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Evaluation Of Perinatal Loss Experience, Level of Support and Coping Among Bereaved Mothers Attending Secondary Health Facilities in Asaba, Delta State

Aninze, Patience, Dr Chizoma Ndikom and Mrs Nkwocha Chioma
Center for Public Health and Toxicological Research University of Port Harcourt
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Abstract

Evaluation of Perinatal Loss Experience, Level of Support and Coping among Bereaved Mothers Attending Secondary Health Facilities in Asaba, Delta State. Three research questions guided the study. The design of the study was a qualitative and quantitative research design. The population of this study comprised an accessible population of 300 Bereaved Mothers Attending Secondary Health Facilities in Asaba, Delta State while the sample size was 188 Bereaved Mothers Attending Secondary Health Facilities in Asaba, Delta State. The result revealed 25.5% of the respondents were between the age of 20 – 25years, 37.3% were between 26 – 30years, 21.4% were between 31 – 35years while 20.8% were between 36years and above, 54% of the respondents had between 1 – 3 children, while 46% had 4 children and above, 61.4% of the respondents had none, primary and secondary education, 22.5% had HND and B.Sc while 16.1% had master PhD and professional. The study further revealed that the women's experiences following perinatal loss were anger, psychological pain, grief and depression which are often neglected by health care provider. The study also revealed that the level of emotional and psychological support provided to perinatal loss bereaved mothers by healthcare workers and other family members were ranged from emotional support such as encouragement, counselling, and assistance. The coping mechanisms adopted were discussing with people and accepting the reality of fact that it has happened (stoicism). The study concluded that mothers who experienced a perinatal death were affected emotionally, physically, socially and economically. Unsupportive behavior of health care providers, financial constraints and feelings of guilt aggravated the grief reactions. This study therefore recommends that there is need to train health care providers in bereavement care, counselling and integration of psychological support system as a crucial part of health care delivery service to better support the grieving mothers navigate the grieving process and its associated complications

Keywords: *Perinatal, Support, Coping, Bereaved Mothers*

INTRODUCTION

The loss of a baby during pregnancy and immediate neonatal period is a painful experience for many women. Perinatal loss is an umbrella term used to describe fetal death as a result of miscarriage(abortion), stillbirth, and neonatal death. The overall prevalence is 15 to 25% for women within the age range of 25 and 29 years with Nigeria estimated to record 12.2% making Nigeria a substantial contribution to the global burden of perinatal loss. Perinatal loss is a major public health challenge especially in developing countries with the largest proportion of the world perinatal loss occurring in late preterm, term and intrapartum period. Globally, the incidence of abortion is approximately 35 per 1000 women. In 2015, there were approximately 2.6 million estimated global stillbirths (Sedgh *et al*., 2016). Perinatal death occurs between the 22nd full week of gestation or when the baby weighs 500 g and 7 days after birth. In spite of its decrease globally, however, about 2% of pregnancies end in stillbirth (Nappi *et al.*, 2016).

The World Health Organization (2019) defines perinatal mortality as "the number of stillbirths and deaths that occur in the first week of life while others include miscarriage and neonatal deaths up to 28 days after birth in the definition of perinatal loss". Perinatal loss is the death of a foetus through intra-uterine death, stillbirth, or neonatal death (Depoers-Beal *et al.*, 2019) Perinatal loss experience is characterized by a woman who has had at least one history of fetal death in her lifetime leading to a severe feeling of sadness and grief. Mothers are believed to be at an increased risk of severe grief and significant life crisis following perinatal loss experience. (Meredith *et al*., 2017; Moore and Côté-Arsenault, 2018; Fenstermacher and Hupcey, 2019; Gandino et al., 2019).

The global perinatal death rate is estimated at around 2.7 million deaths per year (Lawn et al., 2016). In Europe, the average perinatal death rate is 5.5 deaths for every 1000 live births and is lower in Spain with 4.43 deaths for every 1000 live births representing about 2000 affected families each year (Hutti *et al*. 2016). The loss of an infant is the most traumatic and devastating life event of all the pregnancy losses a woman may experience in her lifetime.

