EFFECT OF INDIVIDUALIZED GRIEF COUNSELLING ON POSTPARTUM MOTHERS PSYCHOLOGICAL WELLBEING, FOLLOWING PERINATAL DEATHS IN THARAKA NITHI COUNTY, KENYA

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DECLARATION AND RECOMMENDATION

Declaration

This thesis is my original work and has not been presented for award of diploma or conferment of degree. to any University

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Recommendation

This thesis has been examined, passed and submitted with our approval as University supervisors.

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DEDICATION

This thesis is dedicated to all mothers who have experienced the pain of perinatal loss, carried love but could not carry life whose courage and resilience inspired every page of this work.

And to the memory of every tiny soul, whose heartbeat was too brief; those little lives gone too soon, yet the memory lives forever, whose silent presence continues to speak volumes in our hearts.

I dedicate this work also to my precious family, for their inspiration, unwavering support, encouragement, and sacrifices that made this educational journey possible. To my lovely parents, Esther and Dunstan, thank you for teaching me the meaning of education.

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ABSTRACT

A perinatal death is the death of a foetus or neonate between 28 weeks of gestation and 7 days after birth. Estimated global statistics on perinatal deaths are 3.3 million stillbirths and 2.8 million early neonatal deaths worldwide every year, with about 98% in low and middle-income countries. Perinatal deaths, encompassing stillbirths and neonatal losses, profoundly affect the mental health of postpartum mothers leading to grief, depression, and anxiety. To support the affected mothers, this study sought to assess the effect of individualized grief counseling on postpartum mothers' psychological well-being following perinatal loss in Tharaka Nithi County. The study was based on Kübler-Ross's Stages of Grief theory. Randomized controlled trial (RCT) design was used and it was implemented in three phases, baseline, intervention, and post-intervention phases. Census and purposive methods were used to sample 53 mothers from participating hospitals, where the sampling frame was neonatal and postnatal mortality records. Ten counselling staff working in the selected hospitals with maternity wards in Tharaka Nithi County were also involved. Data collection tools included Perinatal Grief Scale, questionnaires and interview guide. Statistical Package for Social Sciences, (SPSS version 29) software was used to analyze qualitative and quantitatively data. Statistical tools such as regression, correlation, Analysis of variance (ANOVA) and T-test were used for analysis at 95% confidence interval. Results were presented in narratives, figures, and tables. Individualized grief counseling on postpartum mothers' psychological well-being was statistically significant ($t=-3.97$, $p<0.001$) indicating that mothers exposed to skilled grief counseling by the health professionals (experimental group) had significantly lower grief scores compared to those in the control group. The ANOVA test showed that there was no significant statistical difference between pretest and posttest scores ($F=2\ 87$, $p=0.067$), revealing that the post intervention impact of individualized grief counseling between pretest and posttest scores are similar. Correlation results showed that pretest and posttest scores were positively related. The regression results showed that pretest scores were significant predictors of posttest scores on grief levels ($\beta_0=0.61$, $p<0.001$). Pretest WA p-value of $p=0.001$ was less than the conventional 0.05 threshold, implying that individualized grief counseling significantly reduces grief. The findings of the study can be used by policy makers, health workers and academia in improving the management of postpartum mothers who experience perinatal loss.

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LIST OF ABBREVIATIONS AND ACRONYMS

AAGS	Adult Attitude Grief Scale
ANC	Ante-Natal clinic
CBT	Cognitive Behavioral Therapy
CCRH	Chuka County Referral Hospital
DPM	Dual Process Model of Grief
DSM	Diagnostic Statistical Manual
LMICS	Low- and Middle-Income Countries
NACOSTI	National Commission for Science, Technology and Innovations
NMR	Neonatal Mortality Rate
PGS	Perinatal Grief Scale
PNC	Post-Natal Care
PTSD	Posttraumatic Stress Disorder
RCT	Randomized Controlled Trial
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
TNC	Tharaka Nithi County
WHO	World Health Organization

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Mother–child attachment begins very early during pregnancy, developing from the initial stages, intensifying and reaching its peak around the second trimester, and continues to strengthen even after childbirth. This deep emotional and psychological bond is crucial for the well-being of both mother and child. However, despite the hopeful anticipation and preparations an expectant mother makes, pregnancy does not always result in a healthy baby. Unfortunately, one of the most tragic negative outcomes of pregnancy is perinatal death, which encompasses fetal or neonatal losses occurring near the time of birth (Cates *et al.,* 2025). The process of conception, gestation, and awaiting the arrival of a newborn typically takes at least nine months, a period often filled with hopes, dreams, and plans by the parents. When a fetus or baby dies during this time, it is considered a profoundly tragic event that deeply affects the parents and families involved. The emotional pain experienced is often described as one of the most devastating losses a person can endure (Harrop *et al.,* 2020).

The World Health Organization (2020) and Blencowe *et al*. (2025) provide a clinical definition of perinatal mortality, describing it as the death of a newborn occurring at 28 completed weeks of gestation, or in babies weighing at least 500 grams, or within seven days after birth. This period is recognized as critically vulnerable because both fetus and newborn face significant risks that can lead to death. Perinatal death, therefore, is an important indicator of the quality of maternal and neonatal healthcare services in any country. It not only reflects biological and medical factors but also social determinants of health, including access to quality care, maternal nutrition, and socioeconomic conditions. Given its profound emotional and physical consequences, providing an empathetic and caring environment to support mothers and families who experience perinatal loss is seen as an absolute necessity. Ahmadinezhad *et al.,* (2022) highlights that despite the existence of care protocols aimed at supporting grieving families following such losses, many mothers still report dissatisfaction with the care they receive. This dissatisfaction often stems from a lack of emotional support, inadequate counseling, and the absence of culturally sensitive care.

Parents commonly experience perinatal grief following the death of a newborn or fetus. Midwives and nurses, due to their close and continuous contact with mothers during pregnancy, labor, and postpartum periods, are uniquely positioned to initiate supportive actions that can improve the grieving process. Such support should encompass biological, psychological, social, and spiritual factors that influence parents' experiences of grief (Poursalehi *et al.,* 2020). Parents undergoing this process often suffer a range of negative health outcomes, including disruptions in eating and sleeping patterns, exacerbations of chronic diseases, and an overall diminished quality of life. They are also at increased risk for mental health disorders such as anxiety, depression, and posttraumatic stress disorder (PTSD) (Kersting & Wagner, 2022).

The first category of grief associated with perinatal loss is often termed "impending death," which relates to the mother's physical history, symptoms, and fears surrounding the loss. Current research supports the understanding that such loss results in profound emotional shock, which constitutes significant pain and suffering for the bereaved (Fernández-Sola *et al.,* 2020). Statistics indicate that approximately 3.17% of women who have undergone labor experience pathological levels of PTSD. Unfortunately, exact prevalence rates for post-loss risk factors such as complicated grief, depression, anxiety, and PTSD remain unclear because of inconsistencies in research methodologies and clinical definitions. Reported prevalence rates of complicated grief following perinatal loss vary widely, ranging from 25% to as high as 75% (Berry, 2022).

These alarming statistics highlight a significant disparity compared to the general population, where only about 4% of individuals experiencing other types of loss develop complicated grief (Sochos & Aleem, 2022). This difference underscores the uniquely traumatic nature of perinatal loss and the critical need for empathetic, tailored care. Providing a compassionate, supportive environment for mothers and families experiencing perinatal loss is therefore considered essential. When parents perceive that care is inadequate or inappropriate, they may suffer increased and unnecessary distress, resulting in a negative perception of healthcare services following their loss. Multiple factors influence pregnancy outcomes and grief experiences, including social, cultural, economic, environmental, and genetic determinants (Willcox *et al.,* 2022).

Globally, the burden of perinatal deaths remains alarmingly high. According to the Global Burden of Perinatal Deaths report, it is estimated that around 2.7 million stillbirths and 1.5 million early neonatal deaths occur annually, with 99% of these deaths occurring in low- and middle-income countries (WHO, 2020). This disproportionate distribution points to significant inequalities in healthcare access and quality worldwide. Neonatal death rates vary widely between countries depending on income levels. The challenges of managing and preventing perinatal mortality are therefore greater in resource-limited settings. For example, in the United States of America, it is estimated that between 24,000 and 25,000 infants die before birth each year, resulting in stillbirths (Hicks, 2020). Such loss is often referred to as traumatic grief, which has severe psychological implications for parents and requires targeted support to prevent complicated grief and other psychological disorders for both parents and their surviving children. Despite notable advances in obstetric and neonatal care, the global burden of perinatal mortality remains unacceptably high.

WHO (2020) and Blencowe *et al*. (2025) estimate that approximately 3.3 million stillbirths and 2.8 million early neonatal deaths occur annually worldwide, with about 98–99% of these deaths concentrated in low- and middle-income countries (LMICs). The disparity between high- and low-income countries is stark: neonatal mortality in high-income regions averages fewer than 10 deaths per 1,000 live births, while in the least developed countries it often exceeds 50 per 1,000 live births (WHO, 2020). These differences are shaped by multiple factors, including access to skilled birth attendants, timely obstetric interventions, maternal nutrition, health system infrastructure, and socioeconomic status.

In Europe, the perinatal mortality rate is comparatively lower, ranging from 4 to 6 deaths per 1,000 live births (Blencowe *et al.,* 2021). However, the psychological and social impact of perinatal loss remains substantial. For instance, in Italy, approximately nine couples who experience either pre- or post-delivery baby loss become grieving couples daily. In some parts of Italy, perinatal loss is still considered taboo, creating additional barriers to counseling and psychological support, making the grieving process highly complex (Ravaldi *et al.,* 2020). The outcomes of grief after perinatal loss depend on numerous factors. Women’s feelings and thoughts about grief are

influenced by their cultural background, the experience of life they had before the loss, the actual experience of loss, and their expectations about life after the loss. Ravaldi *et al*. (2020) emphasize that these factors vary significantly between different cultural contexts. Thus, grieving processes in European or developed nations may differ markedly from those in African countries, many of which are classified as developing nations with unique socio-cultural challenges.

In high-income settings, such as the United States, approximately 24,000 infants are stillborn each year-around 5.7 per 1,000 live births (Hicks, 2020). While absolute rates are lower than in LMICs, the emotional toll is severe. Perinatal loss in these contexts is increasingly recognized as traumatic grief**,** which carries elevated risks for post-traumatic stress disorder (PTSD), prolonged grief disorder, and other psychological impairments if not adequately addressed (Kersting & Wagner, 2022). Although many high-income countries have established bereavement support frameworks, these are not uniformly implemented and may lack cultural sensitivity.

The likelihood of perinatal mortality is substantially higher in developing countries. In fact, neonatal mortality rates in developing countries are six times higher than in developed countries, and in the least developed countries, this figure rises to more than eight times higher (WHO, 2020). The neonatal mortality rate in Africa is approximately 41 deaths per 1,000 live births. Sub-Saharan Africa's eastern, western, and central regions report neonatal death rates ranging from 42 to 49 deaths per 1,000 live births. South-central Asia records a neonatal mortality rate of about 43 deaths per 1,000 live births, a rate comparable to sub-Saharan Africa. The Latin America and Caribbean region reports a lower rate of 15 neonatal deaths per 1,000 live births. The majority of neonatal deaths still occur in Asia, largely due to its high birth rate. More than forty percent of the global neonatal mortality burden takes place in South-central Asia, making it an area of particular concern for health interventions.

In the least developed countries, neonatal mortality is over eight times higher than in developed countries (WHO, 2020). For instance, Nigeria faces a significant public health challenge with perinatal deaths. In 2019 alone, 171,428 babies were stillborn in Nigeria, indicating a persistent and critical problem (Okunowo & Smith-Okonu, 2020).

Research from Nigeria also suggests that social support plays a protective role against depression and anxiety among women who have experienced perinatal loss. However, social norms and cultural practices in Nigeria often limit the opportunities for bereaved women to reconnect with their social networks after stillbirth. The absence of traditional rituals and funerals for stillborn babies further exacerbates the psychological suffering of mothers, as it hinders the social support mechanisms that are crucial for alleviating grief and emotional distress. This cultural limitation increases the emotional burden on grieving families and impedes their psychological healing (Popoola, Skinner & Woods, 2022).

Ghana's neonatal mortality rate stands at 22.8 deaths per 1,000 live births, a figure that remains behind the targets set by the United Nations Sustainable Development Goals (Kubio *et al.,* 2025). Several factors contribute to the ongoing challenge of reducing neonatal mortality in Ghana. These include disparities in access to quality antenatal care (ANC), postnatal care (PNC), breastfeeding support, and postnatal family planning services. While Ghana has made notable progress in making healthcare more financially accessible to its citizens, these improvements have not been matched with enhancements in critical health infrastructure. As a result, many health facilities still lack the necessary resources and staffing to deliver high-quality care. Moreover, despite the strides made to reduce financial barriers, out-of-pocket costs for healthcare remain a significant hurdle, restricting many families' ability to seek timely and adequate care (Dare *et al.,* 2021). This financial strain has limited progress in reducing infant mortality. The persistent increase in neonatal deaths underscores the urgent need for grief counseling services to support bereaved parents. Such psychological support is essential to help parents cope with their loss and promote their mental well-being (World Health Organization, 2023).

Congenital deaths occurring within the first month of life in Ghana are also a concern, with rates of 22.8 deaths per 1,000 live births (Poulin *et al.,* 2024). Ghana has not yet met the United Nations Sustainable Development Goals related to child health and mortality reduction (Government of Ghana 2019). Improving neonatal mortality in Ghana depends largely on the availability, utilization, and quality of essential maternal and newborn services such as antenatal care, postnatal care, appropriate breastfeeding

practices, and early postnatal family planning (Sacks *et al.,* 2022). Although the government has taken steps to improve financial access to care, there has been limited improvement in the healthcare infrastructure required to ensure quality service delivery (Government of Ghana, 2019). Additionally, efforts to reduce child mortality have not adequately addressed the persistent out-of-pocket costs that many families continue to face. The rise in neonatal deaths further highlights the importance of providing appropriate grief counseling to parents, as it plays a vital role in enhancing their psychological well-being during such distressing times (Kiross *et al.* 2020).

In Malawi, a cross-sectional study conducted within health sectors by Onuwabuchi *et al.,* (2021) revealed that approximately 15% of pregnant women experienced incurable miscarriages. This high rate of perinatal loss has significant implications not only for the physical health of women but also for their emotional and social lives. Perinatal loss affects not only the immediate pregnancy but also subsequent pregnancies and can influence other areas of women's lives, including marital relationships (Charrois *et al.,* 2020).

Traditionally, in many African cultures, miscarriage is regarded as one of the most painful pregnancy outcomes because pregnancy is considered a blessing from God. The loss of a pregnancy is therefore viewed as a negative and often stigmatized event that has profound psychological implications for the mother and her family (Stoianova *et al.,* 2021). Emotional, financial, and psychological support necessary for healthy grieving are often expected to be found within women's social networks and assets. However, because pregnancy is closely tied to cultural and spiritual beliefs about divine blessing, women who experience miscarriages frequently find it difficult to seek counseling or other forms of professional help. This avoidance of grief counseling is often rooted in cultural norms and beliefs that either stigmatize loss or discourage open discussion of such grief, thus making grief counseling challenging to implement effectively (Ayebare et al., 2021).

In Kenya, the current neonatal mortality rate (NMR) is 21 deaths per 1,000 live births, according to data from 2022 (KNBS and ICF, 2023). This reflects a slight improvement from 2014 when the NMR was 22 deaths per 1,000 live births (Nyoni & Nyoni, 2024).

Despite this progress, Kenya's neonatal mortality rate remains higher than the global average, and the country is not on track to meet the Sustainable Development Goals (SDGs) target of reducing neonatal deaths to 12 per 1,000 live births by 2030 (Ouma *et al.,* 2024). A significant gap in Kenya's health system is the absence of comprehensive psychosocial and mental health care interventions designed to support women who experience perinatal loss. Without deliberate provision of psychosocial support and targeted mental health services, women who go through such losses are often left unsupported, which negatively impacts their overall health and well-being (Fernández-Basanta *et al.,* 2020).

In Kenya, although tele-mental health guidelines have been established to address mental health issues during recovery, no specific guidelines currently exist for individualized counseling following perinatal deaths. This gap points to an urgent need for comprehensive policies and programs to provide psychosocial support tailored to the needs of bereaved parents.

1.2 Statement of the Problem

A perinatal death is a tragedy, because of the deep attachment feeling to the mother and father during the pregnancy. The death of a child around the time of birth is one of the most stressful events the parents experience due to the separation from their stillborn or dying babies. After a perinatal death, the parents are left with a heavy psychological burden that at times leads to a post-traumatic stress disorder. In an ideal scenario, postpartum mothers who experience the devastating loss of an infant during the perinatal period receive comprehensive emotional and psychological support. This support will include individualized grief counseling tailored to their unique emotional responses, helping them process the trauma, manage grief, and rebuild their psychological well-being. As a result, these mothers will recover emotionally, leading to improved mental health, reduced incidence of post-traumatic stress disorder (PTSD), depression, and anxiety, and an overall restoration of psychological balance that enables them to function effectively in their daily lives.

In reality, many mothers who experience perinatal deaths of infants often struggle with profound grief and psychological distress. These women frequently face a lack of

specialized psychological support, with many relying on general counseling or facing long waiting times for appropriate intervention. Existing counseling services are often not tailored to the specific needs of postpartum mothers experiencing infant loss, and the counseling provided may not be individualized or comprehensive enough to address the deep psychological scars left by the traumatic event. As a result, many mothers continue to suffer from prolonged emotional and psychological challenges, including depression, anxiety, and complicated grief, which can impede their ability to heal emotionally and physically.

Insufficient research and practical application of individualized grief counseling for postpartum mothers who have experienced perinatal loss brings out the gap. While there is an understanding that grief counseling is beneficial for those who suffer traumatic losses, there is limited data and evidence that examine the impact of individualized grief counseling on the psychological well-being of postpartum mothers following infant deaths during the perinatal period. Consequently, the gap exists between the ideal situation where mothers receive personalized therapeutic interventions that promote healing, and the current situation where such interventions are not widely available or systematically implemented. This study aims to bridge this gap by investigating how individualized grief counseling can improve postpartum mothers' psychological health, reduce grief-related symptoms, and support their overall recovery following perinatal infant deaths through individualized grief counselling.

1.3 Objectives of the Study

1.3.1 General Objective

To evaluate the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya.

1.3.2 Specific Objectives

i. To examine the grief levels on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya.
ii. To assess the post-loss coping mechanisms on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya.

iii. To assess the postpartum counseling care offered on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya.

iv. To determine the sociocultural factors affecting the coping mechanism on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya.

v. To evaluate the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya

1.4 Research Questions

i. What are the grief levels experienced by postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya, and how do they affect their psychological wellbeing?

ii. What coping mechanisms do postpartum mothers use after perinatal loss, and how do these affect their psychological wellbeing in Tharaka Nithi County, Kenya?

iii. What postpartum counselling care is offered to mothers following perinatal deaths, and how does it influence their psychological wellbeing in Tharaka Nithi County, Kenya?

iv. What sociocultural factors influence the coping mechanisms of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya?

1.5 Research Hypothesis

Ho1: Individualized Grief Counselling has no statistically significant influence on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya.

1.5 Significance of the Study

This study was intended to significantly influence healthcare policies on maternal mental health, particularly for mothers experiencing perinatal loss. Policymakers may use the findings to advocate mandatory mental health interventions, reducing risks of depression and PTSD to grieving mothers. Additionally, the research supports

integrating mental health services into maternal care, promoting a more holistic postpartum recovery approach.

This study was significant for mothers as it aimed to enhance their emotional recovery after perinatal loss. By demonstrating the effectiveness of individualized grief counseling, it empowered mothers with personalized support to navigate their grief in a healthy way. This intervention can help reduce isolation, depression, and anxiety, fostering better psychological adjustment. Additionally, the study raises awareness about the availability of such support, encouraging mothers to seek the help they need during this difficult time.

This study was meant to transform how counsellors, doctors, psychologists and nurses' approach maternal grief, emphasizing the integration of grief counseling into nursing practice. The results of this study aimed at enabling nurses recognize signs of complicated grief, facilitating early referrals to specialized support. By promoting a holistic approach that addresses both physical and emotional well-being, the research equips nurses to provide compassionate, informed care, ultimately improving support for grieving mothers. The study shows the importance of communities including churches in supporting mothers going through grief.

Further, the study findings form the basis of future studies, as it may be referred by other future researchers in their literature review, as it helps the researchers' model on the results to expect.

1.6 Scope of the Study

This is an intervention study that was carried out in 4 hospitals at Chuka County Referral Hospital, Magutuni Level 4 Hospital, Tharaka Level 4 Hospital and Kibung'a level 4 Hospitals in Tharaka Nithi County. The study sought to establish the effect of individualized counselling on mothers' psychological wellbeing after perinatal loss. The study focused on the care offered to mothers to mitigate maternal post-partum grief, effectiveness of the individualized counselling done to mothers and socio-cultural factors influencing psychological grief exhibited by women following perinatal deaths. The study involved the counselors who offer psychosocial counselling after the child

loss, and the mothers who have experienced perinatal loss during the period of the study. Monthly follow up visits was done to monitor the implementation and thereafter effectiveness was evaluated.

1.7 Limitations of the Study

i. The study may face the challenge of the self-reporting variables, where healthcare workers may be required to rate themselves and their services. This may lead to exaggeration, as a person may rate himself/herself higher than his/her actual performance. The researcher delimited this limitation by using multiple sources of data, and thus, the instruments will validate themselves.

ii. Healthcare in Kenya is devolved, and thus, each county handles priorities, especially healthcare, differently. Thus, the findings of this study cannot be applied in other counties, as their level of commitment to healthcare may be different from the case in TharakaNithi County.

1.8 Delimitations of the Study

i. The researcher may face perinatal attrition due to emotional difficulties faced by mothers. This made some of them hold crucial information. To mitigate this, the researcher introduced herself to the mothers, created rapport, and explained to them that the purpose of the inquiry was to conduct academic research.

ii. The research was carried out in the leading hospitals in TharakaNithi County. Hence, the findings obtained were particular to the mothers who experienced perinatal loss in those hospitals only. The findings may fail to show the situation of those mothers who delivered in other counties and private hospitals.

1.9 Assumptions of the Study

The assumptions that were used in the study included the following;

i. The respondents would be available for the study and will give an honest and truthful opinion. This assumption implies that participants provided accurate and honest information when answering questions or engaging in any other data collection activities.

ii. The respondents were able to clearly describe their thoughts and feelings clearly. This relied on the presumption that the participants did not withhold relevant details or intentionally provide false information that could affect the study outcomes.

iii. The intervening variables remain constant during the study. These are factors that influence the relationship between independent and dependent variables of the study. By assuming that they were constant, researcher aimed to isolate and analyze specific relationship between the independent and dependent variables under investigation. Within the appropriate time, sufficient data was collected.

1.10 Operational Definitions of Terms

Coping Mechanism Technique used by counselors to manage grief, emotions, and challenges associated with grief and loss to facilitate emotional recovery.

Counselor A psychologist who is trained to work in therapeutic settings, assessing mothers' concerns and life circumstances. They provide help with mental health conditions like depression, anxiety, stress and grief.

Effect Profound and far-reaching impact on various aspects of a mother's life: emotional, physical, psychological, and social well-being following a perinatal death.

Grief A deep and emotional response to the loss of connections that define us. It may include feelings of sadness, anger, guilt, and despair. Grief is profound and may affect a mother's mental health and future experiences.

Individualized Grief Counselling: This is a tailored therapeutic approach designed to support grieving mothers. It focuses on the unique emotional and psychological needs of a mother experiencing loss, using techniques such as counseling.

Midwife A midwife is a healthcare professional who provides care and support to mothers during pregnancy, childbirth, and the postpartum period. Midwives offer holistic and personalized approach to mothers including counselling, collaborating, advocacy and education.

Perinatal death the death of a baby between 28 weeks of gestation (or weighing 500 g) and 7 days after birth.

Postpartum Loss	Grief and emotional pain experienced after the loss of a baby shortly after birth or during the postpartum period.
Postpartum Mothers	Refer to mothers who have recently given birth and experienced the loss of their fetus or neonate during the perinatal period and are coping with the psychological and physical changes of the postpartum phase.
Posttraumatic Stress	Is a psychological condition that arises after a mother has lost a baby in the post-partum period. It often manifests through symptoms such as flashbacks, nightmares, intense anxiety, and persistent, distressing thoughts related to the grief.
Psychological Wellbeing:	The ability of a postpartum mother to adapt and recover emotionally after experiencing a perinatal death.
Stress	This refers to experiences of intense grief, anxiety, depression, panic, and disturbing emotional or physical reactions experienced long after the traumatic event has ended.

CHAPTER TWO
LITERATURE REVIEW

2.0 General Overview

This chapter provides a review of relevant and significant literature on the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. The literature which is guided by the study objectives is presented in key thematic areas. Firstly, grief levels on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. Secondly, assess the post-loss coping mechanisms on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. Thirdly, assess the postpartum counseling care offered on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya, inclined towards grief counseling, supportive counseling and peer counseling. Also a review based on the fourth objective, which was to determine the sociocultural factors affecting the coping mechanism on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya, which was influenced by societal issues, religious issues and family issues. In addition, the chapter also discusses the intervention measure implemented to impact on the breastfeeding practices among teenage mothers attending public hospitals. Further, a summary of gaps in literature is discussed. Lastly, this chapter provides a theoretical framework and conceptual framework.

2.1 Perinatal Loss

Losing a child is a painful and most traumatic experience that parents- and more so the mother- ever face in their lives. According to Kim *et al*. (2021), the loss can eventually affect mothers' physical and psychological wellbeing. Perinatal loss, as defined for this study, includes miscarriages, stillbirths, and neonatal deaths. The most recurrent type of pregnancy loss is also known as a miscarriage. It refers to the spontaneous expulsion of a fetus by means not interpreted as natural in a gestational period of up to 20 weeks (Cena, Lazzaroni, & Stefana, 2021). Stillbirth is defined as the delivery of a dead fetus after 20 weeks of pregnancy, most often unexpectedly in the intrauterine period or during labor (Centers for Disease Control, 2019). Death of a child until twenty-eight days after birth is called neonatal mortality.

Perinatal loss, encompassing stillbirth and early neonatal death, remains one of the most distressing experiences a woman can endure. It not only disrupts the anticipated trajectory of motherhood but also causes significant psychological, social, and even physical consequences that extend beyond the immediate period of loss. Research on perinatal bereavement has expanded considerably in recent decades, moving from a narrow focus on clinical and epidemiological outcomes toward a more nuanced understanding that includes mental health, coping strategies, cultural contexts, and the effectiveness of psychosocial interventions (Imbo *et al.,* 2021). This literature review synthesizes contemporary evidence from global, regional, and Kenyan contexts to situate the current study, which focuses on individualized grief counseling for postpartum mothers in Tharaka Nithi County, Kenya. It integrates epidemiological data, theoretical perspectives, and empirical findings, highlighting both the burden of perinatal loss and the need for culturally adapted interventions that address the psychosocial dimensions of grief.

The direct causes of perinatal death are well-documented: preterm birth complications, intrapartum events such as birth asphyxia, severe infections, and congenital anomalies are the leading contributors (WHO, 2024). However, the determinants extend beyond clinical events to include structural factors such as poor access to skilled birth attendants, inadequate antenatal care, and systemic underinvestment in maternal health. Global health frameworks now emphasize the integration of bereavement support into maternal and newborn care policies, recognizing that the psychological toll of perinatal loss can be as debilitating as the physical outcomes (Cassidy, 2023).

Globally, perinatal mortality continues to be a major public health challenge. Recent data from the World Health Organization (WHO, 2024) and the United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME, 2023) indicate that approximately 1.9 to 3.3 million stillbirths and early neonatal deaths occur annually. The burden is disproportionately concentrated in low- and middle-income countries (LMICs), where structural inequities, inadequate health systems, and socio-economic disparities hinder progress. Stillbirth rates, for instance, remain as high as 14 per 1,000 total births globally, with sub-Saharan Africa and South Asia accounting for the majority of cases (UNICEF, 2024). The highest number of premature deaths occurs

during the neonatal period because most children globally are born in Asia, which faces the largest burden of neonatal mortality. This high mortality rate in South-central Asia presents an enormous public health challenge, requiring urgent and sustained intervention efforts.

In developed countries, the usual rates of stillbirth are between 4- 8 stillbirths for every 1,000 live-born infants, and neonatal death rates are usually less than five infant deaths per 1,000 live-born infants (Office for National Statistics (ONS), 2020). However, stillbirth rates have not gone down, and not all groups have been affected: women of advanced maternal age, those with pre-existing medical problems, or those who are poor. In the U.S., the stillbirth rate was about 5.7 stillborn per 1000 live births (CDC 2022). These rates include complications due to pregnancy and maternal medical history (diabetes, hypertension) and have, for the most part, been caused by things that can be prevented, like smoking and lack of prenatal care. According to the NHS Digital Secondary Care Analysis, across England, about 20 percent of pregnant women will have a miscarriage, which equates to between 45,000 and 48,000 hospital admissions related to it each year (NHS Digital Secondary Care Analysis, 2019). In 2019, there were more than 2500 stillbirths in England and Wales and more than 1700 neonatal deaths in England in 2018 (ONS, 2020a, 2020b).

In sub-Saharan Africa, the prevalence of perinatal loss remains stubbornly high. The region accounts for nearly half of the world's stillbirths and neonatal deaths, with some countries reporting rates above 30 per 1,000 births (WHO, 2024). Beyond the epidemiological burden, cultural attitudes toward perinatal death shape both the experience of loss and the accessibility of support. Studies indicate that in many communities, infant death-especially when it occurs before formal naming or ritual introduction-is often socially minimized or regarded as an event that should not be publicly mourned (Poursalehi *et al.,* 2020). This phenomenon, referred to as "disenfranchised grief," deprives mothers of communal recognition of their loss, thereby amplifying feelings of isolation (Nyoni & Nyoni, 2024).

Perinatal loss in Africa remains a pressing concern. According to the World Health Organization (WHO, 2020), sub-Saharan Africa has the highest stillbirth rate in the

world, with an estimated 19.4 stillbirths per 1,000 live births. Neonatal mortality in the region is also alarmingly high, with rates reaching approximately 28 per 1,000 live births (UNICEF, 2021). Several countries, such as Nigeria, South Africa, and the Democratic Republic of Congo, report particularly high perinatal mortality rates, which reflect the disparities in maternal and child health across the continent (WHO, 2020). Despite some reductions in these rates in certain African nations, perinatal loss continues to account for a significant proportion of all deaths in this group, driven by inadequate healthcare access, late antenatal care, and preventable medical conditions.

While countries in North Africa (e.g., Tunisia and Egypt) generally report lower perinatal mortality rates compared to sub-Saharan Africa, significant regional disparities persist (Al-Selw I & Barkat, 2023). In sub-Saharan Africa, where healthcare infrastructure is less developed and access to skilled birth attendants is limited, the rates of stillbirth and neonatal mortality are disproportionately high (UNICEF, 2021). For instance, in Nigeria, stillbirth rates are on the highest in the world, with studies reporting rates up to 43 per 1,000 live births (Maguire *et al.*, 2021). In countries such as Somalia, Chad, and the Central African Republic, stillbirth rates can exceed 50 per 1,000 live births (UNICEF, 2022). These figures underscore the persistent gaps in maternal and child health services despite ongoing international efforts to reduce perinatal mortality in Africa.

Kenya's neonatal mortality rate has declined in recent years from 22 per 1,000 live births in 2014 to about 18 per 1,000 in 2022 but remains higher than the Sustainable Development Goal target of 12 per 1,000 by 2030 (Kenya Demographic and Health Survey [KDHS], 2022). Stillbirth rates remain poorly documented but are estimated to be between 16 and 20 per 1,000 births in some counties, with significant rural–urban disparities (Ministry of Health, 2023). In counties like Tharaka Nithi, maternal health services face challenges including understaffing, limited access to emergency obstetric care, and inadequate integration of mental health services into routine maternal care. Although Kenya's national reproductive health policy acknowledges the need for post-loss counseling, implementation at facility level is inconsistent. Bereavement care is often ad-hoc, dependent on the empathy and initiative of individual providers rather than a standardized protocol (Nyoni & Nyoni, 2024).

Perinatal loss impacts women from all socioeconomic backgrounds and of all ages, with long-term economic and psychosocial consequences for families affected (Doraiswamy *et al.,* 2020). There is no nation in the world that can claim that it is not being affected by perinatal loss as this would be unrealistic (Wheeler, 2021). In turn, it has created the need for research to be done to obtain information on perinatal loss and its influence on the mother's emotional and mental wellbeing. Worth mentioning is that a majority of the studies on perinatal loss focused their attention on specific psychological factors that are associated with it (Onambele, *et al.,* 2023; Doraiswamy *et al.,* 2020). Despite the prevalence of perinatal loss, western societies often fail to recognize the significance of such losses and the psychological impact on those who experience them (Doraiswamy *et al.,* 2020; Al-Selwi & Barkat, 2023). However, the psychological consequences can be significant, with depressive disorders directly following a miscarriage being reported in 10-50% of cases (Al-Selwi & Barkat, 2023) and post-traumatic stress disorder found to be seven times more likely for mothers bereaved by stillbirth or neonatal loss.

When perinatal loss occurs adjusting to the new normal can be difficult. Parents go through the different stages of grief. They often experience anxiety, a sense of low self-esteem, disturbance in their sleep pattern, postpartum depression and the reality of their child's death shifts their worldview (Fernández-Sola *et al.,* 2020). The fragmented approach to research exploring perinatal loss has meant there is a lack of understanding of what makes a meaningful difference to women's experiences in a pregnancy following a perinatal loss. Understanding of the whole journey from loss to subsequent pregnancy from the perspective of those who have lived through the experience is vital in order to improve services in the future.

