second and third globally with 42.9 stillbirths and 35 neonatal deaths per 1000 births respectively ([3]; UNICEF, 2021b; [33,11]). Despite effort made by Nigeria in improving antenatal care provision and uptake, perinatal death rate remains high thereby reflecting that many women continue to experience complex, intense, and long-lasting

grief, poorer physical and mental health outcomes [8,12,28,29]. Existing literature from LMICs show that women's grief is unacknowledged, and many are significantly stigmatised by cultural beliefs leading to isolation in their experience [21,3,22,23,29]. Adequate bereavement care and support contribute to fewer symptoms of grief, less post-traumatic stress disorder (PTSD), depression and anxiety and prevents the development of maladaptive coping mechanisms ([7,22,30]; Mulvihill and Walsh, 2013). The care and support from healthcare professionals following perinatal death can determine the grieving process, and short and long-term outcome for mothers, and families. However, there is a gap in the literature on the care and support that women, partners and their families receive in Nigeria following perinatal death.

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<https://doi.org/10.1016/j.wombi.2023.11.004>

Received 24 April 2023; Received in revised form 14 November 2023; Accepted 17 November 2023

1871-5192/© 2023 Published by Elsevier Ltd on behalf of Australian College of Midwives.

Thus, this study is aimed at exploring the lived experience of care and support of women following perinatal death in South-Western Nigeria.

## Methodology and methods

### Study design

This study is part of a larger research that sought to explore the experience of bereavement care and support in Nigeria from the perspectives of women, partners and families who had experienced perinatal death, and health care professionals. This qualitative study was guided by Heideggerian (hermeneutic) phenomenology which is concerned with understanding and interpreting experiences [18,26]. Two authors were mental health nurses, and one was a midwife, with experience in conducting qualitative research into mental health and perinatal death. The authors also have clinical experience of supporting individuals who have experienced perinatal death and mental health difficulties.

### Patient and public involvement

The Postpartum Support Network Africa (PSN), a non-governmental organisation in Lagos, Nigeria, provides psychological support to women who experience perinatal death, and mental health difficulties in the postnatal period supported the participant recruitment by advertising the study at their meetings. The topic guide was piloted with the first two mothers who expressed interest in taking part in the study and had experienced perinatal death in Nigeria. Further patient and public involvement in designing this study was hindered by the COVID-19 travel restrictions in Nigeria and the United Kingdom (UK).

### Ethics

Ethical approval was gained. Audio-recorded verbal consent was obtained from all participants. Participants' identity was concealed using pseudonyms. A distress protocol was developed, highlighting steps to follow, should a participant experience distress during the interview.

### Setting and participants

Women were eligible for participation if they; were 18 years old and above, had experienced perinatal death within the last five years and received care at a hospital in South-Western Nigeria. A purposive sample of 14 women were recruited via PSN Africa and a federal government hospital in Lagos State. Recruitment commenced in November 2020 until July 2021. Due to COVID-19 global pandemic travel restrictions, participants were recruited virtually via the Chief Nursing Officer at the hospital and lead co-ordinator at PSN Africa who were contact persons for this study.

The COVID-19 pandemic impacted the original recruitment strategy therefore changes had to be made. Two methods were adopted, one with the support of the Chief Nursing Officer, and the other via PSN Africa. Study information sessions were provided to contact persons via telephone call, and participant information sheets (PIS) and consent forms were sent electronically. The Chief Nursing Officer identified individuals who met the inclusion criteria and introduced the study. Thus, the contact person at PSN Africa explained the study at virtual support group meetings/platform. Potential participants were invited to contact the researcher directly to express their participation interest. Following this contact, PIS and consent forms were sent to participants electronically by the researcher. The participants were contacted after 24 hours to gain their consent to participate and schedule a time for interview.

### Rigour

In this study, to ensure credibility and dependability, the steps taken were described to provide a clear, logical, and traceable audit trail of

study processes. Verbatim quotes were also used to ensure the participants' voices reflected in the findings, and the researcher's thoughts and voice was captured in field notes and a reflexive diary, thereby achieving confirmability. In ensuring transferability, a description of the demographics of the population, research context, methods and data analysis was provided. These all contributed to the rigour in this study.