Perinatal death is one of the most painful traumatic experiences for parents and families who have to undergo grieving and coping processes that include biological, psychological, social and spiritual aspects (Rosenbaum et al., 2015). Although parents have not built up a relationship with the loss infant. Grief after pregnancy loss does not differ significantly in intensity from other loss scenario. Perinatal loss experience entails a normal and highly individualized process with multiple biopsychosocial repercussions (Burden *et al.*, 2016). Perinatal bereavement is a global healthcare problem that may cause serious psychological problems to bereaved women and their families (Lawn *et al*., 2016). The loss of an infant is the most stressful, traumatic, and devastating life event of all the possible pregnancy losses mothers may experience (Adekanbi *et al.*, 2015).

Following a perinatal loss, a woman might experience a wide range of emotional instability leading to psychological problems, low self-esteem, complicated grieving process, consequently might find themselves in shock or disbelief, loss of interest in normal activities, and self-blame particularly in subsequent pregnancy loss, with significant depression and anxiety (George *et al.*, 2015). The high level of complicated grieving process are generally associated with a poorer state of the mothers mental health, lack of support and insensitivity from families and health care workers which may exacerbate the trauma of perinatal loss experience. Self-blame may prolong the grieving process especially if there's a feeling of

ambivalence towards pregnancy loss or the mother perceived to have done something wrong. Women who experience a pregnancy with subsequent pregnancy loss are vulnerable to developing post-traumatic stress disorder.

The physical symptoms of perinatal loss experience include decreased appetite, weight loss, insomnia, increased chronic diseases, and decreased quality of life (Bhat and Byatt, 2016). On a psychological level, parents who suffer perinatal death have a greater predisposition to suffer anxiety, depression, post-traumatic stress syndrome, and even an increased risk of suicidal attempt (Gravensteen et al., 2018; Chung and Reed, 2017). In the family environment, the death of a baby modifies family relationships and changes the behavior and type of care for older children varying from overprotection to the distancing of other children and neglect of parental obligations and roles (Gopichandran et al., 2018). Perinatal loss experience also affects older siblings who experience feelings of guilt, fear, anxiety and misunderstanding over the occurrence The couple's life is also affected as they may become distant from each other, and there is an increase in the frequency of conflicts and marital strife. (Tseng *et al.,* 2017).

Perinatal loss and maternal mortality are major public health challenges especially in developing sub-Saharan countries (Ghimire *et al.* 2019). Perinatal loss is one of the devastating pregnancy outcomes affecting millions of mothers and families in many low and middle-income countries. Most developing countries in west and central Africa still experience high maternal and perinatal deaths despite a decade of maternal and perinatal death review programs. This accounts for ten times higher rate of perinatal loss occurrence when compared with high income countries making Nigeria a substantial contribution Perinatal loss can significantly affect marital relationships which may further lead to separation and divorce, possible suicidal attempt, withdrawal and isolation from social life is not easily minimized (Heazell *et al.*, 2016).

Losing a newborn fetus can lead to feeling of sadness and grief (Onaolapo *et al.*, 2020). Currently, loss of any pregnancy through stillbirth, intrauterine fetal death, or neonatal death presents a significant life crisis for any woman. It has far-reaching implications for a couple's future aspirations and goals in life. Stress, depression, substance and alcohol abuse with other related mental health problems are some traumatic events following a mother's failure to cope after perinatal loss. It potentially drains the bereaved mothers and other family members with subsequent lifestyle changes. Mothers are believed to be at an increased risk of post-traumatic stress disorder following perinatal loss. (Clossick, 2016). Studies has shown that depression and anxiety were highly associated with a previous pregnancy loss which may have a persisting pattern that continues after the birth of a subsequent healthy child (Lafarge, 2016).