2.2 Grief of Postpartum Mothers Following Perinatal Deaths

Grief following perinatal death can be one of the most devastating experiences a mother can endure (Obst *et al.,* 2020). The postpartum period, typically characterized by joy and anticipation, becomes instead a time of profound sorrow and emotional upheaval for mothers who experience the loss of their children (Alvarez-Calle *et al.,* 2023). Grief following perinatal death can be categorized as a unique and distinct type of mourning, which the particular circumstances of the loss can influence, the gestational age at death

and the mother's psychological and emotional state prior to the loss (Farren *et al.*, 2021). Cassidy (2023**)** argues that perinatal grief is often overlooked or minimized by society, which tends to focus more on the grief of parents following the death of older children. However, research by Setubal *et al,* (2021) has shown that perinatal death leads to profound and often long-lasting psychological distress for mothers, with the grief experienced often comparable to the grief experienced following the death of an older child.

Grieving is a normal, universal and habitual reaction to a significant loss. However, it is characterized by complicated grief when the individual manifests an excessive, persistent, distressing and disabling grieving process, representing a serious public health problem which reflects on the person, family and society (Furtado-Eraso *et al.,* 2021). According to Prigerson *et al.,* (2021) complicated grief has recently been recognized as a mental disorder, and its inclusion in the 5th and last edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), and in the next International Classification of Diseases (ICD-11). The loss of a child before birth is one of the most common situations for the process of complicated grief, elaborated at the imaginary level since there was no baby to hear crying, no memories and no shared life experiences. It is a contradiction of the so-called "natural order of life" that children die before their parents, as there is months of planning and expectation for the birth of a lifeless child. (Aggarwal & Moatti, 2022).

Pregnancy is considered a time of high vulnerability to mental illness, including both the first onset of mental illness and the relapse of previous conditions (Cantwell, 2021). Bereavement can also be a time of considerable distress, particularly in the case of experiences of disenfranchised grief such as perinatal loss (Cassidy, 2023). Whereas in a first pregnancy loss may be neither expected nor anticipated, the pregnancy following a loss is experienced through the filter of the link between pregnancy and death (Doraiswamy *et al.,* 2020). A pregnancy after loss is not only potentially a time of fear and anxiety due to previous pregnancy experiences (Al-Selwi & Barkat, 2023), it is also a time when the individual is still possibly grieving their loss. The intensity of their grief may be heightened by the experiences of the new pregnancy due to triggering memories of their previous pregnancy, particularly when antenatal care is being

provided in the same clinic or hospital as the previous pregnancy (Howard, & Khalifeh, 2020). Those with a lack of social support are particularly at risk of experiencing perinatal mental health problems after a perinatal loss.

Grief following perinatal death is complex and multifaceted, often characterized by a range of emotions such as shock, sadness, anger, guilt, and despair. According to Stein, (2024**)**, grief is a natural response to loss, but the intensity and duration of grief can vary greatly from one individual to another. Markin, (2024**)** suggests that grief following perinatal loss is complicated by the ambivalence of emotions: mothers may simultaneously mourn the loss of the child while also experiencing relief, especially if the pregnancy was complicated or medically difficult.

In the postpartum period, this grief can be exacerbated by hormonal changes, physical recovery from childbirth, and the societal expectations surrounding motherhood. Immediately following perinatal death, mothers often experience shock and disbelief, which may delay the full processing of the loss. This initial phase is described by Garrod, (2022**)** as part of the five stages of grief, though not all mothers may experience these stages in a linear manner. Some mothers may initially deny the reality of the loss, leading to difficulties in emotional adjustment. Goldberg *et al.,* (2021) found that mothers who experienced stillbirth often reported a sense of detachment and numbness in the first few weeks, a defense mechanism that protected them from the overwhelming nature of their grief.

Longitudinal studies have documented elevated risks of depression, anxiety, and post-traumatic stress disorder (PTSD) among bereaved mothers compared to those who experience live births (Kersting & Wagner, 2022). These mental health impacts can persist for months or even years, influencing maternal functioning, partner relationships, and care for subsequent children. Qualitative studies from Kenya and other African contexts reveal that mothers often experience social withdrawal, diminished self-esteem, and feelings of being “less of a woman” following perinatal loss (Aggarwal & Moatti, 2022). The psychological toll of perinatal loss is profound and multifaceted. Acute grief reactions include shock, denial, anger, guilt, and intense sadness (Markin, 2024). Unlike some other forms of bereavement, perinatal loss

involves a unique form of attachment grief; mothers grieve not only the infant but also the anticipated future, including milestones, caregiving experiences, and family dynamics. This grief can be further complicated by physiological postpartum changes such as lactation, which serve as constant reminders of the absence of the baby (Cassidy, 2023).

The cumulative effect of these psychological outcomes underscores the importance of timely, targeted, and culturally sensitive interventions. Without adequate support, grief can become complicated, leading to chronic mental health issues that burden both the individual and the broader family system. This evidence supports the rationale for the current study's focus on individualized grief counseling as an integral component of maternal healthcare in Tharaka Nithi County.

Mothers who have had stillbirths are typically detached and numb in the weeks after, as per Goldberg *et al.,* (2021), protecting them from grief (Cantwell, 2021). Loss can also be a period of high subjective experiences, especially if it is an example of end-of-life grief, especially perinatal death (Cassidy, 2023). While the first pregnancy loss is normatively defined as neither expected nor anticipated, the pregnancy after a loss occurs already under the sign of pregnancy and death (Doraiswamy *et al.,* 2020). Accordingly, pregnancy after loss is not only likely to be a time of fear and anxiety because of the previous pregnancy experiences (Al-Selwi & Barkat, 2023) but also a time when the person may still be mourning the loss. The intensity of their grief might be the experiences of the new pregnancy because it reminds them of the previous pregnancy, especially if they are receiving antenatal care in the same clinic/ hospital as that of the previous pregnancy, as highlighted by Howard and Khalifeh in 2020. On all women who had perinatal loss, those who had no social support had a higher propensity to have perinatal mental health problems.

Sadness is the most common emotion associated with perinatal death, with Thompson *et al.,* (2020) noting that a deep sense of loss often accompanies feelings of profound sadness and despair as mothers mourn the lost potential of their child. The emotional pain can be further compounded by physical postpartum symptoms, such as the production of breast milk in the absence of a child to nurse. This physiological response

can act as a constant reminder of the loss, intensifying feelings of sadness and sorrow. Guilt is a prevalent and complex emotion for mothers who have experienced perinatal death. Many mothers internalize the loss, wondering whether they could have done something differently to prevent the death. Massmann *et al.,* (2025) found that mothers often engage in self-blame, particularly if the death was preceded by complications such as preterm labor, fetal abnormalities, or medical interventions. This guilt can manifest in intrusive thoughts and persistent rumination over "what could have been done" to alter the outcome. Mothers who have experienced a stillbirth, in particular, may struggle with a heightened sense of guilt, even in the absence of any clear medical explanation for the death.

Anger is another typical emotional response, particularly in mothers who perceive the loss as unjust. Research by Anderson (2023) revealed that mothers may experience anger directed at healthcare providers, their bodies, or even family members who have not experienced similar losses. In some cases, anger may be expressed in outward frustration with the world or resentment towards other parents with living children. This anger can sometimes complicate the grieving process, particularly if the mother feels that her grief is not fully understood or validated by others.

Post-traumatic stress disorder (PTSD) is another significant factor in grief following perinatal loss. For mothers who experience stillbirth or traumatic delivery, symptoms of PTSD, such as flashbacks, hyperarousal, nightmares, and avoidance behaviors, are common. Doka and Martin (2024) identified that mothers who had traumatic births or stillbirths were more likely to develop PTSD symptoms than those who experienced less traumatic pregnancies. The trauma of childbirth and the subsequent loss of the child can be psychologically overwhelming, leading to long-lasting emotional scars.

Grief levels are not uniform across all mothers who experience perinatal death. Several factors influence how intensely and for how long a mother grieves. The timing of the loss-whether it occurs during pregnancy (miscarriage or stillbirth) or after birth (neonatal death)-affects the nature and intensity of the grieving process. Harris *et al.,* (2020) found that mothers who experienced stillbirth often reported deeper feelings of loss and greater difficulty in reconciling their grief, as the pregnancy had progressed far

enough to establish emotional bonds with the child. In contrast, mothers who experienced earlier pregnancy losses may have had fewer opportunities to form these bonds, leading to different grief experiences. Mothers with a history of mental health disorders, such as depression or anxiety, may be more vulnerable to experiencing complicated grief following perinatal death. Johnson *et al.,* (2021) found that mothers with pre-existing mental health issues were at a higher risk for developing depression, anxiety, and prolonged grief disorder following a perinatal loss. Their findings underscore the need for early mental health screenings and interventions to help mitigate the risk of complicated grief.

2.3 Post-loss Coping Mechanisms of Postpartum Mothers Following Perinatal Deaths

Parental child attachment in pregnancy is considered a factor in children's physical and psychological health (Papapetrou *et al.,* 2020). Antenatal anxieties (Papapetrou *et al.,* 2020) may nevertheless delay maternal-fetal attachment. Our results are consistent with the previous findings that in the subsequent pregnancy following a loss, women use coping strategies designed to insulate them (such as drawing distance away from the developing fetus) to handle the fetus loss (Ertmann *et al.,* 2021). In fact, emotional cushioning that women rely on while they are pregnant after loss may be referred to as the range of defensive behaviors to help cope with the hope/fear that can arise after a loss (Ertmann *et al.,* 2021).

As such, this loss is often followed by depression, anxiety, post-traumatic stress, or complicated grief (Sheehy & Baird, 2022). But research has revealed that parents -most notably, moms- come up with all kinds of coping strategies to 'deal' with their grief. Emotion-focused coping strategies are mostly used when the parent does not feel powerless to change the situation (e.g., stillbirth or neonatal death). That is, these mechanisms are designed to prevent the distressing emotions that go along with grief rather than change the situation itself. Literature further underscores the role of gender norms and marital dynamics in shaping post-loss experiences. In some contexts, women who experience stillbirth or neonatal death may be blamed for the loss, face marital strain, or even be subjected to social exclusion. Such dynamics exacerbate the psychological consequences of bereavement and can impede help-seeking behaviors

(Aggarwal & Moatti, 2022). Importantly, health systems in the region often lack structured protocols for bereavement care, resulting in inconsistent, provider-dependent responses that may or may not meet the emotional needs of mothers (Kersting & Wagner, 2022).

Initially, many parents cope with the shock and trauma of perinatal loss through avoidance or denial, which allows them to manage overwhelming emotions. Donegan *et al.,* (2023) describe avoidance as a common reaction during the early stages of grief, when the reality of the loss is difficult to accept. Mothers may engage in activities that distract them from the pain, or they may avoid talking about the loss to protect themselves from intense emotional suffering. Denial can serve as a temporary emotional buffer, allowing parents to gradually process their grief. However, while avoidance can be protective in the short term, it can complicate the grieving process if it prevents parents from confronting their emotions and processing their loss fully (Jones *et al.,* 2022).

Another common emotion-focused coping strategy is emotional expression. Massmann *et al.,* (2025) found that for many mothers, expressing grief through crying, verbalizing emotions, or engaging in memorialization activities (such as writing letters to the lost child) is an essential part of their healing process. Expressive coping mechanisms allow parents to externalize their emotions, which can relieve emotional pressure and provide a sense of release. This cathartic process helps individuals better understand and come to terms with their grief.

Social support is one of the most widely recognized coping mechanisms following perinatal loss. Smorti *et al.,* (2020) highlights that grieving parents often turn to family, friends, or support groups to help process their grief. Emotional support from loved ones can validate grief, provide a sense of comfort, and reduce feelings of isolation. However, Papapetrou *et al.,* (2021) note that the effectiveness of social support depends on the type and quality of support received. Support that is empathetic, patient, and nonjudgmental tends to be more helpful, while dismissive or invalidating comments can worsen feelings of isolation and distress. Support groups, especially those comprised of individuals who have experienced similar losses, can also be an important

source of coping. Jones *et al.*, (2022) found that participation in support groups allowed mothers to share their grief openly, learn from others, and gain comfort from hearing others' experiences. These groups can provide a sense of solidarity, which can be critical in reducing feelings of loneliness and alienation.

For many parents, spirituality and religious practices are key coping mechanisms following perinatal loss. Zeanah and Zeanah (2019**)** suggest that individuals may seek solace in religious beliefs, prayer, or rituals that provide meaning and comfort. For some, spirituality offers a framework for understanding the loss and finding hope in the face of grief. Thompson *et al.*, (2020) found that religious rituals, such as memorial services, prayer, or connecting with a faith community, helped grieving parents feel supported and gave them a sense of connection to something greater than their immediate pain. Spiritual beliefs can provide both emotional comfort and existential meaning during a time of intense sorrow.

Some parents cope with perinatal loss by seeking more information about the loss itself. This may include asking healthcare providers about the cause of death, seeking medical explanations, or exploring the possibility of future pregnancies. Papapetrou *et al.*, (2020) found that seeking information about the loss provided mothers with a sense of control over an otherwise uncontrollable situation. By understanding the circumstances surrounding the death, parents may feel they can better prepare for the future or prevent similar tragedies.

After a loss, some parents engage in new activities or focus on future goals as a way of finding meaning or creating new purpose in life. Cassidy (2021) discusses how some mothers cope by returning to work, taking up hobbies, or focusing on self-care. These activities provide emotional relief by offering a distraction from grief and helping to re-establish a sense of normalcy. Engaging in new activities may also offer opportunities for personal growth and resilience as parents find ways to adapt to life after loss.

In Wheeler's (2021) integrative review of the impact of perinatal loss on the 'maternal foetal relationship' in the subsequent pregnancy they found evidence for the use of coping mechanisms, including "emotional detachment from the foetus", and an

awareness by mothers of the impact this may have on the relationship with their infant. Wheeler's (2021) review focuses on the mothers' response to loss, and coping strategies, and although the authors highlight an increase in healthcare utilization in the next pregnancy, the review does not address the impact of the support these women receive, either post loss or during the next pregnancy.

Increased understanding of the importance of the grieving process, has led to active encouragement by professionals for memory making with the deceased infant (Sansone, 2020), including the use of cold cots to extend the timeframe families can spend with their babies (Smith, Vasileiou, & Jordan, 2020). However, there is some evidence that those who hold their babies after a stillbirth are more likely to experience symptoms of depression and posttraumatic stress (Baron, 2020).

A systematic review of the evidence on the impact of contact with the baby following stillbirth, on parental mental health and wellbeing, found not enough quality research to draw conclusions (Zeanah & Zeanah, 2019). Yet, using objects of comfort, such as blankets and clothing, in the making of memories is seen as helpful to parents in their grief process by recognizing and giving meaning to their experiences and mothers do not regret their choices to hold their deceased infants (Sheehy & Baird, 2022). Finding meaning in the midst of the loss experience is thought to be an important process in order to adjust to life beyond the loss.

2.4 Psychological Care offered to Postpartum Mothers following Perinatal Deaths

The support provided to women after a perinatal loss varies widely, and there are mixed findings on what interventions are helpful (Qian *et al.,* 2022). Social support plays a key role in loss responses and the healing process (Wheeler, 2021), with peer support playing a particularly significant role in giving bereaved mothers the opportunity to connect to those with shared experiences (Li *et al.,* 2022). Both social and professional post-loss support has been found to make a difference to the levels of psychological distress experienced by mothers (Astakhov, Batsylyeva, Puz & Shudrikova, 2022).

Midwives and nurses play a significant role in both the care of those experiencing a perinatal loss and recognizing and supporting those with perinatal mental health issues

(Yenal, Tektaş, Dönmez & Okumuş, 2023). Although midwives are well placed in terms of contact with women who require care, both studies of midwives' perceptions of care (Jones *et al.,* 2022) as well as reports on current midwifery practice (Eikemo, R. 2025) refer to the need for better training and support for these healthcare professionals. Healthcare professionals want to better understand bereavement and how to provide sensitive care to those experiencing perinatal loss but lack confidence in how to interact with families (Richards, Graham, Kool *et al.,* 2023). Midwives are also responsible for the emotional wellbeing of mothers antenatal and in the early postnatal period, despite feeling underequipped to fulfil this role, particularly in relation to bereavement (Wheeler, 2021).

There is an increasing consensus for the need for improvements in bereavement care provided in the healthcare setting after the loss of a baby (Shakespeare *et al.,* 2020), however this global effort focuses predominantly on stillbirths, which therefore does not acknowledge the needs of women who experience earlier perinatal losses. Reports evaluating this initiative highlights an improvement in care within the trusts included, with positive feedback from both parents and professionals questioned (Donaldson, 2019). However, there are still examples of inconsistent or insensitive care within hospitals, and the report highlights the way in which on-going care is solely provided through referrals to outside agencies, relying heavily on the third sector to provide psychological support. This means that despite improving standards of bereavement care within hospitals and improving consistency across different trusts, there will remain different levels of support within the community depending on what is locally available.

A study by Danna *et al,* (2023). women's experience of pregnancy after loss found that they needed regular contact with their health-care team to voice concerns and receive reassurance. It is not only the frequency of appointments offered, but also the quality of the care received those impacts upon outcomes, as highlighted by a study which found that satisfaction with healthcare services was linked to decreased symptoms of perinatal grief after miscarriage (Freedle, 2020).

In United Kingdom, Bridges and Bridges, (2019) found that the provision of support is heavily reliant on individuals, with decisions about who cares for those going through a loss being decided by who felt most able to cope on any particular shift. Only 12% of neonatal units made bereavement training mandatory, and even for those trained in bereavement care, staff were only able to provide support on an ad-hoc basis, as they lacked dedicated time in their schedule, requiring them to fit bereavement support around their existing workload (Linares-Gallego, Á., 2023).

Healthcare staff may also experience grief in relation to perinatal loss, and the lack of acknowledgement and support for this has a knock-on effect on their capacity to support bereaved families (Bouderbala, 2022). Adequate support to help staff cope with the challenging emotional situations they face is required in addition to training in order to provide effective care (Farrales *et al.,* 2020). Bouderbala (2022) advocates a mindfulness-based training program for healthcare providers who work with perinatal loss. As well as providing a form of self-care to support them with their vulnerability to mood disturbances as a result of exposure to death in the workplace, this would support them in developing more meaningful relationships with patients, and therefore equip them to provide better bereavement care (Bouderbala, 2022). The way in which women are supported by midwives during and following a loss has a significant impact on women's loss experiences and how they cope with the grieving process (Zsák, 2022). The midwives also have an important role to play in the experience of the subsequent pregnancy, where the risks of depression and anxiety are elevated due to the loss experience.

For healthcare professionals, regular contact with pregnant women through routine visits provides a unique opportunity to identify those who are experiencing mental health problems. Midwives' understanding of the implications of a perinatal loss is particularly important in the subsequent pregnancy (Donegan *et al.,* 2023). Despite the prevalence of antenatal depression being as high as postnatal depression, it is far less likely to be detected (Sheehy & Baird, 2022). Improved training to more adequately equip midwives with the skills and knowledge they need to identify perinatal mental health issues is one way to address this disparity. However, this will have limited

consequences unless there are clear referral pathways and support systems in place for those who are identified with needs.

In addition to initial care, follow-up support is critical. Fernández-Basanta *et al.,* (2018) found that many mothers felt abandoned by healthcare providers after the loss, particularly once the immediate postpartum care had ended. Continuous follow-up appointments, especially with healthcare providers who are familiar with the mother's emotional and physical journey, are essential in providing ongoing support. Cacciatore *et al.,* (2019) recommend that healthcare providers offer regular check-ins or referrals to mental health professionals, as mothers may not seek out help on their own due to the stigma or shame often associated with grief following perinatal loss.

2.5 Sociocultural Factors affecting Postpartum Mothers following Perinatal Deaths

Cultural factors, including religious beliefs, can impact individuals' responses to loss, as well as the way in which their losses are framed by those around them. Different cultures may have traditional ways of framing perinatal losses, but grief responses are difficult to generalize, due to the variation on both religious and cultural practices even within ethnic groups (Sheehy & Baird, 2022). There are complex interactions between socioeconomic status, family context, religious beliefs and cultural norms in perinatal experiences.

A perinatal loss is not only a time of bereavement but can also become a threat to women's identities, due to societal pressure and cultural expectations around having children, as well as personal expectations that can lead to feelings of failure and guilt (Murphy, 2022). The perceived failure to nurture and protect the developing infant can lead to self-blame, despite the lack of control over the experience (Murphy, 2022; Testoni *et al.,* 2020). This is compounded by the way in which the social elements of parenthood, such as taking care of and raising the infant, are privileged over biological elements of parenthood, such as contributing genetically and physically carrying the baby during pregnancy.

Cultural norms dictate not only the ways in which grief is expressed but also the duration and intensity of mourning. For example, in many Western societies, grief is often acknowledged and supported, with public expressions such as memorial services or counseling widely available (Wheeler, 2021). However, in other cultures, emotional restraint may be expected, and grief may be internalized rather than outwardly expressed. For instance, in some Asian cultures, such as in China or Japan, the mourning period for a loss may be more subdued, and grieving openly can be seen as a sign of weakness (Zheng *et al.,* 2024). In these settings, mothers might face additional pressure to suppress grief, potentially delaying their emotional healing. A study of women in Chhattisgarh, India noted the value placed on women's ability to produce healthy children, with some reports of abandonment by partners after stillbirth, or replacement by another woman who could bear living children (Li *et al.,* 2020). Cultural practices also influence the experience of perinatal loss in Kenya. In some communities, mothers are discouraged from holding or seeing their deceased infants, which may hinder the reality acceptance process (Poursalehi *et al.,* 2020). Religious and spiritual interpretations of loss-ranging from attributing it to divine will to viewing it as a test of faith-can provide comfort for some mothers but may also be invoked to discourage prolonged expressions of grief. These dynamics necessitate interventions that respect cultural beliefs while ensuring that mothers have the opportunity to process their grief in a supportive environment.

Religion and spirituality often provide mothers with a sense of meaning in the face of loss, with different religious traditions offering unique frameworks for understanding perinatal death. Christian mothers, for example, may take comfort in the belief that their child is in heaven, which can aid in coming to terms with the loss (Zheng *et al.,* 2024). In contrast, some religious or spiritual systems might see perinatal death as a test or punishment, leading to feelings of guilt or unworthiness, which could exacerbate psychological distress (Smorti *et al.,* 2020). Furthermore, in some Indigenous cultures, spiritual rituals and community-based mourning practices, such as ritualized ceremonies or communal grieving, play a vital role in processing grief. These rituals may help mothers maintain connections with the deceased child, facilitating emotional healing.

In collectivist societies, such as in many parts of Africa, Asia, and Latin America, family support is often the cornerstone of emotional healing (Raza, 2021). Extended families may play an active role in supporting mothers through the grieving process, with family members sharing responsibilities for household chores, childcare (for other children), and emotional support. This collective approach helps alleviate the isolation that might otherwise occur in cultures that emphasize individualism (Afuape *et al.,* 2021). However, in more individualistic societies, such as the United States or parts of Western Europe, mothers might experience greater isolation in their grief, as extended family structures may be weaker, and the expectation for individuals to process grief independently is more prevalent (Aeschlimann *et al.,* 2024).

The relationship between the grieving mother and her partner is another key component in coping with perinatal death. Studies have shown that shared grieving between partners can reduce the likelihood of depression and anxiety in both individuals (Afuape *et al.,* 2021; Li *et al.,* 2020; Papapetrou *et al.,* 2020). However, not all partners cope in the same way-while some might express their grief openly, others might internalize it, which can lead to emotional disconnection (Zsák, 2022). Discrepancies in grieving styles may strain relationships and affect the emotional well-being of both partners. In some cases, cultural norms regarding masculinity or femininity might affect how each partner copes with grief, with mothers often expected to bear the emotional burden of mourning, while fathers may feel pressured to remain stoic and focused on providing practical support (Blake & Simpson, 2023).

In some cultures, the community plays a significant role in supporting mothers who have experienced perinatal loss (Denney-Koelsch *et al.,* 2024). Peer support groups, particularly those that bring together individuals who have experienced similar losses, can provide a safe space for sharing emotions and coping strategies (Denney-Koelsch *et al.,* 2024). Such groups help mothers feel understood and less isolated, facilitating the healing process. In contrast, in cultures where miscarriage, stillbirth, or neonatal death is stigmatized or not openly discussed, mothers may feel socially isolated and unsupported, which can hinder the grieving process.

In some cultures, perinatal death is a taboo subject, and mothers may feel pressured to keep their grief private. For example, in certain African and Middle Eastern

communities, there can be a strong societal expectation that women should have children and be able to carry a pregnancy to term without complications. This expectation can lead to feelings of shame or personal failure when a pregnancy ends in loss (Murphy, 2020). The stigma can also prevent mothers from seeking professional help or talking openly about their grief, leading to prolonged emotional distress and psychological disorders such as depression, anxiety, and PTSD.

After a perinatal loss, mothers may experience difficulty reintegrating into their social circles (Kirui & Lister, 2021). In cultures where motherhood is a significant part of a woman's identity, the inability to bear children or the loss of a child can result in social exclusion. The pressure to "move on" or "get over" the loss may be felt acutely in such contexts, particularly when there is little understanding of the depth of grief associated with perinatal death (Denney-Koelsch *et al.,* 2024). The inability to process grief in a culturally sensitive and supportive environment can increase the risk of mental health problems. In multicultural societies, it is essential for healthcare providers to recognize and respect cultural differences in how perinatal loss is experienced and grieved. Culturally competent care involves understanding the grieving rituals, beliefs, and support systems that are important to the mother, and offering care that aligns with these values (Roberts *et al.,* 2024). This is particularly important when dealing with perinatal death, as emotional and spiritual care may be as important as medical care in the healing process.

In addition to cultural competence, practical issues related to healthcare access, including financial constraints, geographic location, and availability of mental health services, can affect the support that mothers receive (Zeanah & Zeanah, 2019). Mothers in rural or low-income areas may face additional barriers to accessing professional support for mental health, which can exacerbate feelings of isolation and depression (Brown, et al., 2021). In some societies, healthcare systems may fail to address the full range of emotional and psychological needs of mothers following perinatal death, limiting the resources available for grieving and healing (Li *et al.,* 2020, Afuape *et al.,* 2021). In cultures where mental health issues are stigmatized, mothers may be less likely to seek professional help for postpartum depression, which could lead to untreated or inadequately treated conditions. Furthermore, cultural norms around

emotional expression can affect how depression is experienced and recognized (Afuape *et al.,* 2021). For instance, mothers in collectivist cultures might experience depression through physical symptoms rather than verbalizing their emotional distress, which can lead to underreporting and underdiagnoses of mental health issues (Li *et al.,* 2020).

Support groups and self-help groups all function to help individuals going through the same experience. With specific regards to perinatal loss, support groups have been found to be quite effective when it comes to provision of social support and psycho education (Freedle, 2020). It also plays an important role when it comes to improving coping strategies, relationship quality with the partner, and even the overall well-being. Key issues discussed in perinatal loss support groups are usually concerns about how to involve the siblings in the grieving, pregnancies in the future, guilt, marital problems, communication issues, how to resolve feelings of jealousy towards friends that are pregnant, how to celebrate anniversaries, birthdays and other important dates like due dates (Eliott, *et al.,* 2021). It has been reported that after attending the support group's mothers report reduced feeling of guilt and shame, acknowledgement of the experiences and finding healthy ways to mourn and cope with the loss. The groups are also known to better communication between the mothers and their partners and to also restore hope.

2.6 Individualized Grief Counselling on Postpartum Mothers following Perinatal Deaths

Individualized grief counseling for mothers after perinatal loss (the loss of a fetus or infant during pregnancy, birth, or shortly after) is an essential part of the healing process. This type of grief is profoundly unique and often complicated by a combination of intense emotions, societal expectations, and personal experiences (Berger, 2022). The goal of individualized counseling is to provide emotional support, validate the mother's grief, help her process complex feelings, and guide her in finding a path forward in a way that respects her unique journey (Berger, 2022). Perinatal loss may cause major emotional problems in adjustment during bereavement period. Feeling of unpreparedness to face painful reality of the loss, denial, and feeling that their world no longer makes sense are commonly expressed (Herbert *et al.,* 2022). Parents who have experienced perinatal loss may feel hardship and face difficult time during this period.

Markin, (2024) reported that mothers with perinatal loss expressed their wishes that people should acknowledge their losses, be considerate and sensitive, and give them a listening ear and emotional support. Considering that up to 60% of parents experience PTSD following perinatal loss, it is critical to understand the traumatic nature of miscarriage, stillbirth, and neonatal death to effectively address parents' complex bio-psychosocial needs following perinatal loss.

Following perinatal loss, the psychological impact can be immediate, but it may also persist for years, leading to ongoing emotional distress, depression, and anxiety. Research has found that up to 25% of women experience significant symptoms of postpartum depression (PPD) following a perinatal death, and this can be exacerbated by grief (Thomas et a, 2021). The emotional consequences of perinatal loss include feelings of guilt, shame, anger, sadness, and helplessness, with women often struggling with the loss of a future identity and disrupted sense of self (Barry, 2022). Perinatal loss can induce both anticipatory grief (before the loss) and intense, prolonged mourning after the death. Mothers often experience complex grief, characterized by a prolonged and unresolved emotional state that interferes with the ability to engage in daily life (Furtado-Eraso *et al.*, 2021). These mothers also face trauma-related symptoms, such as flashbacks and intrusive thoughts about their baby's death (Afuape *et al.*, 2021). Women who experience perinatal loss are at a higher risk for developing depression, post-traumatic stress disorder (PTSD), anxiety, and complicated grief (Denney-Koelsch *et al.*, 2024). Several studies indicate that the psychological impact of perinatal loss can be more severe when the loss is unexpected or follows a difficult or complicated pregnancy (Barry, 2022).

Standardized grief counseling methods often fail to address the diverse emotional and psychological needs of mothers following perinatal death (Shaohua & Shorey, 2021). Individualized counseling, as opposed to a one-size-fits-all approach, recognizes that each mother's experience of loss is unique and shaped by a variety of factors, including personality, cultural background, family dynamics, and prior experiences with grief (Olivier, 2023). Individualized counseling focuses on customizing therapeutic interventions based on the mother's specific needs, coping mechanisms, and emotional readiness to process the grief. This type of counseling helps to create a safe space for

the mother to express emotions, work through complicated feelings, and develop resilience.

Different mothers experience grief in different ways, which is referred to as "grief trajectories" (Neal, 2023). Some mothers may need help addressing guilt or trauma, while others might struggle with anger, feelings of disconnection, or relationship strain. An individualized approach ensures that therapy aligns with the mother's specific grief trajectory, offering the best support for her emotional healing (Massmann *et al.,* 2025). The counselor's role is to support the mother's autonomy and provide gentle guidance through the grieving process. Counselors trained in perinatal loss understand that grief may evolve over time and that long-term support may be required. A counselor who is attuned to a mother's unique emotional responses, cultural sensitivities, and family context can be instrumental in helping her process loss.

Baron (2020) in his experience of counselling bereaved parents, describes the struggle to find meaning in the chaotic and overwhelming circumstances surrounding death, while at the same time searching for ways to remain connected to their lost child. Many of her observations apply as much to perinatal loss as the loss of an older child, particularly the way in which society has names for those who have lost a partner (widow or widower), and those who lose their parents (orphan) but there is inadequate language to represent parents' experiences of losing a child (Baron, 2020). The death of a child seems unexpected because of the way in which it disrupts the 'natural order', which assumes that babies should outlive their parents (Zsák, 2022). Perinatal loss may be a particularly unique form of grief due to the embodied experience of loss (Garrod & Pascal, 2019) and the combination of both guilt and connection of mothers to their lost child.

Grief responses to perinatal loss are deeply influenced by cultural, social, and familial norms. Research highlights the importance of recognizing cultural and religious practices when offering counseling to mothers following perinatal death ((Testoni *et al.,* 2020). An individualized counseling approach must be culturally sensitive, respecting the mother's values and understanding how her cultural context may shape her grief process. For example, some cultures may emphasize silence and private

mourning, while others may encourage public expressions of grief or memorialization (Sheehy & Baird, 2022).

Understanding the cultural nuances allows counselors to provide more effective support and create a safe space for the mother to grieve without judgment (Shaohua & Shorey, 2021). In many cultures, the family plays an essential role in grieving and coping with loss. An individualized counseling approach might also involve family members, encouraging open communication, and providing joint counseling if appropriate (Yıldız Karaahmet, & Bilgiç, 2024). The role of a supportive partner, friends, and social networks is central to the mother's healing, and counselors must assess how these relationships can be fostered or supported during therapy.

The importance of individualized counselling after perinatal loss cannot be overstated. Given the highly personal and varied nature of grief, a one-size-fits-all approach to therapy is rarely effective. Instead, counseling must be tailored to the mother's unique emotional, psychological, and social needs. The goals of individualized counseling typically include helping the mother process her grief, address feelings of guilt or anger, foster emotional resilience, and navigate the practical implications of the loss (Cacciatore, 2023). A key component of individualized counseling is providing a safe, empathetic space where the mother's grief.

