

MOTHERS' ACCESS TO SUPPORTIVE HOSPITAL SERVICES AFTER THE LOSS OF A BABY THROUGH STILLBIRTH OR NEONATAL DEATH

Ms J Conry

MSD (Play Therapy)

Social Worker: Randaid, Lyndhurst

Dr C Prinsloo

DPhil

Senior Lecturer: Department of Social Work and Criminology, Faculty of Humanities, University of Pretoria, Pretoria

Corresponding author: reineth.prinsloo@up.ac.za

Keywords: grief; hospital services; neonatal death; stillbirth; support

ABSTRACT

Every year, 3-5% of pregnant mothers in South Africa lose their babies to a stillbirth or neonatal death. These mothers need adequate services to prevent complications in their grieving process. Most of these babies are lost in hospital settings, so the treatment medical staff provide is vital. This study examined mothers' experiences of accessing hospital, religious, formal and social services after a stillbirth or neonatal death. An exploratory research design was used to conduct applied research. A semi-structured interview schedule was used with a sample of 15 mothers who had lost a baby in the last 5 years. The findings were analysed quantitatively and qualitatively. The primary focus of this article is the quantitative findings relating to hospital services. The sample was small and these results cannot be generalised, but some conclusions are reached and recommendations are made to service providers in hospitals working with mothers who have lost babies. Mothers generally experienced the support services from hospitals as inadequate, compared to what hospitals could offer. Mothers that receive support after the loss of a baby generally cope better. This support thus assists them in the grieving process. Hospital staff can be trained to provide these services.

OPSOMMING

In Suid-Afrika verloor 3-5% swanger moeders hulle babas deur stilgeboorte of neonatale dood. Hierdie moeders benodig voldoende dienste om komplikasies in die rouproses te verhoed. Die behandeling deur mediese personeel is uiters belangrik omdat die meeste van dié babas in 'n hospitaalopset sterf. Hierdie studie het moeders se ervarings van die toeganklikheid van hospitaal-, godsdienstige, formele en sosiale dienste na die dood van hulle babas deur stilgeboorte of neonatale dood ondersoek. Toegepaste navorsing is met behulp van 'n verkennende navorsingsontwerp gedoen. 'n Semi-gestruktureerde onderhoudskedule is gebruik met 'n steekproef van 15 moeders wat hulle babas in die vorige 5 jaar verloor het. Die bevindinge is kwantitatief en kwalitatief ontleed. Hierdie artikel fokus primêr op die kwantitatiewe bevindinge wat op hospitaaldienste van toepassing is. Die steekproef was klein en bevindinge kan nie veralgemeen word nie, maar gevolgtrekkings en aanbevelings word gemaak vir diensverskaffers in hospitale wat met moeders werk wat hul babas verloor het. Respondente het die ondersteuningsdienste by hospitale oor die algemeen as onvoldoende ervaar in vergelyking met dié wat hospitale behoort aan te bied. Moeders wat wel ondersteuning na die verlies van 'n baba ontvang, funksioneer oor die algemeen beter. Die ondersteuning help hulle in die rouproses. Hospitaalp personeel kan opgelei word om hierdie dienste te verskaf.

INTRODUCTION

Losing a child is probably the most painful and devastating event that a parent can ever experience. One expects to lose one's parents, and becoming a widow or widower is entirely possible, although painful. But in our society, to lose one's child to death seems out of order, unthinkable, a stunning, devastating turning of the tables (Milo, 1997:443).

The death of a baby appears to be something that is outside the "natural order" and it is a particularly painful and difficult event. For many people, this is their first encounter with grief. Bereaved parents have described their feelings as numbness, emptiness, fear, desperation, frustration and bewilderment. Chumbley (1997:107-109) emphasises that although every parent experiences grief differently, all have to go through the difficult grieving process.

The death of a baby is no less significant a death than any other. "Nobody understands" is a feeling that those left behind often express after the loss of a child. Comments like "you can always have another one" and "it would have been worse if the child were older" leave parents feeling isolated. This lack of understanding by the general community often leads to a sense that there is inadequate or no support. It also causes suppressed grief and intense loneliness (Moody & Arcangel, 2002:41-42). To prevent complications in the grieving process, it is essential that any services offered be easily accessible and of a high standard.