Even though a significant reduction in child mortality has been recorded recently in Ethiopia, its perinatal loss is highest in Sub-Saharan Africa and perinatal death in Wolaita Sodo is tremendously high, which requires significant attention (Ababa, 2019). Women pregnant after a previous perinatal loss experience are skeptical about their health and subsequent pregnancy outcome. In many cases, there is a risk that the sadness and anxiety felt by individuals and families affected may go on to cause longer-term problems (Clossick, 2016). Loss of interest in normal activities, fear of an impact and losing another baby in the future, emotional instability, lack of support from others, fear of bad news from society, and impact on self and the baby were the most common emotions reported by women following a perinatal loss (Lafarge, 2016). Planning another pregnancy following perinatal loss is still difficult, full of

ambivalence and doubts regardless of this challenge most women become pregnant within a year following perinatal loss

Evaluation of perinatal loss experience has shown that the level of support and coping strategies plays a crucial role in helping the bereaved mother navigate their pregnancy loss experience. The health care professionals also play a vital role in providing support and support system during this challenging time to the bereaved mother and families has she copes with the grief and the grieving process

1.3 Aim and Objectives of the study

The aim of the study is to evaluate the perinatal loss experience, level of support and coping among bereaved mothers attending Secondary Health facilities in Asaba, Delta State.

The specific objectives of the study are to:

1. Explore the perinatal loss experience of bereaved mothers.
2. Identify level of emotional and psychological support provided to perinatal loss bereaved mothers.

METHODLOGY

A mixed research method was used consisting of a quantitative descriptive cross-sectional study design and a qualitative in-depth interview research design to survey a sampled population and obtain numerical and qualitative data on various aspects of perinatal loss experience, level of support and coping among bereaved mothers attending secondary health facilities in Asaba, Delta state. **A** target population of 300 women who had experienced miscarriage, stillbirth or neonatal death within the last two years and were cared for by the three secondary health facilities in Asaba, Delta state were the target population for the research study. A sample size of 188 bereaved mothers who experienced forms of perinatal loss were sampled out of a total population of 300 bereaved mothers through a purposive sampling technique was adopted. Questionnaire and in-depth interview guide was used to collect both quantitative and qualitative data. The data analysis used in this study served as a process of inspecting, transforming and interpreting numerical data to obtain information draw conclusion and support decision making on perinatal loss experience, level of support and coping among bereaved attending secondary health facilities in Asaba, Delta State. Result was presented with the use of Statistical Package for Social Sciences (SPSS version 25).

RESULTS

Demographic Data

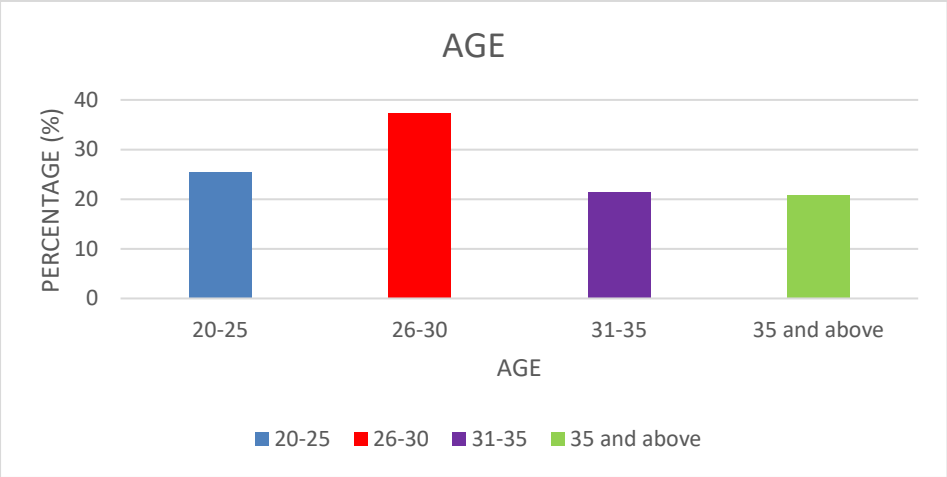

Fig. 4.1: Frequency distribution and percentage of age.