2.7 Summary of Gaps in Literature

Losing a child is a painful and most traumatic experience that parents- and more so the mother- ever face in their lives. Perinatal loss in Africa remains a pressing concern. According to the World Health Organization (WHO, 2020), sub-Saharan Africa has the highest stillbirth rate in the world, with an estimated 19.4 stillbirths per 1,000 live births. Neonatal mortality in the region is also alarmingly high, with rates reaching approximately 28 per 1,000 live births (UNICEF, 2021). Despite some reductions in these rates in certain African nations, perinatal loss continues to account for a significant proportion of all deaths in this group, driven by inadequate healthcare access, late antenatal care, and preventable medical conditions.

Perinatal loss impacts women from all socioeconomic backgrounds and of all ages, with long-term economic and psychosocial consequences for families affected (Doraiswamy *et al.,* 2020). This has created the need for research so as to establish the causes and influence of perinatal loss on the mother's emotional and mental wellbeing. The available review showed that there was inadequate information on the effect of perinatal loss on the grieving mothers since majority of the studies focused their attention on specific psychological factors that are associated with it (Onambele, *et al.,* 2023; Doraiswamy *et al.,* 2020). The psychological consequences can be significant, with depressive disorders directly following a miscarriage being reported in 10-50% of cases (Al-Selwi & Barkat, 2023) and post-traumatic stress disorder. The fragmented approach to research exploring perinatal loss has meant there is a lack of understanding of what makes a meaningful difference to women's experiences in a pregnancy following a perinatal loss. Understanding of the whole journey from loss to subsequent pregnancy from the perspective of those who have lived through the experience is vital in order to improve services in the future. This the gap that the study under consideration sought to bridge by evaluating the impact of individualized grief counseling on postpartum mothers' psychological wellbeing, following perinatal losses in Tharaka Nithi County.

Grief following perinatal death can be one of the most devastating experiences a mother can endure (Obst *et al.,* 2020). The postpartum period, typically characterized by joy and anticipation, becomes instead a time of profound sorrow and emotional upheaval for mothers who experience the loss of their children (Alvarez-Calle *et al.,* 2023). Grief following perinatal death can be categorized as a unique and distinct type of mourning, which the particular circumstances of the loss can influence, the gestational age at death and the mother's psychological and emotional state prior to the loss (Farren *et al.,* 2021). Cassidy (2023**)** argues that perinatal grief is often overlooked or minimized by society, which tends to focus more on the grief of parents following the death of older children. Setubal *et al,* (2021) has shown that perinatal death leads to profound and often long-lasting psychological distress for mothers, with the grief experienced often comparable to the grief experienced following the death of an older child.

According to Prigerson *et al.,* (2021) complicated grief has recently been recognized as a mental disorder, and its inclusion in the 5th and last edition of the Diagnostic and

Statistical Manual of Mental Disorders (DSM-V), and in the next International Classification of Diseases (ICD-11). The loss of a child before birth is one of the most common situations for the process of complicated grief, elaborated at the imaginary level since there was no baby to hear crying, no memories and no shared life experiences. Grief following perinatal death is complex and multifaceted, often characterized by a range of emotions such as shock, sadness, anger, guilt, and despair. Immediately following perinatal death, mothers often experience shock and disbelief, which may delay the full processing of the loss. Post-traumatic stress disorder (PTSD) is another significant factor in grief following perinatal loss. For mothers who experience stillbirth or traumatic delivery, symptoms of PTSD, such as flashbacks, hyperarousal, nightmares, and avoidance behaviors, are common. Johnson *et al.,* (2021) found that mothers with pre-existing mental health issues were at a higher risk for developing depression, anxiety, and prolonged grief disorder following a perinatal loss. Their findings underscore the need for early mental health screenings and interventions to help mitigate the risk of complicated grief. As evidenced by the review there was need for an intervention to help postpartum mothers through the journey of grieving as a way of looking out for their well-being (burden lessened) a gap that this study under consideration sought to bridge.

Parents cope with the shock and trauma of perinatal loss through avoidance or denial, which allows them to manage overwhelming emotions, Donegan *et al.,* (2023). Another common emotion-focused coping strategy is emotional expression, Onwumere *et al.,* (2023). Expressive coping mechanisms allow parents to externalize their emotions, which can relieve emotional pressure and provide a sense of release. This cathartic process helps individuals better understand and come to terms with their grief. Social support is one of the most widely recognized coping mechanisms following perinatal loss. Smorti *et al.,* (2020) highlight that grieving parents often turn to family, friends, or support groups to help process their grief. Emotional support from loved ones can validate grief, provide a sense of comfort, and reduce feelings of isolation. However, Papapetrou *et al.,* (2021) note that the effectiveness of social support depends on the type and quality of support received.

Support that is empathetic, patient, and nonjudgmental tends to be more helpful, while dismissive or invalidating comments can worsen feelings of isolation and distress. Support groups, especially those comprised of individuals who have experienced similar losses, can also be an important source of coping. Jones *et al.,* (2022) found that participation in support groups allowed mothers to share their grief openly, learn from others, and gain comfort from hearing others' experiences. These groups can provide a sense of solidarity, which can be critical in reducing feelings of loneliness and alienation. For many parents, spirituality and religious practices are key coping mechanisms following perinatal loss. Zeanah and Zeanah (2019**)** suggest that individuals may seek solace in religious beliefs, prayer, or rituals that provide meaning and comfort. For some, spirituality offers a framework for understanding the loss and finding hope in the face of grief. Thompson *et al.,* (2020) found that religious rituals, such as memorial services, prayer, or connecting with a faith community, helped grieving parents feel supported and gave them a sense of connection to something greater than their immediate pain. Spiritual beliefs can provide both emotional comfort and existential meaning during a time of intense sorrow. It is evident that postpartum mothers need support to pull through the trauma and distress that emanates from perinatal losses. Expressing oneself, family and social support and professional guidance are essential mechanisms adopted by postpartum mothers to help them cope through the grieving period. The available review has shown these mechanisms but has not sought to assess the impact of this mechanisms. Therefore, this study sought to evaluate the effect of individualized grief counseling on postpartum mothers' psychological wellbeing, following perinatal losses in Tharaka Nithi County.

Social support plays a key role in loss responses and the healing process (Wheeler, 2021), with peer support playing a particularly significant role in giving bereaved mothers the opportunity to connect to those with shared experiences (Li *et al.,* 2022). Both social and professional post-loss support has been found to make a difference to healthcare professionals want to better understand bereavement and how to provide sensitive care to those experiencing perinatal loss, but lack confidence in how to interact with families (Richards, Graham, Kool *et al.,* 2023). Midwives are also responsible for the emotional wellbeing of mothers antenatal and in the early postnatal period, despite feeling underequipped to fulfil this role, particularly in relation to bereavement

(Wheeler, 2021). There is an increasing consensus for the need for improvements in bereavement care provided in the healthcare setting after the loss of a baby (Shakespeare *et al.,* 2020), however this global effort focuses predominantly on stillbirths, which therefore does not acknowledge the needs of women who experience earlier perinatal losses.

Reports evaluating this initiative highlights an improvement in care within the trusts included, with positive feedback from both parents and professionals questioned (Donaldson, 2019). However, there are still examples of inconsistent or insensitive care within hospitals, and the report highlights the way in which on-going care is solely provided through referrals to outside agencies, relying heavily on the third sector to provide psychological support. This means that despite improving standards of bereavement care within hospitals and improving consistency across different trusts, there will remain different levels of support within the community depending on what is locally available. A study by Danna, *et al.* (2023), women's experience of pregnancy after loss found that they needed regular contact with their health-care team to voice concerns and receive reassurance. It is not only the frequency of appointments offered, but also the quality of the care received those impacts upon outcomes, as highlighted by a study which found that satisfaction with healthcare services was linked to decreased symptoms of perinatal grief after miscarriage (Freedle, 2020).

Cacciatore *et al.,* (2019) notes that psychological counseling and support to postpartum mothers after perinatal loss is documented to be an essential intervention aspect that enhances healing throughout the grieving period. Health professional counseling is one of the significant intention measures that gives measurable results. Thus this study was established on the basis of determining the effect of grief counseling on postpartum mothers' well-being after perinatal losses a concept that had limited information based on the available review (Kochen *et al.,* 2020).

Cultural factors, including religious beliefs, can impact individuals' responses to loss, as well as the way in which their losses are framed by those around them. Different cultures may have traditional ways of framing perinatal losses, but grief responses are difficult to generalize, due to the variation on both religious and cultural practices even

within ethnic groups (Sheehy & Baird, 2022). There are complex interactions between socioeconomic status, family context, religious beliefs and cultural norms in perinatal experiences. A perinatal loss is not only a time of bereavement but can also become a threat to women's identities, due to societal pressure and cultural expectations around having children, as well as personal expectations that can lead to feelings of failure and guilt (Murphy, 2022). The perceived failure to nurture and protect the developing infant can lead to self-blame, despite the lack of control over the experience (Murphy, 2022; Testoni *et al.,* 2020). This is compounded by the way in which the social elements of parenthood, such as taking care of and raising the infant, are privileged over biological elements of parenthood, such as contributing genetically and physically carrying the baby during pregnancy.

Cultural norms dictate not only the ways in which grief is expressed but also the duration and intensity of mourning. For example, in many Western societies, grief is often acknowledged and supported, with public expressions such as memorial services or counseling widely available (Wheeler, 2021). Religion and spirituality often provide mothers with a sense of meaning in the face of loss, with different religious traditions offering unique frameworks for understanding perinatal death. Some religious or spiritual systems might see perinatal death as a test or punishment, leading to feelings of guilt or unworthiness, which could exacerbate psychological distress (Smorti *et al.,* 2020).

Furthermore, in some Indigenous cultures, spiritual rituals and community-based mourning practices, such as ritualized ceremonies or communal grieving, play a vital role in processing grief. These rituals may help mothers maintain connections with the deceased child, facilitating emotional healing. In multicultural societies, it is essential for healthcare providers to recognize and respect cultural differences in how perinatal loss is experienced and grieved. Culturally competent care involves understanding the grieving rituals, beliefs, and support systems that are important to the mother, and offering care that aligns with these values (Roberts *et al.,* 2024). In addition to cultural competence, practical issues related to healthcare access, including financial constraints, geographic location, and availability of mental health services, can affect the support that mothers receive (Zeanah & Zeanah, 2019). Mothers in rural or low-

income areas may face additional barriers to accessing professional support for mental health, which can exacerbate feelings of isolation and depression (Onwumere *et al.,* 2023).

In cultures where mental health issues are stigmatized, mothers may be less likely to seek professional help for postpartum depression, which could lead to untreated or inadequately treated conditions. It is evident that customs and norms of a given society have a very significant impact on postpartum mothers after the loss of their babies. Societal scorns on women who loss or are unable to bear children do not offer conducive environment to enable them overcome grief. Limiting them from mourning and expressing their pain affects them internally leading to severe trauma and in some cases depression. To these reasons there is need for an intervention to assist these mothers to overcome their grievances. Due to limited information assessing the effect of grief counseling on postpartum mothers after the perinatal loss, this study sought to bridge this gap.

2.8 Theoretical Framework

This study will be guided by Kübler-Ross's Stages of Grief theory. Elisabeth Kübler-Ross's (1969) model of grief was groundbreaking in its approach to understanding the emotional journey of individuals confronting death. The five stages are denial, anger, bargaining, depression, and acceptance are not intended to be a linear or universal progression (Corr *et al.,* 2020). Instead, they represent common emotional responses to loss, with individuals experiencing them in different ways and orders or sometimes even skipping some stages altogether.

The feeling of denial involves a refusal to accept the reality of the loss (Corr *et al.,* 2020). On the other hand, the feeling of Anger is characterized by feelings of frustration, helplessness, and resentment. The third stage is bargaining, which is the desire to reverse or prevent the loss, often through promises or making deals. The fourth stage is depression, which encompasses feelings of deep sadness, despair, and withdrawal (Corr *et al.,* 2020). The final stage is acceptance, which refers to coming to terms with the loss and finding a way to move forward. These stages have been instrumental in both clinical settings and grief counseling. However, when applied to

the grief of mothers after perinatal death, the appropriateness of the model has been debated.

Perinatal loss is often a traumatic event for mothers. The grief process is shaped by multiple factors, including the nature of the loss (e.g., stillbirth, neonatal death, and miscarriage), the mother's psychological and emotional resilience, cultural influences, and the social support systems available. Mothers may experience a wide range of emotional responses, including shock, disbelief, guilt, sorrow, anger, and isolation (Kuczewski, 2019). Research has also shown that mothers who experience perinatal death often face additional societal challenges, such as the invalidation of their grief by others who may not recognize the significance of the loss or who may not understand the depth of maternal attachment to a fetus (Blencowe *et al.,* 2024).

Several studies have explored the applicability of Kübler-Ross's stages to perinatal grief. For example, one study by Wang & Wang (2021) found that many mothers do experience a range of emotions that echo the stages proposed by Kübler-Ross, but they did not necessarily experience these stages in the predicted order or with the same intensity. Some mothers may go through periods of denial or numbness early in the grieving process, while others might experience prolonged bouts of depression or anger. A study by Bernau (2024) echoed these findings, noting that while some stages might appear (e.g., depression), they might manifest in different ways from what Kübler-Ross originally described.

Moreover, some researchers argue that Kübler-Ross's model oversimplifies the experience of grief. Perinatal loss may invoke complex feelings that transcend the stages outlined by Kübler-Ross, such as ambivalence (both sorrow and relief, particularly in cases of prolonged illness or difficult pregnancies) or the desire to maintain a connection with the lost child (Wang & Wang 2021). The grief associated with perinatal loss may also be influenced by factors such as previous pregnancy history, the presence of a support system, and cultural norms regarding mourning and motherhood (Corr *et al.,* 2020).

The grief experienced by mothers after perinatal loss is complex and deeply personal, and while Kübler-Ross's stages of grief offer some insights, they do not fully capture the diverse and sometimes contradictory emotions that mothers face after losing a child in the perinatal period. The linear, stage-based model may not sufficiently account for the nuances of grief, including the cyclical, fragmented, and sometimes prolonged nature of maternal grief.

2.9 Conceptual Framework

A conceptual framework showing the relationship of the study variables is shown below.

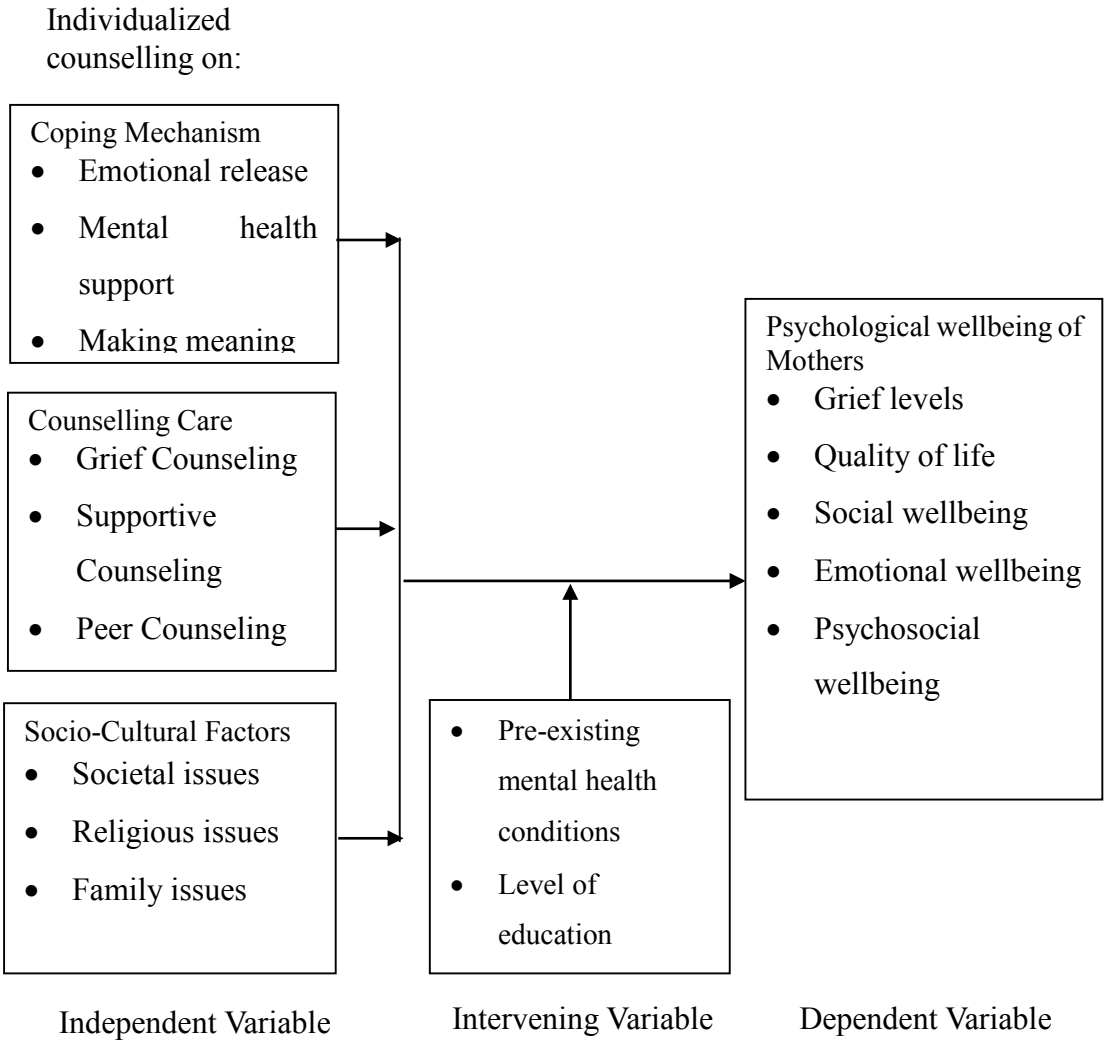

Figure 1: Conceptual Framework on Effect of Individualized Grief Counselling on Postpartum Mothers Psychological Wellbeing Following Perinatal Deaths

Source: Author (2025)

The conceptual framework for this study is designed to examine the relationship between individualized grief counselling and the psychological outcomes of postpartum mothers following perinatal deaths in Tharaka Nithi County. It identifies the key variables involved and illustrates how these interact to influence the mothers' emotional well-being.

Socio-cultural factors like societal, religious and family issues affect a mother's response to grief counselling. Mothers with higher support levels have better awareness and receptiveness to counselling interventions. Respecting diverse religious beliefs while offering counselling and addressing family conflicts through communication techniques improves recovery. In Tharaka Nithi County, understanding the cultural norms and religious practices significantly shape perceptions of grief and counselling on mental health. Addressing discrimination, marginalization, and societal expectations will help in emotional support of the mothers. Support from family and community, as well as acceptance of counselling as a coping mechanism, will improve the effectiveness of the intervention.

On coping mechanisms, mothers are guided through safe emotional expression, providing individualized counselling by counsellors and encouraging mothers on making sense of death and finding benefits from the event to recognize some positive value of life. A mother's prior exposure to perinatal loss and her existing coping strategies will influence the counselling and psychological outcomes. Mothers who have experienced multiple losses may require more intensive counselling to address compounded grief. Grief counselling is designed to help mothers process their loss, understand emotions, and find coping mechanisms. Supportive counselling will offer a therapeutic approach offering emotional validation, encouragement, and guidance to grieving mothers while in peer counselling mothers who have experienced similar losses provide support, reducing isolation and fostering a sense of shared understanding.

Intervening variables influence the counseling process by affecting how individuals perceive, process, and respond to interventions. If the intervening variables are not addressed effectively, it will hinder the intervention's effectiveness. Mothers with pre-

existing mental health conditions might need specialized therapeutic approaches because some conditions may impair problem-solving skills, requiring tailored interventions for coping mechanisms. The level of education will influence the individual's ability to understand and interpret and implement counselling strategies.

The dependent variable are vital indicators of the effectiveness of the counselling intervention in alleviating the profound emotional distress associated with perinatal loss. The psychological wellbeing of postpartum mothers following perinatal loss is complex and influenced by multiple factors. Effective grief counseling and supportive interventions can help improve grief management, enhance emotional and social wellbeing, and ultimately lead to better mental health outcomes. By addressing these dimensions, counsellors can support mothers in regaining emotional balance, improving their quality of life, and fostering resilience. By addressing these variables, the study aims to provide evidence-based recommendations for enhancing grief counselling services in Tharaka Nithi County.

CHAPTER THREE
METHODOLOGY

3.1 Study Area

This research study was conducted in four public hospitals in Tharaka Nithi County: Chuka County Referral Hospital, Magutuni Level 4 Hospital, Kibung'a Level 4 hospital and Tharaka Level 4 Hospital. These hospitals had been selected because they handle most cases of maternal health complications and thus address the cases of prenatal deaths and provided counseling to the affected mothers. In addition, the hospitals' location makes it possible for the research to sample all the regions in TharakaNithi County since the three hospitals were referral hospitals for Tharaka, Maara, and Chuka-Igambang'ombe Sub Counties, respectively.

CCRH is a government hospital situated in Chuka town in Tharaka-Nithi County. The political, social, and economic backups of this health facility were Chuka Town and Tharaka-Nithi County, respectively. Meru County adjoins it to the North East and North, Embu County to the South and South West, and the South East and Eastbound Kitui County. The geographical coordinates of the hospital range from latitude 0° 15' 0" to longitudinal 37° 1' 45". The research would take place in the hospital counseling sections. The site was chosen because the vast majority of patients with pregnancy complications, stillbirths, and miscarriages whose condition was detected in Level 2, level 3, or Level 4 health systems were referred to CCRH, Magutuni Level 4 Hospital, or Tharaka Level 4 Hospital. CCRH had a bed capacity of about 219 patients and average monthly deliveries was 350. The above hospital serves as the largest county hospital in TharakaNithi County.

Magutuni Level 4 Hospital is an approved health care facility based in Magutuni and is under TharakaNithi County in Kenya. This hospital is situated in the Mwimbi sub-county. Geographically, the hospital falls within latitudes 00.22'44" and longitude 370.62'67". It is a sub-county hospital like many others in Kenya, and it forms part of the key healthcare facilities for supplying health services to the population in the region at a local and municipal level. Some of the many services offered by Magutuni Level 4 Hospital included outpatient services, inpatient services, maternal services, emergency services, immunization/vaccination, and health promotion. This was an essential

service delivery system in the provision of health care to the population in remote rural settings, whereby it delivers both the first and the second level of health care services. Hospitals under level 4, such as Magutuni, were critical in offloading the demands on more prominent regional or national hospitals. Magutuni Level 4 Hospital conducted 120 admissions per month, with an average of 45 deliveries and a hospital bed capacity of 83 patients.

Tharaka Level 4 is a public hospital that is located in Tharaka in TharakaNithi County of Kenya. It is a Level 4 hospital at Tharaka South sub-county in the district between latitude 0o15'80" and longitude 37o 97'52". It caters to the local population, providing different types of healthcare: outpatient and inpatient services, maternity, emergency and specialized care. It is a part of the enlarged system of public healthcare facilities in Kenya that sought to address the problem of providing efficient and affordable medical services to rural populations. It had a vital role in enhancing access to health care, especially bearing in mind that this area was quite distant from large urban centers. Tharaka Level 4 Hospital had a bed capacity of 70 patients and conducted an average of 150 deliveries per month.

Kibung'a is a public hospital that is located in Tharaka Constituency in Tharaka Nithi County of Kenya. It is a Level 4 hospital at Tharaka South sub-county between latitude -0.112898 longitude 37.97454780o15'80". It provides outpatient and inpatient services, maternity and emergency care. It has a bed capacity of 35 patients and it sought to address the problem of providing efficient and affordable medical services to rural populations. The average deliveries per month was 10.

3.2 Research Design

According to Durrheim (2006), a research design is a systematic way through which a researcher seeks to make a linkage between the research questions and the actual execution of the study. This involves a well-developed map out of how data is collected, investigated, and results interpreted. Essentially, the research design is an expression of the conceptual foundation upon which the study is guided. The general objective of this study was to evaluate the effect of individualized grief counseling on postpartum mothers' psychological well-being after perinatal loss. The researcher employed a

descriptive approach that focused on exploring the cause-and-effect relationships of the research in a bid to answer the study questions. According to Mugenda & Mugenda (1999), research guided by the descriptive approach should adopt both qualitative and quantitative research methodologies. Qualitative and quantitative research methodologies were applicable in this study. The descriptive approach offered more insights into the study problem that was not exhaustively researched.

The study adopted a randomized controlled trial study design to evaluate the effects of individualized grief counselling on postpartum mothers psychological wellbeing following perinatal deaths, on mothers attending public hospitals in Tharaka Nithi County. Randomized Control Trial (RCT) design is the most traditional technique that was employed in defining the differences between two treatments (Zabor *et al.,* 2020) and also measure effectiveness of a new intervention or treatment ((Dahal et al., 2024).

Randomization acts as a protection against threats to validity within the context of measuring the impact an intervention had on an effect. This was because randomization brings equivariance of subject characteristics (measurable and non-measurable) between the groups, making it possible to infer any variation in the outcome of the study intervention. Besides, it creates a chance to obtained new information in a particular field of study, thus managing the problem under study. This was because the act of randomization balances participant characteristics (both observed and unobserved) between the groups allowing attribution of any differences in outcome to the study intervention. Therefore, mothers who had experienced perinatal loss in the Chuka County Referral hospital, Kibung'a level 4 hospital, Magutuni Level 4 Hospital and Tharaka Level 4 hospital were randomized to either control or intervention group. The RCT design was appropriate because it would explore and describe the relationship between variables in their natural setting without manipulating them so that the outcome of interest was attributed to the outcome of study (Bhide *et al.,* 2018). Further, it provides the opportunity to discover new knowledge in a given area of study thus control of the problem under investigation. Randomized controlled trials avoid bias in the selection of participants (selection bias) (Phillips *et al.,* 2022) and in the allocation of participants to the research.

3.3 Study Population

The target population refers to the clinical and demographic areas from which the sample was selected (Willie, 2024). The study population can be defined as the total number of all items or objects that hold similar characteristics of study and which the researcher wishes to employ for the specific study (Mugenda & Mugenda, 1999). Mugenda & Mugenda (1999) also postulate that the study population, which is selected from the target population, is the subset or sampling frame from which a researcher draws the sample size. On the other hand, the target population is the population through which the study findings will be generalized (Mugenda & Mugenda, 1999). Essentially, the target population is the entire population that the researcher intends to conduct a study. In contrast, the study population is the population group that forms the sampling frame for the sample selection. For this reason, the target population for the study was the postpartum mothers' who had a perinatal loss.

Tharaka Nithi County had an average of 360 perinatal deaths over a period of 4 years, since the year 2020. During the study period (November 2024 to January 2025), the average perinatal deaths averaged about 53. The target population of this study consisted of 53 mothers who voluntarily agreed to participate and provided informed consent, had experienced a perinatal death within the three-month study period in the county government health facilities and those assessed to be in stable mental health was considered eligible for inclusion Mothers who declined to provided informed consent and experienced a perinatal death outside the specified three-month timeframe would not be considered for participation. Mothers who were currently undergoing counseling for postpartum grief would also be excluded, as this may influence the outcomes related to coping mechanisms and psychological wellbeing being studied. This data was from the hospital's postnatal registers and the perinatal mortality registers. The study also targets the ten-counselling staff working in the selected hospitals with maternity wards in Tharaka Nithi County.

Table 1: Study population

Hospitals	Number of Mothers
Magutuni	11
Kibung'a	5
Marimanti	7
Chuka	30
Total	53

3.4 Sample Size Determination and Sampling Procedure

3.4.1 Sample Size Determination

According to Kothari (2004), sampling can be defined as a way through which researchers statistically select a subset of a target study population to generate deductions from observations and data. Essentially, the subset or sample refers to the unit of a target population used for the particular study (Mugenda & Mugenda 1999). The choice of a sample size is determined by the nature of the study that a researcher wishes to conduct and the study's timeframe and resources. The study under consideration utilized Chan *et al.,* (2008) formula for calculating sample size.

$Total\ sample\ size\ =\ C\ -\ 16.58$ for 80% power of the study (from statistical tables). δ was the standardized effect size (0.6), considering a clinical significance of 30%.

According to Chan *et al.,* (2008), a clinical significance of 0.2 units and an SD of 0.5 units of a normal distribution was acceptable for interventional studies. The researcher considered a 30% (0.3) clinical significance with an SD of 0.5.

Therefore, an effect size of 0.6 was considered in this study.

A $sample\ size = 46\ +\ 2 = 48\ participants$

An attrition rate of 5% was considered to accommodate nonresponse. To obtain a sample size from each study group the formula; $0.05\ x\ 48\ =\ 23\ i.e.2\ participants$

48 + 2 = 50 was employed resulting in approximately 25 patients for each study group hence a total sample size of 50 participants.

3.4.2 Sampling Procedure

According to Hariton and Locascio (2018), a sample was a representative of the large population. Sampling was the procedure of choosing one or more elements within a population in a way that the chosen item possesses some features of the other items in the population. The primary sampling techniques that was employed for this study were purposive sampling and census. According to Acharya *et al.,* (2013), purposive sampling falls under the types of non-probability random sampling and involves the selection of a unit based on the researcher's preference of who could hold the necessary information on the area of study. Under the purposive sampling, the study closely used key informants within the referral hospitals, that is, ten counseling staffs per hospital

where the research was conducted. The need for adopting purposive sampling for the state agencies and representatives is because most of these agencies' information is considered highly confidential and thus restricted to few individuals. According to Trochim & Donnelly (2001), identifying experts in purposive sampling enhances data reliability by selecting a sample population within a specific area of expertise. As such, this study adopted purposively selected experts for the various key informants within the referral hospitals since data generated from knowledgeable personnel will be significant for this study.

In this study, the target population consisted of all postpartum mothers who experienced perinatal deaths within selected health facilities in Tharaka Nithi County, Kenya, over a three-month period; November 2024, December 2024, and January 2025. To ensure comprehensive coverage and reduce selection bias, the study employed a census sampling method, whereby all eligible mothers who experienced a perinatal death during the specified timeframe was included in the sample.

3.4.3 Sampling Methods

The researcher applied purposive sampling to sample 10 counsellors in selected public hospitals in Tharaka Nithi County who were working in the maternity unit. These were targeted as they pose the required information crucial to this research. They would also enhance standardization of the intervention thus maintaining the internal validity. The counsellors had expertise in counselling and thus ensured that patient improvement was due to the intervention and not the counselor's personal style, helping control the counsellor related bias.

The hospitals were considered because of the high number of mothers delivering in the facilities. The researcher had access to target population and they ensured that these variations do not confound the study results thus improved the study’s external validity. The facilities also had the counsellors working in the maternity units who would provide the counselling services.

The study therefore employed census to sample 53 mothers with perinatal deaths within the study period. The data was obtained from the hospital records department under the

postnatal registers and perinatal mortality registers. Further Chan's formula was employed to determine the sample size.

The census approach was appropriate given the relatively small number of cases expected within the defined period, which allows for the inclusion of the entire population of interest without overextending resources. This method enhances the reliability of findings and increases the generalizability of results within the study context (Creswell & Guetterman, 2023).

Identification of eligible participants was done through a thorough review of postnatal and perinatal mortality registers from participating health facilities. The sampled mothers were assigned to either the experimental or control group based on the study design and ethical considerations.

3.5 Research Instruments

This study employed various means of data collection. Essentially, data collection instruments are used to gather data and information that is useful for quality research. In this study, the primary sources were adopted to assist in answering the research questions, testing the hypothesis, and assessing the results (Mugenda & Mugenda 1999). This research applied three sets of data collection instruments; perinatal grief scale, interview guide and questionnaires.

3.5.1 Perinatal Grief Scale

The Perinatal Grief Scale (PGS) developed by Toedter, Lasker, and Alhadeff (1988) was administered by the researcher in order to measure the grief levels of the perinatal mothers (Appendix 5). The scale offers an objective procedure for measuring the extent of grieving and the kind of grieving in perinatal loss survivors. The Likert scale comprises 33 items and had response options that range from strongly agree one and strongly disagree 5. There were three subscales in the PGS; Active Grief (questions 1-11) were questions where respondents refer to sobbing for their infant, grief, or mourning the baby as they feel it was natural to grieve. It measures the ruminative reactions, the current effect of psychological response, and the coping following a loss. The difficulties of sorrow could be, for instance, that the person had no support

(questions 12 to 22 were questions that measure how well the person can cope). Consequence (questions 23–33) describes hopelessness and shows how one feels when experiencing prenatal bereavement on a long- term basis. They had identified that intensification of the response takes place, progressing from Active Grief to Difficulty Coping with Despair. Each of the subscales included 11 items. For the perinatal grief assessment, the sum of the subscale score ranges between 33 and 165. A score above 90 was given an operation note of having a psychological disorder that requires intervention.

3.5.2 Interview Guide

Data from the mothers who had experienced perinatal loss was collected by use of a structured in- depth interview (Appendix 3). This data was used to identify the type of post-loss coping mechanisms of postpartum mothers following perinatal deaths. The interview schedule had questions related to the post-loss coping mechanisms they had applied following perinatal loss in the public hospital in Tharaka Nithi County. The researcher developed the interview guided by the objectives of the study and the literature reviewed.

3.5.3 Questionnaires

The study focused on the primary data, which was collected by distributing semi-structured questionnaires that included both closed-ended and open-ended questions to the counsellors of the particular healthcare facilities. Hence, questionnaires were the primary sources of data collection because they provided an efficient manner of data gathering for strategic purposes. Fife-Schaw (2020) points out that questionnaires were advantageous because they offer opportunities for anonymity, and this makes the respondents open, as can be seen in the sensitive aspect of governance and/or management. However, questionnaires were preferred since they allow a high response rate as they were administered to the respondents for self-completion by research assistants. Bihu (2024) notes that questionnaires were preferred since they allow a high response rate as they were administered to the respondents for self-completion. They also allowed a chance to stay anonymous as the subject names were not asked on the completed questionnaires, and as an added advantage, they contain fewer opportunities for bias as they were formatted in the same manner. There were three sections in the

questionnaire: section A, demographic information; section B, information as to the nature of counseling care given to postpartum mothers after perinatal deaths; section C, and sociocultural practices affecting postpartum mothers after perinatal deaths Appendix 4). The questionnaires were self-administered and ware offered using a drop-and-pick method later. This was done by providing follow-up on the submission of the questionnaires on the due date, which was set. Questions that were developed to form the questionnaire was answered on the interval type point scale or the Likert type scale.