Many stillbirths and neonatal deaths occur within a hospital setting. As a result, the services and support that the bereaved mothers (and, by implication, fathers) receive from the hospital staff are particularly relevant. According to Kohner and Henley (1997:47), most parents have vivid memories of their baby's death and of the events surrounding it. The empathy and care that the parents receive at the hospital generally colour their memories of their child. Members of the nursing staff need to be informed about and trained in how to support bereaved mothers adequately. Awareness of the needs of these mothers and the necessity for helpful accessible services are paramount. Stillbirth and neonatal death affect between 3% and 5% of South African mothers (South Africa People, 2002:1; Perinatal Education Programme, 2003:2). According to Engler

and Lasker (2000:231) and Curren (2001:118-120), understanding the significance of the loss of a child is tremendously meaningful in recovering from such a loss.

CONTEXTUALISING THE RESEARCH

Grief, mourning and bereavement

Although bereavement, grief and mourning are closely linked, the meanings of these terms are very distinct. Oliviere, Hargreaves and Monroe (1998:121) define bereavement as the loss of a loved one, grief as the emotional process that occurs in one's longing for the loved one, and mourning as the way in which one expresses that grief in one's culture.

The grieving process

The grieving process consists of a number of stages comprising distinct emotions that the grieving person experiences. No two people experience the grief process in the same way (Kübler-Ross, 1997:25-47; Moody & Arcangel, 2002:58; Parkes, 2003:37-46). Cook and Oltjenbruns (1998:98-99) and Keaggy (2002:89) agree that the most intense feelings should have subsided after about two years and continue to lessen over time. Nevertheless, anniversaries such as the child's birthday and the date of death frequently evoke intense emotions, often years after the loss of the child.

According to Schiff (1979:24) and Kübler-Ross (1997:25-47), the stages of the grieving process include shock, denial and isolation, anger, bargaining, depression and acceptance. These stages are discussed below with specific reference to the loss of a child:

- **Shock, denial and isolation:** This stage occurs immediately on hearing of the loss of the child and continues for some time. Denial acts as a defence mechanism to help the parent absorb the reality of the loss slowly. Sleeplessness, poor concentration, detachment and periods of intense pain are all symptomatic of this stage.
- **Anger:** Anger and bitterness are particularly common following the death of a child, as the death appears to be an injustice and does not seem to follow what appears to be the natural sequence of events (Mehren, 1997:108).

According to Moody and Arcangel (2002:38), anger frequently manifests itself as bitterness, hatred, rage and resentment. Doctors, nurses, paramedics, spouses, God and even the deceased individual are often the targets of such emotions. Parents often feel guilty about these feelings. Most frequently, feelings of anger are turned inwards following the loss of a child, thus manifesting as intense guilt.

- **Bargaining:** According to Kübler-Ross (1997:93-95), this is the phase of grief where the parent attempts to contract some sort of agreement, usually irrationally, to change what has happened. This attempt is usually linked to those issues about which the parent feels guilty.
- **Depression:** Moody and Arcangel (2002:45) suggest that depression occurs when the reality of what has occurred is acknowledged and sinks in, and the pain of the loss begins to take its course. Support is essential in order to prevent ongoing depression.
- **Acceptance:** Acceptance means that the parent ultimately becomes resigned to the fact that nothing can be done to change what has happened. Some people move beyond acceptance of the death to the promise to do all that they can to further the legacy of the person who has passed away. Many research foundations, support groups, hospitals and other organisations have been founded in memory of people who have passed away.

Dysfunctional grief responses

According to Moody and Arcangel (2002:96), the function of a normal or healthy grief process is to allow survivors to identify, acknowledge, feel and integrate what they love but are now without. Dysfunctional grief prolongs suffering, interrupts normal activities and prevents life from being lived to the full. Cook and Oltjenbruns (1998:125) and Friedrichs, Daly and Kavanaugh (2000:302-304) refer to dysfunctional grief as complicated grief. Grief can become complicated if the relationship between the survivor and the deceased was conflicted, the survivor has had previous mental health problems, there is a perceived or actual lack of support for the survivor, the death was sudden or unanticipated, there is a perception that the death may have been preventable, the death is the loss of a child,

or the survivor has unresolved past losses.

Grieving for a baby

Thomas (1993:18) writes: "I really don't think there can be anything more horrifying than to have your own baby breathe his last breath in your arms." The loss of a child is especially painful for parents and is unique in its impact and intensity. When a baby dies, the parents' hopes and dreams for that child die too. Instead of planning a nursery and a future for the child, the parents are left to deal with a funeral.