The result in fig. 1 shows that 25.5% of the respondents were between the age of 20 – 25years, 37.3% were between 26 – 30years, 21.4% were between 31 – 35years while 20.8% were between 36years and above.

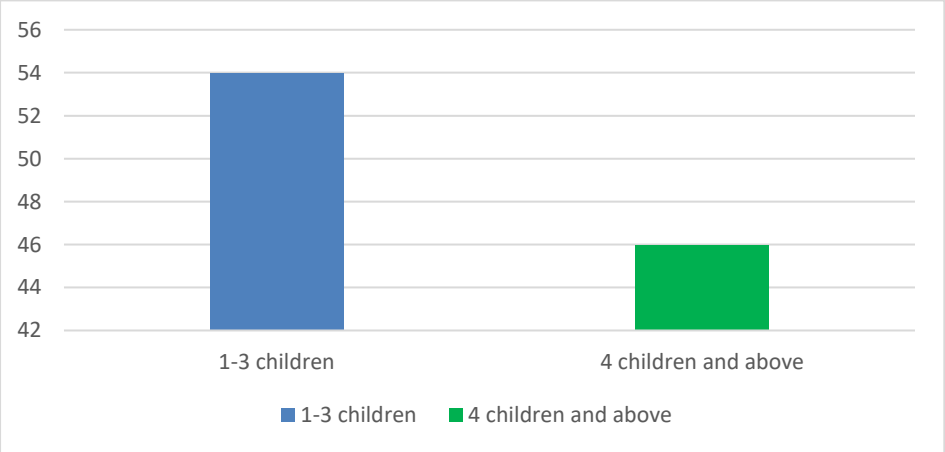

Fig. 4.2. Frequency distribution and percentage of parity.

Fig. 4, revealed that 54% of the respondents had between 1 – 3 children, while 46% had 4 children and above.

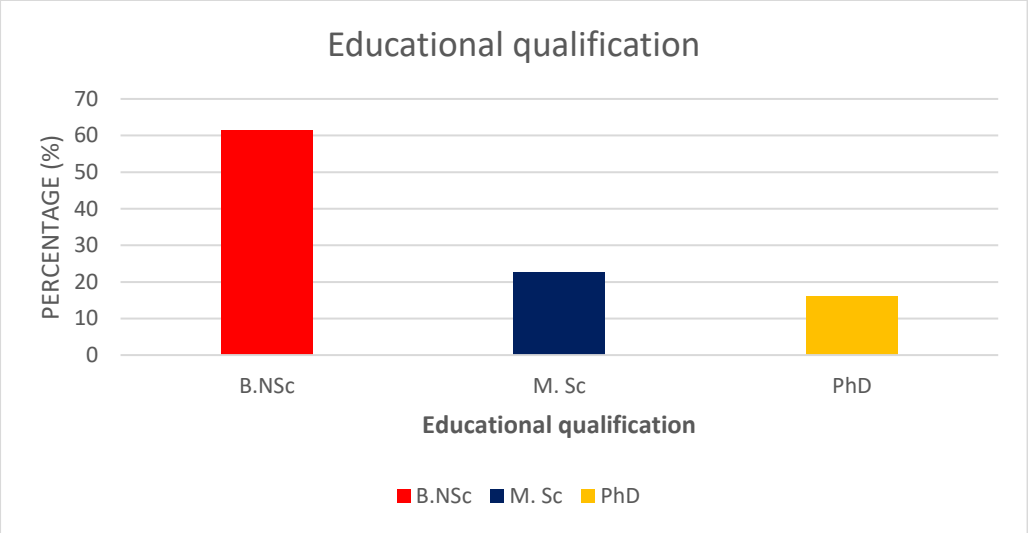

Fig. 4.3: Frequency distribution and percentage of educational qualification.