3.6 Pretest of the Instruments

The data collection instrument was pretested at Kerugoya County Referral Hospital in Kirinyaga County. This was because the population of mothers and counselors and the services being offered were more comparable to the selected hospitals in TNC. A purposive sample was identified and the questionnaires issued. The need for a pretest study was to enhance the reliability of the research instruments by ensuring that the inferences drawn from the study are similar (Bujang *et al.,* 2024). With the results from the pretest study, the researcher established the efficiency of the research instruments and thus guided the research instruments modification and amendments to align with the research objectives as she prepared for the actual data collection. After pretesting, the necessary modifications were made to the questionnaires. Ambiguous questions detected was deleted and rephrased appropriately to improve clarity. Items that were identified not to measure the intendent content were modified. Mugenda and Mugenda (2019) support the pretest of the research instruments by applying it to a similar sample to the actual sample. She argues that researchers should avoid using subjects in the actual sample in the pretest. The pretest sample would comprise 10% of the sample, and they used purposively sampled. Five mothers and one counselor was selected for pretesting. The researcher would use the results of the pretest study to test inter-observer reliability and check the validity of the instruments used.

3.6.1 Validity Testing

Validity entails the appropriateness, meaningfulness and usefulness of inferences a researcher makes based on the data collected (Lim, 2024). According to Heale & Twycross (2015), validity can be defined as the magnitude to which the hypothesis of

the study is accurately evaluated. Essentially, this means that the research instruments adopted for the study are used to measure the right concept.

Validity for this study was ensured by consulting with my supervisors, who helped identify any gaps in the research instruments for improvement by the researcher. Also, professionals or experts during seminar presentations and workshops who were well versed with the research concepts helped to ascertain the extent to which the research instruments like questionnaires and interview guides covered the concept in question. According to Trochim & Donnelly (2001), adopting experts in purposive sampling involves selecting respondents with the knowledge and expertise within the specific study area to enhance the quality of the inferences drawn from the questionnaires and interviews. The form of validity employed through the use of professionals is content validity which also narrows down to face validity.

Further, generating inferences from a representative sample of the population ensured the study's external validity (Tongco, 2007). Also, conducting the research correctly ensured the study's internal validity since the credibility of the deductions drawn from the sampling instruments was improved. Therefore, to enhance the credibility of the data collection instruments and the data received from the respondents, it would be good to have measurements done repeatedly. In addition, conducting a pre-test on the sampling instruments was essential to reduce limitations and bias on data validity.

3.6.2 Reliability Testing

Kennedy (2022), define reliability as involves a measure of the degree to which a research instrument yields consistent research or data after repeated trials. Reliability, according to Heale & Twycross (2015), is the ability of the research instruments to offer similar inferences if it is employed on similar measurements repeatedly. This research adopted both purposive and census techniques with questionnaires and interviews as the key data collection instruments. Essentially, the data collection instruments should be able to generate similar deductions when applied to a similar sample several times. According to Tongco (2007), reliability of the study was understood as the level in which the inferences made by the key informants of the study manifest a similarity on various counts. Further, bias from the respondents resulting from the informants giving

false information voluntarily or involuntarily could affect the reliability of data deduced from the questionnaires and interviews. With the study being objective, it was crucial to adopt questionnaires and interviews that were guided by the objectives of the study to enhance reliability. As Tongco (2007) posits, the researcher must formulate questions that provide the right information that is being sought. As such, to ensure the reliability of the data collection instruments, the research adopted a pre-test survey that involved evaluating the effectiveness of tools from random respondents before the actual test.

Random errors reduced reliability of the research and pre-test would enable researcher identify most possible source of error and respond before carrying out the actual study. The questionnaires were pretested using the test-re-test method. It involved administering the same test to the same group of participants on two different occasions and then correlating the scores. A high correlation indicated that the test produced reliable results. The researcher used Cronbach's alpha coefficient to test the reliability of the questionnaire. Cronbach's alpha was used to estimate internal consistency reliability by determining the manner in which different items of the instrument related to each other and to the entire instrument. This would require the use of statistical software (Mugenda & Mugenda 2019, Taber 2018). In this study, the pretest results yielded a reliability coefficient of 0.86. Cronbach's alpha values which attained the cut-off more than 0.7 was adequate to confirm the reliability of the instrument as recommended by Taber, K. S. (2018).). The study tool was reliable since it met the proposed reliability threshold and was therefore adopted.

3.7 Procedure for Data Collection

The researcher administered the data collection instruments both at the pretest and main study. The respondents were issued with the questionnaire to check on the knowledge gaps in the pretest individually. The researcher then offered individual counseling to the experimental group only, accompanied by a follow-up. After 3 months, the researcher issued a post-test interview for all the mothers. All findings were recorded for analysis.

3.7.1 Phase 1: Baseline Survey

Phase one of data collection was conducted at the hospital. During this period the postnatal registers and perinatal mortality registers were used to identify mothers with perinatal deaths from November 2024 to March 2025. Baseline data was collected on mothers in regard to adherence to the recommended procedures and individualized grief counseling on maternal postpartum stress following perinatal deaths, emotional, psychological, sociocultural, and socio-economic aspects of each of the mothers, and facility factors on the management of post-traumatic stress. After identification, the purpose of the study was explained, and consent was obtained before data collection. The intention was explained to the mothers in a language that they would prefer, both orally and in writing. Then, the participants were required to give informed consent by signing the consent form, which the researcher provided. They were then given a semi-structured questionnaire to fill out under the researchers' supervision. The questionnaire was utilized to collected quantitative data.

3.7.2 Phase 2: Intervention

Based on the gaps that were identified in phase one findings, mothers would need to be educated on the best ways to cope with postpartum grief. Through simple randomization, mothers were randomized either to the control and experimental group using a random number generator. Mothers in the control group underwent routine, standardized care throughout their study period without any additional interventions. Their grief levels and post-loss coping mechanisms data was obtained during the baseline survey.

The intervention group underwent individualized counseling during their routine planned hospital visits for 3 sessions, slotted at every third week for a period of three months. The researcher assigned the counsellors in the hospitals with specific tasks of counselling the mothers who were classified in the experimental group. The researcher adapted the individualized counselling based on the challenges the mother exhibits during the counselling sessions. The individualized counseling sessions were tailored to the gaps identified during the baseline survey of the pre-intervention phase and the individual needs of each patient. Each patient underwent a total of 3 sessions, where the researcher would evaluate the progress of the mother gradually, and adjust the

counselling towards the mother's response. The sessions also took into consideration the emotional, psychological, sociocultural, and socio-economic aspects of each of the mothers. At the end of the intervention phase, the researcher did an evaluation of the mother's psychological wellbeing.

3.7.3 Phase 3: Post-Intervention Survey, Monitoring, and Evaluation

The intervention and control group were followed up for three months to monitor their coping mechanisms. Monthly follow-up visits in counseling clinics were done to monitor the implementation of what was taught, and the control group was also be followed up for the control data. After six months of follow-up, data collection tools that was used during the baseline survey was re-administered, and the findings was compared. Follow up ensures to measure changes in psychological wellbeing, grief levels, and social functioning and determine whether these factors had improved, worsened, or remained stable.

3.8 Data Analysis and Presentation

Dahal (2024) ascertains that analysis means sorting, arranging, categorizing, ordering, manipulating, tabulating and summarizing of data to obtained answers to research questions. Statistical Package for Social Sciences, (SPSS version 29) software was used to analyze data quantitatively as per the objectives. Data collected was edited, coded, classified on the basis of similarity and then tabulated. Descriptive statistics which included frequencies, percentages, weighted means were carried out for quantitative data. Thematic analysis was done for qualitative data.

Different inferential statistics were done; correlation t-test and multiple regression analytical tools to analyze the data and explain the study outcomes. T test analysis was done at a 95% confidence level to determine the effect of intervention on individualized grief counselling on mothers in control and intervention groups. Regression analysis was used to determine intensity of variable for categorical predictors influencing the relationship. This entailed evaluating the effect of individualized counselling.

Using a measuring scale of 1-5, items of the instruments was analyzed and descriptive statistics presented as mean scores, standard deviation, frequency distributions and percentages to summarize and relate variables which was obtained from the study. Weighted average accounts for the relative importance of different data points by assigning specific weight ensuring that certain values have more influence on the final result. This method is important when combining information from different responses and categories (Sun 2024). ANOVA was used to identify variation between the pretest and posttest scores on the grief levels of postpartum mothers. Qualitative data was analyzed thematically to identify patterns and meanings. The findings obtained were used to reinforce the findings of quantitative data.

3.8.1 Statistical Tools

The study employed the use of T-test, ANOVA and regression analysis which are explained as follows.

3.8.1.1 T-test

To analyze the data collected, t-test was employed as the main statistical tool to examine difference both between and within groups. The T-test is appropriate for determining whether there is a statistically significant difference between the means of the two groups, (Field, 2018). In this study two types of T-tests were used: the independent sample t-test and paired sample t-test.

Independent sample T-test was used to compare the post-test scores between the control group (which was not exposed to the intervention) and the experimental group (which received intervention). This was appropriate because the two groups were mutually exclusive and independent of the one another (Pallant, 2020). For independent sample T-test, the independent variable: Group type (control Vs experimental) while the dependent variable was posttest scores the outcome measure. Therefore, the independent T-test assessed whether the intervention had statistically significant effect by comparing the average scores of the two groups after the intervention period.

For the second form of the T-test, that is, paired sample T-test, it was used to assess within group change by comparing pretest and posttest scores for each group separately. This test was suitable as the measurements were taken from the same participants at two different times, making the data paired or independent, (Creswell & Creswell 2018). The independent variable for paired sample T-test is time (pretest Vs posttest) while the dependent variable was scores on the outcome measure and the groups were assessed separately (control group and experimental group). The paired T-test determined whether there was significant improvement (or decline) scores over time for each group, offering insights into the effectiveness of the intervention within the experimental group and any natural changes in the control group.

On statistical significance all tests were conducted using a significance level of $\alpha = 0.05$. Assumptions for t-tests, including normality and homogeneity of variance, were checked prior to analysis.

3.8.1.2 Analysis of Variance

In a study involving pretest and posttest measurements for both experimental and control groups, Analysis of variance (ANOVA) serves as a powerful tool to evaluate the effectiveness of an intervention, Field (2013). The main purpose of the ANOVA is to help us assess whether the intervention had a significant impact compared to the control condition. Note that the experimental group had been subjected to an intervention while the control group had no intervention. Anova in this study has been use in two cases; within effect where we looking at the variation between pretest and posttest scores over time and between effect where we looking at the variation between groups, that is, experimental and control groups over the time. Therefore, in this study Anova was used because it detects difference even with modest sample sizes, assuming assumptions are met and the fact that it's possible to obtain the within effect between pretest and posttest and the between effect between experimental group and control group (Nayeri *et al.,* 2023).

3.8.1.3 Linear Regression

Regression analysis is a statistical methodology used to examine the relationship between one dependent variable and one or more independent variables. It is primarily

used for prediction, forecasting, and hypothesis testing. In the context of educational, psychological or social research, regression is often employed to determine whether scores on the pretest (administered before intervention) can predict outcomes on a posttest (administered after intervention). In the pretest-posttest control group design participants are typically assigned to either an experimental group (which receives the intervention) or a control group (which does not). Both groups take pretest and posttest. The goal is to assess the impact of the intervention by comparing the groups' scores while adjusting for initial differences. In this study regression analysis was used to; First, test whether pretest scores predict for posttest scores and secondly test whether the effect of the intervention, adjusting for pretest performance (Marsden & Torgerson, 2012).

The typical regression model is of the form

$Y = \beta o + \beta 1X1 + \beta 2X2 + \epsilon_i$ where:

Bo, β1, β2 coefficient of predictors

Y = represents the outcome score for individual group

X_1 = the initial score

X_2 = is the binary indicator e.g., 0=control, 1=experimental

The model assumes normalcy, linearity, independence and homogeneity.

3.8.1.4 Correlation

Correlation is a measure of the linear relationship between two variables. In this study we have pretest and posttest scores thus correlation is meant to show the linear relationship between pretest and posttest. That is, it shows how scores before and after intervention relate. A high correlation suggests that individuals who scored high on pretest also tended to score high on posttest, low or no correlation indicates that pretest performance does not predict posttest performance and negative correlation might imply an inverse relationship. In this study correlation was used to show whether the scores for pretest and posttest remained stable after the intervention.

Table 2: Data Analysis Plan

Objective	Type of data	Method of analysis
To assess the grief levels of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya.	Descriptive Continuous	Frequencies, percentages, means
To assess the post-loss coping mechanisms of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya.	Categorical	Themes
To assess the counseling care offered to postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya	Descriptive Continuous	Correlation, Regression Weighted Averaged
To determine the sociocultural factors affecting the coping mechanism of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya.	Descriptive Continuous	Correlation, Regression Weighted Averages
To evaluate the effect of individualized grief counseling on the psychological well-being of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya.	Descriptive Continuous Categorical	Frequencies, percentages, means Regression Correlation T-Test ANOVA

3.9 Ethical Considerations

The researcher obtained authorization and approval to conduct study from Chuka University Institutional Ethics and Research Committee. The committee reviewed and approved the research projects in a view to ensure that they meet the ethical standards. The approval number (CUIERC/NACOSTI/732) indicates that the study received the committee's approval (Appendix 7 & 8).

A research permit to carry out the study was sought from National Commission for Science, Technology and Innovation (NACOSTI), before administering the questionnaires to respondents. This permit with license number NACOSTI/P/4173686, (Appendix 14) indicates that the study was authorized by the overseeing regulatory body. The County Director of Health Services in Tharaka Nithi County and the administrative management of the four hospitals provided permission for the data collection to take place. Authorization to collect data from the hospitals are indicted by the following reference numbers; TNC/CDH/R/VOL.2/136 (Appendix 10)- County Director of Health, CKA/MED/T/16/VOL.VI/355 (Appendix 11)-Chuka County Referral Hospital, TNC/TDH/ATT/VOL.5/186 (Appendix 13) -Marimanti Level IV

Hospital, MGTN/VOL.1/2/2025 (Appendix 12) -Magutuni Sub-district Hospital and TNC/KSDH/ATT.VOL.5/186 (Appendix 9) -Kibung'a Sub-County Hospital.

The participants in the study were provided with information on the study's purpose. They were informed that participation would be voluntary and they had freedom to withdraw from the study at any stage. This ensured participants autonomy. Further, informed consent was sought from respondents before data collection (Appendix 1). The respondents were assured of non-disclosure of their identity for any information given. The interview schedules (Appendix 3) and the questionnaires (Appendix 2) were serialized for anonymity. Concerning confidentiality, the respondents were assured that the information provided would only be used for research purposes only and would not be disclosed to unauthorized individuals. The respondents were given freedom to choose to participate or not to participate in the study. Respondents were assured that information collected was analyzed and reported objectively to facilitate policy formulation.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Response Rate

The researcher administered 50 questionnaires to various respondents for the study, and the results obtained are presented in Table 3.

Table 3: Response Rate

Instrument		Pre-intervention		Post intervention	
	Category	Response F (%)	Non response F (%)	Response F (%)	Non response F (%)
Perinatal grief scale	Intervention	23 (92%)	2 (8%)	22 (88%)	3 (12%)
	Control	23 (92%)	2(8%)	22(88%)	3(12%)
Questionnaire	Intervention	10 (100%)	0	10(100%)	0
	Control	10 (100%)	0	10(100%)	0
Interview	Intervention	23 (92%)	2(8%)	22 (88%)	3(12%)
	Control	23 (92%)	2(8%)	22(88%)	3(12%)

Out of a calculated sample size of 50, only 46 (92%) of the respondents participated in the study. The other 4 declined to participate. The 46 who gave a written consent participated in the pre-intervention assessment individually in the various public hospitals in Tharaka Nithi County. At the end of the study, only 46 participated in the post- test assessment recording an attrition rate of 4%. For the healthcare workers that were sampled, all (100%) of the healthcare workers took part in the study, in both pre-intervention and post-intervention studies.

4.2 Social Demographic Data

The study was conducted among the mothers who had experienced perinatal losses within Tharaka Nithi County, who had provided consent prior to data collection. The participants had the following demographics characteristics as shown in Table 4.

Table 4: Age of the mothers

Age of Respondents	Frequency	Percentage
20 years and below	2	4.3
20-25 years	4	8.7
25-30 Years	6	13.0
30-35 Years	9	19.6
35-40 Years	24	52.2
40 years and above	1	2.2
Total	46	100.0

The majority of participants were in the 35-40 years age bracket, accounting for 52.2% of the total sample. This suggests that perinatal loss is most prevalent among older reproductive-age women, potentially due to biological risks associated with advanced maternal age, such as hypertension, diabetes, or chromosomal abnormalities. Notably, only 4.3% of respondents were 20 years and below, indicating fewer cases among adolescent mothers, or possibly lower representation due to social stigma or underreporting.

Table 5: Marital Status

Marital Status	Frequency	Percentage
Single	27	58.7
Married	8	17.4
Divorced	2	4.3
Widowed	9	19.6
Total	46	100.0

The findings on Table 5 reveals that more than half of the respondents (58.7%) identified as single, while 19.6% were widowed, and only 17.4% were married. This distribution raises concerns about the role of spousal or partner support in maternal well-being. Single and widowed mothers may lack emotional and financial backing during and after the loss, contributing to deeper emotional trauma and prolonged grief. Changes in social cultural trends may have led to delayed or reduced marriage rates, and the possible relationship strain associated with perinatal loss, which left mothers without partners during the postpartum period.

Table 6: Level of Education

Education Level	Frequency	Percentage
Primary School Level	26	56.5
Secondary School Level	10	21.7
College/tertiary level	6	13.0
University Level	4	8.8
Total	46	100.0

From Table 6, the educational attainment of respondents shows that 56.5% had completed only primary school, and a combined 21.7% had reached secondary level. Only 8.7% had attained university education. Respondents with secondary, college/tertiary and or university education have an adequate level of knowledge that

can help them interpret situations. For example, they know they have to get proper and timely antenatal and postnatal services. Majority of the respondents had primary education implying they are not very elite and tend to have reduced awareness of prenatal care, limited access to reproductive health services, socioeconomic challenges, limited access to higher education opportunities in rural settings and persistent barriers that prevent women from advancing beyond basic education. The findings suggest that low education levels may influence health-seeking behaviors and coping strategies among bereaved mothers and also poor health-seeking behavior. These factors likely contribute to increased risk of perinatal complications and loss.

Table 7: Responses on the Occupation of Mothers

Occupation	Frequency	Percentage
Student	7	15.2
Peasant Farmer	12	26.1
Unemployed	14	30.4
Employed (informal sector)	3	6.5
Employed (Civil Servant)	10	21.8
Total	46	100.0

On Table 7, in terms of occupation, the highest proportion of respondents were unemployed (30.4%), followed by peasant farmers (26.1%). Only 6.5% were engaged in the informal sector, while 21.7% were employed as civil servants. Economic vulnerability is clearly evident and may affect a mother's ability to access quality maternal healthcare services, contributing to adverse pregnancy outcomes.

Table 8: Responses on Number of Previous Pregnancies

Number of previous pregnancies	Frequency	Percentage
1	18	39.1
2	10	21.8
3	12	26.1
4	2	4.3
5 and above	4	8.7
Total	46	100.0

The data on responses on previous pregnancies shown on Table 8, indicates that 39.1% of mothers had one previous pregnancy, and 26.1% had three pregnancies. The distribution reflects that perinatal loss affects both first-time mothers and those with prior pregnancies. However, the higher percentage of first-time pregnancies associated

with loss may indicate a lack of pregnancy experience or inadequate prenatal preparation.

Table 9: Number of Previous Live Births

Number of previous Live Births	Frequency	Percentage
1	27	58.7
2	8	17.4
3	3	6.5
4	2	4.3
5 and above	6	13.1
Total	46	100.0

Table 9 shows that the majority (58.7%) had one previous live birth, while 13.0% had five or more. This mix of primiparous and multiparous women highlights that perinatal loss is not confined to maternal experience level and may recur across pregnancies if root causes, such as healthcare access or pre-existing conditions, are not addressed. This can be attributed to care-seeking behavior as women who already have children may feel more confident and fail to attend all the recommended ANC visits. As a result there would be lateness in detection of complications that would cause perinatal deaths.

Table 10: Types of Prenatal Loss

Types of Prenatal Loss	Frequency	Percentage
Miscarriage,	14	30.4
Ectopic pregnancy	6	13.1
Termination of pregnancy,	3	6.5
Stillbirth	11	23.9
Neonatal death	12	26.1
Total	46	100.0

The findings on Table 10 shows that most frequently reported type of perinatal loss was miscarriage (30.4%), followed by neonatal death (26.1%) and stillbirth (23.9%). These figures reveal that both early and late perinatal periods are vulnerable phases. Miscarriages may stem from poor antenatal care or undiagnosed maternal illnesses, while stillbirths and neonatal deaths may be linked to delivery complications, poor intrapartum care, or neonatal infections. Ectopic pregnancies accounted for 13.0%, a relatively lower but critical statistic due to their life-threatening nature and the urgent medical intervention they require. Unlike other forms of perinatal loss, ectopic pregnancies often pose a direct risk to the mother's health and future fertility

necessitating rapid diagnosis medical management to prevent morbidity and mortality. Their occurrence highlights gaps in early pregnancy screening, delays in accessing care or inadequate awareness of early warning symptoms among expectant mothers.

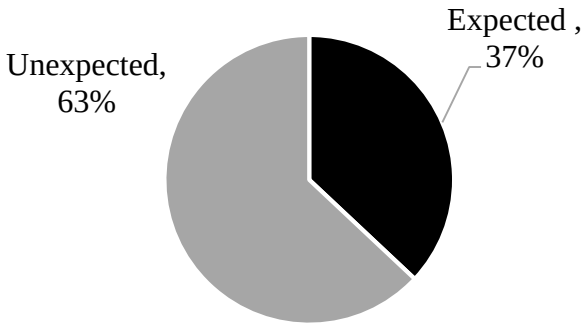

Figure 2: Response on the Expected Loss of the Child

The findings of Figure 2 reveal that the majority (63%) of the respondents indicated that they did not expect the loss, whereas 37% indicated that they had anticipated that child loss. Anticipated losses occurred from pre-existing medical conditions that worsened towards end of pregnancy, previous obstetric history where mothers had recurrent miscarriages, stillbirths or perinatal complications and anticipated poor prognosis like extremely preterm labor. This suggested that for most participants, perinatal loss occurred suddenly or without warning signs, leaving them emotionally unprepared to cope with the events. Such unexpected losses were often associated with heightened emotional distress and difficulty in initiating coping strategies.

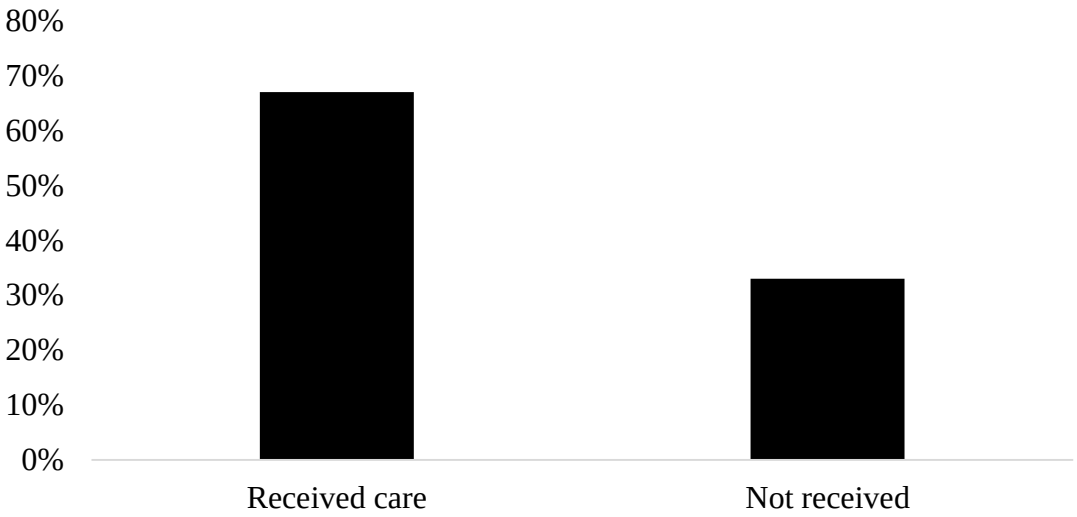

Figure 3: Response on Care at the Facility

On Table 3, the study established that 67% of the respondents indicated that they received care at the hospital immediately after they lost their child while 33% indicated that they did not receive care. This may be partly because they may not have experienced the loss while at the hospital, or as a result of other factors. Additional factors included financial constrains limiting access to health care services, lack of awareness regarding the availability of services and importance of post loss grief counselling and the social cultural beliefs. Absence of counsellors or specialized bereavement support, ineffective administrative and referral systems, low perceived need for follow up care and emotional withdrawal were also considered to hinder health seeking behavior.

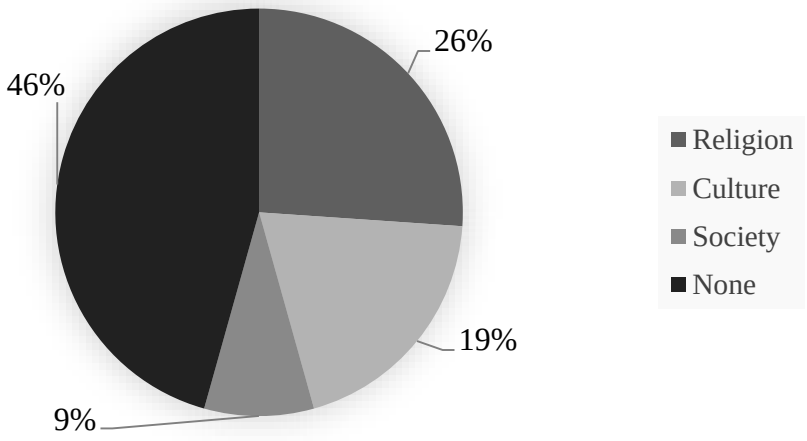

Figure 4: Response on the Sources of Support, Religion or Culture or and Society

From Figure 4, the majority (46%) of the respondents did not receive any support from the society and religion, while 26% of the respondents had received help and assistance from religious institutions. Significant support had also been given by the culture at a response of 19% and society at a response of 9%. Based on the results, it is evident that majority of the respondents had not received any support which can be explained by the stigma surrounding pregnancy loss, cultural and religious beliefs that discourage open mourning and the absence of structured psychosocial support systems within communities and hospital settings. Consequently, many bereaved mothers preferred to mourn in silence due to shame, guilt or fear of judgment.

Table 11: Availability of the Skilled Healthcare Professionals

Professional Role	Frequency	Percentage
Midwife	2	20
Obstetrician	2	20
Nurse	2	20
Counselor/Psychologist	4	40
Length of Service		
Less than 1 year	0	0
1-3 years	1	10
4-6 years	5	50
7-10 years	2	20
More than 10 years	2	20
Total	10	100

The findings in Table 11 reveal that the counselors/Psychologists make up the largest group, comprising 40% (n = 4) of the participants. This indicates a strong presence of mental health professionals in maternal care settings, particularly relevant in contexts dealing with perinatal loss or emotional support needs. The Midwives, Obstetricians, and Nurses are equally represented, each accounting for 20% (n = 2) of the sample. This even distribution suggests a balanced input from various clinical care providers involved in maternal health.

This even distribution suggests a balanced input and growing recognition from various clinical care providers involved in maternal health. The multidisciplinary approach to maternal healthcare is also acknowledged where expertise from different cadres contributes to holistic care. The balanced representation of these groups also reflected coordinated interprofessional collaboration, which is critical for integrating physical, emotional and social long-term emotional recovery of affected mothers. This multidisciplinary presence enhanced the quality of bereavement care, and facilitated early detection of complicated grief to promote timely interventions that improve maternal mental health outcomes.

The findings on the Table 11 reveal that the largest group (50%, n = 5) reported having 4–6 years of experience, indicating a moderately seasoned workforce. 20% (n = 2) of the participants had 7–10 years of experience, and another 20% (n = 2) had more than 10 years, suggesting that a significant proportion are highly experienced. Only 10% (n = 1) of respondents had 1–3 years of experience, while none had less than a year. The

dominance of professionals with over four years of experience (90% of respondents) implies that the views and practices reported are likely informed by sustained exposure and practical engagement with maternal health, increasing the reliability and depth of insights.

4.3 Grief levels on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

The first objective of the study sought to establish the grief levels of the mothers after experiencing perinatal loss. The researcher used a Perinatal Grief Scale (PGS) to establish the grief levels on both control and experimental groups of the study. The findings obtained for both Experimental and control groups are presented in table format.

4.3.1 Pre-intervention Results

The researcher did a comparison of grief levels experienced by mothers in an experimental group and a control group following perinatal loss. The objective is to delineate the various facets of grief, including Active Grief (AG), Difficulty Coping (DC), and Despair (D), and their cumulative impact as represented by a Total Grief Score and categorized Grief Level.

To provide context for the subsequent analysis, a detailed overview of the demographic characteristics and loss distributions within both the experimental and control groups is presented. This foundational understanding is crucial for interpreting the observed grief levels and identifying potential confounding factors.

4.3.1.1 Pre-intervention Scores for Perinatal Grief Scale (PGS) on Experimental Group

Table 12: Pre-intervention Scores for Perinatal Grief Scale (PGS) on Experimental Group

Time Since Loss	Type of Loss	Active Grief (AG)	Difficulty Coping (DC)	Despair (D)	Total Score	Grief Level
4 months	Neonatal death	43	29	49	121	High
6 months	Miscarriage	45	40	49	134	Severe
2 months	Miscarriage	44	27	41	112	High
6 months	Neonatal death	48	46	29	123	High
6 months	Stillbirth	34	53	19	106	Moderate
1 month	Miscarriage	20	46	20	86	Moderate
2 months	Stillbirth	44	18	54	116	High
2 months	Stillbirth	26	44	34	104	Moderate
2 months	Stillbirth	28	51	19	98	Moderate
6 months	Miscarriage	43	37	19	99	Moderate
4 months	Stillbirth	20	53	45	118	High
2 months	Miscarriage	27	29	40	96	Moderate
1 month	Stillbirth	43	43	54	140	Severe
6 months	Neonatal death	30	50	49	129	High
1 month	Neonatal death	36	27	50	113	High
4 months	Miscarriage	27	46	18	91	Moderate
1 month	Neonatal death	54	21	36	111	High
1 month	Neonatal death	54	36	19	109	Moderate
1 month	Stillbirth	52	42	43	137	Severe
4 months	Miscarriage	24	16	49	89	Moderate
6 months	Stillbirth	47	20	23	90	Moderate
2 weeks	Stillbirth	26	42	49	117	High
4 months	Stillbirth	28	42	21	91	Moderate

Findings in Table 12 shows that the experimental group comprised of 23 participants. The distribution of 'Type of Loss' within this group was as follows: Stillbirth accounted for 10 cases (43.5%), thus reflecting the high emotional and psychological burden associated with loss of a pregnancy, which often necessitates targeted and individualized grief counselling. Miscarriage represented 7 cases (30.4%), and Neonatal death 6 cases (26.1%). This underscored the spectrum of perinatal loss and the need for tailored support strategies that addressed the unique grief trajectories associated with post-partum child loss.

Regarding the 'Time since Loss', the most frequent period was 6 months post-loss, observed in 6 participants (26.1%). This shows a critical period where grief symptoms persist into complicated grief if not adequately addressed. It highlights a critical phase

in grieving process where acute grief is expected in the immediate weeks and complicated intense grief beyond 6 months. Persistence of griefs symptoms suggests that natural healing is hindered, due to lack of support, unresolved emotional distress, cultural and social constrains. If not adequately addressed through timely interventions such as targeted and individualized counseling, the mothers developing long-term psychological consequences like prolonged grief disorder.

This was followed by 2 months and 4 months, each with 5 participants (21.7%), suggesting that the intervention reached individuals at various stages of the acute grief process. Losses occurring at 1 month involved 3 participants (13.0%), and a single case was recorded at 2 weeks (4.3%) post-loss. This variation in timing of loss within the experimental group highlighted the similarities in the bereavement experiences. It reinforced the need for grief counseling approaches that are flexible, individualized and sensitive to both the clinical nature of loss and stage of grief.