According to Kohner and Henley (1997:9), the significance of a baby's death has not been fully recognised in the past, and bereaved parents have often struggled with their grief alone. The loss of a baby is just as significant as the loss of any other child or person. Gensch and Midland (2000:290) explain that grief is experienced in relation to the significance of the attachment, not the length of the pregnancy. The parent has a significant attachment to his or her child, regardless of the child's age.

The lack of understanding for their feelings of grief often leaves parents who are mourning a baby questioning their emotions and feeling guilty about the intensity of what they are experiencing. The emotions are often overwhelming. Abnormal grief responses are not uncommon. According to Engler and Lasker (2000:228), as many as 20-30% of women show some form of complicated grief in the first year following a perinatal loss. (In this study, the focus was on mothers. This is not meant to imply that fathers experience the loss of a child less intensely, but their particular responses fall beyond the scope of this study.)

Maternal grief predictors

According to Engler and Lasker (2000:229-231), a number of factors can be used to predict whether or not a mother's grief will be healthy or complicated. These factors include the following:

- Support - strong familial and social support, as perceived by the mother, can make a significant difference to her ability to cope with her grief. According to Engler and Lasker (2000:229), Riches and Dawson (2000:10) and Rich (2000:246), the experience of everyday support, patterns of family interactions, friends, relationships with people at work and in the

neighbourhood, specialised agencies and self-help groups are crucial in coming to terms with bereavement.

- Relationship satisfaction - a strong marital or couple relationship, where there is a deep understanding of each other, aids in the grief process.
- Ways of coping - people who cope by using their own inner strength along with the support offered by others generally manage the grief process better than those who try to cope on their own (Rybarik, 2000:222).

SERVICES AVAILABLE TO MOTHERS AFTER THE DEATH OF A BABY

According to Kohner and Thomas (1995:1) and Ryan (2000:3), the lack of understanding displayed by society at the significance of the death of a baby has often resulted in poor and sub-standard support services for these mothers. Accessing services that offer support is essential if the grief process is to be well managed (Rich, 2000:246). Awareness of the needs of mothers who have lost a baby and the need for helpful accessible services must be raised in order to assist mothers through the grief process and to prevent complicated grief.

Hospital services

Because most stillbirths and neonatal deaths occur in a hospital setting, the supportive nature of the hospital services provided to bereaved mothers is particularly relevant. According to Kohner and Henley (1997:47), Gensch and Midland (2000:288), Ryan (2000:159-165) and Rybarik (2000:222), most parents have vivid memories of their baby's death and the surrounding events. The support that the mother receives in the hospital where her baby dies often dictates the nature of her memories. Parents who receive adequate support after the death of a baby generally come to terms with their loss more easily and are able to carry on with their lives with greater ease.

It appears that hospital support programmes are often inadequate and, in many cases, non-existent. According to Gensch and Midland (2000:286-287), many of the recommendations offered to parents experiencing a loss actually tend to deny the existence of their baby and

their identity as parents to the baby who died. Few antenatal classes offer advice on how to deal with such a loss. The shock and numbness that parents feel often leads to them to make decisions concerning their baby that they later regret.

Gensch and Midland (2000:286-290) suggest that a number of points should be taken into account by hospital staff when they are devising a strategy to deal with bereaved parents. These points are also emphasised by the Child Bereavement Trust (2000:2), Ujda and Bendiksen (2000:310-321) and Kavanaugh and Paton (2001:369-376). The following are some of the options hospital staff can offer parents:

- Parents should be encouraged to hold or touch the baby following the death and this offer should remain open for some time. According to Durlak (1998:61), preventing opportunities to see and hold the deceased baby complicates the mother's grief.
- Photographs of the baby should be taken from different angles. These may be the mother's only physical reminders of her child and many mothers who are not given photographs of their child regret this later.
- Journals, memory boxes or memory books should be given to the parents. Significant mementos such as footprints, handprints, locks of hair, toys and worn clothing may be placed in such boxes. The baby should be weighed and measured and this information should also be included in the journals.
- Baptisms or religious ceremonies should be offered to the parents. Parents should also be aided through funeral plans.
- Accurate information concerning the cause of death should be provided to the parents. Hospital staff must be honest. Ongoing communication ultimately enhances the wellbeing of the parents.
- Mothers who have lost their babies must not be placed in the maternity ward with other new mothers, since it is difficult for the bereaved mothers to see others with their healthy babies.
- Many mothers have expressed appreciation for hospital staff who showed sincere emotions when the babies died and showed them that their babies had had an impact on lives other than their own.