### Data collection

Face-to-face semi structured interviews were initially planned however due to the COVID-19 pandemic, telephone interviews were conducted via WhatsApp. A topic guide aided the interview. Prompts were used to guide the conversation and clarify aspects of experiences. Most interviews were conducted in English, and two were in Yoruba, which the researcher is fluent in. All interviews were audio recorded and transcribed verbatim, except one, where the participant did not consent to be recorded. For this interview, written notes were taken contemporaneously by the researcher, where time and connection permitted, the key points of the interview were summarised to clarify accuracy of interpretation. Field notes and a reflexive diary were completed after each interview to capture non-verbal data and personal thoughts about the participants' experience. One participant experienced mild emotional distress during the interview and was signposted to PSN Africa according to their preference. The researcher made telephone contact with this participant the daily for two days after the interview for additional support and they confirmed that they contacted the support network.

### Data analysis

Data analysis was guided by Van Manen's approach which aided transformation of the lived experience, as narrated by participants, into textual expressions of meanings which were structured by the themes [1, 36]. Analysis occurred in three stages; (1) "Wholistic approach" –text was examined by reading and re-reading transcripts to become immersed in the data. (2) Selective approach – as the text was read, salient aspects were highlighted, and underlined with explanatory notes. (3) Detailed/line-by-line approach – texts were related with each other line by line and were grouped in clusters based on similarities (Ritru-chai et al., 2018; [1], Van Manen, 1990). The researcher followed the hermeneutic circle, moving repeatedly between the whole text and parts to ensure accuracy and achieve an in-depth and subjective interpretation [16,17,25]. From the analysis, the researcher and supervisors generated themes and subthemes, and achieved the final interpretation with regular discussion and guidance of the supervisory team.

### Findings

Interviews were conducted with 14 mothers, who were all married and between the age of 22–41 years old, with varying employment status and educational levels. The mothers were of diverse occupation such as business owners, civil servant, and nurse. Most mothers (n = 8) knew the cause of their baby's death such as Vein of Galen, necrotising enterocolitis (NEC), prolonged labour, infection, Hepatitis C, and breech birth. Table 1 shows the characteristics of participants. Four main themes, with subthemes emerged from the data; "They did not tell me the baby died", "Response of health care professionals after the baby died", "Moving on from hospital", and "Support from family".

#### Theme 1: "They did not tell me the baby died"

Communication was fundamental for women, as being aware of their baby's health status was important when they had concerns. There were delays in the communication from health care professionals which caused distress and upset for mothers who preferred to be informed promptly if their baby had died or was still alive.

**Table 1**  
Characteristics of Study Participants (Women).

Characteristics	Women	Total
Age	22–31	6
	32–41	8
Marital status	Married	14
Ethnicity	Yoruba	12
	Igbo	1
	Edo	1
Living status	With immediate family	14
Educational level	High School Certificate	2
	HND/OND	7
	BSc	5
Religion	Christianity	11
	Islam	3
Employment status	Full time employed	2
	Self-employed	8
	Unemployed	4
Living children	Yes	10
	No	4
Gender of deceased baby *includes one who lost 2	Male	8
	Female	6
	Unknown	1
Parity	1st	7
	2nd and above	7
Type of death	Stillbirth	5
	Neonatal death	9

### Waiting to be told

There were often delays in informing mothers when antepartum stillbirth was diagnosed, which caused feeling of anxiety and uncertainty. When mothers presented with pregnancy concerns, health professionals referred for diagnostic ultrasound scan and all mothers reported being fully informed about the rationale for referral. Concern and dissatisfaction amongst mothers arose from scan results not being communicated by the sonographer. Rather reports were given to mothers in an envelope for the referring health care professional who interpreted and informed them of their baby's death. Mothers preferred being informed immediately of the results as opposed to waiting to be told by the referrer. The delay and feeling of uncertainty were difficult to bear for some mothers who chose to read the result before handing it to a healthcare professional.

*“... when the [sonographer] did the scan, with the look of the man when he was asking me what hospital I was using. I said “general hospital”.... He said I guess you will go there today and show them this report. I said what happened? He said nothing, that I should just show them... I opened the [scan] result myself...I saw fetus not (alive).... So, I had to go through the [internet] and read about it so I came to notice that its meaning that the baby is not breathing” [Banky].*

A few mothers described being informed by health care professionals and aware of the concerns about their baby's health status prior to or at onset of labour. They felt emotionally prepared when their baby was born and did not survive. In such cases, the death of the baby was also verbally communicated immediately after birth by health care professionals to mothers.