Fig 2, reveals that 61.4% of the respondents had none, primary and secondary education, 22.5% had HND and B.Sc while 16.1% had masters, Ph.D and professionals.

Table 4.1: Mother's experiences following perinatal loss.

S/N	EXPERIENCE	Yes	No
1	I was slightly annoyed and angry	150 (80%)	38 (20%)
2	I Accepted loss as a fate	142 (75%)	46 (35%)
3	I could not communicate with people for months	113 (60%)	75 (40%)
4	I was frustrated, confused and battered	160 (85%)	28 (15%)
5	I felt guilty and self-blamed	170 (90%)	18 (10%)
6	I lacked understanding and support of health care professionals.	160 (85%)	28 (15%)
7	I avoided every discussion that reminds me of the death and loss	132 (70%)	56 (30%)

Table 4.1 revealed that mother's experiences following perinatal loss were anger, feeling frustrated, confused, avoiding every discussion that reminds me of the death and loss. The study further revealed that four different themes to elicit bereaved mothers reactions and experience following perinatal loss.

Deprived care

The theme described perceptions of bereaved mother on healthcare services rendered during the period leading to the perinatal loss. Bereaved mother generally felt that adequate care was not provided when it was needed nor giving in a safe and effective manner. This has contributed

to the loss of their babies and thus, described it as a painful and traumatic experience for them. There were two sub-themes under this theme, poor communication and negligence.

Poor communication

Most Participants generally felt that communication between them and the health providers was inadequate. This has led to intense tension between mothers and the health care provider, thereby, making it so difficult for mothers to express their feelings or communicate their needs even when she feels her baby needs attention due to a deteriorating condition. Thus, participants could not get attention from the health provider as they would have expected, making these bereaved mothers to conclude that poor communication between them and the health care providers has contributed to the poor outcomes of the care that they received.

I could not establish rapport with her [nurse] and even when I realized that there was something wrong with the baby's eye which made me scared, I could not tell her because there was tension between us ***(Participant 1).***

They [midwife] do not get to communicate with me. So, when my baby was having a [high] temperature, I could not inform her because there was no communication at all between us. I felt she was un approach and I didn't want any issues ***(Participant 2).***

Negligence

The second sub-theme described the moment when participants felt that health care providers had neglected their duty of care and did not demonstrate interest toward patients care While some participants could not communicate their requests for care to the health care provider because of seeming tension, some of the bereaved mother who did felt that nurse either failed to act appropriately or delayed in providing the appropriate care for their babies as required. *I asked her [nurse] about the oxygen the doctor requested her to administer to my baby. I remember that terrible look on that nurse's face. she rolled her eyes at me and walked away. She wasted so much time in bringing the oxygen for my baby I felt so bad and helpless* ***(Participant 5).***

My baby became so hot to touch so I went to the nurses and told them to& please call the doctor for me. One of them shouted at me that I complained too much and I should go back to my bed, another nurse said she's eating while the last nurse was busy with her phone, ***the three of them never shown concern*** *"I think it is the nurse's negligence because if at least one of nurse had attended to me, they would have saved my baby" I will never forget what they did to me. I lost my joy, my world turned upside down* ***(Participant 7)***

Avoidance

Avoidance was used as coping strategy by bereaved mothers of perinatal loss but this was not always by choice rather enforced by others such as family members or as a result of cultural beliefs. Certain cultural beliefs discourage bereaved mothers from speaking or thinking about the deceased baby, it is believed to be an effective method of coping and prevent future fertility

issues. Consequently, mothers avoid thinking or speaking about their baby's death by placing focus on others things or engaging in other activities, although some mothers longed to speak about it as a means of expressing their minds and ease of psychological effect following the pregnancy loss.

"even the pictures we took of the baby have been seized by my uncles, in a bid to help me not talk or remember the event, to prevent me from crying or being sad…They [my family] said if I talk or think about it so much, I will be so depressed and also that chances of having another baby will be so slim". (participant 11)

Table 4.2: level of emotional and psychological support provided to perinatal loss bereaved mothers by healthcare workers and other family members.