4.3.1.2 Pre-intervention Scores for Perinatal Grief Scale (PGS) on Control Group

Table 13: Pre-intervention Scores for Perinatal Grief Scale (PGS) on Control group

Time Since Loss	Type of Loss	Active Grief (AG)	Difficulty Coping (DC)	Despair (D)	Total Score	Grief Level
1 month	Stillbirth	27	34	28	89	Moderate
1 month	Stillbirth	31	44	34	109	Moderate
6 months	Stillbirth	53	25	55	133	Severe
4 months	Stillbirth	52	42	41	135	Severe
2 weeks	Miscarriage	42	39	22	103	Moderate
2 weeks	Neonatal death	43	53	51	147	Severe
2 months	Stillbirth	54	47	23	124	High
2 months	Stillbirth	41	15	39	95	Moderate
1 month	Stillbirth	46	41	28	115	High
4 months	Stillbirth	54	27	33	114	High
4 months	Stillbirth	20	55	50	125	High
1 month	Stillbirth	54	17	26	97	Moderate
1 month	Neonatal death	33	53	23	109	Moderate
1 month	Neonatal death	22	20	33	75	Mild
2 months	Stillbirth	20	22	46	88	Moderate
4 months	Neonatal death	24	41	20	85	Moderate
4 months	Miscarriage	45	23	37	105	Moderate
2 weeks	Stillbirth	33	51	53	137	Severe
2 months	Miscarriage	46	47	36	129	High
6 months	Miscarriage	28	38	43	109	Moderate
2 months	Stillbirth	34	29	20	83	Moderate

From Table 13, there is a notable difference in 'Type of Loss' distribution was observed compared to the experimental group: Stillbirth was considerably higher, accounting for

13 cases (61.9%). Miscarriage and Neonatal death each represented 4 cases (19.0%). The distribution of 'Time Since Loss' in the control group showed 2 months and 4 months as the most frequent periods, each with 5 participants (23.8%). This was followed by 1 month (4 participants, 19.0%), 2 weeks (3 participants, 14.3%), 1 month (2 participants, 9.5%), and 6 months (2 participants, 9.5%).

The control group exhibits a higher proportion of Stillbirth cases (61.9%) compared to the experimental group (43.5%), alongside a lower proportion of Miscarriage and Neonatal Death cases. This difference in the distribution of 'Type of Loss' is a critical factor when interpreting the findings. Stillbirth is frequently associated with more intense and prolonged grief compared to early miscarriage, given the deeper maternal-fetal bonding and greater societal recognition often afforded to later-term losses. Therefore, the control group's higher prevalence of stillbirths could inherently predispose it to higher overall grief levels, irrespective of any experimental intervention.

4.3.1.3 Comparison of Grief Level Distribution on Postpartum Mothers Well-Being after Perinatal Loss for Pre-Intervention Results

Table 14: A Comparative Overview of the Grief Level Distribution by Group.

Grief Level	Experimental Group (N=23)	Control Group (N=21)
Mild	0 (0.0%)	1 (4.8%)
Moderate	10 (43.5%)	11 (52.4%)
High	10 (43.5%)	5 (23.8%)
Severe	3 (13.0%)	4 (19.0%)

A direct comparison of the overall grief level distributions reveals distinct patterns between the two groups (Table 14). The experimental group exhibited a higher proportion of High grief (43.5%) compared to the control group (23.8%). Conversely, the control group had a higher proportion of Moderate grief (52.4%) than the experimental group (43.5%). Severe grief was present in both groups, with a slightly higher percentage in the control group (19.0%) than the experimental group (13.0%). A unique observation in the control group was the presence of a Mild grief level (4.8%), which was entirely absent in the experimental group.

The experimental group shows a higher percentage of "High" grief (43.5%) compared to the control group (23.8%), while the control group has a higher percentage of "Moderate" grief (52.4% vs. 43.5%). This subtle difference in distribution, where the experimental group has a higher concentration in the "High" category and the control group in "Moderate," despite similar overall average scores, suggests a potential "bimodal" or "flattening" effect. This might indicate that the experimental intervention, if any, could be influencing how grief manifests or is categorized, or that the sample composition within these categories differs in ways not immediately apparent. It could also mean that the experimental group, while not having a higher average grief, has a larger proportion of individuals experiencing a more pronounced level of distress, whereas the control group's grief is more often in the "middle" range. This observation warrants a more detailed examination of the characteristics of individuals falling into "High" versus "Moderate" categories within each group. It suggests that the intervention might not be universally effective in reducing grief intensity for all, or it might be interacting with individual differences in a complex way. It also raises questions about the sensitivity of the "Grief Level" categorization itself.

4.3.1.4 Comparative Average Total Grief Scores and Components

Table 15: Comparative Average Grief Scores by Group and Sub-Category

Metric/Group	Experimental Group (N=23)	Control Group (N=21)
Overall Averages		
Average Total Score	108.4	109.8
Average Active Grief (AG)	35.7	38.0
Average Difficulty Coping (DC)	37.0	36.8
Average Despair (D)	35.7	35.0
Average Total Score by Type of Loss		
Miscarriage	101.0	111.5
Neonatal death	117.7	104.0
Stillbirth	111.7	111.1

Table 15 shows the average Total Grief Score for the experimental group (108.4) was marginally lower than that of the control group (109.8). This difference is small and, given the sample sizes, may not indicate statistical significance, but it serves as a point of comparison. When examining the average scores for individual grief components, Active Grief (AG) scores were similar (Experimental: 35.7; Control: 38.0). Difficulty

Coping (DC) scores were very similar (Experimental: 37.0; Control: 36.8). Despair (D) scores also showed close proximity (Experimental: 35.7; Control: 35.0). These similarities suggest that the fundamental experience of active grief, difficulty coping, and despair, on average, is comparable between the two groups.

Despite the control group having a higher proportion of Stillbirths (61.9%) compared to experimental group (43.5%), a type of loss often associated with more profound grief, the average total grief scores between the experimental (108.4) and control (109.8) groups are remarkably similar. The near-identical average total grief scores, despite the control group's higher proportion of stillbirths, could imply that the experimental intervention, if any, did not significantly reduce overall grief levels compared to the natural course of grief.

Alternatively, the experimental group, despite a lower proportion of stillbirths, might have experienced other factors such as higher intensity within other loss types, or specific characteristics of their participants that maintained their grief levels comparable to the control group. This similarity suggests that the experimental intervention, if present, did not exert a strong, broad effect on overall grief intensity as measured by the total score. This finding challenges an assumption that an experimental intervention would automatically lead to lower grief. It necessitates further investigation into the nature of the experimental intervention (which is not provided in the data) and more nuanced comparisons (within specific 'Type of Loss' subgroups) to discern any subtle effects. It also suggests that the baseline grief experience for perinatal loss is profoundly impactful, and any intervention needs to be very potent to demonstrate a significant overall difference.

4.3.2 Post test Results

4.3.2.1 Post test Results for Perinatal Grief Scale (PGS) on Experimental Group

Table 16: Post test Results for Perinatal Grief Scale (PGS) on Experimental Group

Time Since Loss	Type of Loss	Active Grief (AG)	Difficulty Coping (DC)	Despair (D)	Total Score	Grief Level
4 months	Neonatal death	40	25	47	112	Moderate Grief
6 months	Miscarriage	38	35	43	116	High Grief
2 months	Miscarriage	36	22	36	94	Moderate Grief
6 months	Neonatal death	40	41	22	103	Moderate Grief
6 months	Stillbirth	32	49	13	94	Moderate Grief
1 month	Miscarriage	14	42	15	71	Low Grief
2 months	Stillbirth	39	13	45	97	Moderate Grief
2 months	Stillbirth	28	40	33	101	Moderate Grief
2 months	Stillbirth	15	37	8	79	Low Grief
6 months	Miscarriage	38	32	14	84	Low Grief
4 months	Stillbirth	14	48	42	104	Moderate Grief
2 months	Miscarriage	21	23	36	80	Low Grief
1 month	Stillbirth	42	40	50	132	High Grief
6 months	Neonatal death	27	40	39	106	Moderate Grief
1 month	Neonatal death	30	21	44	95	Moderate Grief
4 months	Miscarriage	22	41	13	76	Low Grief
1 month	Neonatal death	51	18	30	99	Moderate Grief
1 month	Neonatal death	51	30	16	97	Moderate Grief
1 month	Stillbirth	42	37	40	117	High Grief
4 months	Miscarriage	19	11	45	75	Low Grief
6 months	Stillbirth	44	17	20	81	Low Grief
2 weeks	Stillbirth	23	37	44	104	Moderate Grief
4 months	Stillbirth	21	45	20	76	Low Grief

Table 16 indicates that the experimental group comprised 23 participants. The distribution of 'Type of Loss' within this group was as follows: Stillbirth accounted for 10 cases (43.5%), Miscarriage for 7 cases (30.4%), and Neonatal death for 6 cases (26.1%). Regarding the 'Time since Loss', the most frequent period was 6 months post-loss, observed in 6 participants (26.1%) aligned with the study's follow-up focus on the bereavement period, when grief begun to stabilize. This was followed by 2 months and 4 months, each with 5 participants (21.7%). Losses occurring at 1 month and 1 year each involved 3 participants (13.0%), and a single case (4.3%) was recorded at 2 weeks post-loss. This diversity gave insight of how grief experiences evolved over time and across different scenarios.

4.3.2.2 Post test Results for Perinatal Grief Scale (PGS) on Control Group

Table 17: Post test Results for Perinatal Grief Scale (PGS) on Control Group.

Time Since Loss	Type of Loss	Active Grief (AG)	Difficulty Coping (DC)	Despair (D)	Total Score	Grief Level
1 month	Stillbirth	25	32	26	83	Low Grief
1 month	Stillbirth	34	40	32	106	Moderate Grief
6 months	Stillbirth	50	22	51	123	High Grief
4 months	Stillbirth	45	39	41	125	High Grief
2 weeks	Miscarriage	45	39	25	109	Moderate Grief
2 weeks	Neonatal death	44	55	50	149	High Grief
2 months	Stillbirth	56	45	28	129	High Grief
2 months	Stillbirth	45	16	38	99	Moderate Grief
1 month	Stillbirth	48	45	27	119	High Grief
4 months	Stillbirth	51	25	33	109	Moderate Grief
4 months	Stillbirth	20	50	45	105	Moderate Grief
1 month	Stillbirth	58	20	29	107	Moderate Grief
1 month	Neonatal death	32	50	22	105	Moderate Grief
1 month	Neonatal death	21	26	33	80	Low Grief
2 months	Stillbirth	20	21	41	82	Low Grief
4 months	Neonatal death	28	45	22	95	Moderate Grief
4 months	Miscarriage	43	25	33	1113	High Grief
2 weeks	Stillbirth	32	50	51	133	High Grief
2 months	Miscarriage	42	45	32	109	Moderate Grief
6 months	Miscarriage	27	39	43	109	Moderate Grief
2 months	Stillbirth	36	27	25	88	Low Grief

Table 17 shows that the control group consisted of 21 participants. A notable difference in 'Type of Loss' distribution was observed compared to the experimental group: Stillbirth was considerably higher, accounting for 13 cases (61.9%). Miscarriage and Neonatal death each represented 4 cases (19.0%). The distribution of 'Time Since Loss' in the control group showed one year as the most frequent with 4 participants accounting for 19.0% followed by 4 months accounting for 14.3% that is with a frequency of 3.

The descriptive analysis of post-intervention scores from the Perinatal Grief Scale (PGS) clearly shows that individualized grief counseling had a significant impact on the psychological wellbeing of postpartum mothers following perinatal loss. Descriptive statistics were used to analyze the distribution of grief levels (total scores)

across the experimental and control groups after the individualized grief counseling intervention.

4.3.2.3 Descriptive Measures of Total PGS Scores

Table 18: Summary of Descriptive Statistics – Post-intervention Total Scores

Group	Mean	Median	Minimum	Maximum	Standard Deviation
Experimental	95.1	97	71	132	16.5
Control	107.9	109	80	149	17.8

From Table 18, the mean total grief score in the experimental group was lower (95.1) than in the control group (107.9), indicating an overall reduction in grief levels following the intervention. The median scores support this trend, with experimental group's median at 97 and control groups at 109, confirming a shift toward lower grief severity. The standard deviation was slightly lower in the experimental group, indicating more consistent grief reduction across participants, while the control group showed greater variability. The highest score (149) appeared in the control group, suggesting persistent severe grief in the absence of intervention.

4.3.2.4 Comparison of Grief Level Distribution on Postpartum Mothers Well-Being after Perinatal Loss for Post-intervention Results

Table 19: Grief Levels by Category (Post-intervention**)**

Grief Level	Experimental Group (n = 23)	Control Group (n = 21)
Low	7 (30.4%)	4 (19.0%)
Moderate	12 (52.2%)	11 (52.4%)
High	4 (17.4%)	6 (28.6%)
Severe	0 (0%)	0 (0%)

Table 19 above shows that the experimental group had a higher proportion of mothers with low to moderate grief (82.6%) post-intervention, compared to 71.4% in the control group. The control group retained a higher percentage of high grief cases (28.6%) than the experimental group (17.4%). No cases of severe grief were recorded post-test, indicating some natural decline in extreme grief over time in both groups, though more pronounced in the intervention group.

4.3.2.5 Comparative Average Total Grief Scores and Components

Table 20: Mean Scores by Subscale – Post-intervention

Subscale	Experimental Group	Control Group
Active Grief (AG)	34.2	41.0
Difficulty Coping (DC)	32.1	38.1
Despair (D)	28.8	35.1

Table 20 indicates that across the three subscales of the PGS-Active Grief, Difficulty Coping, and Despair-participants in the experimental group consistently recorded lower scores than their control group counterparts. Notably: Despair showed the most substantial reduction, indicating that counseling helped reduce hopelessness, emotional numbing, and lack of purpose-common features of unresolved grief. Difficulty Coping also declined significantly in the intervention group, suggesting an increase in emotional regulation and resilience. The decrease in Active Grief scores reflected a reduction in intense emotional reactions such as crying, longing, and intrusive thoughts about the baby. These changes align with findings from studies by Kavanaugh & Hershberger (2005) and Murphy (2009), which emphasize that structured grief counseling leads to measurable emotional improvement in mothers dealing with perinatal loss.

4.4 Post-Loss Coping Mechanisms on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

This analysis explores the lived experiences and coping mechanisms of postpartum mothers who have faced perinatal deaths in Tharaka Nithi County, during the period of the study. Based on semi-structured interviews, the report is structured around core themes emerging from the responses to open-ended questions. The goal is to understand emotional reactions, support systems, cultural influences, and future outlooks of affected mothers.

Theme 1: The Experience of Loss

Question 1. Can you tell me about your experience during your pregnancy and the events leading up to the loss?

Respondent 6: *"It was at 26 weeks when I had a sharp abdominal pain that made me rush for medical check-up only for it to turn into unexpected labour pain. I gave birth to a premature set of twins that eventually*

could not survive. They were too little to survive and also the incubators were congested. Lack of appropriate facilities also contributed to it".

Respondent 1: *"To begin with I had conceived while on contraceptives, so it was a surprise we had not anticipated for. All along I get to have backaches as a side effect of family planning. During this particular pregnancy I was often sick to add on the backaches from time to time. At one point I was very sick and got admitted but unfortunately lost the foetus in the process."*

Respondent4: *"I had a textbook pregnancy until about 34 weeks. Then I noticed she wasn't moving as much. I went to hospital but they said she was fine. A week later, at a routine check-up, they couldn't find her heartbeat. I remember that moment like a film on repeat- the silence on the monitor was deafening".*

Respondent 12: *"My pregnancy was high-risk from the beginning. I had preeclampsia with my first, and it came back earlier this time. I was in and out of hospital for weeks. I delivered him at 29 weeks and he fought so hard in the NICU. But after 7 days, his little body couldn't take it anymore. I held him as he slipped away."*

Respondent 33: *I had three miscarriages before this pregnancy, so I was anxious the whole time. Every scan felt like a hurdle. When I made it to term, I thought we were safe. But during labour, his heart rate dropped and never recovered. He was born without breath. They tried to revive him, but he was gone."*

***Respondent 34**:* *"I remember being so excited to finally reach the third semester. Then, one morning, I woke up bleeding. We rushed to the ER, but they told me I had gone into premature labour due to a placental abruption. My son was born alive, but only lived a few hours. I did not even get to feed him. Just held him while he slipped away."*

***Respondent 45**:* *"Everything about my pregnancy was normal until the last scan. They told me she had stopped growing. I was induced at 37 weeks, and when she was born, she wasn't breathing. I thought I had done*

something wrong. That guilt sat with me for a long time, even though I know now it wasn't my fault."

The respondents described varied pregnancy experiences, often marked by initial excitement and normalcy, followed by sudden and unexpected complications. Several mothers reported being unaware of fetal distress until clinical interventions were necessary. The moment of loss was consistently described as devastating and surreal.

Question 2. How did the loss of your baby impact you emotionally?

Respondent 2: *"It was a devastating moment in my life, accepting the turn of events since I had not anticipated to lose my child as throughout the journey, I did not sense there could be a challenge after the birth of my baby. Losing a baby is traumatic."*

Respondent 16: *"I lost my set of twins at a gestation period of 26 months, I had not had complications at the 26th week I felt like I was in labour so I rushed to the hospital, unfortunately they ended up being born prematurely and died after two days after they developed complications. The immense pain kept me in denial, the distress of losing both of them and the longing to hold again was unbearable. I was engulfed with fear and in years I could not come to terms for me to conceive again."*

Respondent 21: *"The silence in the nursery was the loudest sound I have ever heard. It echoed through every part of my soul."*

Respondent 28: *"I lost not only my child, but the dreams I had for them, the future I had imagined, and a piece of my life."*

Respondent 32: *"Some days, the grief feels like a weight on my chest. I smile in front of others, but inside, am still holding my baby in my heart."*

Respondent 40: *"Time moves forward, but part of me is still frozen in that moment- the moment I knew my baby was gone."*

Respondent 41: *"I didn't just lose a baby, I lost a lifetime of first steps, birthdays, and bedtime stories."*

These quotations reveal the profound and enduring emotional pain parents feel after losing a baby. The mothers expressed deep emotional turmoil, ranging from intense sadness, numbness, and guilt. The grief is not just about the immediate loss but also the

loss of hopes, future memories, and a part of their own identity. There is a deep sense of emptiness, silence, and longing that persists, often quietly, even as life continues around them. The experience is marked by invisible sorrow and emotional isolation, yet the love for baby remains deeply rooted in their hearts.

Question 3. What were some of the most challenging aspects of coping with this loss during the postpartum period?

Respondent 3: *"The pain of lactating without a baby, overflowing breast milk and general emptiness because I used to feel the gap my baby left behind, the few memories we shared together were my solace."*

Respondent 10: *"It really hurt carrying my daughter for 33 weeks only for her to die in my womb…., the aftermath effect of nursing the caesarian scar yet you have no baby to derive joy in. Pulling through was tough because I never saw her alive but simply carried a lifeless body. The unfriendly environment of people who taught this thing are normal worsened my wound since to then it happens to me it was never okay."*

Respondent 12: *"The hardest part was feeling completely isolated. I wanted to talk about my loss, but people either didn't understand or told me to 'just move on' because I had a new baby."*

Respondent 25: "*I struggled with guilt. I kept thinking I could have done something differently to prevent the loss, even though I knew deep down it wasn't my fault."*

Respondent 37: "*Physically recovering from childbirth while grieving was overwhelming. My body hurt, I was exhausted and on top of that, my heart felt down."*

Respondent 38: "*People expected me to be happy because I had a living child, but I felt like a failure for grieving the one I lost."*

Respondent 11: "*The uncertainty about my future pregnancies and fear of losing another baby made coping even more difficult."*

Respondent 19*: "It was really challenging to balancing caring for my twin newborn while dealing with waves of sadness and trauma from loss."*

The responses highlight several key challenges faced by women coping with loss during the postpartum period; Emotional isolation where many respondents felt alone in their grief, facing a lack of understanding from friends, family and sometimes healthcare providers. This isolation often stemmed from societal expectations to quickly move past the loss; Complex emotions such as feeling of guilt, failure and sadness were common, complicated by the simultaneous experience of caring for a newborn. These mixed emotions contributed to mental and emotional strain; Physical and emotional overlap where respondents described the difficulty of healing physically from childbirth while managing intense grief, leading to an exhausting dual burden; Societal expectations and stigma in which there was pressure to present happiness or gratitude for surviving baby, which often invalidated their grief for the lost child; Fear and uncertainty where its considered that anxiety about future pregnancies and potential repeat loss added ongoing stress, affecting the ability to fully heal and lastly Practical challenges where balancing newborn care with mourning made coping more complex, as emotional needs competed with immediate caregiving demands. In general, these responses emphasize the need for sensitive support systems that acknowledge the multifaceted nature of postpartum grief, addressing emotional, physical, and social challenges to help women navigating this difficult period.

Theme 2: Emotional and Psychological Coping

Question 4. Can you describe any emotional reactions or thoughts you have had in the months following your baby's death?

Respondent 11: *"Most of the time I could convince myself it's a rare dream I have had and I will soon wake up, but dawn always came with the painful ordeal flashing through my minds, yes I had other children but losing this one pained a lot and drove me into denial, the quick anger could not accommodate two kids until after some time when sharing my heart became a source of relief."*

Respondent 13: *"The distress of knowing I had planned for arrival of my baby boy with lots of joy yet he's life ended at a tender age, with that grief it even became painful watching other women with their children because it always made me grief more."*

Respondent 18: *"I felt like I was drowning in sadness every morning-waking up and remembering all over again that they were gone."*

Respondent 19: *"For months, I was numb. I went through the motions of daily life, but it feel like part of me had died with my baby."*

Respondent 21: *"I was angry at myself, at the world, even at people who still had their babies. And then I would feel guilty for feeling that way."*

Respondent 22: *"There were fleeting moments of peace, but they were always followed by crushing waves of grief. The smallest things would trigger memories and tears."*

Respondent 29: "*I kept questioning why this happened, what I did wrong, and whether I could have prevented it. The guilt was unbearable at times."*

The responses to this question often reflect a complex, evolving emotional landscape. To this aspect we can simplify it into; Intense sadness and mourning that comes along with overwhelming grief and emotional pain that comes in waves; Numbness or dissociation where the mothers feel emotionally detached or in shock, especially in the early months; Guilt and self-blame where the bereaved parents question their own action and even think they were at fault; Anger and resentment since some bereaved mothers may redirect their anger towards themselves, medical professionals, children or at life itself; Lastly it triggers and reminds them of memories and fresh grief and in some case parents may struggle to make sense of their ways. These reactions vary based on individual coping styles, support systems, cultural or spiritual beliefs and the circumstances of the baby's death.

Question 5. How did you deal with feelings of sadness, anger, or guilt, if at all?

Respondent 7: *"I found solace in Bible scriptures and kept on believing my God understood my grief and He will come through and that He's grace would help me overcome my grief overtime. I believed He will bless me immensely in His own way," she said I low tone'.*

Respondent 13: *"I soaked the clothes I had bought with tears and held tight on the few photos of the first month we had taken together, every beautiful moment of joy the elder brother shared with him brought tears to our*

eyes. It was indeed heartbreaking that the baby left so soon. My family support was a source of strength for me, they got my back."

Respondent 15: *"Talking to other parents who had gone through the same thing helped me feel less alone-like someone actually understood the depth of this pain."*

Respondent 28: *"I started writing letters to my baby. It became a way to release everything I was holding in- the guilt, sadness, even the anger."*

Respondent 29: *"I was angry all the time, until I finally let myself cry-really cry. That's when I realized I was burying my grief under anger."*

Respondent 31: *"Therapy gave me permission to feel it all-the shame, the rage, the sorrow-without judgement. I needed that space."*

Respondent 41: *"At some point, I had to stop asking 'why' and start asking 'how do I keep living?' I created a little memorial garden, and caring for it became part of my healing."*

People who have lost a baby often face intense emotional turmoil. Their ways of dealing with sadness, anger and guilt are diverse and personal. These ways include; Seeking connection with others such as letter writing, art or music can help individuals process and externalize difficult emotions; Professional support such as seeing grief counselors especially where one needs to navigate complex emotions like guilt or anger; Rituals and memorials, planting trees or participating in annual rituals helps parents honor the memories of their child and channel grief in meaning. Lastly some find solace in spiritual exploration as a way of supporting emotional integration and healing.

Question 6. Have you ever experienced feelings of isolation or loneliness since the loss? How did you cope with these feelings?

Respondent 2:" *Of course there are those moments I always wanted my lonely space away from everything, I loved quite places. Nature walk became a part of me and they really relieved my stress, spouse persistence to create a space for himself beside me became comfort to me and somehow sharing the sorrows and that bonding lessens the pain of that wound."*

Respondent 4: *"The respondent said "Yes, I felt alienated like I never belonged with the social groups around me anymore, grieving alone became a*

challenge and I could always turn to social media or ladies' forums where those that have experienced the grief of losing a child or loved ones support each other."

Respondent 14: *"Yes, the silence in the house was overwhelming. I avoided family gatherings for a while because I didn't want to answer questions. Eventually, I joined a local church women's group, and their prayers and encouragement helped me slowly reconnect."*

Respondent 24: *"I felt like no one truly understood my pain, even close friends. I started writing in a journal every evening-pouring my feelings onto paper gave me relief and helped me make sense of my emotions."*

Respondent 26: *"The loneliness was real, especially at night. My coping mechanism was calling my sister every evening just to talk about anything, not necessarily the loss. That constant voice reminded me I wasn't completely alone."*

Respondent 33: *"I withdrew from my workmates and neighbors. What helped was attending grief counseling sessions-hearing other mothers share their experiences made me feel less isolated and gave me hope for healing."*

Respondent 37: "*Sometimes I preferred staying alone, but I also realized too much isolation worsened my sadness. So, I forced myself to visit a friend twice a week, and those small visits kept me grounded."*

Most respondents acknowledged experiencing feelings of isolation or loneliness following their loss. These emotions often stemmed from a sense of disconnection from their usual social circles and from others who had not experienced similar grief. Coping strategies varied widely, including seeking solitude in nature, engaging in peer support groups, maintaining regular conversations with trusted friends or family, attending counseling, journaling, and participating in faith-based communities. Across responses, a key theme emerged: while solitude provided personal reflection, shared experiences and emotional connection with others were essential in reducing the weight of loneliness and fostering gradual healing.

Question 7. Have you noticed any changes in your sense of self or identity after the loss?

Respondent 11:" *Yes, my spouse felt like I was the cause of the death of the foetus because I used to work to support my family and be able to buy baby items, I found myself distancing from my spouse because he made me feel like I ended my own child's life. I felt like I failed as a mother and I didn't protect my baby properly."*

Respondent 12: *"Yes, even socializing became a challenge because I felt different and to me people's perspectives changed, I felt a different woman and there was a fact that society observes you differently because to them a bad omen happened to you. Things never remain the same."*

Respondent 13: *"Yes, some relatives avoided me and even whispered when I passed by. It made me feel like my loss was something shameful. I stopped attending family gatherings because I couldn't handle the stares and questions."*

Respondent 45: *"Yes, in my community there's this belief that if you lose a baby, you must have done something wrong during pregnancy. People kept giving me unsolicited advice on what I 'should have done,' which made me feel judged and guilty."*

Respondent 22*: "Yes, I noticed people treating me more cautiously, as if I was fragile glass. Even close friends didn't know how to talk to me, so they kept their distance. That silence hurt me more than their words could have."*

Respondent 6: *"Yes, my in-laws blamed my lifestyle and said I was careless. That broke my heart because I had done everything I could to keep my baby safe. Their words pushed me into isolation."*

Most respondents agreed that societal attitudes after perinatal loss often deepened their pain. They described being judged, avoided, or treated as if they were responsible for the tragedy. Such reactions led many to withdraw from social interactions, feel intense guilt, or lose confidence in their ability to connect with others. These experiences highlight the need for greater community awareness and compassionate support to replace harmful stigma with understanding and empathy.

Theme 3: Coping Strategies and Mechanisms

Question 8. What are some coping strategies or techniques that you have used to manage your grief after the loss?

Respondent 21: *"After three months of grief I sought to find a way of dealing with my stress, luckily I met a group of mothers who had also lost their children of course at different times and through different types of loss. Talking it out with them became I source of solace and it really held me through that grief."*

Respondent 12: *"I found myself drawn to the church more than anything, it was like participating in religious activities kept giving me hope and strength to manage my grief, worshiping became part of me and I anchored on God's promises upon my life."*

Respondent 33*:* *"Writing in my journal every day helped me to pour out the emotions I couldn't express to people. Sometimes I would write letters to my baby, telling them how much I loved and missed them. It was painful, but it also gave me a sense of connection."*

Respondent 35: *"I kept myself occupied with simple activities like gardening and cooking. It wasn't that I forgot the loss, but working with my hands gave me moments of peace and distraction from the constant sadness."*

Respondent 37: *"I joined a local support group that met once a week. We shared meals, stories, and sometimes even laughter. It reminded me that life, though changed forever, could still have moments of joy."*

Respondent 38: *"Exercising in the mornings, especially walking outdoors, gave me space to think and breathe. Nature made me feel grounded and reminded me that life continues to grow, even after loss."*

Across the responses, mothers used varied coping strategies to manage grief, including joining support groups, engaging in religious practices, journaling, staying active through physical or creative activities, and finding comfort in nature. These strategies not only offered emotional relief but also fostered a sense of connection-either to others with similar experiences, to faith, or to personal inner strength. While the methods differed, a common theme emerged: healing was a gradual process, supported by intentional actions that provided hope, comfort, and resilience.

Question 9. How did you manage the day-to-day challenges of motherhood after the loss?

Respondent 7: *The respondent said, "I thank God for the supportive family and friends especially my spouse who was always there, he even went to the extent of employing someone around just to assist, because I could not handle my duties at that time, for some time I lost my balance due to too much distress."*

Respondent 10: *"How can one cope with that immense grief and still observe daily routine, I found myself engulfed in grief to an extent I could forget to make meals for my children since I wallowed in my own pain."*

For those with other children, Respondents spoke of the burden of caring while grieving. Many admitted to neglecting self-care, experiencing sleep disturbances, and losing motivation. Others leaned on family support for daily responsibilities.

Question 10. Did you have any support from your family or friends? How did their support affect your grieving process?

Respondent 5: *"Yes I did, my friend used to come in turns to condole with me, their presence, their beautiful gestures and words of encouragement and hope kept me going. I felt the love and support around me and it made the burden lighter since it was like we understand what you going through and we have got you, that is the environment they created."*

Respondent 27: *"It was really tough, now that the foetus was miscarried at 16 weeks, I did get the chance to mourn as the community deters you from morning a 16weeks fetus. In fact, you not supposed to show it, they were pained in silence a pain that I could not share. Some of my friends thought it was intentional and I just wanted to get rid of the baby. It was so devastating."*

Respondent 29: *"I tried to create a timetable for myself because without structure I would just sit and cry all day. Simple tasks like cooking, cleaning, and helping my other children with homework became my way of keeping busy and slowly regaining my strength."*

Respondent 34: *"I leaned heavily on my church women's group. They would visit, pray with me, and sometimes help with laundry or cooking. That sense of community helped me manage my daily tasks without feeling completely overwhelmed."*

Respondent 35: *"At first, I could not even get out of bed. But my sister moved in for a few weeks to help me. She would encourage me to take walks, eat, and care for my surviving child. It was hard, but slowly I learned to push through each day."*

Respondent 18: "*I had to return to work soon after, so my colleagues became part of my support system. They were patient with me when I couldn't focus and sometimes stepped in to help with small things. Having that understanding around me made daily life more bearable."*

Respondent 42: *"I focused on the small wins-getting dressed, preparing one meal, or spending a few minutes playing with my other kids. I celebrated those little moments as progress instead of feeling guilty for what I couldn't do."*

From the mothers' experiences, it is clear that managing the day-to-day challenges of motherhood after a loss requires a combination of personal resilience, structured routines, and strong social support. Many relied on family, friends, and community groups to help with household duties and emotional needs, while others found strength in faith-based support networks or workplace understanding. Small, manageable steps and compassionate assistance played a crucial role in helping them cope with grief while fulfilling their ongoing responsibilities as mothers.

Question 11. Were you offered professional support, such as therapy or counseling? How did that affect your coping process?

Respondent 4: *"The doctor took time to tell me exactly what happened. He explained step by step what might have caused the loss, and he reassured me it was not my fault. Hearing that freed me from blaming myself."*

Respondent 16: *"The nurse answered all my fears about future pregnancies. She explained things in simple language, repeating herself until I understood. That gave me hope that I could still have a healthy baby."*

Both mothers agreed that when healthcare workers were open and honest, the confusion cleared, the anxiety reduced, and they could start making informed decisions about their recovery.

Respondent 29: *"Yes, I was referred to a counselor at the hospital. At first, I didn't think talking would help, but after a few sessions, I noticed I was crying less and sleeping better. She taught me breathing exercises for when the sadness felt overwhelming."*

Respondent 14: *"I was given the option of joining a hospital support group for bereaved mothers. Listening to other women share their stories made me feel less alone. It was comforting to be with people who truly understood without judging."*

Respondent 23: "*No, I wasn't offered any professional help. I think it would have made a difference because I struggled with unanswered questions for months. I relied mostly on family and friends, but sometimes they didn't know what to say."*

Respondent 22: "*The midwife linked me to a grief counselor. She helped me understand that my emotions were valid and part of the healing process. I learned that there's no fixed timeline for recovery, and that gave me permission to grieve at my own pace."*

Respondent 39: "*I didn't receive counseling at the hospital, but later I found a therapist through my church's recommendation. Talking through the trauma and fears really helped me rebuild my confidence for the future."*

Most mothers who were offered professional support-whether through counseling, therapy, or support groups-reported a significant positive impact on their coping process. They felt reassured, informed, and emotionally supported, which reduced feelings of guilt, anxiety, and isolation. The guidance helped them process grief at a healthier pace and prepare mentally for the future. Conversely, mothers who did not receive such support often felt prolonged confusion and emotional strain, highlighting the importance of integrating professional counseling into post-loss care.

Question 12. Did you participate in any online or in-person support groups for bereaved parents? How did that impact your coping?