*“They have prepared my mind already. I was having contractions like [at] 5 mins, [and] 2 mins interval. The doctors said with this condition [frequency of contractions] the baby's breathing [was] dropping...and the baby was not feeling good [well]. They had told me this is what [was] going to happen with the baby even if I deliver this baby, it might not live. The following morning...I was rushed to the labour room and they brought out the baby, it was already dead.” [Sege].*

In some cases, there were no delays in being informed of their baby's death such as when unexpected intrapartum stillbirth occurred in vaginal birth, mothers were often aware as they either did not hear the baby cry, and/or witnessed resuscitation attempts. Thus, they were

often informed immediately of the baby's death by health care professionals.

*“After I gave birth then the doctor told me [immediately] that I can see that the baby is not alive.” [Yanu]*

*They didn't tell me the baby died, they deceived me*

Some mothers identified that health care professionals used deception to delay informing them of their baby's death where there were risks to their own health following birth. This was common amongst mothers who birthed via caesarean section (CS) under general anaesthetic and experienced neonatal death or intrapartum stillbirth. They were often informed that their babies were being cared for at the neonatal unit within the same hospital or at another hospital, which was not the case. This was to prevent them from actively insisting on seeing their baby. Partners and family members maintained the same story, despite already being aware of the baby's death.

*“When one delivers [gives birth], they will place the baby by their side so [I asked] where my baby was? The nurses were telling me that the baby is okay, and that they were giving them oxygen. When it was morning, I asked where is the baby, why can I not go and see the baby. They now said that they have taken the baby to the general hospital, that when I get better, they will take me there.” [Koko]*

A few mothers sensed that their babies had died, and the truth was being hidden, when they were repeatedly prevented by both nurses and family members from seeing them for several days.

*“I told my husband that the baby is gone because every time I attempt to make a move to see the baby, they will discourage me.” [Bidemi]*

The use of deception initially caused upset and anger in most mothers, as they were led to believe that their baby was still alive.

*Ah! When they didn't tell me, I was angry. I was telling my husband that they should have told me on time ...” [Koko].*

*They told her immediately that the baby died, and she gave up [died]*

Most mothers realised that delay and deception were used to limit risks of physical deterioration and allow sufficient time to recuperate medically. A few mothers appreciated this approach because of their awareness of health complications that may occur if informed about their baby's death prematurely whilst recuperating.

*... I had a friend, she went to give birth and she was even operated [had a caesarean section], after giving birth the baby was not alive then they told her immediately [about the baby's death] then she gave up [died]... So, I thank God that they did not tell me immediately. [Yanu]*

### Theme 2: response of health care professionals after the baby died

Mothers expected comprehensive emotional support from health care professionals following their baby's death. They were mostly dissatisfied with interactions and approach from these professionals and felt their input was to uphold hospital policies and avoid litigation rather than being supportive.

*I need to see a live baby, not a dead baby*

Mothers' hopes of welcoming a living baby were dashed when their babies died. Regardless of their grief, for many mothers seeing and holding their deceased baby was important. This was facilitated by some health care professionals.

*“The baby was handed over to me [to see and hold], once I was ready, they [health care professionals] said they'll take the baby off me..., they gave me all the time I needed. I was touching her, touching her face,*

*touching her eyes, touching her nose, touching every part of her body.” [Remide]*

A few mothers found seeing and/or holding their deceased baby unbearable and preferred not to do so to avoid having a negative memory of them.

*“I need to see a live baby. They wanted to show me...but I said no. So far he [the baby] has gone his own way, let him go. I don’t want to [see him] because if I see, I will keep remembering and it will cause something else [sadness and sickness] into my body and I don’t want that.” [Banky]*

However, this was an issue where health care professionals imposed seeing and holding on some mothers, to confirm their baby’s identity as opposed to helping manage their grief. Some mothers were prevented by partners and family due to cultural beliefs discouraging contact with dead babies as it is regarded as a taboo/bad omen to bury one’s child. The majority of the mothers were not involved or present at their baby’s burial because of cultural beliefs. This was also a source of distress for some mothers who had wished to see and be present at the funeral of their baby.