S/N	LEVEL OF SUPPORT RECEIVED AND PROVIDED	Yes	No
1	Had professional-based support from health provider	150 (80%)	38 (20%)
2	Received adequate emotional support from partner	142 (75%)	46 (35%)
3	Received adequate emotional support from other family members	160 (85%)	28 (15%)
4	Received emotional support including provision of quality health care for subsequent pregnancies	132 (70%)	56 (30%)

Table 4.2 revealed that women who had perinatal loss had professional-based support from health provider, received adequate emotional support from partner, received adequate emotional support from other family members and received emotional support including provision of quality health care for subsequent pregnancies. The study further revealed that;

Support from partners, family and community

Respondents gave different opinions about the support received during the pregnancy loss. some reported that the relationship between bereaved women, partners and families and with the community were impacted either positively or negatively by perinatal death. It is believed that existing relationship is associated with the support provided. Some reported that the bond with their partners was strengthened as they lived through and coped with the grief jointly. The sustenance of relationship was in some cases reliant on its quality relationship prior to perinatal death. This could be strengthening the bond between partners or result in marital strife and conflicts.

I have the most amazing and supportive husband in the whole world…he did not let me feel bad despite that I lost my baby. Our relationship never changed. He is so funny and dramatic that all his dramatic acts in the house make me forget my loss" nothing has change for us, more babies will come ***(Participant 18)***.

However, some mothers experienced breakdown in relationships due to their baby's death which caused marital strife, sadness and regret for some couples resulting in withdrawal and staying them apart. This was also precipitated in a few cases where bereaved mothers were blamed by partners, and extended family members for the death of the baby Thus, mothers experienced marital strife, separation, emotional and verbal abuse from partners, family members including co-wives and stigmatization in and by communities causing some mothers experience of post-traumatic stress disorder and poor mental health

"I had a previous [pregnancy] loss, and this again! At a point my husband started frustrating me, coming back home late at night, refuse to eat my food, make life unbearable for me, anytime l sees him, my heart cut…he even threatened to bring in another woman as a wife" it was hell for me, l regretted marrying him. I became a laughing stock, life become uninteresting, **(Participant 13)**.

Discussion

This study aimed at exploring the experiences of perinatal bereaved mothers regarding their pregnancy loss. The study categorized participants' experiences into four main themes – deprived care, poor communication, negligence and avoidance were examined to elicits bereaved mother's immediate reactions to the loss, painful reminders of the loss, and coping strategies adopted. Many participants felt that poor communication between them and the health providers as well as negligence to their duties contributed to the death of their baby. Indeed, similar feelings of mismanagement by health care workers or a lack of enthusiastic care contributing to perinatal loss have been reported in other study carried out. This is in line with the study carried out by Caelli et al., 2018.which posits that such feelings by bereaved mothers are likely to be engender with anger and feelings of mistrust towards health care providers during perinatal loss experience.

Perinatal bereaved mothers tend to feel guilty, blaming themselves for not being careful enough or taking appropriate actions that would have prevented the death, even when they are told that they are not to blame (Caelli et al., 2018; Frost et al., 2017; Gausia et al., 2019). Participants in this current study were not exempted from such guilt feelings. This feeling of guilt is compounded when others infer that bereaved mothers are to blame and, in some cases, seek to punish them for that. In an Ethiopian study, women who had experienced multiple perinatal losses were blamed, mistreated, or even divorced (Sisayet al., 2014). Although most bereaved mothers in this study did not report being blamed, stigmatized or maltreated for their loss, one participant shared how her husband had threatened to bring in another woman as a wife should she fail to have a successful pregnancy and a positive pregnancy outcome. In line with a study carried out by Caelli et al., 2018; Meredith et al., 2017; Moore and Côté-Arsenault, 2018 opined that such feelings of guilt and self-blame has the potential to affect mother's self-esteem leading them to question their capacity to carry a pregnancy to term and/or even mother a child, and this is strongly brought to the fore when another pregnancy occurs.