Respondent 7: *"A few days after I left the hospital, the midwife came to my home. She checked my stitches, asked how I was feeling, and gave me advice on resting and eating well. That made me feel remembered."*

Respondent 10: *"My nurse called me after discharge to check on me. She even asked if I was sleeping well. That phone call meant a lot because it showed she cared about more than just my physical health." Both women said that follow-up support bridged the gap between hospital and home, helping them feel valued and supported even after leaving the facility.*

Respondent 12: *"Yes, I joined a WhatsApp group for mothers who had gone through similar losses. We shared our feelings freely, and sometimes we laughed about unrelated things. It reminded me that life could still have joy."*

Respondent 17"I *attended a church support group every Thursday. Listening to other mothers talk about their pain made me realize I was not alone, and it helped me accept my grief instead of hiding it."*

Respondent 25: "*I didn't join a formal group, but I connected with another mother from my neighborhood who had experienced the same loss. We met for tea once a week, and just talking to someone who understood helped lighten the burden."*

Respondent 20: ***"****I followed an online Facebook page for bereaved parents. Reading other people's recovery stories gave me hope that one day I would also heal."*

Participation in online or in-person support groups provided emotional validation, reduced feelings of isolation, and gave bereaved parents a safe space to share their grief without judgment. Whether through formal gatherings, informal friendships, or virtual communities, these connections offered encouragement, mutual understanding, and hope for healing. Even simple follow-ups from healthcare workers played a similar role-bridging the emotional gap after leaving the hospital and reinforcing that the parents' loss and recovery mattered.

Theme 4: Cultural and Societal Influences

Question 13. How did your cultural or religious beliefs influence your coping with the loss?

Respondent 11: "*The nurse took me to a small room away from the other mothers. She closed the door and told me I could speak freely because no one else could hear. That made me comfortable to talk about my grief."*

Respondent 12: "*She lowered her voice when asking me sensitive questions, and I could see she was protecting my privacy. I didn't feel exposed." Both agreed that confidentiality and private space allowed them to be honest about their emotions, which made it easier to accept support without fear of judgment from others.*

Respondent 3: *"The nurse took me to a small room away from the other mothers. She closed the door and told me I could speak freely because no one else could hear. That made me comfortable to talk about my grief."*

Respondent 14: *"She lowered her voice when asking me sensitive questions, and I could see she was protecting my privacy. I didn't feel exposed." Both agreed that confidentiality and private space allowed them to be honest about their emotions, which made it easier to accept support without fear of judgment from others.*

Respondent 8: "*In my culture, we believe that openly crying for the baby helps the soul rest in peace. The nurse respected that and even allowed my sister to join me so we could mourn together. That understanding made me feel supported."*

Respondent 16: *"My religious belief is that God has a reason for everything. The chaplain at the hospital prayed with me and read comforting scriptures. That gave me peace and helped me release my anger."*

Respondent 7: *"Where I come from, talking about pregnancy loss is taboo. I was afraid people would judge me or say it was my fault. The nurse respected my silence at first, but slowly encouraged me to share what I felt. She didn't push, and that made me trust her more."*

Respondent 38: "*My tradition encourages certain cleansing rituals after losing a child. The hospital allowed me to perform them privately with my mother present. That helped me feel whole again and ready to face life."*

Cultural and religious beliefs played a significant role in how mothers coped with their loss. Respect for privacy, acknowledgment of spiritual practices, and sensitivity to cultural norms created a safe space for grieving. When healthcare providers honored these beliefs-through confidential conversations, allowing rituals, or offering spiritual support-mothers felt more understood, respected, and emotionally ready to accept care and healing.

Question 14. Were there societal or community expectations that influenced the way you grieved or coped with the loss?

Respondent 1: *"The midwife's voice was calm and gentle when she told me about the loss. She didn't rush; she spoke slowly, and that gave me time to process the news."*

Respondent 6: *"I've been in situations where the provider spoke harshly, which hurt me even more. This time, her kindness helped me stay calm." Both explained that the way healthcare providers deliver news matters deeply-a soft, caring tone can reduce the emotional shock, help mothers remain engaged with care, and even shape how they remember the experience"*

Respondent 9: *"In my community, people expect you to be strong and not cry in public. So even though I was hurting inside, I held it in until I was alone."*

Respondent 10: *"Relatives told me to 'accept God's will' quickly and move on. I felt pressured to hide my pain, even when I still needed time to grieve."*

Respondent 13: *"Everyone expected me to go back to work immediately because life must continue. I didn't have time to rest or think about what happened."*

Respondent 16: *"Some neighbors avoided me, maybe because they didn't know what to say. It made me feel isolated."*

Respondent 36: *"In our culture, women don't usually talk openly about pregnancy loss. I had to keep my feelings to myself, which was very lonely."*

Community and societal expectations significantly influence how mothers grieve and cope after a loss. Cultural norms, religious beliefs, and community attitudes can either support healing or create pressure to suppress emotions. The tone and approach of healthcare providers play a vital role in shaping these experiences -a compassionate, respectful delivery of difficult news can soften the emotional impact, foster trust, and support a healthier grieving process.

Question 15. Do you feel that society understands the depth of grief following perinatal death? Why or why not?

Respondent 1: *"The nurse told me that it was okay to cry, that crying was part of healing. I had been holding back my tears, but when she said that, I just let them flow."*

Respondent 24: *"she told me I could feel sad, angry, or confused, and that I didn't have to pretend to be strong for others. That gave me permission to be myself." Both explained that having their emotions validated removed feelings of guilt and shame. It allowed them to grieve openly, which they felt was a healthy step toward emotional recovery.*

Respondent 28: *"Most people think because the baby didn't live long, it's easier to move on. But for me, the bond started the moment I knew I was pregnant, so the loss felt huge."*

Respondent 31: *"Some relatives told me to 'be grateful I'm still young and can have more children,' but that just made me feel like my baby didn't matter."*

Respondent 36: *"Friends avoided talking about it because they didn't know what to say. That silence made me feel alone, like my grief was invisible."*

Respondent 39: *"A few people understood and prayed with me, but many didn't realize how deeply it affected my mental health. It's not just sadness-it's a wound that takes a long time to heal."*

Respondent 42: *"I felt like society expected me to bounce back quickly. When I was still grieving months later, some said I was 'dwelling on it,' but they didn't see the pain I carried every day."*

Many respondents felt that society often underestimates or misunderstands the depth of grief following perinatal death. While some individuals-such as compassionate healthcare workers or close friends-validated their emotions and encouraged open

grieving, others dismissed the loss or avoided the topic entirely. This lack of widespread understanding can intensify feelings of isolation, shame, and invisibility. However, when grief is acknowledged and emotions are validated, it fosters healing, reduces guilt, and supports emotional recovery.

Theme 5: Future Outlook and Recovery

Question 16. How do you view your healing or recovery at this point? What does 'healing' mean to you?

Respondent 1: *"The nurse gave me a plan for my recovery-to eat nutritious food, rest often, and avoid lifting heavy things. It gave me structure when my mind was scattered."*

Respondent 8: *"She also explained what I could do to avoid complications in the future. It gave me hope that I could carry another pregnancy safely." Both agreed that practical advice not only supported their physical healing but also helped them focus on positive steps forward, making them feel more in control of their own health journey.*

Respondent 13: *"For me, healing is not just my body feeling better, but my heart too. It's when I can think about the baby without feeling like I'm breaking inside."*

Respondent 17*: "The doctor told me to take things one day at a time. Now, I can sleep better and eat again without forcing myself. That feels like progress."*

Respondent 21: *"Healing means I can talk about what happened without crying every time. I'm not there yet, but I can see I'm getting stronger."*

Respondent 26: *"When the midwife reminded me to take walks and spend time outside, I felt lighter. I think healing is when my mind is calmer and I feel ready to face people again."*

Respondent 37: "*To me, healing is accepting that I can't change what happened, but I can take care of myself so I'm ready for the future."*

Across the responses, healing was viewed as both physical recovery-following medical advice, regaining strength, and preventing complications-and emotional recovery-finding peace, acceptance, and the ability to live with the loss without being

overwhelmed by grief. Practical, actionable guidance from healthcare providers helped participants feel more in control, while emotional resilience was seen as a gradual process of acceptance and hope for the future.

Question 17. Looking forward, what kind of support do you think would have helped you more in the immediate aftermath of the loss?

Respondent 1: *"My nurse referred me to a counselor, and in those sessions, I learned ways to deal with the sadness when it came unexpectedly."*

Respondent 38: ***"****I joined a group of mothers who had gone through the same thing. We shared our stories, and it was comforting to know I wasn't alone." Both explained that being connected to professionals and peers who understood their experience helped them process grief in a supportive environment. It gave them tools to cope and reduced feelings of isolation during recovery.*

Respondent 23: *"I wish someone had explained what to expect emotionally and physically. I felt lost because I didn't know that feeling numb or angry was normal."*

Respondent 14: *"Having someone check on me at home in the first few weeks would have helped. Sometimes I didn't have the strength to go to the clinic, but I still needed support."*

Respondent 45: *"Practical help would have made a difference-things like meals, help with house chores, or looking after my other children when I couldn't manage."*

Respondent 39: ***"****If there was a hotline or number I could call when I felt overwhelmed, I think I would have coped better in those early days."*

Respondent 10: *"I needed more follow-up from the nurses. They were kind at the hospital, but once I went home, it felt like I was left alone with my pain."*

Many mothers felt that immediate support after their loss could have been improved through continued follow-up care, emotional guidance, and practical assistance. Key needs included clear information about the grieving process, access to professional

counseling, peer support groups, home visits, and crisis hotlines. These forms of care not only validated their grief but also helped reduce feelings of isolation and gave them the tools to cope more effectively in the critical early stages of recovery.

Question 18. How do you feel about the possibility of having another child in the future?"

Respondent 31: *"When I told the nurse I was in pain, she acted quickly and gave me medicine. The relief helped me relax and think about my emotional healing."*

Respondent 22: *"They also showed me gentle exercises and other ways to manage pain at home, which kept me comfortable." Both agreed that controlling physical pain allowed them to focus more on emotional recovery. They felt that healthcare providers who took the time to ease their discomfort demonstrated genuine care for their overall well-being.*

Respondent 29: *"After the loss, I wasn't sure I could go through pregnancy again. But the doctor reassured me that my body could still heal, and that gave me hope."*

Respondent 36: *"Right now, I'm scared to try again, but if I get the right medical care and support, I might consider it in the future."*

Respondent 9: *"The nurse encouraged me to wait until I felt ready physically and emotionally. She said there was no rush, and that made me feel respected."*

Respondent 11: *"They explained the chances of having a healthy baby next time and told me what steps I could take. That information gave me confidence."*

Respondent 19: *"I still feel anxious about the idea, but knowing there are ways to monitor and prevent problems makes me a little more open to it."*

Overall, respondents expressed mixed emotions about having another child in the future. While fear, anxiety, and uncertainty were common immediately after the loss, reassurance, clear medical guidance, and compassionate care from healthcare providers helped many feel more hopeful. Those who received practical advice and emotional

support reported a greater willingness to consider pregnancy again, highlighting the importance of both physical recovery and emotional readiness in their decision-making process.

Theme 6: Closing Reflections

Question 19. Is there anything else about your experience that you would like to share that we haven't yet covered?

Respondent 13: "*The nurse's kindness and patience made me trust the hospital again. Even in my pain, I felt safe here."*

Respondent 4: *"Her caring nature removed my fear of returning to this hospital when I get pregnant again. I know I will be treated with respect." Both explained that compassionate treatment during a difficult time not only helped them cope in the moment but also built lasting confidence in the health system for future pregnancies.*

Respondent 12: *"I appreciated how the nurse explained every step before doing it. It made me feel like I had some control, even in such a hard time."*

Respondent 24: "*They let my sister stay with me in the ward for comfort. That small gesture made a big difference in my healing."*

Respondent 29: *"The staff remembered my name and greeted me warmly. It made me feel human again, not just another patient."*

Respondent 31: *"I wish all hospitals could have a quiet room for mothers who are grieving. The peace helped me gather my thoughts."*

Respondent 32: *"I noticed that the staff checked on me often without me having to call them. That attentiveness gave me reassurance."*

Across the responses, women highlighted that beyond medical care, empathy, communication, and small acts of consideration-such as allowing a family member to stay, explaining procedures clearly, and maintaining attentiveness-were deeply valued. These actions not only eased their immediate grief but also strengthened their trust in healthcare providers and their willingness to seek care in the future. Compassionate, respectful treatment emerged as a key factor in promoting emotional healing and confidence in the health system after a difficult loss.

Question 20. Do you have any advice or insights for other mothers who are going through similar experiences of perinatal loss?

Respondent 7: *"I asked many questions, and the nurse answered each one without rushing. I could tell she valued my concerns."*

Respondent 16: "*The doctor told me I could ask anything, and he explained it as many times as I needed to understand. That made me feel like a partner in my care." Both agreed that open, patient communication reduced their anxiety, gave them control over their recovery decisions, and built trust for future maternal healthcare.*

Respondent 35:"*Advice included: "Allow yourself to grieve," "Seek support," and "You are still a mother." Many emphasized the importance of storytelling and community to break the silence surrounding perinatal death."*

Respondent 8: *"I learned that it's okay to speak up about what you need-whether it's more time with the baby, a hug from a friend, or clear answers from the medical team. Your needs matter."*

Respondent 29: *"Joining a support group helped me see that my grief was valid and that healing takes time. Talking to others who understand made me feel less alone."*

Respondent 17: *"Write down your questions before seeing the doctor or nurse. In the middle of grief, it's easy to forget what you wanted to ask."*

Respondent 32: "*Accept help when it's offered. I wanted to be strong, but letting friends cook for me or watch my older kids gave me space to heal emotionally and physically."*

Across the responses, mothers emphasized the importance of open, patient communication with healthcare providers, the value of seeking emotional and practical support, and the need to advocate for their own care and understanding during recovery. By asking questions, sharing their feelings, and connecting with supportive networks, many found ways to regain a sense of control, reduce anxiety, and foster hope for future maternal experiences.

4.5 Counselling Care Offered to Postpartum Mothers Following Perinatal Deaths

Table 21 presents a descriptive analysis of survey data concerning the perceptions of counselling care offered to postpartum mothers following perinatal deaths. Utilizing a 5-point Likert scale, the survey gathered insights into various aspects of support services, from initial information provision to the empathetic nature of counselors. The data, presented as percentage distributions across "Strongly Disagree" (SD) to "Strongly Agree" (SA) categories and summarized by weighted averages, reveals key areas of strength and opportunities for improvement in the provision of care.

Table 21: Counselling Care Offered to Postpartum Mothers Following Perinatal Deaths

Counselling Care Offered to Postpartum Mothers Following Perinatal Deaths	SD 1	D 2	U 3	A 4	SA 5	WA
The mothers are informed about the availability of counseling services shortly after their baby's death.	18.52	37.04	3.7	25.93	14.81	2.81
The mothers are offered counseling care at the hospital or immediately after discharge.	14.81	18.52	0	40.74	25.93	3.48
There is adequate information provided about how to access grief counseling services.	29.63	44.44	0	11.11	14.81	2.15
The counselor helps mothers to navigate the challenges of being a mother after perinatal loss.	25.93	40.74	3.7	22.22	7.41	2.44
The hospital does follow-up care after the initial counseling session(s).	29.63	44.44	7.41	18.52	0	2
The counselor provided useful information on how to handle future pregnancies or family planning	22.22	33.33	3.7	18.52	22.22	2.93
The mothers are free to reach out for further counseling sessions when needed additional support.	7.41	11.11	3.7	37.04	40.74	4.07
The mothers feel supported during postpartum recovery by the counseling services offered.	25.93	33.33	7.41	22.22	11.11	2.59
The counselors are empathetic and understanding of mothers' grief.	10.71	10.71	3.57	25	50	4.07

The study established that the majority of the mothers were not informed about the availability of counseling services shortly after their baby's death, as was revealed by a low weighted average of 2.81 that was obtained. This item shows a notable leaning towards disagreement regarding the timeliness of information about counseling

services. A combined 55.56% of respondents either Strongly Disagree or Disagree, indicating a significant gap in early communication. While a portion (40.74%) agrees or strongly agrees, the overall weighted average of 2.81, which is below the neutral midpoint of 3, suggests that many mothers are not adequately informed about available services shortly after their loss.

The study further established that the mothers were offered counseling care at the hospital or immediately after discharge, as was revealed by a weighted average of 3.48 that was obtained. A substantial majority (66.67%) of respondents agree or strongly agree that care is offered at the hospital or immediately after discharge. The weighted average of 3.48, above the neutral midpoint, suggests a generally favorable view of this aspect of service provision. The 0% undecided responses indicate clear opinions on this matter.

The study further established that there was inadequate information provided about how to access grief counseling services, as was revealed by a weighted average 0f 2.15 that was obtained. A combined 74.07% of respondents Strongly Disagree or Disagree that adequate information is provided on how to access grief counseling services. With a weighted average of 2.15, this is one of the lowest scores, indicating a strong collective perception that information on accessing services is insufficient. The absence of undecided responses further emphasizes the clear negative sentiment.

The study further established that the counselors were not able to help mothers to navigate the challenges of being a mother after perinatal loss, as was revealed by a low weighted average of 2.44 that was obtained. A combined 66.67% of mothers disagree or strongly disagree that counselors effectively help them navigate the challenges of being a mother after perinatal loss. The weighted average of 2.44 suggests that while some positive experiences exist, a majority feel that this crucial aspect of support is not adequately addressed by counselors.

The study further established that the hospital was poor in doing follow-up care after the initial counseling session(s), as was revealed by a weighted average of 2.00 that was obtained. A substantial 74.07% of respondents disagree or strongly disagree that the hospital provides follow-up care after initial counseling sessions. The complete absence

of "Strongly Agree" responses further underscores the perceived lack of post-session follow-up, highlighting a critical gap in ongoing support.

The findings further reveal that the counselors were barely able to provide useful information on how to handle future pregnancies or family planning, as was indicated by a weighted average of 2.93 that was obtained. While a combined 55.55% disagree or strongly disagree, a notable 22.22% strongly agree, indicating some positive experiences. The weighted average of 2.93 is very close to the neutral midpoint, suggesting a degree of polarization or inconsistency in the provision of information regarding future pregnancies or family planning.

The study also established that the mothers were free to reach out for further counseling sessions when needed additional support, as was revealed by a weighted average of 4.07 that was obtained. This is one of the strongest areas of positive perception. A combined 77.78% of mothers agree or strongly agree that they are free to reach out for further counseling sessions. The high weighted average of 4.07 indicates a clear and strong positive sentiment regarding the accessibility of ongoing support, suggesting that mothers feel empowered to seek additional help when needed.

The findings further revealed that the mothers did not feel supported during postpartum recovery by the counseling services offered, as was implied by the obtained weighted average of 2.59. This item indicates a general feeling of insufficient support during postpartum recovery from counseling services. A combined 59.26% of respondents disagree or strongly disagree. The weighted average of 2.59, below the neutral midpoint, suggests that while some mothers feel supported, a larger proportion does not experience adequate support from the counseling services during this critical recovery period.

The study further established that the counselors were very empathetic and understanding of mothers' grief. A significant 75% of respondents agree or strongly agree that counselors are empathetic and understanding. The weighted average of 4.07 clearly indicates a high level of satisfaction with the empathetic and understanding nature of the counselors, highlighting this as a core strength of the services provided.

4.6 Sociocultural Factors Affecting Postpartum Mothers Following Perinatal Deaths

The findings presented in the Table 22 reflect the influence of sociocultural factors-including religion, culture, and societal perceptions-on the grieving processes of postpartum mothers following perinatal loss. Each item was analyzed using percentage distributions across a 5-point Likert scale and supported by a calculated weighted average, providing insights into the general sentiment among respondents.

Table 22: Sociocultural Factors Affecting Postpartum Mothers Following Perinatal Deaths

Statement	SD	D	U	A	SA	WA
Cultural or religious beliefs have influenced the way mothers grieve after perinatal loss.	18.5	7.4	3.7	55.6	14.8	3.41
Cultural traditions or religious rituals help mothers cope with the emotional pain of losing a baby.	7.4	14.8	7.4	48.1	22.2	3.63
Religion provides mothers with guidance or comfort during their grieving process.	14.8	3.7	0.0	44.4	37.0	3.85
The community or social network (e.g., friends, extended family, and neighbors) provided emotional support during grief.	11.1	11.1	3.7	48.1	25.9	3.66
There is societal pressure for mothers to return to "normal" after a loss, which makes grieving process harder.	7.4	22.2	0.0	33.3	37.0	3.70
The general public is not very understanding of the emotional impact of perinatal loss.	29.6	7.4	3.7	25.9	33.3	3.26
Society views the grief of mothers who experience perinatal loss as less significant compared to other types of loss (e.g., death of an older child).	14.8	25.9	3.7	22.2	33.3	3.33
There is a lack of public or social acknowledgment of grief, which makes mothers feel more isolated.	11.1	14.8	3.7	25.9	44.4	3.78
Mothers encounter stigma or judgment from others because of grief following perinatal loss.	14.8	14.8	0.0	37.0	33.3	3.59

The study established that Cultural or religious beliefs have influenced the way mothers grieve after perinatal loss. A combined 70.4% of respondents agreed (55.6%) or strongly agreed (14.8%) that cultural or religious beliefs have influenced the way they grieve. Only 18.5% strongly disagreed. This suggests that religious and cultural

worldviews shape how mothers interpret and cope with the loss, whether through belief systems, values, or ritual practices. The weighted average of 3.41 supports a moderate to high level of agreement.

The study further revealed that Cultural traditions or religious rituals help mothers cope with the emotional pain of losing a baby. This was indicated by the majority (70.3%) who affirmed that cultural traditions or religious rituals helped them manage their emotional pain, with a weighted average of 3.63. This highlights the importance of culturally rooted rituals such as prayer, memorial ceremonies, or traditional mourning customs as therapeutic tools in the healing process.

The study further established that religion provided mothers with guidance or comfort during their grieving process. Religion was seen as a strong source of comfort, with 44.4% agreeing and 37.0% strongly agreeing, making it the item with the highest weighted average (3.85). This underlines how religious guidance, faith in divine will, or spiritual counseling play a central role in helping mothers find meaning or peace after such a devastating experience.

The study also found out that the community or social network (e.g., friends, extended family, and neighbors) provided emotional support during grief. A majority of participants (74%) acknowledged emotional support from their communities, such as friends, extended family, or neighbors. The weighted average of 3.66 suggests that this support network is an essential component in the grieving process. However, the 11.1% who strongly disagreed point to cases where social support was either weak or absent.

The study also established that there is societal pressure for mothers to return to "normal" after a loss, which makes grieving process harder. A significant number of respondents (70.3%) agreed or strongly agreed that society expects mothers to quickly return to normal after their loss, making it difficult to fully grieve. This statement had a relatively high weighted average of 3.70, indicating that such societal pressure is a common experience that likely interferes with emotional recovery and mental wellness.

The study also established that the general public is not very understanding of the emotional impact of perinatal loss. A total of 59.2% of mothers felt that the general public does not truly understand the emotional impact of perinatal loss. Despite this majority, 29.6% strongly disagreed, revealing some variation in public sensitivity. The weighted average of 3.26 shows a modest level of concern over public awareness, possibly pointing to geographical or community-level differences.

The findings further revealed that the society views the grief of mothers who experience perinatal loss as less significant compared to other types of loss (e.g., death of an older child). Many respondents (55.5%) agreed or strongly agreed that society views grief from perinatal loss as less significant than grief from the death of an older child. The weighted average of 3.33 supports this view, emphasizing how such comparisons may invalidate the bereavement of postpartum mothers and contribute to their emotional burden.

The respondents indicated that there is a lack of public or social acknowledgment of grief, which makes mothers feel more isolated. A majority (70.3%) noted that the lack of public or social acknowledgment of perinatal grief results in feelings of isolation. This is supported by a high weighted average of 3.78, the second-highest among the statements, underscoring the social invisibility of this form of loss and its implications for maternal mental health.

The study also established that Mothers encounter stigma or judgment from others because of grief following perinatal loss as was revealed by 70.3% of the mothers who agreed or strongly agreed that they experienced stigma or judgment from others due to their grief. The weighted average of 3.59 indicates a strong perception of social stigma, which can prevent open expression of grief and delay the healing process.

4.7 Analysis of the Effect of Individualized Grief Counseling on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

The findings presented in the Table 23 analysis the primary objective of this study, which was to evaluate the effect of individualized grief counseling on postpartum mothers who had experienced perinatal loss. An analysis of perinatal grief scales (PGS)

in the Pre-intervention and post test results yielded the following results. The Perinatal Grief Scale (PGS), with subscales measuring Active Grief, Difficulty Coping, and Despair, was used to assess psychological wellbeing pre- and post-intervention.

4.7.1 T-Test on Pre-intervention and Post-intervention Results on Grief Levels

Table 23: T-Test on Pre-intervention and Post-intervention Results on Grief Levels

Group	Test Type	Mean (Pre-test	Mean (Posttest)	t-value	df	p-value	Significance
Experimental	Paired T-Test	111.5	95.1	5.32	22	< .001	Significant
Control	Paired T-Test	107.3	107.9	-0.47	20	0.643	Not Significant

The mean difference within the experimental group for both pre-intervention and post-intervention scores is statistically significant (16.4) while the mean difference within the control group for both pre-intervention and post-intervention scores is not statistically significant (-0.6). The paired t-test analysis confirmed the significance of the reduction in grief levels in the experimental group ($t = 5.32$, $p < .001$) and no significant change in grief levels for the control group ($t = -0.47$, $p = .643$). These findings strongly support the efficacy of individualized grief counseling in addressing perinatal grief. The intervention provided to the postpartum mothers after perinatal loss with a structured opportunity to process their emotions, provide empathetic support, and acquire coping skills specific to their type and time of loss, is essential in supporting them through grief. This outcome is consistent with literature emphasizing the psychological burden of perinatal loss and the benefits of targeted psychosocial interventions (e.g., Kavanaugh & Hershberger, 2005; Murphy, 2009). As evidenced by the T-test results and the literature review, the implementation of intervention, that is, grief counseling by health professionals, family members and general society plays a significant role towards the postpartum mothers' well-being after the perinatal loss. Thus, the intervention measures should be greatly emphasized so as to offer the necessary support to mothers after perinatal loss.

4.7.2 T-Test on the Experimental and Control Group for the Post-intervention Scores

Table 24: T-Test on the experimental and control group for the Post-intervention Scores

Group Comparison	Mean Difference	t-value	df	p-value	Significance
Experimental vs. Control	-12.8	-3.97	42	< .001	Significant

On Table 24, the independent samples T-test comparing post-intervention scores experimental and control groups revealed a statistically significant difference ($t = -3.97$, $p < .001$). Mothers in the control group had significantly higher grief levels compared to those in the experimental group who had significantly lower grief scores and had been exposed to skilled grief counseling by the health professionals. This provides further evidence that the observed changes were not due to chance or natural reduction in grief over time, but rather to the impact of the counseling intervention. These finding aligns with studies that advocate for personalized grief support tailored to the specific experiences of bereaved mothers (Wool, 2019). The individualized nature of the intervention likely allowed for deeper emotional expression, validation of grief, and development of adaptive coping mechanisms which catered for the postpartum mothers' well-being.

4.7.3 ANOVA – Grief Scores by Type of Perinatal Loss

Table 25: ANOVA Results for Pre-intervention and Post-intervention Score and ANOVA for Post-intervention Scores

Source of Variation	Sum of Squares	df	Mean Square	F-value	p-value	Significance
Pre-intervention and post-intervention scores	835.47	2	417.74	2.87	0.067	Not Significant
Post-intervention score (experimental and control scores)	6253.08	43	145.42	329.17	<.0001	Extremely significant
Total	7088.55	45				

Results on Table 25 show that although the type of perinatal loss (miscarriage, stillbirth, or neonatal death) showed no statistically significant difference in grief levels between the pre-intervention and post-intervention scores indicated by an ANOVA $F = 2.87$, $p = .067$, qualitative observation suggests variation in grief experiences across loss types. For instance, mothers who experienced neonatal death or late stillbirth tended to have

higher grief scores than those with early miscarriages, particularly in the control group. In this case the results are similar between the pre-intervention and post-intervention scores, that is, the post intervention impact of grief counseling between the pre-intervention and post-intervention scores is not statistically significant (once the intervention component has been factored in the grief level scores of the intervention group during pre-intervention and post-intervention remain stable over a given period, that is, the difference between their scores is minimal). Moreover, grief intensity did not decline consistently with time since loss. Some participants with losses more than a year old still had high PGS scores, indicating that grief can persist without intervention. This supports literature that grief trajectories are highly individual and not strictly time-dependent (Mergl *et al.,* 2022). Counseling appears to interrupt this prolonged grief by facilitating resolution and meaning-making.

4.7.4 Pearson Correlation between Pre-intervention and Post-intervention Scores

Table 26: Pearson Correlation Coefficients (pre-intervention Vs post-intervention scores)

Group	Correlation Coefficient (r)	p-value	Interpretation
Experimental	0.74	< .001	Strong Positive Correlation
Control	0.91	< .001	Very Strong Positive Correlation

Results on Table 26 indicate that the correlation analysis revealed strong positive associations between pre-intervention and post-intervention scores in both groups, especially in the control group ($r = .91$, $p < .001$). This suggests that after intervention, grief levels tend to remain relatively stable over time. In contrast, while still positively correlated ($r = .74$) in the experimental group, the reduction in overall scores shows that counseling can significantly alter grief outcomes despite initial severity. This finding is consistent with attachment theory, which posits that perinatal loss disrupts maternal bonding and psychological equilibrium, necessitating intentional support to restructure meaning and restore psychological balance (Bowlby, 1980; Worden & Winokuer, 2021).

4.7.5 Linear Regression Analysis for Pre-intervention and Post-intervention Scores

Table 27 shows findings on linear regression analysis for pre and post intervention scores.

Table 27: Coefficients of Regression

Coefficient	Estimate	t-value	p-value
Intercept	0.61	6.10	0.001
Pre-intervention WA	-13.8	-3.98	0.001

Regression analysis confirmed that participation in the pre-intervention was a significant predictor of post-intervention grief levels, the intercept (0.61, $p < .001$), suggests that there was no significant base shift in post-intervention scores irrespective of whether it was on an experimental group or control group. The negative coefficient for Pre-intervention WA (-13.8) indicates an inverse relationship: respondents with lower pre-intervention scores saw the greatest improvement**,** suggesting the intervention was particularly effective for those with less favorable grief counseling. However, the Pre-intervention WA p-value = 0.001 is less than the conventional 0.05 threshold, indicating grief counseling significantly reduces grief.

These findings are in line with international recommendations from the WHO and American Psychological Association, which advocate for early, individualized mental health support for bereaved mothers to prevent long-term psychological morbidity (WHO, 2016). The findings strongly support the effectiveness of individualized grief counseling in reducing perinatal grief among postpartum mothers. While the control group showed negligible change, the experimental group experienced statistically significant improvements across all grief dimensions: Active Grief, Difficulty Coping, and Despair.

The significant difference between post-intervention scores of the experimental and control groups affirms the impact of the intervention. Correlation analysis revealed that initial grief levels are strongly associated with post-intervention levels, but that intervention meaningfully altered the trajectory of grief, particularly in the experimental group. ANOVA results suggest some influence of the type of perinatal

loss, though this was not statistically significant in this study. Regression analysis confirmed that pre-intervention grief levels and participation in the intervention are strong predictors of post-intervention outcomes. These results validate the study hypothesis and support the integration of grief counseling into postnatal care services.

4.8 Chapter Summary

According to the results for both pre-intervention (controlled group) and post-intervention (controlled group) grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths is significant. Grief levels in this case are said to be moderately distributed among the postpartum mothers after perinatal loss. The results on coping mechanisms reveals a profound and complex grieving journey shaped by emotional, cultural, social, and spiritual factors. Coping mechanisms are diverse and personal, with varying degrees of support. There is a pressing need for more empathetic healthcare responses, community awareness, and accessible grief counseling to support postpartum mothers after perinatal loss.

Responses on care given to postpartum mothers showed that majority of the mothers were not informed about the availability of counseling services shortly after their baby's death, as was revealed by a low weighted average of 2.81 that was obtained. Although on the contrary a weighted average of 3.48 showed that mothers were offered counseling care at the hospital or immediately after discharge.

The weighted average of 3.41 showed that Cultural or religious beliefs have influenced the way mothers grieve after perinatal loss. This suggests that religious and cultural worldviews shape how mothers interpret and cope with the loss, whether through belief systems, values, or ritual practices. The study further revealed that Cultural traditions or religious rituals help mothers cope with the emotional pain of losing a baby. This was indicated by the majority (70.3%) who affirmed that cultural traditions or religious rituals helped them manage their emotional pain, with a weighted average of 3.63.

The study also found out that the community or social network (e.g., friends, extended family, and neighbors) provided emotional support during grief. A majority of participants (74%) acknowledged emotional support from their communities, such as

friends, extended family, or neighbors. The weighted average of 3.66 suggests that this support network is an essential component in the grieving process. The study also established that the general public is not very understanding of the emotional impact of perinatal loss. A total of 59.2% of mothers felt that the general public does not truly understand the emotional impact of perinatal loss. Despite this majority, 29.6% strongly disagreed, revealing some variation in public sensitivity. The weighted average of 3.26 shows a modest level of concern over public awareness, possibly pointing to geographical or community-level differences. The respondents indicated that there is a lack of public or social acknowledgment of grief, which makes mothers feel more isolated. A majority (70.3%) noted that the lack of public or social acknowledgment of perinatal grief results in feelings of isolation. This is supported by a high weighted average of 3.78, the second-highest among the statements, underscoring the social invisibility of this form of loss and its implications for maternal mental health.