- Counselling by a trained professional should be offered to the parents prior to (if possible) and immediately after the death. Details on support groups and website addresses must also be provided. Follow-up phone calls should be made to the parents after they leave the hospital (Ujda & Bendiksen, 2000:267).

AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to explore the access that bereaved mothers have to services following the death of their babies due to a stillbirth or neonatal death. The objectives of the study were:

- to investigate the loss of a baby through stillbirth or neonatal death;
- to investigate access to support services offered to mothers following the death of a baby due to a stillbirth or neonatal death; and
- to reach some conclusions and make recommendations on the current practices and future research on the services offered to mothers who have lost a baby due to a stillbirth or neonatal death.

RESEARCH METHOD

The research design was exploratory in nature in that there has been no prior research into the experiences of bereaved mothers in Gauteng regarding the availability of support services following the loss of their babies due to a stillbirth or neonatal death. A one-shot case study method was used – this means that a single group that had the same experience was purposively selected. This study involved applied research, as it provided information on how support services for such mothers could be improved at a practical level. The research had immediate application value at the time of completion, as recommended by Bless, Higson-Smith and Kagee (2006:45) and Salkind (2006:15).

A number of experts were consulted in the course of the study because, as Strydom (2005:207) argues, despite the wealth of literature that may be available on a particular topic, the invaluable contribution that can be made on a particular topic by experts in the field should never be overlooked. In the study, an interview schedule with a list of questions was used as a measuring instrument (Rubin & Babbie, 2001:209).

Fouché and De Vos (2006:134) explain that semi-structured interviews can be used fruitfully to collect data in exploratory designs. The interview schedule was piloted with three mothers who did not form part of the final research sample. The literature review done in this study and the pilot test both informed the final interview schedule.

A combination of quantitative and qualitative approaches were used, particularly the dominant-less-dominant model outlined by Cresswell (1994) in De Vos (2002:266), with the quantitative approach more dominant than the qualitative approach in this study. The nature of the topic, namely the experiences of mothers in accessing services following the death of a baby, dictated the choice of a more quantitative approach. Data was collected by using an administered interview schedule – for the purposes of this study, it was used both qualitatively and quantitatively. Although the mothers were given an opportunity to add personal extra information, the survey was primarily quantitative in that many of the questions that the mothers were asked were structured and sought a response to a specific question, and most of the information obtained from the schedule was analysed statistically, as described by Salkind (2006:187).

The study featured some qualitative aspects. Some of the questions in the interview schedule made ample allowance for the responding mothers to explore their own personal experiences so that information could be gathered concerning the uniqueness of each experience. Some of the questions in the schedule were therefore open-ended, allowing for further exploration. These open-ended questions were analysed by looking for themes and sub-themes, an aspect that makes part of the study qualitative, as explained by De Vos (2005:338).

Non-probability sampling was selected as the preferred method for the study. The sample was selected based on the availability of bereaved mothers and was not representative in terms of the criteria explained by Strydom and Venter (2002:207). A number of criteria were predetermined for the sample, making it purposive in nature, as explained by Bless *et al.* (2006:106). These criteria included the following:

- the respondents were all mothers, of any age, who had lost a baby;

- the baby was lost due to a stillbirth or neonatal death;
- the baby had passed away within the last five years; and
- the mothers were all members of a support group, either Compassionate Friends or Baby Angels.

Fifteen semi-structured interviews were conducted by one of the authors, and all were conducted in English. The interviews were time-consuming because of the sensitive nature of the topic. The interview schedule included the following:

- identifying details – the age of the respondent, the number of children the mother had (including the baby who passed away), each child's current age and sex, the age of the sibling(s) at the time of the baby's death, the respondent's age at the time of the baby's death and the cause of the baby's death;
- support – need for support to help deal with the loss of the baby, to whom the respondent turned for support, the nature of the support sought and received and the respondent's experience of society's understanding of the loss;
- hospital services – description of hospital experience (Did the mother hold and touch the baby? Were photographs taken of the baby? Was a book of remembrance given? Were mementos of the baby provided?), provision of information concerning the cause of the baby's death, the respondent's experience of hospital staff and the way they dealt with the respondent after the death of the baby, the most supportive aspect at the hospital, the least supportive aspect at the hospital, how the hospital could improve services to bereaved parents following the loss of a baby;
- formal services – hospital counselling (Was any counselling provided by the hospital? What were the benefits and shortcomings of the counselling? Were the respondents provided with details of support groups/support websites or outside counsellors by the hospital?), external individual counselling in order to cope with loss of the baby, support groups to cope with the loss of the baby; and
- suggestions for improving services and for other

services to be provided.