#### Culture of little talk

Many mothers expected extensive support including counselling and desired to discuss their loss and feelings in-depth with doctors in particular. Although some mothers had the opportunity, disappointment arose where health care professionals were insensitive and engaged in minimal to no communication and interaction. *“Nobody spoke to me about anything” [Bidemi]*. Most mothers reported that doctors’ direct input ended immediately after birth.

*“It’s supposed to be the doctor that is meant to be giving me hope, you understand? [They should be reassuring me that] this is not the end of the world, ... [instead] The doctor just left.” [Bankole]*

A mother labelled this a “culture of little talk” based on their experience that health care professionals had better communication and interactions with those with living babies.

*“...people say that it’s almost like the health care professionals go about their [duties]...they kind of revert back to business as usual. But if the baby did make it [survived], it’s almost like they’re more present...” [Remide]*

In contrast to doctors, mothers perceived nurses had more contact and communication with them but they expected this to be much more in-depth than they received.

*“...the nurse-in-charge came to meet me and offered her condolences and said a short prayer. When I was taken back to my ward, the nurse-in-charge there came and offered her condolences.” [Remide]*

#### They were very very supportive

Physical care particularly from nurses, was positive for most mothers who felt adequately cared for. For instance, nurses administered medication and ensured that they were made comfortable on the wards.

*“After I delivered my baby, they came around, gave me my drugs [medication], they served me urinary pan. They were very very supportive.” [Kanyinsola]*

Dissatisfaction was also expressed by some mothers who found health care professionals’ to be rude, non-empathetic and harsh.

*“They [health care professionals] don’t know how to relate with people. They talk anyhow like trash.” [Bankole]*

Notably, the level of mutual rapport determined the interaction some mothers received which seems to suggest that nurses favoured women

with whom they had better rapport. For instance, a mother received more interactions from a nurse because they shared the same last name thus creating a stronger rapport between them.

*“It was a woman [nurse] that was there [for me and provided more care because] we are bearing the same surname, that was consoling me that it’s okay.” [Tania]*

There were some negative experiences of care where mothers felt neglected by nurses, but these appeared to be isolated occurrences particularly where disagreements and poor rapport existed between both parties. Some blamed the personality of nurses’ for their negative care experiences.

*The health care professionals were too busy to support us*

The workload and priorities of health care professionals seemed to interfere with their ability to offer support and was seen as responsible for the lack of adequate interaction. Thus, efforts were made to gain answers to their concerns and worries independently either from doctors where possible or other sources.

*“...I was even the one bringing up more questions about the baby with the doctors. As soon as when can I have another, as soon as when can I conceive or as soon as when can I go for another round of the procedure and all of that. I was the one bringing up this with the doctors than vice versa” [Remide]*

#### Theme 3: moving on from hospital

##### No emotional support or counselling

Follow-up appointments were offered by health care professionals on discharge from hospital, all bereaved mothers were offered a routine 2- or 6-week postnatal appointment, the same as for women with a living baby. This appointment had greater focus on physical health than emotional wellbeing. Many mothers found that attending health care professionals were unaware of their baby’s death. This reflected a lack of sensitivity to the bereavement experience and needs of mothers. It was disappointing to them that health care professionals did not acknowledge their baby’s death, lacked empathy and did not offer emotional support or counselling.

*“They gave me [an appointment for] 2 weeks after to come for postnatal check-up. I got there; I was expecting the doctor to say something [about the baby’s death]. He did not even say anything. He just checked me [medical assessment]... I feel maybe he didn’t know [that the baby died]. I now told him, he said oh sorry madam, as in just sorry madam. As in he didn’t even [show], no remorse, no pity.” [Bidemi]*

*That’s my problem...it’s not their business*

There was an expectation from most mothers of follow-up contact for support in the community such as a phone call from the hospital. This stemmed from the belief that they had suffered the death of a baby and should be offered emotional support beyond their hospital stay. There was no offer or provision of further follow-up after the postnatal appointment and all input/care from health care professionals ceased.

*“There’s nobody that called me oh. Nobody called me. They [health care professionals] left it that that’s my problem, it’s happened so it’s not their business.” [Koko]*

##### Nurses’ follow-up outside of health care system

Recognising the lack of formal follow-up, some nurses made voluntary effort to offer support after discharge. A few mothers received follow-up phone calls from nurses on a personal level, outside of their

role. Some mothers also initiated contact with nurses by asking for their phone numbers.

*“It was one nurse. She was the one that used to call me [to ask] “ah how are you feeling?” I purposely collected her number.” [Bankole]*

In the absence of a formal follow-up, many mothers independently sought support from individuals with a health care professional background to address their concerns and gain emotional support. For instance, Sege approached a retired matron as a source of support following her discharge.

*“...[It was] a matron in my church [who has been supportive]. We do talk...she’s a retired matron. She came home and I explained things to her. She told me things to do” [Sege]*

#### Theme 4: support from family

Family members, mothers of bereaved mothers, and partners were a source of emotional and physical support for some mothers.

##### Partners’ support towards mothers

Mothers with supportive partners expressed the belief that men were “stronger” and able to suppress their grief to be present for them. They identified that their partners were grateful that they survived and used this in reassuring mothers of hope for future pregnancies and living babies.

*“He was always there to encourage me that ...thank God you’re alive, the most important thing here is your life and thank God you’re alive and now that you’re alive there is hope, we can make other babies.” [Kanyinsola]*

However, a few mothers had unsupportive partners, with some choosing to end the relationship and marriage due to the baby’s death.

*“I and my husband are as good as not being together now because he is angry that he spent too much and at the end, we lost the baby. He abandoned me. He said let’s not pretend, that he sef [too] is tired of the marriage.” [Adedoyin]*

##### Gaining support from other family members

Most mothers consistently expressed that besides partners and other family members such as siblings, their own mothers or mothers-in-law were a strong and constant source of support. These women and family members lived with the bereaved mother in her own home for a period following hospital discharge, offering support. This ranged from providing physical help with activities of daily living, dressing surgical sites, to emotional support.

*.... my family also came from time to time to check on me and speak with me. They did not leave me... If I’m alone too they would not let me be alone. They’ll tell me to come play and watch TV, and all that.” [Koko].*

Some mothers felt their mothers’ approach to supporting them was too stern which initially upset them. For instance, their mothers threatened return to their own home if they remained sad or tearful despite their presence and support. Another mother explained that her mother asked for the nursery to be cleared to avoid the constant reminder of the baby’s death. Although it was a difficult experience, they understood their mothers’ actions were an effort to support them through their grief.

*“when I got home..., because the baby’s room is opposite my room... my mum told my husband to dismantle everything and tidy it up, I just started crying” [Kanyinsola].*

Conversely, one mother chose to stay with her in-laws who allowed her to grieve in her own way which she regarded as very supportive.

Nevertheless, she expressed she needed someone external to her family thus chose a close friend to speak with about her experiences. Some mothers also found their older children as a source of emotional support and encouragement. For instance, Banky said;

*“...if he see [sic] me that I’m depressed, I used to see it in his face. It feels somehow. He will just be looking at me that mummy are you okay? What happened? I’ll tell him I’m fine. Nothing is happening. Until I smile, the boy will not leave my front. If he did not cheer up, he will not go anywhere. He will just sit down and be saying my mummy is not talking to me.” [Banky]*

#### Discussion

This study explored the lived experiences of women of care and support following perinatal death in South-Western Nigeria. This study is significant because it fills the gap in literature on the topic in Nigeria, one of the countries with the highest global prevalence of perinatal death, which has not been explored previously. The findings reflect some shared similarities amongst women in other studies conducted in Sub-Saharan Africa such as Malawi, Uganda, Kenya and South Africa [2, 21,27]. Mothers felt bereavement care and support following the death of their baby was inadequate, and their expectations were unmet by health care professionals. It was also identified that the experience of care received from health care professionals when there is a living baby is marginally different from when the baby dies, a view also shared by Actis Danna et al.’s (2022) study in Malawi, Tanzania and Zambia. The experience of inadequate care following perinatal death has been mostly linked to areas and regions with poor socioeconomic stances such as Sub-Saharan Africa [13]. However, this finding has also been shared in some HICs as identified in Froen et al.’s [14] study.

Sensitive and kind interactions from health care professionals have been identified as an important aspect of care following perinatal death (Aiyelaagbe et al., 2017). As with the findings in this study, lack of information, communication and emotional support from health care professionals following perinatal death is shared in LMICs and HICs as studies have also found inadequacies in the timings and content of information to mothers, and interactions from health care professionals [8,27,31,32]. This has been associated with exacerbation of the grief experience of perinatal death [24]. Bakhbakhi et al. [6] and Siassakos et al. [32] explained that communication following perinatal death should be concise and timely from health care professionals with a view of preventing worsened grief experiences. The importance of emotional support from health care professional has been identified as aiding the validation of the loss, because perinatal death is not socially recognised thus mothers often feel stigmatised and become prone to mental health difficulties such as anxiety and depression [9,15,20]. There are practices that achieve emotional support for mothers that are encouraged such as seeing and holding their deceased babies as was found to have been inconsistently done in our study. Numerous studies such as Atkins et al., [4] Flenady et al., [13], Hughes et al., [19], Kuti and Ilesanmi, [23] have shown that seeing and holding their deceased babies is a form of emotional support. However, this carries a risk of compounding emotional distress, and negative meanings in some cultural beliefs thus there is often a mixed reception of this practice amongst mothers and health care professionals in LMICs, as also seen in this study [3,5].

Overall, it has been identified in different studies that a structured approach to robust bereavement support within the hospital setting and following discharge such as referral to perinatal death support groups provides better opportunity for mothers to address their grief ([9]; Johnson and Langford, 2015; [15]). Ellis et al. [10] in their systematic review from high income countries found that follow-up support following discharge was appreciated by mothers following perinatal death. This is an initiative that will be beneficial within the Nigerian setting as this is currently not being provided as part of routine bereavement care, and embracing this practice will contribute positively

to the mental wellbeing of mothers following perinatal death.

Although physical support such as assistance with personal care needs, medication administration for instance, were regarded as essential and satisfactory in this and other studies such as Williams et al., [37]. Emotional support remained of utmost importance to mothers in this study.

### Strengths and limitations

One of the strengths of this study is that it explored in-depth the experience of bereaved mothers affected by perinatal death, in a population that has not been studied, in South-Western Nigeria. This created an understanding of the feelings of mothers in relation to their treatment by health care professionals and the system as whole. In addition, data collection was conducted virtually via telephone interviews while mitigating global COVID-19 pandemic restrictions. This had a positive impact as it allowed; a wider reach and, participants to discuss their experiences freely. However, face to face interviews may have helped create a closer rapport between the researcher and participant and allowed a better observation of non-verbal cues thereby adding to the richness of the data. Thus, these are some of the limitations of the virtual approach to data collection. Another limitation of the study was the virtual participant recruitment, there were time gaps between contact persons informing potential participant and their expression of interest to the researcher. Thus, some participants may have been lost during that time. Furthermore, there were difficulties in recruiting partner and family members virtually which was also a limitation in this study. However, the virtual nature of the study is a strength, as it has shown that qualitative studies into lived experiences can be undertaken effectively with the assistance of technology.

### Conclusion

Overall, this study offers a unique insight into the areas where care and support are lacking and the perception of mothers in relation to their experience of the provision. It is evident from this study that mothers feel inadequately supported by the health care professionals and system due to the lack of defined procedures on bereavement care and support following perinatal death, and increased workload particularly on nurses. The recommendations from this study include that bereaved mothers should be treated as a priority, communication should always be maintained by health care professionals, emotional support should be considered beyond words of encouragement, and follow-up support post discharge should be developed. Nonetheless, further research is required to explore ways of improving the care and support provided to mothers following perinatal death in South-Western Nigeria. There is also a need for further research into the care and support experiences of partners and family members following perinatal death.

### Funding Sources

There has been no financial assistance with this review.

### Ethical Statement

Ethical approval was gained from the University of Manchester and Lagos State Government Research Ethics Committee.

### CRedit authorship contribution statement

**Omotewa Kuforiji:** Conceptualization, Writing, Data collection and analysis, Writing – review & editing. **Karina Lovell:** Supervision, Review, Editing. **Tracey Mills:** Supervision, Review, Editing.

### Declaration of Competing Interest

None Declared.

### Acknowledgements

This study was conducted under the supervision of the researcher's PhD supervisory team.

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