Specific interventions to manage such potential situations have been advocated for (Caelli et al., 2018; Kelley and Trinidad, 2019; Meredith et al., 2017; Moore and Côté-Arsenault, 2018). Guilt has also been associated with depression among perinatal bereaved mothers (Gausia et al., 2018). Continuous reassurance of bereaved mothers that they did not cause the death helps in dealing with feelings of guilt (Kelley and Trinidad, 2019). Denial has also been reported among some perinatal bereaved mothers as part of their initial reactions to the loss as

implicated.in line with Elisabeth kubbler theory in her book" death and dying "a study on dying people proposed the patient focused pattern and identify the five stages of grieving process observed by most bereaved mother and other death scenario. These stages are Denial. anger. bargaining, depression and acceptance. Efforts should be directed to mitigate symptoms of pregnancy loss (Kalu et al., 2018).

The level of emotional and psychological support provided to perinatal loss bereaved mothers by healthcare workers and other family members is crucial in aiding these mother navigate through their grieving process. Research has shown that mothers dealing with perinatal loss experience a wide range of emotions over an unpredictable period, yet the support they receive is often insufficient .According to Fenstermacher & Hupcey, 2018 opined that Lack of knowledge and discomfort with bereavement care among healthcare providers can lead to inadequate care provision for those experiencing perinatal loss (Lang et al., 2011). In line with the study carried out by Fenstermacher &Hupcey 2018 suggested that effective support systems for mothers, fathers, and families after perinatal death includes General support, bereavement counseling and therapy, and specialized psychological support plays a curial role in assisting beavered go through this period positively (Koopmans et al., 2008). Social and intimate support also play a vital role in helping bereaved mothers cope with perinatal grief (Testoni et al., 2020). Healthcare professionals are faced the challenges in understanding the psychological states of bereaved mothers to provide effective support as needed(Cena & Stefana, 2020). The ability of health care provider to offer proper bereavement support significantly impacts the psychological outcomes of mothers after perinatal loss (Qian et al., 2022). Establishing an infrastructure for bereavement outreach can centralize communication, provide consistent support, and improve programmatic responses of feedback from bereaved families (Cole et al., 2020). While cultural norms may dictate silent acceptance of perinatal loss, there is a need for healthcare workers to recognize and address the intense grief experienced by bereaved mothers (Meyer et al., 2016). Support from family members, religious group, and support networks can help fill the gaps in social support for those grieving as a result perinatal loss (Fenstermacher & Hupcey, 2019; Gold et al., 2018). It is essential to identify and treat anxiety disorders and other mental health issues in bereaved mothers to improve their well-being and promote quality mental wellbeing (Gold et al., 2018).

Conclusion

Mothers who experienced perinatal death were significantly affected emotionally, physically, socially and economically. Unsupportive behaviour of health care providers, financial constraints and feelings of guilt with self-blame aggravated the grief reaction which is often worsen by lack of societal and health care provider's acknowledgement. Postnatal care, acknowledgment of pregnancy loss and emotional support of the grieving mother were suggested support system for the mothers after a perinatal loss.

Recommendations

Recommendations on evaluation of perinatal loss experience, level of support and coping among bereaved mothers with perinatal loss was drawn from various research findings.

- it is crucial for health care providers to provide expertise and compassionate care to bereaved mothers and their families experiencing perinatal loss. Healthcare providers should understand and appreciate the grieving process, identify grief factors in mothers

promptly, and offer prompt emotional, social, and psychological support in a holistic manner.

- Emotional support and management of postnatal complications are recommended for mothers facing perinatal loss as a way of addressing their unique needs and protect bereaved mothers from post-traumatic stress disorder arising from pregnancy loss and its associated mental health challenges
- Furthermore, it is essential to increase awareness of the support system needed by perinatal bereaved mothers and ensure the provision of adequate emotional, social, and psychological support during grieving moments.

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