ETHICAL CONSIDERATIONS

The research was approved by the Research Proposal and Ethics Committee of the Faculty of Humanities at the University of Pretoria. Given that the information provided was highly sensitive, it was necessary for a number of ethical issues to be taken into consideration in conducting the research, as recommended by Babbie and Mouton (2001:522-527) and Strydom (2002:64-73):

- Informed consent was obtained from all respondents.
- The confidentiality of the respondents' details was ensured.
- No harm came to the mothers (this was ensured through the sampling criteria, making it necessary for all the participating mothers to have access to a support group network).
- Any necessary debriefing was done.
- The limitations of the study methodology were outlined.

FINDINGS ON MOTHERS' ACCESS TO HOSPITAL SERVICES

Identifying details

A total of 15 mothers were interviewed. Their ages ranged from 23 years to 41 years, with a mean age of 31 years. Four (26.7%) of the mothers interviewed had no other children besides the one who passed away. Six (40%) of the mothers had two children, four (26.7%) had three children and one (6.6%) had four children. All these figures include the baby/babies that passed away. Three of the mothers were pregnant at the time of the interviews, one with her second child and two with their fourth child. Two of the mothers had lost twins.

In total, these 15 women had lost 17 babies. Of these babies, twelve (70.59%) were male and five (29.41%) were female. For ten (66.67%) of the mothers interviewed, the baby who passed away was their first child. Five (29.41%) of the babies were stillborn. Three mothers were aware of the reasons for the stillbirth, but two were not. Five (29.41%) babies died due to premature birth. One of these babies was five days old, one was three days old and three were two days old when they

died. Three (17.65%) babies died due to genetic abnormalities. One of these babies was five days old, one was three days old and one was two days old at the time of death. Three (17.65%) babies died as a result of illness. One of these babies was one day old at the time, one was nine days old and the oldest baby was twenty days old at the time of her death. Finally, one (5.88%) of the babies died as a result of asphyxia during the birth process. He lived for a day. The mean age of the babies at the time of their death was three days old.

Hospital services

All 15 mothers interviewed lost their babies in hospital. Of the mothers interviewed, ten (66.7%) described their stay at the hospital as being generally supportive, but five (33.3%) felt that it was not.

Parents who have lost a baby should be encouraged to hold the baby and this offer should remain open for a while. Preventing such opportunities can complicate the grief process. Of the mothers interviewed, 14 (93.3%) were given an opportunity to hold their babies while or after they died. Many of these mothers expressed regret that they had not been able to do so for longer.

All of the mothers were put in their own rooms. Only one mother had her baby's photograph taken by the hospital as a matter of protocol. The rest of the mothers either took their own photographs or had somebody take photographs for them. Although 12 (80%) of the mothers were given footprints of their babies as mementos when leaving the hospitals, most of the mothers expressed the view that they would have liked more mementos. The mothers particularly regretted not being given a lock of their baby's hair.

Of the mothers, four (26.7%) had their babies baptised at the hospital. The hospital arranged the baptism in only one case. McGoldrick and Walsh (2005:190) are of the opinion that in cases of perinatal loss, grief is facilitated by encouraging a couple to name and have contact with the newborn, hold a simple memorial service and bury the child in a marked grave.

Of the mothers interviewed, seven (46.7%) felt satisfied with the information provided to them on the cause of their baby's death and found the doctors approachable.

Eight (53.3%) of the mothers were not provided with such information. Some of these mothers felt that their doctors were unapproachable and insensitive, and that this was the reason for their lack of information, while others felt that the information was not provided to them because it was unknown to the doctors. No autopsies were carried out on any of the babies, although one mother regretted this decision.

Three main themes emerged from the mothers' descriptions of the hospital staff. The staff were seen as either totally supportive, compassionate and understanding, or conversely, as totally unsupportive, or respondents said that some staff members were supportive while others were not. Interestingly, the number of mothers who saw the staff as being totally unsupportive was very close to that of the mothers who described the hospital experience as unsupportive. Engler and Lasker (2000:229), Riches and Dawson (2000:10) and Rich (2000:246) all believe that the support received by the mother following the death of her child is the single most important factor in predicting the nature of the grief process that she will experience.

Twelve (80%) of the mothers described ways in which the hospital was supportive of them. The themes of support that emerged were some very supportive staff members, the opportunities they were offered to make memories of their babies and the permission they had to have visitors at any time. By contrast, the themes identified by 93% of mothers as unsupportive in the hospitals were certain unsupportive staff members, and the lack of opportunities provided to them to make memories of their babies.

Formal services

Only one of the mothers interviewed received counselling from the hospital. This was only one session, which she was unable to remember as a result of the medication she had been given. She indicated that she would have appreciated being approached at a more appropriate time. Eleven (73.3%) of the mothers stated that they would have liked to have been given an opportunity to see a hospital counsellor. Five (33.3%) of the mothers were given the details of support structures by the hospitals. Two (13.3%) of the mothers were visited by support groups at the hospital, two (13.3%) were given details of support groups and one

(6.7%) was given the details of a counsellor. McGoldrick and Walsh (2005:190) emphasise the need for brief couples' therapy or a focused couples' group to facilitate the mourning process and help the bereaved parents to provide mutual support. This helps the couple to get the individual support that they need, since they cannot assuage each other's sense of loss and emptiness.

Suggestions for improving services

All but one respondent gave suggestions on how they felt the hospital could improve the services offered to mothers. A strong theme emerging from these responses was that hospitals should have a more structured procedure in place for dealing with bereaved mothers. Another main theme was that hospital staff need more training. A sub-theme was more information, both on the grief process and their baby's cause of death. Gensch and Midland (2000:286-287) and Kavanaugh and Paton (2001:369-376) emphasise that hospital staff must be adequately informed about and trained in how to deal with parents in times of loss. Understanding the depth and significance of the loss of a baby is essential and a suitable strategy and programme need to be in place for parents following the death of their child.

Three (20%) of the mothers felt that bereaved mothers should be kept pain-free and a further three (20%) felt that hospitals should employ a person specifically trained to deal with bereaved mothers. Three (20%) mothers felt that hospitals should follow up on bereaved mothers. Other suggestions included improving communication and offering referral information upon discharge. Thomas (1993:21) suggests that counsellors should be available to offer support as soon as possible after the death of the baby, if not before; they should provide the parents with options concerning their child and make sure that options are explored before decisions are made.

- Information should be clarified for the mother and, if necessary, contact should be made with the medical staff responsible for the baby in order to do so.
- Home visits and follow-up counselling services after the mother has been discharged from the hospital are essential.
- Medical staff should be trained in how to deal with mothers who lose a baby and make sure

that proper procedures and structures are in place if such an eventuality does occur.

CONCLUSIONS AND RECOMMENDATIONS RELATING TO HOSPITAL SERVICES

Given the small sample size and the findings of this study, the findings cannot be generalised. However, the study still provides valuable information from which conclusions may be drawn. The findings in relation to the hospital services are listed below:

- Mothers need support after losing a baby through a stillbirth or neonatal death.
- Society at large does not understand the profundity and significance of the loss of a baby. It appears that society believes that grief lessens with time.
- Hospital services provided to mothers who have lost a baby through a stillbirth or neonatal death are inadequate. Although ten (67%) of the mothers in this study described the hospitals in which they lost their babies as having been supportive, based on the literature outlining the procedures that could or should be in place for bereaved mothers and the mothers' descriptions of the services that they actually received, the services appear to be inadequate.
- Most hospitals do not have a procedure in place to assist bereaved mothers, and hospital staff members are not adequately trained in how to help bereaved mothers.
- Most mothers surveyed in this study, whether they defined their hospital experiences as supportive or not, had regrets pertaining to their hospital stay. These relate particularly to their making memories of their deceased babies.
- The most important factors defining the hospital experiences of mothers are the support of the staff and the opportunities provided to the mothers to make memories of their babies.

In general, these mothers were not provided with counselling by their hospitals after the deaths of their babies at the hospitals, despite the general desire amongst mothers to receive such counselling.