The paired t-test analysis confirmed the significance of the reduction in grief levels in the experimental group ($t = 5.32$, $p < .001$) and no significant change in grief levels for the control group ($t = -0.47$, $p = .643$). These findings strongly support the efficacy of individualized grief counseling in addressing perinatal grief. The intervention provided to the postpartum mothers after perinatal loss with a structured opportunity to process their emotions, provide empathetic support, and acquire coping skills specific to their type and time of loss, is essential in supporting them through grief. Regression analysis confirmed that participation in the pre-intervention was a significant predictor of post-intervention grief levels, controlling for pre-intervention scores (0.61, $p < .001$), suggesting that there was no significant base shift in post-intervention scores irrespective of whether it was on an experimental group or control group. The negative coefficient for Pre-intervention WA (-13.8) indicates an inverse relationship: respondents with lower pre-intervention scores saw the greatest improvement**,** suggesting the intervention was particularly effective for those with less favorable grief counseling. However, the Pre-intervention WA p-value = 0.001 is less than the conventional 0.05 threshold, indicating grief counseling significantly reduces grief.

In general, we can ascertain that the significant difference between post-intervention scores of the experimental and control groups affirms the impact of the intervention.

Correlation analysis revealed that initial grief levels are strongly associated with post-intervention levels, but that intervention meaningfully altered the trajectory of grief, particularly in the experimental group. ANOVA results suggest some influence of the type of perinatal loss, though this was not statistically significant in this study. Regression analysis confirmed that pre-intervention grief levels and participation in the intervention are strong predictors of post-intervention outcomes. These results validate the study hypothesis and support the integration of grief counseling into postnatal care services. The findings of this chapter lead as to the next chapter which summarizes the results and compares them thoroughly to the available literature review.

CHAPTER FIVE

DISCUSSION

5.1 Grief levels on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

5.1.1 Pre-intervention Results

The analysis of grief levels in mothers following perinatal loss consistently demonstrates that this experience is associated with significant and often prolonged emotional distress across both experimental and control groups. A substantial portion of mothers in both cohorts reported high or severe grief levels, emphasizing the profound impact of such losses on maternal well-being. This is in agreement with the findings of Setubal *et al.,* (2021) study which has shown that perinatal death leads to profound and often long-lasting psychological distress for mothers, with the grief experienced often comparable to the grief experienced following the death of an older child. Grief following perinatal death is complex and multifaceted, often characterized by a range of emotions such as shock, sadness, anger, guilt, and despair. Immediately following perinatal death, mothers often experience shock and disbelief, which may delay the full processing of the loss.

The observed heterogeneity in grief responses, characterized by a wide range of scores and the unique presence of mild grief in the control group, underscores that individual factors likely play a critical role in shaping the grief trajectory. This variability suggests that a mother's pre-existing psychological resilience, social support network, or personal coping strategies may significantly influence how intensely and for how long grief is experienced. For instance, single mothers and those widowed dominated the sample size showing the correlation between social support, financial capabilities and perinatal loss (Bennett *et al.,* 2022). Further, as established by Johnson *et al.,* (2021) mothers with pre-existing mental health issues are at a higher risk for developing depression, anxiety, and prolonged grief disorder following a perinatal loss. Their findings underscore the need for early mental health screenings and interventions to help mitigate the risk of complicated grief. Thus, it is evident that the findings of the study support existing literature advocating for psychological support after perinatal death (Koopmans *et al.,* 2020; Stroebe & Schut, 2021).

The distribution of 'Type of Loss' within the experimental group based on the respondents was as follows: Stillbirth accounted for the most cases followed by miscarriage then Neonatal death. This aligns with the findings from similar studies indicating that stillbirth is often the most prevalent type of perinatal loss reported among mothers seeking post-loss support (Adugna *et al.,* 2021; Gold *et al.,* 2020). Regarding the 'Time since Loss', the most frequent period was 6 months post-loss, followed by 2 months and 4 months. This duration coincides with literature suggesting that grief symptoms often peak within the first six months post-loss, particularly when psychosocial support is limited (Koopmans *et al.,* 2020).

On the other hand, the control group showed a notable difference in 'Type of Loss' distribution compared to the experimental group. For instance, the stillbirths were considerably higher followed by miscarriage and Neonatal death. The distribution of 'Time Since Loss' in the control group showed 2 months and 4 months as the most frequent periods, followed by 1 year, 2 weeks, 1 month, and 6 months. This variation reflects the diverse emotional and coping trajectories associated with different types and timings of perinatal loss (Burden *et al.,* 2020).

The control group exhibits a higher proportion of Stillbirth cases compared to the experimental group, alongside a lower proportion of Miscarriage and Neonatal Death cases. This difference in the distribution of 'Type of Loss' is a critical factor when interpreting the findings. Stillbirth is frequently associated with more intense and prolonged grief compared to early miscarriage, given the deeper maternal-fetal bonding and greater societal recognition often afforded to later-term losses (Cacciatore *et al.,* 2021; De Vincenzo *et al.,* 2024). Therefore, the control group's higher prevalence of stillbirths could inherently predispose it to higher overall grief levels, irrespective of any experimental intervention. The results of this study concur with those of the study by Atkins, Kindinger, Mahindra, Moatti & Siassakos (2023) which indicate that still birth remains devastating for not only parents but family, communities and care providers. The study recommends provision of high quality, supportive, and compassionate bereavement care to improve mothers' wellbeing.

The minimal difference in overall average total grief scores between the experimental (108.4) and control (109.8) groups warrants careful consideration. The primary purpose of an experimental group is often to test the efficacy of an intervention against a control group representing the natural course of a condition (Polit & Beck, 2021). The minimal difference in average grief levels suggests that, based solely on these total scores, the experimental intervention (if it was designed to reduce overall grief intensity) may not have had a substantial broad impact. However, without knowledge of the nature of the intervention (whether it was a support group, a therapeutic technique, or a pharmaceutical), it is impossible to draw definitive conclusions about its effectiveness or lack thereof. It is conceivable that the intervention was not designed for a broad effect on overall grief, or that its effects are subtle or manifest in ways not fully captured by the total score (influencing specific grief components, or fostering long-term resilience) (Stroebe & Schut, 2021). This observation highlights a critical gap in the data provided for drawing actionable conclusions about the intervention's success. It underscores the necessity for comprehensive study documentation in research reporting, including detailed methodology and intervention descriptions, to allow for meaningful interpretation of results (Moher *et al.,* 2019). Furthermore, it suggests that future analyses with more detailed data might need to explore interaction effects between the intervention and specific participant characteristics or loss types (Kaburu *et al.,* 2024).

The subtle differences in grief level distribution, such as the higher percentage of "High" grief in the experimental group and "Moderate" grief in the control group, despite similar averages, could indicate that the intervention influences how grief manifests or is categorized, rather than simply reducing its overall intensity. This could imply that the intervention might be interacting with individual differences in a complex way, leading to a shift in the distribution of grief levels rather than a uniform reduction. Such patterns have been observed in previous research, which suggest that that grief interventions often produce heterogeneous outcomes depending on individual coping styles, attachment patterns and nature of support received (Bonanno *et al.*, 2024). According to Kaburu *et al.,* (2024; Heazell *et al.,* 2022), these findings underscore the need for multifaceted, individualized approaches to grief care, acknowledging that interventions may alter the quality rather than the quantity of grief responses.

The consistent contribution of Active Grief, Difficulty Coping, and Despair to the total score in both groups suggests that these are core dimensions of perinatal grief that any intervention should target. The data also clearly illustrates that grief after perinatal loss is not necessarily resolved within a few months. The presence of severe grief a year later in both groups indicates that for a significant minority, grief remains profoundly impactful. This finding challenges the common societal expectation that individuals "get over" such losses quickly and highlights the potential for prolonged and complicated grief as studied by Zhang, Chen, Zhao, Yuan, Zeng & Wu (2024). According to Zhang *et al.,* (2024), complicated grief symptoms persist for a long time with some lasting up to 10 years or even lifetime. Clinically, this means healthcare providers and support systems must be prepared to offer long-term, flexible support rather than time-limited interventions. Policy-wise, it suggests the need for extended bereavement leave and ongoing access to mental health services for parents who have experienced perinatal loss, recognizing that the emotional toll can be enduring.

A significant observation is the prevalence of High and Moderate grief levels across both cohorts, with a notable proportion also experiencing severe grief. This finding underscores the profound and persistent emotional impact of perinatal loss. The wide spectrum of grief levels, ranging from Mild to Severe within both groups, even for similar types of loss or timeframes, suggests the highly individualized nature of the grieving process. This variability indicates that while the event is universally traumatic, individual coping mechanisms, social support structures, or other unmeasured factors likely modulate the intensity and manifestation of grief (Mørk *et al.,* 2023; Uçar *et al.,* 2025). Such diverse presentations of grief emphasize the need for personalized grief support interventions rather than a uniform approach, implying that any experimental interventions should be designed to address a broad range of emotional responses (Li *et al.,* 2024; De Vincenzo *et al.,* 2024). While overall average scores were similar, differences in the distribution of grief levels and the composition of loss types between the groups necessitate careful interpretation of the findings.

5.1.2 Post-intervention Results

According to the pre-intervention results the results of the experimental and control group were similar with stillbirth being the main type of loss followed by miscarriage

and neonatal death. The experimental group consisted of 23 participants control group consisted of 21 participants. A notable difference in 'Type of Loss' distribution was observed compared to the experimental group: Stillbirth was considerably higher followed by Miscarriage and Neonatal death. The distribution of 'Time Since Loss' in the control group showed one year as the most frequent followed by 4 months accounting.

The findings revealed that a large proportion (82.6%) of mothers in the experimental group experienced either low or moderate grief levels after the counseling intervention. In contrast, 28.6% of mothers in the control group still experienced high grief levels, with no participants in the experimental group falling within this range post-intervention. This difference strongly suggests that individualized grief counseling plays a crucial role in mitigating the emotional impact of perinatal loss. The intervention likely offered participants a structured space to process their loss, receive validation, express emotions, and learn adaptive coping strategies. This is consistent with Worden's Task Model of Grieving, which identifies the need to accept the reality of the loss, process the pain, adjust to the environment without the deceased, and reinvest in life (Worden & Winokuer, 2021). The intervention addressed all four tasks. The present study is in line with Helm (2023) study which acknowledges individualized counselling as the best practice in offering psychological support to parents who have experienced prenatal and perinatal loss. The study acknowledges that, grief following perinatal death can be one of the most devastating experiences a mother can endure (Obst *et al.,* 2020). The postpartum period, typically characterized by joy and anticipation, becomes instead a time of profound sorrow and emotional upheaval for mothers who experience the loss of their children (Alvarez-Calle *et al.,* 2023).

Moreover, the absence of severe grief in both groups during the post-intervention phase suggests a natural decline in intense grief over time. However, the much greater reduction in the experimental group demonstrates that grief counseling accelerates recovery and prevents the persistence of high grief, which could otherwise develop into complicated grief disorder Li *et al.,* 2024).

The descriptive analysis clearly demonstrates the effectiveness of individualized grief counseling in lowering grief severity among postpartum mothers. Mothers in the experimental group experienced a shift from high and moderate grief to low and moderate categories, while control group participants remained largely unchanged, with persistent high grief in some cases. The subscale reductions reflect improvement not only in the mothers' emotional state but also in their coping and cognitive adaptation to the loss. These outcomes confirm the theoretical foundation of grief counseling, which emphasizes structured emotional support, validation, and meaning-making as pathways to healing. The World Health Organization (WHO, 2016) recommends integrating bereavement care into maternal and child health programs. In Kenya, where mental health services are still developing, these results highlight the importance of contextual, culturally sensitive grief interventions. Moreover, the findings underscore the unique grief experiences of mothers following miscarriage, stillbirth, or neonatal death-losses that are often minimized in society. This study provides empirical evidence to challenge that minimization and emphasizes the value of targeted mental health interventions.

5.2 Post-loss Coping Mechanisms on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

The findings indicate that mothers who received individualized grief counseling experienced significantly reduced levels of grief, despair, and difficulty coping compared to those who did not. These improvements were not only evident in the total grief scores but also across the key dimensions of grief: active emotional expression, behavioral adjustment, and cognitive reframing of the loss. The intervention helped mothers move from high or severe grief levels to more manageable states, including moderate and low grief, thereby enhancing their ability to function and reintegrate emotionally and socially. The findings of the present study are supported by Tuncel (n.d.) who states that grief is a unique and individual process that demand individualized care. Similarly, Li et al. (2024) and Ersoy and Altinbas (2024) found that individualized grief counseling significantly reduces grief intensity and fosters adaptive coping following perinatal loss.

The findings also revealed that the mothers in the experimental group who received individualized grief counseling showed a significant reduction in overall grief levels

compared to the control group. This reduction was evident in both total Perinatal Grief Scale (PGS) scores and in the dimensions of active grief, difficulty coping, and despair. A majority (over 80%) of mothers in the experimental group transitioned to low or moderate grief levels post-intervention, whereas the control group retained a higher proportion of mothers in high grief levels. This indicates that counseling facilitated emotional processing and healthier grief resolution. These results agree with Pinheiro, Gonçalves, Nogueira, Pereira, Basto, Alves & Salgado (2022) findings suggest that higher emotional processing capability is associated with the transformation of grief-related maladaptive emotions and with the improvement of complicated grief conditions. Similarly, Li *et al.* (2024) reported that individualized psychological support promotes resilience and decreases the intensity of grief responses.

Participants in the intervention group reported better coping abilities, as seen in decreased scores in the "difficulty coping" and "despair" subscales. This reflects enhanced psychological resilience and adaptation following their loss. The control group, which did not receive targeted coping interventions, exhibited little to no improvement in psychological wellbeing over time, suggesting that passive coping or reliance on time alone is insufficient to resolve perinatal grief. These finding resonates with the findings of Zalli (2024) that building resilience in the face of grieving entails developing coping mechanisms that function, creating social support systems, nourishing happy feelings, and discovering meaning and purpose in the midst of loss.

Li et al. (2024), found that the effectiveness of individualized counseling was consistent across various types of perinatal loss and different time intervals since the loss, indicating the broad applicability of post-loss coping mechanisms. Similarly, Ersoy and Altinbas (2024) reported that grief counselling significantly reduced grief levels among women following pregnancy termination, regardless of loss type, reinforcing the broad therapeutic relevance. Strong correlations were found between pre-intervention and post-intervention grief scores, particularly in the control group. However, the intervention significantly altered the trajectory of grief for the experimental group, breaking the otherwise stable pattern of persistent grief.

These findings underscore the critical importance of structured post-loss coping strategies, especially grief counseling, in promoting psychological healing among bereaved postpartum mothers. The results further support recommendations by African researchers such as Afolabi *et al.* (2023) and Mothiba and Maputle (2022), who emphasized integrating culturally sensitive grief interventions into maternal health care systems to enhance emotional recovery following perinatal loss. The results support the integration of such interventions into routine maternal healthcare following perinatal loss.

According to the literature expressive coping mechanisms allow parents to externalize their emotions, which can relieve emotional pressure and provide a sense of release. Talking it out helps postpartum mothers better understand and come to terms with their grief. Social support is one of the most widely recognized coping mechanisms following perinatal loss. Smorti *et al.,* (2020) highlights that grieving parents often turn to family, friends, or support groups to help process their grief. Emotional support from loved ones can validate grief, provide a sense of comfort, and reduce feelings of isolation. However, Papapetrou *et al.,* (2021) note that the effectiveness of social support depends on the type and quality of support received. This justifies the reason as to why family, friends, society at large and the skilled health professionals offer support that is empathetic, patient, and nonjudgmental which tends to be more helpful, while dismissive or invalidating comments can worsen feelings of isolation and distress. Support groups, especially those comprised of individuals who have experienced similar losses, can also be an important source of coping. Jones *et al.,* (2022) found that participation in support groups allowed mothers to share their grief openly, learn from others, and gain comfort from hearing others' experiences. These groups can provide a sense of solidarity, which can be critical in reducing feelings of loneliness and alienation.

It is evident that postpartum mothers need support to pull through the trauma and distress that emanates from perinatal losses as shown in the results and in the available literature review. Expressing oneself, family and social support and professional guidance are essential mechanisms adopted by postpartum mothers to help them cope

through the grieving period. These findings support existing literature advocating for psychological support after perinatal death.

5.3 Postpartum Counseling Care Offered on Postpartum Mothers' Psychological Wellbeing, Following Perinatal Deaths

It was identified that majority of the mothers were not informed about the availability of counseling services shortly after their baby's death, as was revealed by a low weighted average of 2.81 that was obtained. This item shows a notable leaning towards disagreement regarding the timeliness of information about counseling services, indicating a significant gap in early communication. The findings of the present study showed that many mothers are not adequately informed about available services shortly after their loss. This agrees with de Andrade Alvarenga *et al.,* (2021) study which showed that midwives caring for women throughout the labor, birth, and early postnatal period admitted to having struggled with emotional commitment needed to provide perinatal loss care as well as with how to communicate openly and share information with these women.

On the other hand, the mothers were offered counseling care at the hospital or immediately after discharge, as was revealed by a weighted average of 3.48 that was obtained. Further, there was inadequate information provided about how to access grief counseling services, as was revealed by a weighted average of 2.15. Similarly, information on accessing services was insufficient which affected most mothers by denying them access to perinatal loss care when most needed. Delgado *et al.,* (2023) argues that most hospitals continue to experience challenges with early perinatal loss care including communication to mothers because this area of healthcare remains to be the most neglected in health systems in the world

Responses on care given to postpartum mothers showed that majority of the mothers were not informed about the availability of counseling services shortly after their baby's death. This is related to Fernández-Basanta *et al.,* (2018) findings where many mothers felt abandoned by healthcare providers after the loss, particularly once the immediate postpartum care had ended. Continuous follow-up appointments, especially with healthcare providers who are familiar with the mother's emotional and physical journey,

are essential in providing ongoing support. Psychological counseling and support to postpartum mothers after perinatal loss is documented to be an essential intervention aspect that enhances healing throughout the grieving period. Health professional counseling is one of the significant intention measures that gives measurable results (Li *et al.,* 2024).

Findings on strengths in counselor qualities and accessibility revealed a strong positive sentiment regarding the empathy and understanding of counselors and the freedom for mothers to reach out for further sessions. This suggests that when mothers engage with counselors, the quality of interaction and the perceived availability of ongoing support are highly valued. Conversely, findings on significant gaps in information and follow-up pointed to critical weaknesses in the provision of adequate information on how to access services and the lack of hospital follow-up care after initial sessions. These are the lowest-scoring items, indicating systemic issues in the initial and ongoing administrative aspects of care. These findings relate to the findings of Thomson, McNally & Nowland (2024) study which indicate that effective support to mothers after perinatal loss should focus on active listening, use of therapeutic tools, and developing a positive relationship with the therapist to ensure follow-ups.

Mothers also expressed considerable dissatisfaction with the extent to which counselors helped them navigate the challenges of being a mother after perinatal loss. They indicated having received minimal support during postpartum recovery. This suggests that while counselors may be empathetic, practical and holistic, support for the unique challenges of this experience may be lacking. Similar findings were reported by Mothiba and Maputle (2022), who observed that bereaved mothers in South Africa experienced limited professional follow up and emotional support after childbirth. Likewise, Afolabi *et al.* (2023) emphasized that although psychosocial interventions exist in sub-Saharan Africa, they are often fragmented, under-resourced, and inadequately tailored to mothers' post-loss needs. Global studies, such as Li *et al.*, (2024) and Ersoy and Altinbas (2024), also highlight the gap between empathetic counseling and the provision of sustained, integrative care that addresses postpartum grief and maternal role adjustment after loss.

The findings indicated a divided opinion regarding provision of information on future pregnancies or family planning. This indicates inconsistency in delivery or varying needs among mothers. The present study points to a strong service that requires human element (empathy) and accessibility for self-initiated follow-up. Major challenges identified include deficiency in proactive information dissemination, comprehensive navigational support, and structured post-session follow-up. The present study underscores the role of social support in loss responses and the healing process as advocated by Wheeler (2021), with peer support playing a particularly significant role in giving bereaved mothers the opportunity to connect to those with shared experiences (Li *et al.,* 2022).

Midwives are also responsible for the emotional wellbeing of mothers antenatal and in the early postnatal period, despite feeling underequipped to fulfil this role, particularly in relation to bereavement (Wheeler, 2021). Although some information contradicts indicating inconsistent or insensitive care within hospitals, and the report highlights the way in which on-going care is solely provided. In addition to initial care, follow-up support is critical.

The results contradict at one point where some respondents claim not to be aware of the counseling services and others claim to have accessed grief counseling sessions that have been helpful. Midwives have the responsibility of catering for postpartum mothers' well-being, and they should therefore support these mothers after perinatal loss (de Andrade Alvarenga *et al.,* 2021). They should therefore do follow ups to familiarize themselves with grieving mother's emotional and physical journey to be able to provide the necessary support. Care giving should be extended to other geographical locations where there is no or there are limited counseling services. Therefore, given the required support the well-being of postpartum mothers after perinatal loss will be catered for.

5.4 Sociocultural Factors Affecting the Coping Mechanism on Postpartum Mothers' Psychological Wellbeing, following Perinatal Deaths

Cultural traditions or religious rituals help mothers cope with the emotional pain of losing a baby by helping them manage their emotional pain. This highlights the

importance of culturally rooted rituals such as prayer, memorial ceremonies, or traditional mourning customs as therapeutic tools in the healing process. These findings agree with those of Kain (2021) study which indicate that perinatal palliative care becomes truly holistic when clinicians remain conservative of the cultural, spiritual, and religious needs of these mothers.

Further, religion provided mothers with guidance or comfort during their grieving process. Religion was seen as a strong source of comfort. This underlines how religious guidance, faith in divine will, or spiritual counseling play a central role in helping mothers find meaning or peace after such a devastating experience. According to Adeleye *et al.,* (2024), diversity in spirituality, religion, and cultural norms among women leads to varying attitudes, grieving processes, and coping mechanisms after loss.

The study also found out that the community or social network including friends, extended family, and neighbors provided emotional support during grief. This support network is an essential component in the grieving process. These findings are contrary to Popoola, Skinner & Woods (2021) study which indicates that though people including perinatal loss mothers turn to their social network for support, being embedded within a network of relationships does not guarantee support for bereaved mothers. According to the present study there is societal pressure for mothers to return to "normal" after a loss, which makes grieving process harder. Thus, societal pressure is a common experience that likely interferes with emotional recovery and mental wellness.

The study also established that the general public is not very understanding of the emotional impact of perinatal loss. The modest level of concern over public awareness, possibly pointing to geographical or community-level differences. The society views the grief of mothers who experience perinatal loss as less significant compared to other types of loss such as death of an older child. Such comparisons may invalidate the bereavement of postpartum mothers and contribute to their emotional burden. These findings concur with those of Salgado *et al.,* (2021) which indicate that the society considers perinatal losses invisible and silences parents going through this kind of loss

offering minimal social support. Similary, Burden *et al.,* (2020) highlighted that mother often experience feelings of guilt and isolation due to societal minimization of their grief. Recent research by Mothiba and Maputle (2022) and Afolabi *et al.,* (2023) further emphasizes that cultural silence surrounding perinatal death limits social validation of grief, leaving mothers to cope in isolation without adequate emotional or culture support.

Cultural factors, including religious beliefs, can impact individuals' responses to loss, as well as the way in which their losses are framed by those around them. Cultural norms dictate not only the ways in which grief is expressed but also the duration and intensity of mourning. It is observed that grief is often acknowledged and supported across societies majorly through counseling. Religions also provide mothers with a sense of meaning in the face of loss, with different religious traditions offering unique frameworks for understanding perinatal death. Culturally competent care involves understanding the grieving rituals, beliefs, and support systems that are important to the mother, and offering care that aligns with these values (Roberts *et al.,* 2024). Mothers in rural or low-income areas may face additional barriers to accessing professional support for mental health, which can exacerbate feelings of isolation and depression (Chala *et al.,* 2024). Societal scorns on women who loss or are unable to bear children do not offer conducive environment to enable them overcome grief. Limiting them from mourning and expressing their pain affects them internally, leading to severe trauma and in some cases depression.

Cultural norms, religion and community at large are meant to help postpartum mothers through grief after perinatal loss. Empathizing and general support to the postpartum mothers strengthens them and gives them the will to pull through the devastating moment or simply overcome distress or depression. Therefore, it is essential to provide grief counseling to the postpartum mothers with an aim of taking interest in their well-being. Myburgh *et al.,* (2025) underscores the urgent need to integrate culturally and spiritually sensitive grief counselling into routine healthcare services to mothers after perinatal loss.

5.5 Effect of Individualized Grief Counseling on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths

The statistically significant mean difference within the experimental group for both pre-intervention and post-intervention scores shows the effectiveness of individualized grief counselling in the mental wellbeing of postpartum mothers who had experienced perinatal loss. Similarly, the independent samples T-test comparing post-intervention scores experimental and control groups revealed a statistically significant difference. However, mothers in the experimental group had significantly lower grief scores compared to those in the control group who had been exposed to skilled grief counseling by the health professionals.

This provides further evidence that the observed changes were not due to chance or natural reduction in grief over time, but rather to the impact of the counseling intervention. This finding aligns with studies that advocate for personalized grief support tailored to the specific experiences of bereaved mothers (Berger, 2022; Wool, 2019). The individualized nature of the intervention likely allowed for deeper emotional expression, validation of grief, and development of adaptive coping mechanisms which catered for the postpartum mothers' well-being (Berger, 2022).

Although the type of perinatal loss (miscarriage, stillbirth, or neonatal death) showed no statistically significant difference in grief levels between the pre-intervention and post-intervention scores, qualitative observation suggests variation in grief experiences across loss types. For instance, mothers who experienced neonatal death or late stillbirth tended to have higher grief scores than those with early miscarriages, particularly in the control group. In this case the results are similar between the pre-intervention and post-intervention times, that is, the post intervention impact of grief counseling between the pre-intervention and post-intervention scores is not statistically significant. Given these variations, Zhuang *et al.,* (2023) recommends that women's perinatal bereavement needs be individualized and diverse. There is need for counsellors, family, and community to understand, identify, and respond to the needs of these mothers in a sensitive and personalized way.

Moreover, grief intensity did not decline consistently with time since loss. Some participants with losses more than a year old still had high PGS scores, indicating that grief can persist without intervention. This supports literature that grief trajectories are highly individual and not strictly time-dependent (Mergl *et al.,* 2022). Counseling appears to interrupt this prolonged grief by facilitating resolution and meaning-making.

There was a strong positive association between pre-intervention and post-intervention scores in both groups, especially in the control group. This suggests that after intervention, grief levels tend to remain relatively stable over time. In contrast, while still positively correlated in the experimental group, the reduction in overall scores shows that counseling can significantly alter grief outcomes despite initial severity. This finding is consistent with attachment theory, which posits that perinatal loss disrupts maternal bonding and psychological equilibrium, necessitating intentional support to restructure meaning and restore psychological balance (Bowlby, 1980; Worden & Winokuer, 2021).

Regression analysis confirmed that participation in pre-intervention was a significant predictor of post-intervention grief levels, controlling for pre-intervention scores, suggesting that there was no significant base shift in post-intervention scores irrespective of whether it was on an experimental group or control group. From these results, respondents with lower pre-intervention scores saw the greatest improvement**,** suggesting the intervention was particularly effective for those with less favorable grief counseling. However, grief counseling significantly reduces grief. These results validate the study hypothesis and support the integration of grief counseling into postnatal care services. Consistent with these findings, Li *et al.,* (2024) reported that nonpharmacological interventions, particularly individualized grief counselling, substantially reduce grief intensity and enhance emotional recovery among parents after perinatal loss. Similarly, Ersoy and Altinbas (2024) found that structured counseling sessions significantly decreased grief levels and improved psychological adjustment among bereaved mothers. In the African context, Afolabi *et al.,* (2023) emphasized that integrating grief counseling within postnatal care frameworks is essential to mitigating prolonged grief and fostering psychological well-being among postpartum mothers.

These results validate the present study's hypothesis and reinforce the importance of embedding grief counseling services into routine maternal healthcare systems.

Individualized counseling focuses on customizing therapeutic interventions based on the mother's specific needs, coping mechanisms, and emotional readiness to process the grief. This type of counseling helps to create a safe space for the mother to express emotions, work through complicated feelings, and develop resilience. An individualized approach ensures that therapy aligns with the mother's specific grief trajectory, offering the best support for her emotional healing (Roberts *et al.,* 2024). The counselor's role is to support the mother's autonomy and provide gentle guidance through the grieving process. Counselors trained in perinatal loss understand that grief may evolve over time and that long-term support may be required. A counselor who is attuned to a mother's unique emotional responses, cultural sensitivities, and family context can be instrumental in helping her process loss.

The results show that after the intervention the grief levels of the postpartum mothers significantly reduced for both pre-intervention and post-intervention scores implying that individualized counseling had provided emotional support, validated the mother's grief and it had also helped her process complex feelings as ascertained by Berger, (2022). Therefore, the importance of individualized counseling after perinatal loss cannot be overstated. Given the highly personal and varied nature of grief, a one-size-fits-all approach to therapy is rarely effective. Instead, counseling must be tailored to the mother's unique emotional, psychological, and social needs. The goals of individualized counseling typically include helping the mother process her grief, address feelings of guilt or anger, foster emotional resilience, and navigate the practical implications of the loss ((Roberts *et al.,* 2024). A key component of individualized counseling is providing a safe, empathetic space where the mother's grief can be expressed and validated.

CHAPTER SIX
SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary of the Findings

The main objective of the study aims to evaluate the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. The first objective of the study sought to establish to examine the grief levels on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. The analysis reveals that perinatal loss consistently leads to significant and often prolonged grief across both groups. The experimental group (N=23) demonstrated a relatively even distribution of Moderate (43.5%) and High (43.5%) grief, with 13.0% experiencing Severe grief. The control group (N=21) showed a higher proportion of Moderate grief (52.4%), with High grief at 23.8% and Severe grief at 19.0%, alongside a single instance of Mild grief (4.8%). The average Total Grief Score for the experimental group was 108.4, marginally lower than the control group's average of 109.8.

The second objective of the study sought to assess the post-loss coping mechanisms on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. This descriptive research report highlights crucial insights into the perceptions of counselling care for postpartum mothers following perinatal deaths. While the empathetic nature of counselors and the accessibility of further sessions are clear strengths, significant areas for improvement exist, particularly concerning the initial provision of information, the comprehensiveness of support for navigating life after loss, and the implementation of follow-up care. The findings underscore the importance of a holistic approach to support, where not only the quality of direct counseling but also the administrative and structural elements of care delivery are optimized. Addressing the identified gaps in information dissemination and follow-up care, alongside enhancing the practical support provided by counselors, could substantially improve the overall experience and well-being of mothers during a profoundly difficult period. These insights provide a clear foundation for targeted interventions aimed at strengthening the continuum of care for this vulnerable population.

The third objective of the study sought to assess the postpartum counseling care offered on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya. Strengths in Counselor Qualities and Accessibility: There was strong positive sentiment regarding the empathy and understanding of counselors (WA 4.07) and the freedom for mothers to reach out for further sessions (WA 4.07). This suggests that when mothers engage with counselors, the quality of interaction and the perceived availability of ongoing support are highly valued. Significant Gaps in Information and Follow-up: Conversely, critical weaknesses are identified in the provision of adequate information on how to access services (WA 2.15) and the lack of hospital follow-up care after initial sessions (WA 2.00). These are the lowest-scoring items, indicating systemic issues in the initial and ongoing administrative aspects of care. Regarding challenges in Navigational Support: Mothers also express considerable dissatisfaction with the extent to which counselors help them navigate the challenges of being a mother after perinatal loss (WA 2.44) and their overall feeling of support during postpartum recovery (WA 2.59). This suggests that while counselors may be empathetic, practical and holistic support for the unique challenges of this experience may be lacking. Mixed Sentiment on Specific Information: The provision of information on future pregnancies or family planning (WA 2.93) shows a more divided opinion, hovering around the neutral point. This could indicate inconsistency in delivery or varying needs among mothers. In summary, the data points to a service that is strong in its human element (empathy) and accessibility for self-initiated follow-up, but critically deficient in proactive information dissemination, comprehensive navigational support, and structured post-session follow-up. Thus, these findings confirm that postpartum counseling care is a vital intervention for promoting mental health and emotional stability in mothers after perinatal death. The evidence supports the integration of grief counseling into routine postnatal services to ensure that bereaved mothers receive the psychological care necessary for full recovery.

The fourth objective of the study sought to determine the sociocultural factors affecting the coping mechanism on postpartum mothers' psychological wellbeing, following perinatal deaths in Tharaka Nithi County, Kenya. According to the results and literature cultural norms, religion and community at large are meant to help postpartum mothers through grief after perinatal loss. Empathizing and general support to the postpartum

mothers strengthens them and gives them the will to pull through the devastating moment or simply overcome distress or depression. Therefore, there exist significant similarity between literature and the present study results implying that it is essential to provide grief counseling to the postpartum mothers with an aim taking interest in their well-being. Thus, sociocultural factors significantly influence the coping mechanisms and psychological wellbeing of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya. Cultural silence around perinatal loss, stigma and blame toward bereaved mothers, and the absence of recognized mourning rituals often hinder emotional expression and suppress grief. Gender-based expectations and inadequate spousal or family support further exacerbate psychological distress, while spiritual or religious interpretations sometimes discourage mothers from seeking professional help. These sociocultural pressures lead many mothers to rely on ineffective coping strategies such as isolation, silence, or fatalistic acceptance, ultimately compromising their emotional recovery. The findings highlight the need for culturally sensitive grief counseling and community education to promote healthier coping and psychological support for bereaved mothers.