As a result of the findings and conclusions from this study, the following recommendations regarding hospital services are made:

- Hospital staff must be better trained in the significance of the loss of a baby and in how to help bereaved mothers.
- A procedure must be put in place at hospitals concerning what to do if a mother loses her baby. All staff members involved with the mother should be trained in this regard.
- Mothers should be encouraged to hold their babies, photographs of the babies should be taken by the hospital and all possible mementos of the babies should be collected.
- The parents should be provided with information concerning the death of their babies and the grief process.
- Mothers should be offered a baptism of their babies.
- Mothers should be given a separate room following the death of their baby.
- Mothers should be kept pain-free following the death of their baby.
- Hospitals should follow up on mothers who have lost a baby.
- Hospitals should refer mothers for outside support upon discharge.
- Hospitals should consider employing or contracting grief experts to help them deal with bereaved mothers.
- Antenatal classes should include, as part of their syllabus, a discussion on the loss of a baby, what parents should do in such circumstances and the grief process.

LIMITATIONS OF THE STUDY

As a result of the nature of the sample under examination (it was small, the cases were reasonably alike and not random), the findings of the study cannot be generalised to society at large. This may affect the reliability, validity and statistical significance of the study. Since the study was limited to the mothers' perceptions of the accessibility and quality of the services, it may also have a limitation of being biased.

Because the study was conducted by means of an administered interview schedule, in the presence of the interviewer, respondent bias may have been present. Very limited local literature was available on the topic; therefore mostly American and British literature was studied. The reliability of the study may therefore have

been affected by the lack of local literature on the topic under review. Some aspects of the data that was gathered required the mothers to recall their perceptions of an emotionally troubling event that had happened (in some cases) some time ago. Although the study limited the sample to mothers who had lost babies within the last five years, time may still have influenced their perceptions. Their current recollections of the events may not have been accurate either because some of the mothers were on medication at the time of the deaths of their babies.

CONCLUSION

In conclusion, it was found that not only is the loss of a baby devastating and heartbreaking for the mother, the services offered to her are neither of adequate quality nor accessible. Good quality services in this regard are desperately needed, as stillbirths and neonatal death are phenomena that affect between 3% and 5% of South African mothers. To prevent complications in the grieving process of these mothers, services need to be of a particularly high quality and should be easily accessible. Hospitals must have a procedure in place to assist mothers who lose their babies, and hospital staff must be trained to work with bereaved mothers. It is clear from the research results that mothers who lose their babies are in shock and need the hospital staff members to support them in ensuring that they receive mementos and go through some helpful rituals. These will ultimately be the only memories that they take home to an empty nursery.

The sample in the study was small and the results therefore cannot be generalised. Larger studies should be done on the evaluation of hospital services provided to bereaved mothers. Adequate support is essential to a bereaved mother for her to overcome her grief and to move on with her life.

The Child Bereavement Trust (2000:1) captures the necessity for support services in the following statement: "Grief that is ignored can harm us in countless ways. To support families at such difficult times and to minimise the effect of long-term psychological problems, it is crucial that professional carers are able to recognise and respond appropriately to families' varied emotional needs."

REFERENCES

- BABBIE, E & MOUTON, J 2001: The practice of social research. Oxford: Oxford University Press.
- BLESS, C; HIGSON-SMITH, C & KAGEE, A 2006: Fundamentals of social research methods. An African perspective; 4th edition. Cape Town: Juta.
- CHILD BEREAVEMENT TRUST 2000: The Child Bereavement Trust: Support and counselling for grieving families. Wycombe.
- CHUMBLEY, J 1997: Cot death: The facts. London: Ward Lock.
- COOK, AS & OLTJENBRUNS, KA 1998: Dying and grieving: Life span perspectives; 2nd edition. Orlando: Harcourt Brace.
- CURRER, C 2001: Responding to grief: Dying, bereavement and social care. New York: Palgrave.
- DE VOS, AS 2002: Combined quantitative and qualitative approach. (In: De Vos, AS; Strydom, H; Fouché, CB & Delpont, CSL eds. 2005: Research at grass roots: For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 363-372).
- DE VOS, AS 2005: Qualitative data analysis and interpretation. (In: De Vos, AS; Strydom, H; Fouché, CB & Delpont, CSL eds. 2005: Research at grass roots: For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 333-349).
- DURLAK, JA 1998: Dealing with traumatic deaths. **Contemporary Psychology**, 43(1), January:61.
- ENGLER, AJ & LASKER, JN 2000: Predictors of maternal grief in the year after a newborn death. **Illness, Crisis and Loss**, 8(3), July:227-243.
- FOUCHÉ, CB & DE VOS, AS 2005: Quantitative research designs. (In: De Vos, AS; Strydom, H; Fouché, CB & Delpont, CSL eds. 2005: Research at grass roots: For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 132-143).
- FRIEDRICH, J; DALY, MI & KAVANAUGH, K 2000: Follow-up of parents who experience a perinatal loss: Facilitating grief and assessing for grief complicated by depression. **Illness, Crisis and Loss**, 8(3), July:296-309.
- GENSCH, BK & MIDLAND, D 2000: When a baby dies: A standard of care. **Illness, Crisis and Loss**, 8(3), July:286-295.
- KAVANAUGH, K & PATON, J 2001: Communicating with parents who experience a perinatal loss. **Illness, Crisis and Loss**, 9(4), October:369-380.
- KEAGGY, B 2002: Losing you too soon: Finding hope after miscarriage or the loss of a baby. Oregon: Harvest House.
- KOHNER, N & HENLEY, A 1997: When a baby dies: The experience of late miscarriage, stillbirth and neonatal death. London: Harper Collins.
- KOHNER, N & THOMAS, J 1995: Grieving after the death of your baby. Buckinghamshire: The Child Bereavement Trust.
- KÜBLER-ROSS, E 1997: On death and dying. New York: Simon & Schuster.
- MCGOLDRICK, M & WALSH, F 2005: Death and the family life cycle. (In: Carter, B & McGoldrick, M eds. 2005: The expanded family life cycle. Individual, family and social perspectives; 3rd edition. Boston: Pearson, pp 185-201).
- MEHREN, E 1997: After the darkest hour, the sun will shine again: A parent's guide to coping with the loss of a child. New York: Simon & Schuster.
- MILO, EM 1997: Maternal responses to the life and death of a child with a developmental disability: A story of hope. **Death Studies**, 21(5):443-476.
- MOODY, R & ARCANGEL, D 2002: Life after loss: Finding hope through life after life. London: Ebury.
- OLIVIERE, D; HARGREAVES, R & MONROE, B 1998: Good practices in palliative care. Aldershot: Ashgate.
- PARKES, CM 2003: Acquainted with grief. **Illness, Crisis and Loss**, 11(1), January:37-46.
- PERINATAL EDUCATION PROGRAMME 2003: Available from: http://www.pepcourse.co.za/newborncare/Unit38_p8.html (Accessed 20 September 2006).
- RICH, DE 2000: The impact of post pregnancy loss services on grief outcome: Integrating research and practice in the design of perinatal bereavement programmes. **Illness, Crisis and Loss**, 8(3), July:244-264.
- RICHERS, G & DAWSON, P 2000: An intimate loneliness: Supporting bereaved parents and siblings. Buckingham: Open University Press.
- RUBIN, A & BABBIE, E 2001: Research methods for social work; 4th edition. Belmont, CA: Wadsworth.
- RYAN, A 2000: A silent love: Personal stories of coming to terms with miscarriage. Harmondsworth: Penguin.
- RYBARIK, F 2000: Perinatal bereavement. **Illness, Crisis and Loss**, 8(3), July:221-226.
- SALKIND, NJ 2006: Exploring research; 6th edition. New Jersey: Pearson.
- SCHIFF, HS 1979: The bereaved parent. London: Souvenir Press.
- SOUTH AFRICA PEOPLE 2002: The 2002 World Fact Book of the United States Central Intelligence Agency 2002. Available from: http://www.greekorthodoxchurch.org/wfb2002/south_africa/south_africa_people.html (Accessed 16 October 2006).
- STRYDOM, H 2002: Ethical aspects of research in the social sciences and human service professions. (In: De Vos, AS; Strydom, H; Fouché, CB & Delpont, CSL eds. 2005: Research at grass roots: For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 62-76).
- STRYDOM, H 2005: The pilot study (In: De Vos, AS; Strydom, H; Fouché, CB & Delpont, CSL eds. 2005: Research at grass roots:

For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 205-216).

STRYDOM, H & VENTER, L 2002: Sampling and sampling methods. (In: De Vos, AS; Strydom, H; Fouché, CB & Delport, CSL eds. 2005: Research at grass roots: For the social sciences and human service professions; 3rd edition. Pretoria: Van Schaik, pp 197-209).

THOMAS, J 1993: Supporting parents when their baby dies before or soon after birth: A guide for staff antenatal, labour ward, postnatal gynaecological and neonatal teams. London: Expression.

UJDA, RM & BENDIKSEN, R 2000: Health care provider support and grief after perinatal loss: A qualitative study. **Illness, Crisis and Loss**, 8(3), July:265-285.