The fifth objective of the study sought to evaluate the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya. The study evaluated the effect of individualized grief counseling on postpartum mothers' psychological wellbeing following perinatal deaths in Tharaka Nithi County, Kenya, and found that the intervention significantly reduced grief levels among mothers who received counseling compared to those who did not.

The significant difference between post-intervention scores of the experimental and control groups affirms the impact of the intervention. Correlation analysis revealed that initial grief levels are strongly associated with post-intervention levels, but that intervention meaningfully altered the trajectory of grief, particularly in the experimental group. ANOVA results suggest some influence of the type of perinatal loss, though this was not statistically significant in this sample. Regression analysis confirmed that pre-intervention grief levels and participation in the intervention are strong predictors of post-intervention outcomes. These results validate the study hypothesis and support the integration of grief counseling into postnatal care services.

Mothers in the experimental group showed marked improvement across all dimensions of grief active grief, difficulty coping, and despair transitioning from severe or high grief to moderate or low levels. In contrast, the control group exhibited minimal change, with many mothers retaining moderate to high grief levels. The findings demonstrate that individualized grief counseling is an effective post-loss coping mechanism that enhances emotional recovery and psychological wellbeing among bereaved postpartum mothers.

6.2 Conclusion

Based on the findings of the study, the researcher makes the following conclusions;
The assessment of post-loss coping mechanisms among postpartum mothers in Tharaka Nithi County revealed that the strategies employed significantly influence their psychological wellbeing following perinatal deaths. Mothers who accessed structured support, such as individualized grief counseling, demonstrated better emotional recovery, lower grief severity, and improved coping capacity compared to those who relied solely on informal or culturally-influenced mechanisms. In contrast, mothers without access to formal support often experienced prolonged grief, emotional isolation, and difficulty adjusting. These findings underscore the importance of accessible, supportive, and culturally sensitive coping interventions in promoting mental health and emotional healing among bereaved postpartum mothers.

Individualized counseling significantly reduced grief severity and improved mothers' ability to cope with their loss, compared to those who did not receive such care. However, postpartum counseling services were limited, inconsistently provided, or not systematically integrated into routine maternal care. As a result, many bereaved mothers relied on informal or culturally influenced coping mechanisms that were often inadequate. These findings highlight the need for strengthening and formalizing postpartum counseling care within the health system to ensure that all mothers affected by perinatal loss receive timely, compassionate, and effective psychological support.

Further, sociocultural factors significantly influence the coping mechanisms and psychological wellbeing of postpartum mothers following perinatal deaths in Tharaka Nithi County. Deeply rooted cultural beliefs, stigma, and societal expectations often

suppress open grieving and emotional expression, leaving mothers to navigate their loss in silence and isolation. The absence of recognized mourning rituals for perinatal deaths, coupled with inadequate family and community support, undermines healthy coping and contributes to prolonged psychological distress. Additionally, gender roles and spiritual interpretations of loss can instill guilt and discourage help-seeking behavior. These findings highlight the urgent need to address sociocultural barriers that hinder effective grief processing among bereaved mothers.

Additionally, the findings show that individualized grief counseling significantly enhances the psychological wellbeing of postpartum mothers following perinatal deaths by providing structured emotional support, promoting healthy coping mechanisms, and reducing the severity of grief. The study demonstrated that mothers who received counseling experienced notable improvements in emotional adjustment, coping ability, and reduction in despair compared to those who did not receive any intervention. These findings underscore the critical role of integrating grief counseling into routine postnatal care, particularly in culturally sensitive settings like Tharaka Nithi County, to ensure that bereaved mothers receive the psychological support necessary for healing and long-term mental wellbeing.

6.3 Recommendations

Based on the findings of the study, the researcher makes the following recommendations;

i. There is need for integration of structured and culturally sensitive post-loss coping interventions such as individualized grief counseling into routine postpartum care for mothers who experience perinatal loss in Tharaka Nithi County. Healthcare providers should be trained to identify and manage complicated grief and offer timely psychological support. Community-based awareness programs promote and destigmatize emotional expression. Establishing peer support groups and involving families can enhance social support and foster collective healing. Policies should also prioritize mental health services in maternal care to ensure that all bereaved mothers receive the necessary resources to cope and recover effectively.

ii. Postpartum counseling should be formally integrated into maternal health services in Tharaka Nithi County. Health facilities should establish structured grief counseling programs and trained health professionals to offer empathetic, culturally appropriate psychological support. Policies should mandate routine mental health screening and follow-up for bereaved mothers. Partnerships with community leaders, religious figures, and local organizations should be strengthened to raise awareness, while establishing peer support groups within communities to provide a safe space for mothers to share experiences, foster resilience, and enhance collective healing.

iii. Culturally sensitive grief counseling should be integrated into maternal health services to support mothers after perinatal loss. Healthcare providers should receive training on local cultural beliefs and practices to offer empathetic and appropriate care. Community education initiatives should challenge stigma, promote open discussion and validate mothers' emotional experiences. Engaging religious leaders, elders, and other influential community figures can foster understanding and support, while establishing peer support groups can encourage shared healing and encourage positive coping strategies.

iv. There is need to integrate individualized grief counseling into routine maternal healthcare, particularly in postnatal care units, to support mothers who experience perinatal loss. Healthcare providers should be trained in culturally sensitive grief support to offer compassionate, personalized care that acknowledges the emotional impact of perinatal death. Community education should be implemented to reduce stigma, encourage emotional expression, and promote help-seeking behaviors specifically the single and widowed. Engaging family members and community leaders in grief awareness programs can strengthen support systems and foster a more understanding and responsive environment for grieving mothers. Overall, any of the intervention adopted whether by healthcare workers, family, or community needs to be very potent to demonstrate a significant overall difference.

6.4 Suggestions for Further Research

i. Research should explore the psychological impact of perinatal loss on fathers and extended family members, and how their involvement in counseling may influence maternal recovery and family coping dynamics.

ii. Effectiveness of individualized grief counseling with other therapeutic approaches such as group counseling, cognitive-behavioral therapy (CBT), or faith-based interventions in supporting bereaved mothers.

iii. Cohort follow up on mothers who conceive again after child loss on psychological wellbeing.

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APPENDICES

Appendix 1: Introductory Letter and Consent Form

Part one: Study Information Sheet

I am Doreen Mbae, a postgraduate student from Chuka University. I am researching on "Effect of Individualized Grief Counselling on Postpartum Mothers Psychological Wellbeing Following Perinatal Deaths in Tharaka Nithi County, Kenya."

You are invited to take part in the study. All the information required is on this form to aid you in deciding whether to take part in the research or not. Feel at liberty to inquire about anything concerning this study. The researcher has obtained all the requirements needed to carry out this study, including a national research permit. Suppose you agree to take part in the research. In that case, you have the right to request any information about it, the freedom to leave the study at any time without penalty, the right to privacy and confidentiality of the information shared, and the right to pull out from the study at any moment.

The procedure for carrying out the study

In 10 minutes, after you consent to participate in the study, the researcher will inquire about your psychological well-being and record the responses. Finally, you will be guided about other activities concerning this study.

Benefits and risks of your participation

Benefits: The results of this study will be of great support to healthcare workers (counselors) in improving individualized counseling for mothers who have lost their babies perinatally.

The mothers will also benefit by having improved psychological well-being and coping mechanisms after the counseling sessions.

Risks and cost: There are no risks in the study. All data collected will be used for this study's purposes and will be handled with great confidentiality. There will be no extra cost since the data collection and all meetings will be scheduled according to your hospital appointment days.

Handling information.

Anonymity, Confidentiality, and Security of Your Information: Special codes will be generated for use as your identification number so that your personal information will not be linked directly to you. To protect your personal information from unauthorized disclosure, alteration, or damage, your details will only be used to further

this study's objectives. The researcher will keep filled-in questionnaires in a tamper-proof cabinet that is accessible only to the researcher.

Contact Information: If you have any questions about this study, my contact is Doreen Mbae, whose phone number is 0726150076, or Chuka University Institutional Research Ethics Review Committee.

Part two: Consent

The details of my involvement in the research "**Effect of Individualized Grief Counselling on Postpartum Mothers Psychological Wellbeing Following Perinatal Deaths in Tharaka Nithi County, Kenya**" are clear to me. All my concerns about the study have been addressed to my fulfillment. I hereby voluntarily consent to participate in the research.

Signature/thumbprint……Date……

Appendix 2: Research Questionnaire for Mothers

Date……

Serial Number…….

Instructions:

Do not write your name or any personal identification information on the questionnaire

Section A: Demographic Information

1. Age: _____
2. Marital Status: _____
3. Education Level: _____
4. Occupation: _____
5. Number of Previous Pregnancies: _____
6. Number of Previous Live Births: _____
7. Type of Perinatal Loss:
8. Gestational Age at Time of Loss: _____
9. Was this loss expected or unexpected?
10. Did you receive immediate care at the hospital after the loss?
11. Religion, culture, and society offered support after the loss.

Appendix 3: Interview Guide

The purpose of this interview guide is to assess the post-loss coping mechanisms of postpartum mothers following perinatal deaths.

General Experience of the Loss

1. Can you tell me about your experience during your pregnancy and the events leading up to the loss?
   Probes: How did you first learn about the loss? How did you feel at the time?
2. How did the loss of your baby impact you emotionally?
   Probes: What kind of emotions did you experience in the days and weeks after? (Sadness, guilt, relief, etc.)
3. What were some of the most challenging aspects of coping with this loss during the postpartum period?
   Probes: How did you feel emotionally and physically after childbirth?

Emotional and Psychological Coping

4. Can you describe any emotional reactions or thoughts you have had in the months following your baby's death?
   Probes: Have these thoughts or feelings changed over time?
5. How did you deal with feelings of sadness, anger, or guilt, if at all?
   Probes: What helped you to manage these emotions? Did you find anything particularly difficult to process?
6. Have you ever experienced feelings of isolation or loneliness since the loss? How did you cope with these feelings?
   Probes: How did you handle social interactions or explain your situation to others?
7. Have you noticed any changes in your sense of self or identity after the loss?
   Probes: How did you feel about being a mother after the loss? How did it affect your relationship with your partner or family members?

Coping Strategies and Mechanisms

8. What are some coping strategies or techniques that you have used to manage your grief after the loss?

Probes: Were there any coping strategies that worked particularly well for you? (E.g., mindfulness, journaling, therapy, religious or spiritual practices)

9. How did you manage the day-to-day challenges of motherhood after the loss?
   Probes: Did you find it difficult to take care of yourself or others during this time?
10. Did you have any support from your family or friends? How did their support affect your grieving process?
    Probes: How did the people around you react to your grief? Was there anything that helped you feel supported or understood?
11. Were you offered professional support, such as therapy or counseling? How did that affect your coping process?
    Probes: What types of professional help, if any, did you find most beneficial?
12. Did you participate in any online or in-person support groups for bereaved parents? How did that impact your coping?
    Probes: What role did these groups play in your healing process?

Cultural and Societal Influences

13. How did your cultural or religious beliefs influence your coping with the loss?
    Probes: Were there any specific rituals or practices that helped you process your grief?
14. Were there societal or community expectations that influenced the way you grieved or coped with the loss?
    Probes: Did you feel pressure to grieve in a particular way or within a specific time frame?
15. Do you feel that society understands the depth of grief following perinatal death? Why or why not?
    Probes: How do you think public perception of perinatal loss affects mothers' grieving processes?

Future Outlook and Recovery

16. How do you view your healing or recovery at this point? What does “healing” mean to you?
    Probes: Are there particular milestones or achievements that have helped you feel more at peace?

17. Looking forward, what kind of support do you think would have helped you more in the immediate aftermath of the loss?

    Probes: Is there anything you wish you had known or done differently?

18. How do you feel about the possibility of having another child in the future? How do you think this would affect your grief and coping process?

    Probes: What are your hopes or concerns about future pregnancies or parenting?

Closing Thoughts

19. Is there anything else about your experience that you would like to share that we haven't yet covered?

    Probes: Any specific moments, people, or events that were significant in your grieving process?

20. Do you have any advice or insights for other mothers who are going through similar experiences of perinatal loss?

    Probes: What would you say to someone in the same situation about coping or seeking help?

Thank you

Appendix 4: Counsellors Questionnaire

The purpose of this questionnaire is to collect information for a Doctorate thesis to evaluate the effect of individualized grief counseling on the psychological well-being of postpartum mothers following perinatal deaths in Tharaka Nithi County, Kenya. Kindly give your honest opinion on the items stated in this questionnaire, and do not write your name.

SERIAL NO: …….

Section A: Demographic Information

1. Professional Role

   ☐Midwife

   ☐Obstetrician

   ☐ Nurse

   ☐ Counselor/Psychologist

   ☐ Other (please specify) _____

2. Years of Experience in Maternal Health

   ☐ Less than 1 year

   ☐ 1-3 years

   ☐ 4-6 years

   ☐ 7-10 years

   ☐ More than 10 years

3. Have you ever (in your practice) experienced perinatal death (e.g., stillbirth, neonatal death)?

   ☐ Yes

   ☐ No

Section B: Counselling care offered to postpartum mothers following perinatal deaths

4. Please respond to the following statements with your opinion on Counselling care offered to postpartum mothers following perinatal deaths. In the responses, indicate whether you strongly disagreed with the statement (SD), Disagree (D), Undecided (U), Agree (A) or Agree Strongly (SA)

Counselling Care Offered to Postpartum Mothers Following Perinatal Deaths	**SD 1**	**D 2**	**U 3**	**A 4**	**SA 5**
The mothers are informed about the availability of counseling services shortly after their baby's death.					
The mothers are offered counseling care at the hospital or immediately after discharge.					
There is adequate information provided about how to access grief counseling services.					

The counselor help mothers to navigate the challenges of being a mother after perinatal loss.					
The hospital does follow-up care after the initial counseling session(s).					
The counselor provide useful information on how to handle future pregnancies or family planning					
The mothers are free to reach out for further counseling sessions when needed additional support.					
The mothers feel supported during postpartum recovery by the counseling services offered.					
The counselors are empathetic and understanding of mothers grief.					

Section C: Sociocultural factors affecting postpartum mothers following perinatal deaths

5. Please respond to the following statements with your opinion on Sociocultural factors affecting postpartum mothers following perinatal deaths. In the responses, indicate whether you strongly disagreed with the statement (SD), Disagree (D), Undecided (U), Agree (A) or Agree Strongly (SA)

Sociocultural factors affecting postpartum mothers following perinatal deaths	**SD 1**	**D 2**	**U 3**	**A 4**	**SA 5**
Cultural or religious beliefs have influenced the way mothers grieve after perinatal loss.					
Cultural traditions or religious rituals help mothers cope with the emotional pain of losing a baby.					
Religion provides mothers with guidance or comfort during their grieving process					
The community or social network (e.g., friends, extended family, neighbors) provided emotional support during grief.					
There is societal pressure for mothers to return to "normal" after a loss, which makes grieving process harder.					
The general public is not very understanding of the emotional impact of perinatal loss.					
Society views the grief of mothers who experience perinatal loss as less significant compared to other types of loss (e.g., death of an older child).					
There is a lack of public or social acknowledgment of grief, which make mothers feel more isolated.					
Mothers encounter stigma or judgment from others because of grief following perinatal loss.					

Appendix 5: Perinatal Grief Scale

PERINATAL GRIEF SCALE 33 Item Short Version

Lori J. Toedter, Ph.D. Moravian College & Judith N. Lasker, Ph.D. Lehigh University

Scoring Instructions

The total PGS score is arrived at by first reversing all of the items EXCEPT 11 AND 33. By reversing the items, higher scores now reflect more intense grief.

Then add the scores together. The result is a total scale consisting of 33 items with a possible range of 33-165.

The three subscales consist of the sum of the scores of 11 items each, with a possible range of 11-55.

Present Thoughts and Feelings about your Loss

Each of the items is a statement of thoughts and feelings which some people have concerning a loss such as yours. There are no right or wrong responses to these statements. For each item, circle the number which best indicated the extent to which you agree or disagree with it at the present time. If you are not certain, use the "neither" category. Please try to use this category only when you truly have no opinion.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. I feel depressed	1	2	3	4	5
2. I find it hard to get	1	2	3	4	5
along with certain people.	1	2	3	4	5
3. I feel empty inside	1	2	3	4	5
4. I can't keep up with my normal activities.	1	2	3	4	5
5. I feel a need to talk about the baby.	1	2	3	4	5
6. I am grieving for the baby.	1	2	3	4	5
7. I am frightened.	1	2	3	4	5
8. I have considered suicide since the loss	1	2	3	4	5
9. I take medicine for my nerves.	1	2	3	4	5
10. I very much miss the baby.	1	2	3	4	5
11. I feel I have adjusted well to the loss.	1	2	3	4	5
12. It is painful to recall memories of the loss.	1	2	3	4	5
13. I get upset when I think about the baby					
14. I cry when I think about him/her.	1	2	3	4	5

15. I feel guilty when I think about the baby	1	2	3	4	5
16. I feel physically ill when I think about the baby	1	2	3	4	5
17. I feel unprotected in a dangerous world since he/she died.	1	2	3	4	5
18. I try to laugh, but nothing seems funny anymore.	1	2	3	4	5
19. Time passes so slowly since the baby died. 20. The best part of me died with the baby.	1	2	3	4	5
21. I have let people down since the baby died.	1	2	3	4	5
22. I feel worthless since he/she died.	1	2	3	4	5
23. I blame myself for the baby's death.	1	2	3	4	5
24. I get cross at my friends and relatives more than I should.	1	2	3	4	5
25. Sometimes I feel like I need a professional counselor to help me get my life back together again.	1	2	3	4	5
26. I feel as though I'm just existing and not really living since he/she died.	1	2	3	4	5
27. I feel so lonely since he/she died.	1	2	3	4	5
28. I feel somewhat apart and remote, even on friends	1	2	3	4	5
29. It's safer not to love	1	2	3	4	5
30. I find it difficult to make decisions since the baby died.	1	2	3	4	5
31. I worry about what my future will be like.	1	2	3	4	5
32. Being a bereaved parent means being a "Second-Class Citizen".	1	2	3	4	5
33. It feels great to be alive	1	2	3	4	5

Appendix 6: Application to Authorization

Doreen Kawira Mbae,
Kirinyaga University,
P.O Box 143-10300, Kerugoya.
29TH May 2025.
P. No: 0726150076
Email: *daurlkson@gmail.com*

TO:
The County Director of Health,
Tharaka Nithi County,
P.O Box 10-60406,
Kathwana.

RE: REQUEST FOR AUTHORIZATION TO CONDUCT RESEARCH.

Dear Sir,

I am a post graduate student at Chuka University pursuing a Degree of Doctor of Philosophy in Nursing. I kindly request for authorization to collect research data within Tharaka Nithi County for the purpose of academic research.

I am currently conducting a research study titled **"EFFECT OF INDIVIDUALISED GRIEF COUNSELLING ON POSTPARTUM MOTHERS PSYCHOLOGICAL WELL BEING, FOLLOWING PERINATAL DEATHS IN THARAKANITHI COUNTY" a**s part of the requirements for my Degree Program at Chuka University. Please be assured that all data collected will be treated with the utmost confidentiality and used solely for academic purposes. Additionally, participation will be voluntary, and all ethical standards and protocols will be strictly followed.

Attached to this letter are copies of the research proposal, institutional authorization letter, research license from NACOSTI and ethical review committee letters for your review.

I would greatly appreciate your consideration of this request.
Thank you.

Yours faithfully,

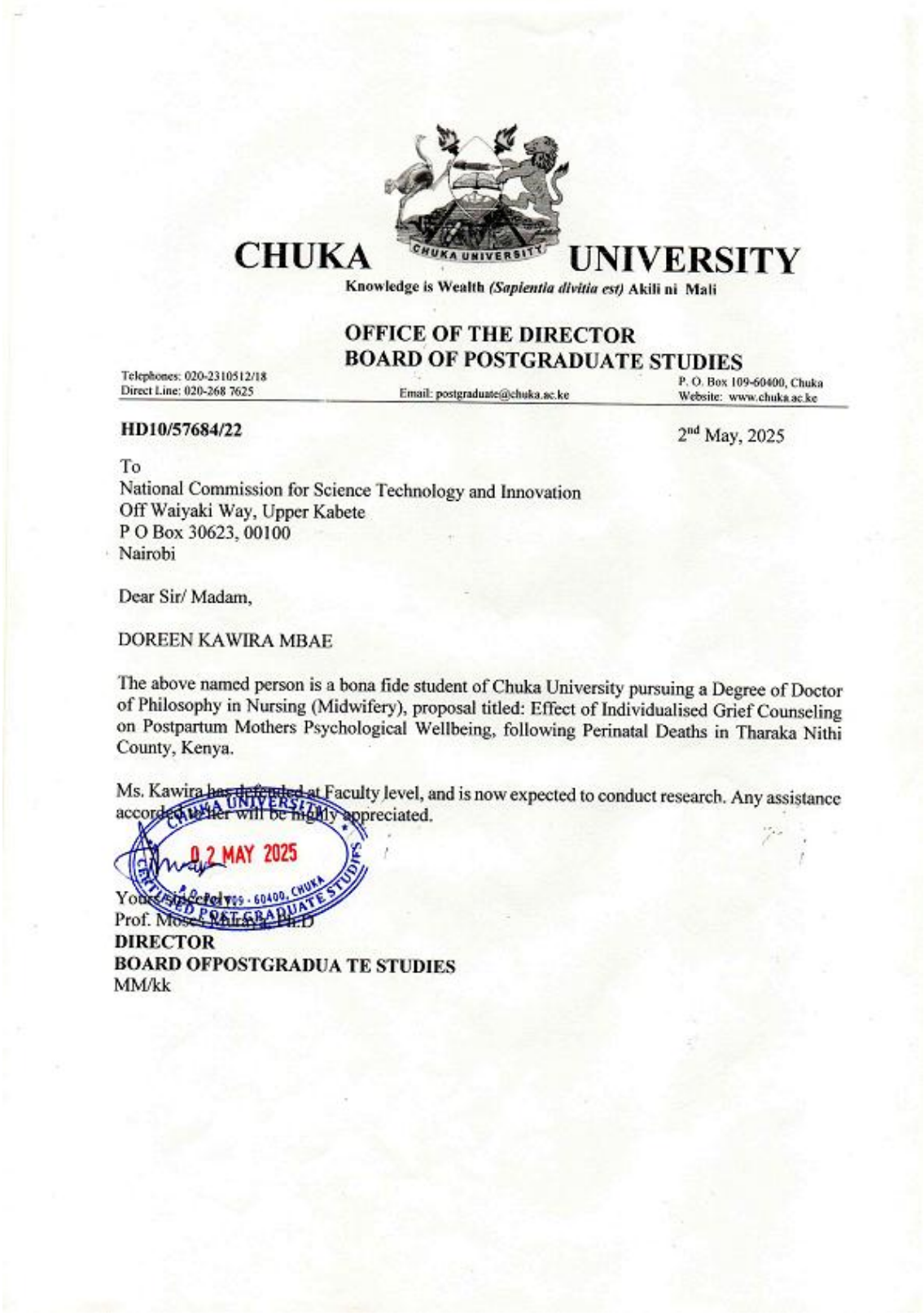
Kawira Mbae

Doreen Kawira Mbae

HD10/57684/22

(Researcher)

Appendix 7: Post Graduate School Clearance Letter



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HD10/57684/22

2nd May, 2025

To
National Commission for Science Technology and Innovation
Off Waiyaki Way, Upper Kabete
P O Box 30623, 00100
Nairobi

Dear Sir/ Madam,

DOREEN KAWIRA MBAE

The above named person is a bona fide student of Chuka University pursuing a Degree of Doctor of Philosophy in Nursing (Midwifery), proposal titled: Effect of Individualised Grief Counseling on Postpartum Mothers Psychological Wellbeing, following Perinatal Deaths in Tharaka Nithi County, Kenya.

Ms. Kawira has defended at Faculty level, and is now expected to conduct research. Any assistance accorded to her will be highly appreciated.

CHUKA UNIVERSITY
CERTIFIED POST GRADUATE STUDIES
P.O. BOX 109 - 60400, CHUKA
02 MAY 2025

Yours faithfully,
Prof. Moses Muriuki, Ph.D
DIRECTOR
BOARD OFPOSTGRADUA TE STUDIES
MM/kk

Appendix 8: Approval by Chuka University Ethics Committee

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CHUKA UNIVERSITY INSTITUTIONAL ETHICS REVIEW COMMITTEE

Telephones: 020-2310512/18
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Email: info@chuka.ac.ke,
P. O. Box 109-60400, Chuka
Website: www.chuka.ac.ke

25th April, 2025

REF: CUIERC/ NACOSTI/732
TO: **Doreen Kawira Mbae**

RE: Effect of Individualized Grief Counselling on Postpartum Mothers Psychological Wellbeing, Following Perinatal Deaths in Tharaka Nithi County, Kenya.

This is to inform you that *Chuka University IERC* has reviewed and approved your above research proposal. Your application approval number is *NACOSTI/NBC/AC-0812.* The approval period is 25th April, 2025 – 25th April, 2026.

This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by *Chuka University IERC.*
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to *Chuka University IERC* within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to *Chuka University IERC* within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to *Chuka University IERC.*

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely

Dr. Benjamin Kanga
SECRETARY

INSTITUTIONAL ETHICS REVIEW COMMITTEE
25 APR 2025
P.O. Box 109-60400 CHUKA
CHUKA UNIVERSITY

Appendix 9: Research Authorization at Kibung'a Sub District Hospital

COUNTY GOVERNMENT OF THARAKA NITHI

DEPARTMENT OF HEALTH SERVICES AND SANITATION

Facility In-charge
Kibungá Sub-County Hospital
P O Box 5 -60215
MARIMANTI

Phone: 0797658696
Email: kibungahosp@gmail.com

REF. TNC/KSDH/ATT/VOL.5/136

9TH JUNE 2025

Ms Doreen Kawira Mbae
Kirinyaga University
P. O. Box 143-100300
Kerugoya

Dear Madam,

RE: RESEARCH AUTHORIZATION

Following your application on the above subject, your request to carry out a research in Kibung'a sub-county hospital on **"Effects of individualized grief counseling on postpartum mothers psychological wellbeing, following perinatal deaths in Tharaka-Nithi county, Kenya"** for the period ending 25th April 2026.
During the study period you are required to note the following;
1. Compliance with the research regulations and authority
2. The period of stay in the hospital should not exceed the stated duration.

We wish you well as you conduct the study.

MEDICAL OFFICER IN-CHARGE
KIBUNG'A SUB-COUNTY HOSPITAL
P. O. Box 5, MARIMANTI

Joshua Muthigani
Facility In-charge
Kibung'a Sub-district Hospital

Appendix 10: Research Authorization by County Director of Health

COUNTY GOVERNMENT OF THARAKANITHI

DEPARTMENT OF HEALTH SERVICES AND SANITATION

OFFICE OF THE DIRECTOR

P. O. BOX 10, 60406
KATHWANA

Email: countyhealthdirector@gmail.com

REF: TNC/CDH/R/VOL.2/136 **DATE: 30th May, 2025**

TO:
DOREEN KAWIRA MBAE
KIRINYAGA UNIVERSITY
PO BOX 143-10300,
KERUGOYA.

RE: RESEARCH AUTHORIZATION FOR DOREEN KAWIRA MBAE.

Following your application for authority to carry out research in Chuka, Kibung'a, Magutuni and Marimanti, Tharaka Nithi County on **"effects of individualized grief counseling on postpartum mothers psychological wellbeing, Following perinatal deaths in Tharaka Nithi County" KENYA"** for the period ending: **25th April, 2026**, I am pleased to inform you that your request to carry out the exercise has been approved.

Ensure that you comply with the research Regulations and Ethics. After the completion of the research you are required to give a copy of research report to the Department of Public Health, Medical Services and ICT

This approval is valid for the stated duration of your research.

Wishing you all the best.

Thank you.

COUNTY DIRECTOR HEALTH
THARAKA NITHI
30 MAY 2025
P. O. Box 10 - 60406,
KATHWANA

Dr. Elijah Kameti
County Health Director
Tharaka Nithi

CC:
- Sub county MOH Chuka, Maara and Tharaka South
- Medical Superintendent, Chuka, Magutuni and Marimanti
- The In-charge Kibung'a

Leaving No One Behind | Haven Of Value Addition

Appendix 11: Research Authorization at Chuka County Referral Hospital

THARAKA NITHI COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES AND SANITATION
CHUKA REFERRAL HOSPITAL
OFFICE OF THE MEDICAL SUPERINTENDENT
P.O. BOX 8 – 60400
CHUKA
CELL: 0728 226 333 **EMAIL**: medsuptchuka@gmail.com
When replying please quote:
REF: CKA/MED/T/16/VOL.VI/355 **DATE: 10TH JUNE, 2025**

DOREEN KAWIRA MBAE
REG NO: HD10/57684/22
ID NO: 24726334

RE: NO OBJECTION TO REQUEST FOR AUTHORIZATION TO COLLECT DATA AT CHUKA COUNTY REFERRAL HOSPITAL

The above subject refers.

Following your request via institution letter dated **2nd May, 2025**, and your application letter dated **10th June 2025**, for an opportunity to carry out data collection on **"effects of individualized grief counselling on Postpartum mothers psychological wellbeing, following perinatal deaths in Tharaka Nithi Count" in Chuka County Referral Hospital from 10th June, 2025, to 25th April, 2026,** your request has been granted.

This is subject to the following;

- That you will adhere to all the Ethical Guidelines for your research as stipulated in your Institutional Ethics Review Committee recommendations.
- That you will commit to share your research findings with the Hospital for purposes of Quality Improvement in Service Delivery.
- That the data collection exercise will not interfere with service delivery at the hospital.

If the conditions stipulated above are acceptable to you, kindly sign below:

NAME Doreen Mbae **SIGN** **DATE** 10/6/25

ENID KARIMI MBAKA
HUMAN RESOURCE OFFICER
CHUKA COUNTY REFERRAL HOSPITAL

CRH
CHUKA REFERRAL HOSPITAL
P.O BOX 8 - 60400, CHUKA.
TEL:0728 226 333
10 JUN 2025
Email: medsuptchuka@gmail.com
MEDICAL SUPERINTENDENT
CRH

Appendix 12: Research Authorization at Magutuni Sub District Hospital

COUNTY GOVERNMENT OF THARAKANITHI

DEPARTMENT OF HEALTH SERVICES AND SANITATION

MAGUTUNI SUB COUNTY HOSPITAL

Tel: 0753792760

P. O. BOX 10, 60401
MAGUTUNI

Email: magutuni@gmail.com

Ref: MGTN//VOL. 1/2/2025

Date: 09TH JUNE2025

MS DOREEN KAWIRA MBAE
KENYA MEDICAL TRAINING COLLEGE
P.O BOX 10- 60401
MAGUTUNI

RE: RESEARCH AUTHORIZATION

Reference is hereby made to your application on the above subject.

Your request for authority to carry out research in Magutuni Level IV Hospital on effects of targeted Health Messages on breastfeeding practices among Teenage Mothers attending public hospitals in Tharaka Nithi County, KENYA" for the period ending 25th April 2026, has been approved subject to the following:

i. Compliance with the research regulations and ethics
ii. The period of stay will be as per the stated duration of your research.

Wishing you well as you conduct your exercise.

MAGUTUNI DISTRICT HOSPITAL
MEDICAL SUPERINTENDENT
Sign.....
P. O. Box 10 MAGUTUNI

Dr. Christine Mbaka
Medical Superintendent
MAGUTUNI SUB COUNTY HOSPITAL

Appendix 13: Research Authorization at Marimanti Level IV Hospital

COUNTY GOVERNMENT OF THARAKA NITHI

DEPARTMENT OF HEALTH SERVICES AND SANITATION

Phone: 0729209880/0713216724
Email: marimantil4h@gmail.com

Office of the Medical Superintendent
Marimanti Level IV Hospital
P O Box 5 - 60215
MARIMANTI

OUR REF: TNC/TDH/ATT/VOL.5/186 **DATE:** 9th June 2025

Ms Doreen Kawira Mbae
Kirinyaga University
P O Box 143-10300
KERUGOYA

RE: RESEARCH AUTHORIZATION

Reference is hereby made to your application on the above subject.

Your request for authority to carry out research in Marimanti Level IV Hospital on **"Effects of Individualized Grief Counseling on Postpartum Mothers Psychological Wellbeing, Following Perinatal Deaths in Tharaka Nithi County, KENYA"** for the period ending 25th April 2026, has been approved subject to the following:

i. Compliance with the research regulations and ethics.
ii. The period of stay will be as per the stated duration of your research.

Wishing you well as you conduct your exercise.

MARIMANTI LEVEL IV HOSPITAL
P. O. Box 5, MARIMANTI
0 7 JUN 2025
MEDICAL SUPERINTENDENT

Angelica Mutuura
Human Resource Management Officer
FOR MEDICAL SUPERINTENDENT

Appendix 14: National Commission for Science, Technology and Innovation (NACOSTI) Research License

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 735547

Date of Issue: 22/May/2025

RESEARCH LICENSE

This is to Certify that Ms.. DOREEN MBAE KAWIRA of Chuka University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Tharaka-Nithi on the topic: EFFECT OF INDIVIDUALIZED GRIEF COUNSELLING ON POSTPARTUM MOTHERS PSYCHOLOGICAL WELLBEING, FOLLOWING PERINATAL DEATHS IN THARAKA NITHI COUNTY, KENYA for the period ending : 22/May/2026.

License No: NACOSTI/P/25/4173686

735547

Applicant Identification Number

Deputy Director
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions