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The Meaning of Grief after Perinatal Loss to Nigerian Women

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Abstract

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Perinatal loss can be a devastating event in the lives of families all over the world. In all cultures it is recognized as a traumatic life event to women and their families. In its broadest definition, perinatal loss is a loss of pregnancy or a baby from conception to six weeks post-delivery. This includes miscarriage, intrauterine fetal death (IUFD), stillbirth, and neonatal death. Grief due to perinatal loss has been widely addressed in the literature from western cultural perspectives. Little research has been done to explore the grief of women from other cultures based on their personal perspectives and experiences. This study explored the meaning of grief after perinatal loss through narrative analysis of semi-structured qualitative interviews of 21 Nigerian women from the Igbo in Eastern Nigeria. The narratives of participants included common features such as foreshadowing or precipitating events prior to the loss, grief experienced as physical pain, and moving out of grief after acknowledging the master narrative that God is in control. Participants highlighted the importance of cultural protective practices such as faith in God, community support, and storytelling as a form of consolation. These findings support the use of the multicultural model of coping as a framework for understanding perinatal loss in an African context. The study findings suggest the importance of cultural considerations in the care of women from Nigeria and maybe other African cultures after perinatal loss. Research is needed to

this study grief after perinatal loss in different ethnic groups in Nigeria and across Africa to understand common experiences and unique cultural differences. This will enable effective nursing care of women and families after perinatal loss that accounts for their individual and culturally determined experiences.

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Dedication

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Chapter 1. Introduction

This chapter introduces the problem of perinatal loss, a universally traumatic life event. It begins with the forms and definition of perinatal loss. Next, the variations in responses to perinatal loss in women from different cultures are presented. Available research on maternal child health, childlessness, grief, and death in Nigeria will provide a more specific context for this research study. An overview of theories and frameworks for understanding grief is presented. The chapter concludes with the purpose statement and the specific aims for the dissertation research.

The experience of perinatal loss is a devastating event in the lives of any affected family. The devastation from perinatal loss has life and health implications for the woman and the family as a whole (Callister, 2006). Wherever it happens, it is recognized as a traumatic life altering event for women and their families. Definitions of what constitutes a perinatal loss are inconsistent and inexact. For the purposes of this dissertation, perinatal loss is defined as the loss of pregnancy from conception to one month after birth (WHO, 2012; Malacrida, 1999; Kersting and Wagner, 2012). This includes sometimes overlapping and ambiguous terms such as miscarriage, stillbirth, intrauterine fetal death (IUFD), and neonatal death.

The problem of perinatal loss has been widely studied primarily from western cultural perspectives. There is a disproportionate lack of research about the experience of perinatal loss for families of non-western cultures in developing countries and when they are immigrants to developed nations (Van and Meleis, 2002; Adolfsson, 2011; and Toedter, Lasker and Alhadiff, 1988). This limited amount of research on perinatal loss in developing countries is especially problematic because these countries bear a higher burden of perinatal loss. This is especially true for Nigeria, the most populated country in Africa. Based on data from the Nigeria Demographic

and Household Survey the neonatal mortality rate, death in the first 28 days of life, was 39 per 1000 live births in 2013 (Morakinyo & Fagbamigbe, 2017). In comparison, the United States has a neonatal death rate of 4/1000 live births (The World Bank Data, 2016). The magnitude of the problem is even greater when miscarriages, intrauterine fetal deaths, and stillbirths are included. According to the World Health organization (WHO), Nigeria had a 41/1000 perinatal loss rate, including stillbirths and death in the first week of life per 1000 total births; this places Nigeria second only to Uganda among African countries (Demographic Health Survey, 2013).

In developed countries, perinatal loss leads to an immediate grief response that may include crying, disbelief, and confusion (Kersting and Wagner, 2012; Ritsher and Neugebauer, 2002; Whitaker et. al, 2010). Long-term consequences may include depression, loneliness or psychological problems (Badenhorst and Hughes, 2007). In Nigerian women, however, little is known about the uniqueness of expression of grief and factors influencing their grief responses after perinatal loss. Nigerian culture likely plays an important role in forming the patterns of grief response. Shaefer (2010) examined variations of the grief response to perinatal loss in diverse cultures. He argued that broadly defined groups such as Arab Americans and African Americans are of diversified nationality, religion, history, culture and politics. Therefore research studies need to examine cultural consideration in perinatal loss among members of more narrowly defined cultures. Cultural humility is a necessary approach to examining perinatal loss; research should be done with an open mind to understand the experience of grief after perinatal loss and what may be supportive of families going through the loss experience.

There are 8 tribes in Nigeria with over 250 dialects. Three of the tribes, Hausa, Yoruba and Igbo are considered as the main tribes in the country population-wise and the other five tribes, Ijaw, Fulani, Ibibio, Kanuri and Tiv as secondary. The ideology of continuity is a belief

that establishes women's role as perpetuating the culture through childbearing and childrearing (Hollo and Whitehouse, 2014). This is a cultural context that may be important in understanding the experience of perinatal loss in Nigerian women. When a woman experiences perinatal loss she feels not only the loss of that particular pregnancy or child but also the loss of continuity. Hollos and Whitehouse (2014) examined the experience of infertility and personal grief in 246 women across Africa, including 25 fertile and 25 infertile women from Ijo tribe in Nigeria. A major role for women was to be the bearers of sons who will eventually take their place in the family and keep their father's name going. By placing the responsibility for cultural continuity upon women, women bear the responsibility for infertility and its negative effects on marriage and families in Nigerian culture. With the society generally blaming women for failure to have children, men are not considered as possible cause for infertility. Men usually have the social sympathy with kindred's support and encouragement to marry a second wife to bear him children. In a survey of 374 married adults from Igbo tribe in Nigeria, the number of children in the family was a significant predictor of marital satisfaction and having children was equated with happiness (Onyishi, et al., 2012). These findings from two major tribes in Nigeria suggest that cultural continuity may be an important aspect of perinatal loss and grief in Nigerian women across the many ethnic groups in Nigeria. With such diverse ethnic groups and languages, the importance of cultural influences should not be minimized. According to Leininger (1991), culture is a complex concept which includes knowledge, beliefs, morals, laws and customs, and any other learned habits and attributes of the society. Therefore, understanding perinatal loss in Nigerian culture requires understanding the culture's approach to women, children, and pregnancy.

Culture and Women

Nigeria is traditionally a patriarchal society that has experienced revolutionary changes to the status of women in recent decades (Holloos and Whitehouse, 2014). Women have attained advanced educational degrees, elected positions in the house of assembly and senate, and leadership of banks and reputable businesses. These are notable expansions of the pre-colonial social status and limitation of women's role to motherhood (Ogbonna, 2000; Oladokun, 2009; and Van and Meleis, 2002) and domesticity (Ezegbe and Akubue, 2012). Despite these changes, a woman's role in Nigerian culture is strongly defined by child bearing. This study in the. According to Hollos and Whitehouse (2014) to the authors, "even one child gives them entry into the next stage of womanhood, regardless of whether that child survives into adulthood or not" (pg.189). It is therefore no surprise that the loss of a child may be especially difficult for women because of the ideology of continuity, with women being expected to produce a child for the family. This loss of continuity may strongly influence Nigerian women's grief response. Badenhorst and Hughes (2007) reported substantial grieving in their study on psychological aspects of perinatal loss in cultures similar to Nigeria in levels of poverty. For example, among middle class Indian women who experienced perinatal loss, family sometimes blame the woman for not producing a healthy child. This evident lack or low level of social support has been associated with prolonged grief, and in some instances mental illness.

The ideology of continuity in Nigeria prioritizes the biological connection between the woman and child, which forces women to repeated attempts at pregnancy since no other option is acceptable. Adoption is not a culturally supported approach of building a family or maintaining cultural continuity. In some regions of Nigeria, people believe that an adopted child is a 'bastard' (Oladokun, Morhason-Bello, and Adewole, 2009). Married men and women in Nigeria with

infertility desired children to maintain their family lineage/name, ensure inheritance, assist at home and work, provide security in old age, be a source of joy and companionship, and gain respect and status in the community (Okonofua et al., 1997). Since adoption is not an option, women go to a great length to seek pregnancy and have a child that will meet these needs.

Pregnancy in Nigerian Culture

The progression of a female in Nigeria to womanhood is a rite of passage that is compared and measured by the ability of the woman to bear children or become pregnant. Going through the process of pregnancy confirms an adult status on women allowing them the rite of passage to function as a matured woman (Holloos and Whitehouse, 2014). In Nigerian culture, respect is given to women who have had a child even if the child died, while those who have never given birth are characterized as not meeting their obligations as married women (Holloos and Whitehouse, 2014). Pregnancy within marriage is celebrated in Nigerian culture and the importance of pregnancy is noted in songs at celebrations of marriage by Nigerian artists like 'Flavor.' When women gather in Igbo land they sing traditional prayerful songs, asking that they will not be passed by when pregnancy is being gifted. Pregnancy outside of marriage, however, is highly stigmatized. More often than not a young girl who gets pregnant outside marriage is not able to marry within her community. A child from such a pregnancy may be given to the church at the "motherless babies home" or the full identity of the child is kept secret.

Children in Nigerian Culture

Nigeria is a society that values children, who are equated with wealth. A Nigerian adage states: "He with children is more important than the rich man" (Onye nwelu mmadu ka onye welu ego). In a traditional agricultural society children provided necessary labor to sustain a family farm. This belief supports the ideology of continuity and the pressure on married women

to bear many children. An Igbo saying goes that “No matter how bad a child is there is no bad bush to dump the child” and you will still love the child. Children are considered the joy and wealth of any home (Onyishi et al., 2012).

Grief and Culture

The cultural expectation of women to bear children to carry on the family lineage may also affect their grief responses (Badenhorst and Hughes, 2007). Grief may be a universal phenomenon and there might be shared aspects or identical cultural rituals, but there are cultural variations related to the cultural background (Dyer, 2001). For example, there are many variations among Latino cultures, their religious practices, and their expression and responses to grief (Whitaker, Kavanaugh, and Klima, 2010). These observed variations support awareness of different cultural perspective when studying grief in a country or ethnic group.

A major determinant of an individual’s thoughts, behaviors, and actions is the culture (Cowles, 1996; Fletcher, 2002). Culture is regarded as an ever-changing set of recommendations that determine the behavior and actions (Sydnor-Greenberg and Dokken, 2000). Culture shapes an individual as the individual also shapes the culture. Consequently, culture determines an individual’s expression of grief, rather than the duration or extent of grief (Hebert, 1998). Cowles (1996) found that a person’s experiences of grief and behavior are influenced by his/her personal characteristics, which is shaped by the culture. Fletcher (2002) noted that people react to loss according to their particular cultural prescriptions regardless of the fact that grief is a universal phenomenon. Shapiro (1994) found extraordinarily diverse meanings and social constructions associated with grief. For example, the attitude toward grief among members of the Yoruba tribe in Nigeria is influenced by their belief that the dead person (adult) becomes a deity (Elegbeleye and Oyedeji, 2003).

Death in Nigerian Culture

Nigeria is a diverse country with at least 250 ethnic groups with varied practices and beliefs. Practices around the response to the death of adults vary in different parts of Nigeria. For example, widowhood is practiced differently in the Western states (Yoruba) and Eastern states (Igbos) cultures; practices differ on the number of seclusion days from the public to distribution of the husband's inheritance (Fasoranti and Arua, 2007). In the Yoruba tribe the death of a twin is understood differently. Twins are believed to have soul bonds, so the Yorubas have an elaborate system and practices intended to control the believed repercussions for severance of twins through physical death of one. When a newborn twin dies, the life of the surviving twin is believed to hang on a balance (McILROY, 2012), so the Yoruba tribe developed a system of elaborate practices and rituals to handle the believed consequences. These practices are upheld by the parents until the surviving twin is old enough to assume and maintain these practices. Example is the "Salaka" which is giving small parties to other little children to make them happy, which the Yorubas believe will keep the dead twin happy and keep him or her from trying to take away the surviving twin.

Cultural beliefs and attitude towards death of a child can influence a mother's response to the loss of pregnancy or baby. There is belief among Nigerians, in supernatural force or curse as a causative factor in the death of babies. For example, a mother's repetitive loss of her babies is blamed on the child being 'Ogbanje' (interpreted as 'frequent flyer'). These children are believed to cycle rapidly and repeatedly through birth and death, sent to torment the family by being conceived, born, and dying at different stages of childhood, never getting to adulthood to be useful to the family (Ilechukwu, 2007). The repeated birth and death of the same child becomes "a malignant form of reincarnation" (pg. 239). A study by Aziken, Omo-Aghoja, (2007) on

perception and attitude of pregnant women and cesarean birth found that the participants believed that ‘supernatural’ forces prevents a woman from progressing normally in labor. Therefore, the woman and the family attempted to address the supernatural forces rather than moving the woman to higher levels of care facility, and alternative forms of delivery such as cesarean birth. This delay often resulted in stillbirth or intrauterine fetal demise in the context of the Nigerian health system where the majority of intrapartum care is provided in maternity homes in the villages.

Theories on Grief and Theoretical Framework

Theory is an organized framework to articulate and give meaning to knowledge (Meleis, 2012). Theory is used to explain, predict, and understand described aspects of certain behaviors among individuals or a group of people. A theoretical framework is the structure of an incomplete theory; the framework helps to give a wider understanding of the relationship between a concept such as grief and its meaning. Most of the research on perinatal grief is based on western theories of grief such as those of Kubler-Ross (Chapman, 2006-2013) which may not apply to the Nigerian experience. It is important to consider the relevance and applicability of a chosen theory to the culture being studied. Theories on grief will be explored more in Chapter 2.

Purpose Statement

This study seeks to understand the meaning of perinatal loss to Nigerian women. The specific aims of the research are to:

1. Describe the narrative of grief in Nigerian women. Using narrative inquiry will help portray and understand women’s lived experiences of the journey through grief and how they survived.

2. Understand the cultural influence on grief among Nigerian women. Explicit and implicit cultural references will be used to extract the cultural influences on grief, from the women's narratives. These may include beliefs about childlessness, raising non-biological children, and the role of women in the family. These cultural beliefs are important to understand their grief.
3. Test the congruency of the multicultural model of coping after pregnancy loss to the grief narratives of the Nigerian women. The theory will be tested by searching for the presence of the key components of the theory in the women's narratives. The analysis will determine whether the grief and related responses trigger connectedness with self, others, religion, or spirituality to facilitate coping. These findings will generate new strategies for nurses to facilitate women's coping with grief.

Conclusion

In summary, multiple studies have examined the grief response to adult death in Nigeria. Many other studies have examined grief responses to perinatal loss in developed countries, but, only a few studies have been focused on maternal grief response after perinatal loss in Nigerian culture. In Chapter 2 I will explore this literature in depth to support the need for a qualitative inquiry about grief after perinatal in Nigerian women.

Chapter 2. Review of Literature

This chapter reviews the available literature findings devoted to grief and perinatal loss in Nigerian women, bereavement and death in Nigerian culture, Nigerian women's grief process, belief and attitudes around pregnancy and death among Nigerians, and grief theories. Findings of the literature review will substantiate the need for this research of grief response to perinatal loss in Nigerian women. Findings from collected available studies will support the identified narrative methodology for the research versus other phenomenology methods such as interpretive, ethnography, or grounded theory.

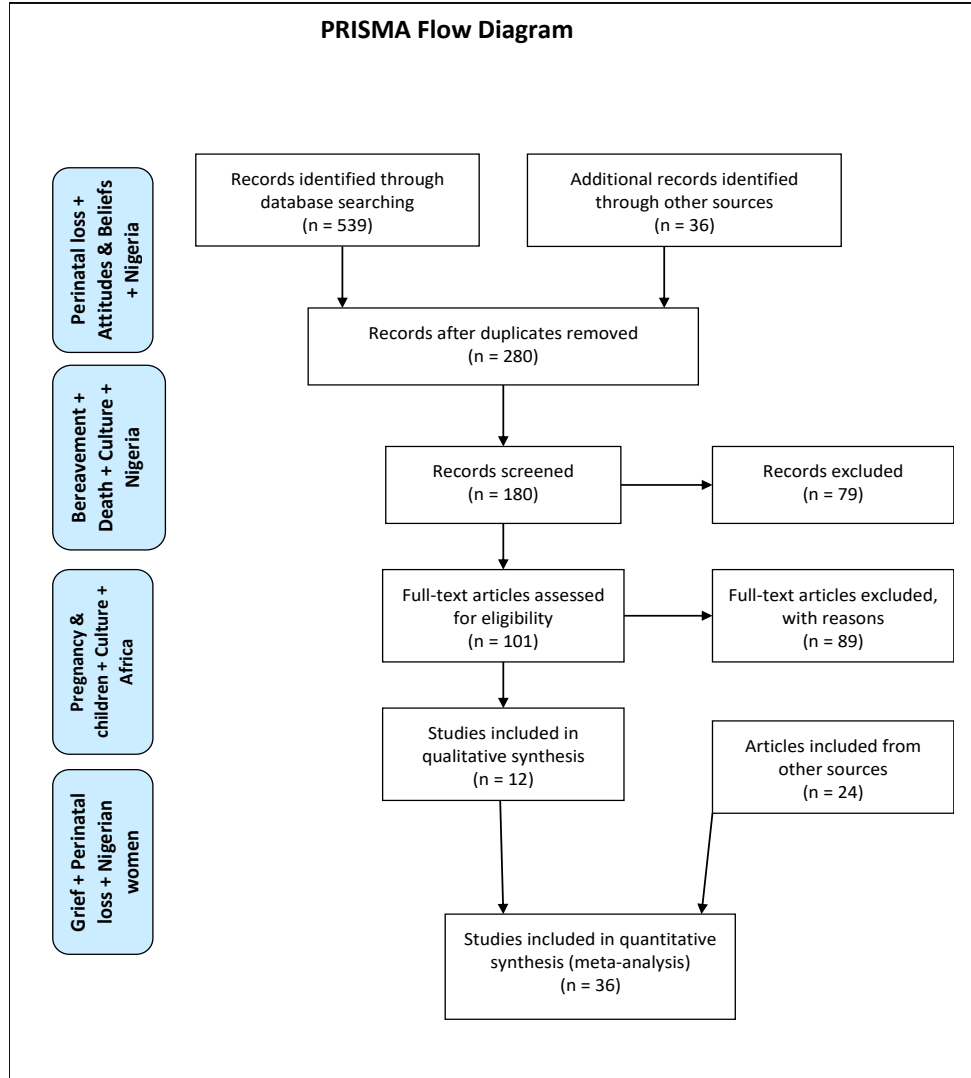
Scientific interest in understanding grief after perinatal loss began in the 1970s. Terms such as bereavement, grief, and mourning have been used interchangeably to describe this phenomenon (Fenstermacher, 2013). While numerous studies focus on grief, perinatal loss, and postpartum depression in women, few studies address cultural perspectives adequately. Cowles and Rogers (1991) theorized that cultures have normative attributes of grief: "each cultural group [has] its own belief system regarding death – related to rituals or behavioral style and expected social behaviors and cultural practices in response to loss and bereavement" (pp. 121-122). Similarly, Bennett, Litz, Lee, and Maguen (2005) expressed the need for research studies on cultural influence on grieving process and the need for the understanding of medical personnel providing care to women from other cultures.

A literature search was performed to identify specific research studies related to perinatal loss in Nigerian women. Data bases searched were: Ovid, PsycINFO, PubMed, Cinhal, Scopus, ProQuest, Hinari, NIH Database, and Google Scholar, using the following search terms (Grief + Perinatal loss + Nigeria then changed to Nigerian women; Pregnancy & children + culture + Africa, then Nigeria; Bereavement + Death + Culture + Nigeria; Perinatal loss + Attitudes +

Beliefs + Nigeria. These terms were used in the different search engines, resulting in a total of 539 identified articles. Narrowing the search, more specific to perinatal loss among Nigerian women resulted in 12 articles that had references to perinatal death or death specific to Nigerian culture. None of these 12 references examined the grief response to perinatal loss. Because of the lack of literature on grief after perinatal loss in Nigeria, I expanded the search to include articles about grief after perinatal loss in other developing countries.

Identified studies on grief and bereavement in Nigerian culture were all in relation to older children and adults. There was only one study specific to perinatal loss with no examination of the grief maternal grief response to the loss. The grief responses addressed in the studies were in terms of women and spousal loss with social impacts. Due to scarcity of studies specific to perinatal loss in Nigeria, articles on general cultural view on death in Nigeria were included. The database search was extended to studies on grief related to perinatal loss in other cultures of comparable maternal and child health problems and other African countries. The expansion of the search yielded 24 articles for a total of 36 grief articles included in the study. I rejected studies about postpartum depression not specific to perinatal loss. Other rejected studies addressed religion, societal impacts, and traditional aspects of loss in Nigerian culture not specific to the perinatal context. The PRISMA flow diagram of the search is presented in Figure 1.

Figure 1. PRISMA flow diagram of literature review. Search terms shown on left.



Alali (1993) explained how death is considered a visible aspect of the Nigerian culture, because of its high rate, estimated at 15.6 per 1000 people per year. He examined 86 obituaries and memoriam advertisements published in 11 Nigerian national newspapers to understand the cultural significance of death in Nigerian culture. Death represented both celebration and mourning of the life lost. Different dimensions are used to manage death and grief as demonstrated in traditional oral communication and in the pages of newspapers. Alali identified ten dimensions of content in these communications about death. For example, death was

represented in pictorial death announcements, open funeral invitations to the community of mourners, and advertisements that are also considered direct contact and communication with the deceased. He also suggested that these newspaper announcements demonstrated a belief in personal immortality of the soul, and that religion is a pervasive and dominating force in advertisements among Nigerians. He suggested that the obituaries show that life and death within the Nigerian cultural context are inseparable because of the unbroken link between the living, their ancestors, and their God or deity.

Ogbuagu (2012) described how the amplification of loss is dependent on the cultural, social standing, and degree of importance allocated to the individual and children of the deceased. This study draws attention to the cultural views and practices around death in Nigeria. He explained that all over the world, for Nigerians in diaspora, the bereavement process is long and strenuous due to their social location outside of their cultural home, and due to cultural expectations and financial burden for completing rituals and rites of passage. The practices explained here causes stress and difficulty for the dependents of the deceased who has to fulfill the expectations, whether the ceremonies are considered traditional or Christian burial rites. These expressed views are for the death of adults. He concluded that, while bereavement is a universal event, the experience of grief was highly varied, especially for Nigerians living in diaspora, because of the extra cultural, social and economic burden from the expectation of performing the funeral and burial rites. He called for the exposure and articulation of cultural differences that show that not all bereavement and losses are “created equal.” Which is to say that cultural differences do exist in how cultures respond to grief related to the death of a love one.

Nwalutu (2012) found that the rituals and practices among the Igbo tribes of Nigeria around widowhood are unique and peculiar to that culture. The rituals of widowhood demonstrate the cultural significance of marriage; a similar significance is shown in the strong connection between marriage and motherhood. Being a married woman and a mother are both statuses of great importance and honor in the culture. Similarly, Stanislaus, Maduawuchi, and Ogbonna (2000) explained the tradition of the Igbos of Nigeria and their belief that dead adults maintain in death the status they held in life. The ancestral home is believed to be the exact location in both the land of the living and the dead, hence the Igbos bury their dead adults in or around their homes or around. With this practice and tradition, the Igbos take their dead home to the ancestral land to be buried. There are no cemeteries in Igbo land. For this same reason, “bad people” are not buried, they are thrown away without respect into the “evil forest” to be eaten by wild animals. Burying someone viewed as a bad person is considered an insult to “mother earth” (Ogbonna, 2000).

McILRoy (2011) explored the African indigenous religious beliefs about death among the Yoruba tribe of Nigeria. They provide a perspective on the loss of a twin because they have a high rate of dizygotic twin births, 19 sets of twins per 1,000 births, the highest rate among Nigerian tribes. The Yorubas believe that twins are closely tied together in body and soul. Separation due to death, especially in childhood, poses external threat to the soul of the surviving twin. Many rituals and customs among the Yorubas are designed to sustain the spirit of the surviving twin. To counteract the negative consequences of losing the “one half living for two,” the spiritual healer is involved in making small wooden figures called “ere ibeji” (sacred image born two) that are meant to house the soul of the dead twin. This image is cared for by the mother and later by the surviving twin and involves elaborate celebration rituals.

Ekore and Lanre-Abass (2016) reviewed religious and cultural perspectives on death in Africa. They reported that the traditional belief system of Africans is based on ancestral worship, a belief that those who are dead are alive in a different world and can reincarnate in new births. Africans believe that death is a rite of passage for those who die at an acceptable old age. When death occurs, cause is sought from the dead ancestors to rule out any foul play such as witchcraft, which would offend one's ancestors or the gods. For the people left behind, death is considered an enemy of life. They concluded that these cultural beliefs influence the African concept of death and advance care directives, and that Africans will be less likely to discontinue life-sustaining treatment once it has been started.

The studies reviewed focused on the rituals of death, grief, and bereavement in adults. There were minimal explorations of the cultural meaning of death, the cultural value assigned to children and childbirth, on the grieving process, or grief after perinatal loss. The available literature focused on the cultural assumptions of western societies. For example, Nwoye (2005) in his study of death and cultural practices in ten African countries, noted that while western research focuses on an individual's reaction to loss, Africans are concerned with the spiritual, systemic, and interactional nature of healing in grieving and the resources the community provides for the bereaved. There is the need for a safe return of the deceased to the ancestors after having lived a good life here on earth, whereas the Christian rite is focused on a loved one's acceptance in heaven, having lived a good life on earth. These studies told us little about grief or grief due to perinatal loss among women in Nigeria, hence the need for further investigation to understand its meaning. There were no discussions on burial rites for infants and children in Nigeria within the available literatures.

In summary, the review of research articles reveals some strong cultural influences surrounding death and grieving practices. However, these studies are mostly on adult deaths in Nigeria. There were no available research studies on maternal grief response related to perinatal loss in Nigerian women. The limited research studies specific to grief in perinatal loss among women in Nigeria or other African countries, prompted me to expand the search for relevant studies on grief after perinatal loss in other developing countries. The findings of such studies will inform research on Nigerian women's grief response using a cultural perspective.

Underserved women experiencing perinatal loss in Northern Ireland need to find meaning in their experiences and create spaces of resistance to medicalization by placing their emotions at the center of their narratives. This was seen to be a powerful indicator that the support required from professionals should consider the meanings the women constructed from their experience of loss (McCreight, 2008). Similarly, there are many differences in the ways U.S. Latinos express grief compared to European Americans. Mexican Americans show increased overt expression and somatization of grief. Some Hispanic cultural imperatives, such as the concept of 'respeto' (respect), religion, and spirituality, influence grief reactions and rituals (Whitaker, Kavanaugh, and Kilma, 2010). Iranian mothers described their grief after perinatal loss as overwhelming and they formed a new identity in their sorrow. The depth of sorrow depended on the length of the pregnancy or age of the baby after birth (Maryam et al., 2016). The mothers in the Iranian study were supported in coping with their grief by cultural practices, family, and interactions with health care providers.

Richards, Graham, Embleton, Campbell, and Rankin (2015) discovered three major themes in mothers' accounts of the perinatal loss of a co-twin: the status of 'special'; the importance of trust; and control and empowerment. The women described the emotional support

of the health professionals as crucial to their wellbeing as the surviving twin remained in the hospital. Some of the mothers used formal bereavement support, while others put their grief on 'hold' in order to support their surviving baby. They showed that addressing patient-identified culturally appropriate requests made a great difference to the wellbeing of mothers after perinatal loss. Grief due to perinatal loss can be a traumatic event and the disrupt core beliefs, resulting in unresolved grief, posttraumatic stress symptoms, or growth following the loss (Krosch & Shakespeare-Finch, 2017).

Badenhorst and Hughes (2007) addressed the psychological aspects of perinatal loss and the value of some culture-based rites or practices in helping mothers deal with their loss. For example, holding the dead baby and memorabilia that represent the baby may be helpful in addressing the strong emotions after perinatal loss. This may not be enough for some women who need professional referrals to deal with complicated and prolonged grief. Van and Meleis (2010) found that perinatal loss was a major life event for African-Americans, even though they may have lost some of their African heritage through acculturation. Culture and life experiences still significantly influenced their daily lives, religious and cultural values, and beliefs. Other factors identified as affecting their grief intensity included the stresses related to economic hardship, their roles and responsibilities in their families, and unsupportive relationships with others. These African-American women were noted to have used religion as a coping resource in their grief or a religious or spiritual leader for seeking answers in their grief. This supports the importance of connectedness in coping with grief successfully. The concept of connectedness will be explored further in examining competing models for grief.

In conclusion, most of the research studies on Nigerian culture about death, dying, cultural and traditional customs were focused exclusively on adult members of the society. There

were no published studies on perinatal loss and the grief response of the women in Nigeria. Studies in other developing cultures show the importance of culture in the grief response.

Theories on Grief and Theoretical Framework

The theoretical framework chosen for this study is the modified ecology theory by Bronfenbrenner. Theory is a belief, a policy proposed or followed as the basis of action. It is an organized framework to articulate and give meaning to knowledge (Meleis, 2012). Theory is used to explain, predict, and understand described aspects of certain behaviors among individuals or in a group of people. Theoretical framework is the abstract, the speculation or the meaning of a theory; it helps give a wider understanding of the relationship between a concept such as grief and its interpretation.

Bronfenbrenner's social ecology theory is based on the belief that the individual's environment influences adaptation to life events. It supports the view that human beings are influenced by their transactions with their environment, and they apply the influence when factors in their environment combine (Bronfenbrenner, 1979). According to Bronfenbrenner, an ecological transition occurs whenever an individual's position changes in role, setting, or both. The focal point is the individual. The individual's attitudes, beliefs, behaviors, and predispositions will lead to poor coping that will place the individual at disadvantage when trying to cope in her loss. Going outward are the direct family, social interactions such as church family, then the work environment and the government, which is considered the macro interaction point. The theory will be applied in this study to illustrate how the effect of culture or environment might have influence on Nigerian women's grief responses after perinatal loss. The modified human ecological model will help illustrate and provide explanation of the complex and dynamic nature of the relationship between an individual and the cultural context

that might affect response to grief over perinatal loss differently from the known popular western cultural grief response as displayed in available studies and bodies of knowledge.

Bronfenbrenner conferred the importance of the transaction between an individual and his/her environment as having effect on health outcomes and how the individual responds to stressors in the environment. The application of the ecological theory will also help in the evaluation of available theories and their adaptability and applicability to women of Nigerian culture.

People's experiences are influenced by their environment, which is the culture they are in when the experience occurred. An understanding of an individual's behavior from the context of their own cultural context will help to understand the orientation of the observed reaction to death and grief as stemming from how a person gets to know grief and death. To understand the lived experience of an individual, the experience has to be examined based on the lived experience as interpreted by the subject in terms of her own enculturation (Rozzano, 2000).

The Multicultural model of coping after pregnancy loss will be used to appraise connectedness among participants and Kubler-Ross grief theory will be compared to the identified grief response after loss among Nigerian. The comparison will provide insight to its appropriateness in assessment of Nigerian women in grief and the possibility of a need for an applicable theory and assessment tools for the women of Nigeria in grief after perinatal loss.

Nwoye's study interviewing participants from five African countries found that Africans are concerned with the spiritual, systemic, and interactional nature of healing in grieving and the resources the community offers to the bereaved (Nwoye, 2005). Similarly, Elegbeleye and Oyedeji (2003) explained that "in the Nigerian society, religious, social, and cultural dimensions are usually emphasized when death strikes, while the psychological dimensions of the loss on the

bereaved are most often overlooked.” These Nigerian cultural specifics pertain to grief at the loss of an adult or a young teenager, not the loss of babies and young children.

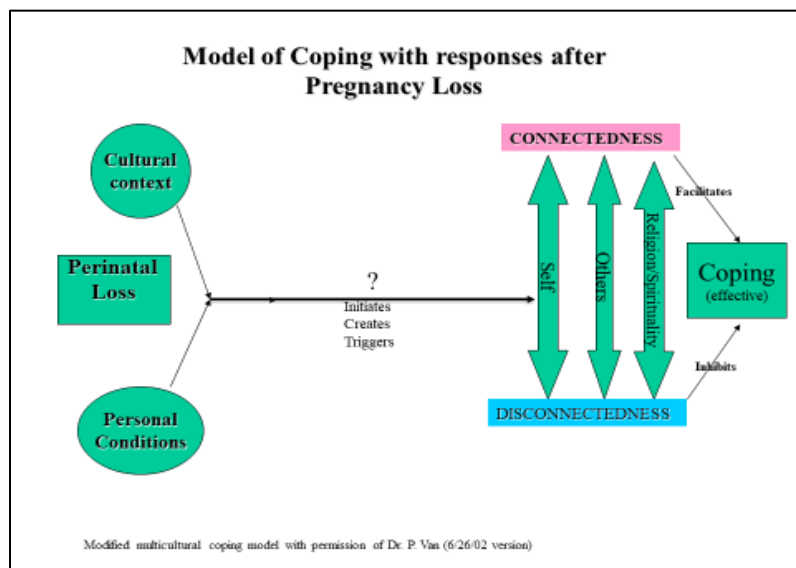
Theoretical models of loss and grief in psychology start with Sigmund Freud’s theory of melancholia and mourning, to present-day theories such as anticipatory grief and disenfranchised grief. Kubler Ross’s grief theory (1969) is arguably among the oldest and most popular theories used in grief, death, and dying studies, and the most popular used in nursing education and in psychology. The Kubler-Ross grief theory is considered a pioneer approach that opened up a worldwide conversation about the process of dying, death, and grief. This model staged grief into five normal responses, and provided a foundation for other theories, including Worden’s dimensions of grief, Parkes’ stages of bereavement, and Rando’s six “Rs” of grief (Harris, 2015). It has since been adapted by other psychologists. The most used version was by Alan Chapman (2006–2013). According to the theory, the five stages of grief (5-stage model) are denial, anger, bargaining, depression, and acceptance. This process was viewed as stages that replace each other, repeat themselves, or co-exist. See Appendix A for more detail on the Kubler-Ross grief stages.

According to Kubler-Ross grief theory, the individual’s ability to go through this process successfully or not will lead to healthy grieving or unresolved grief with its many implications, also called complicated grief. In the Kubler-Ross theory, the grief cycle is spiral, like waves as the individual goes through each cycle stage. The assumption is that an individual must go through the five stages of grief for a healthy resolution or they will be stuck in unresolved grief with its many negative outcomes: anxiety, depression, posttraumatic stress disorder, and other health implications. Because the Kubler-Ross theory was developed and tested in Western contexts, it is unclear whether it applies to Nigerian women experiencing perinatal loss. Does

Nigerian culture have protective aspects that make the grief process for Nigerian women different from western cultures?

An alternative grief theory that may be more relevant to Nigerian women is the multicultural model of coping after pregnancy loss proposed by Van (2012). This model is based on connectedness and had been applied to three other studies on perinatal loss experiences of women of color in the United States. Application of this theory in her studies of perinatal loss has shown a difference in grief response and resolution among women of color. Her qualitative study conducted interviews asking women to describe the processes and strategies they used to cope after pregnancy and included 20 women of color. Identified differences in grief response among women of color following perinatal loss were attributed to the support of caring community in the form of family, faith, and church. See Figure 2 for a representation of the model.

Figure 2. Modified Multicultural Model of Coping (Used with permission of Dr. Pauline Van)



This concept of connectedness is similar to Swanson's Theory of Caring (Swanson, 1993). Caring is defined as "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 354). Her caring theory was based on research of caring in three contexts: women experiencing miscarriage; nurse caregivers in the neonatal intensive care unit; and young mothers receiving public health services. The theory identified five caring processes:

- Being with, as in being emotionally present for the one you are caring for.
- Maintaining belief, which is keeping faith in the other as they go through ordeals in life and believing in their ability to make it through while being realistic in your encouragement.
- Doing for, as in doing for the other what you would do for yourself.
- Enabling, referring to helping the other through their life's transitions.
- Knowing, in reference to trying to understand the one you are caring for without assumptions.

These five processes of caring resonate throughout the multicultural model of coping after pregnancy loss. When nurses apply caring theory, they provide the support mentioned above in terms of connectedness. Such caring helps the patient in her grief resolution. Four additional concepts are included with the theory that refer to metaparadigm concepts such as person, environment, health, and nursing (Swanson, 1993). Swanson's caring theory was based on philosophy and spirituality; the attributes of caring as described here is not unique to nursing, but can be applicable to the way people care for each other in any relationship. Similarly, the connectedness described in the multicultural model of coping referred to the caring and support

given to a mother after perinatal loss, which strengthens the mother's coping ability. It remains to be determined if the multicultural theoretical model of coping after pregnancy loss explains the perinatal loss grief experience of women in Nigeria.

Conclusion

The literature on loss among Nigerian women shows that very little attention has been given to the women's perspectives of their loss. The reviewed literature identified the elaborate practices on death and traditional rites for deaths involving adults in Nigeria observed in the literature review. There are provisions made for surviving twin among the Yorubas of Nigeria. Nigeria is culture that values children and Nigerian women are culturally and socially expected to bear children and motherhood is a rite of passage to womanhood. Married women measure their worth by the number of children they bore. The burden of generational continuity is on the women in Nigerian culture. Narrative inquiry will allow for detailed stories of their loss to be drawn from the participants, which can reveal how the women understand their experiences and their lives. Narrative inquiry will permit relevant content matters of the women's stories to emerge giving meanings to the shared experience.

Chapter 3. Methodology

This chapter includes the discussion on the ontology and epistemology of the study method and the study procedures including design, inclusion criteria, data collection, and the interviews. It also covers the data analysis design, steps taken to maintain the rigor and thrust worthiness of the study, and other important steps involved in conducting a qualitative study outside the United States of America.

Ontology and Epistemology of Narrative Research and Phenomenology

Phenomenology as a philosophical ontology of knowledge and reality is often attributed to Edmund Husserl (1859 – 1938). Phenomenology is conceived from the premise that all our knowledge and understanding of our world is from our experiences (Hein and Austin, 2001). Central to this approach of phenomenology is that consciousness is the condition of all human experience(s) (Wojnar and Swanson, 2007). Phenomenology focuses on a wider aim, studying experiences with detailed particular attention to the way experiences and their meanings mold the individual. It makes sense of one's orientation towards the environment as known to them. Hence, researchers who use a "phenomenological approach seek to make clear the taken-for-granted assumptions that guide our experiences" (Hein and Austin, 2001). In so doing, the reality is the experience of the individual and his/her perceptions of those lived experiences.

Davis (2011) explained that "the meanings we create from our experiences are largely based on the social context." (Davis, 2011 from Encyclopedia of psychology). Phenomenology was recognized as a unique discipline through the works of Husserl and Heidegger. Their work on intentionality and consciousness drew attention and recognition to first-person perspective in philosophy of mind. According to Husserlian phenomenology our experiences represent our

“intends” through thoughts and ideas, and these make up the meaning we give to experiences (Husserl, 2013.Plato.stanford.edu). In other words, this is how we experience the world through consciousness — hence the definition of phenomenology as “the science of pure consciousness” (Earle, 2010). Phenomenology studies individuals’ experiences ranging from perceptions, thoughts, memory, imaginations, emotions, desires, and social activities including linguistic activity.

Narrative is an aspect of phenomenology as a continuing story, accountable for actions in the past that made up narrative of life. According to Bochner and Riggs in “Practicing Narrative Inquiry” (2011) in the Oxford Handbook of Qualitative Research, narrative inquiry was fully recognized in social science in 1982 with the publication of “Narrative Truth and Historical Truth” by Donald Spence. The reaction of the social science/psychology world to the content of the publication gave rise to what they called “the epistemological crisis in social psychology.” When there was a question on the use of narrative in research as a way of learning human phenomenon. This led to the presentation of narrative psychology as an alternative to the positivist paradigm, which had psychology in a state of “disillusionment, mechanistic and reductionist postulates of positivism.” The humanistic paradigm stressed story making, storytelling, and understanding story as a root metaphor for the rebirth of social psychology. Narrative researchers affirmed this idea, supporting the position that human consciousness takes an inherently narrative form. Denzin and Lincoln (2000) confirmed and concluded: “Now, at the beginning of the 21st century, the narrative turn has been taken.”

The approach of narrative inquiry was chosen for this study in an effort to understand the Nigerian women’s experiences of grief through their own ways of knowing. Narrative inquiry is, according to Lieblich, Tuval-Mashiach, and Zilber (1998), any study that utilizes analysis of

narrative data collected as stories or interviews to give meaning to a lived experience. The term “narrative psychology” was first coined by Theodore Sarbin in 1986. Narrative psychology is the study of how human beings construct stories to deal with experiences and behaviors that are best explained through stories. Hence, narrative psychology views narrative from the perspective that human experiences and activities are full of stories and “meaning” instead of logical arguments or formulas. It is differentiated from other forms of qualitative research because it is focused on narratives or stories of life experiences. It takes the premise that “people live and/or understand their lives in storied forms, connecting events in manner that has a beginning, middle and end plot” (Josselson, 2011). Narrative inquiry is a way of understanding and looking into experiences through the researcher collaborating with the participant in a place, over time, or in series of places and social interactions with “milieus” (Clandinin and Connelly, 2000). In sharing their stories collaboratively, women are helping us understand their grief experiences by describing them, and research focuses primarily on the voice in the individual’s narrative, with attention to the content and how the story is told to convey meaning. The stories are who they have become, and these stories sustain them. It is thus appropriate for this study to employ narrative inquiry, a branch of phenomenology, and it calls for negotiating research texts that respectfully represent participants’ lived and told stories.

The founders of phenomenology, like Edmund Husserl, defined it as a philosophical approach to knowledge and reality (Husserl, 1859 -1938) to describe how people experience through consciousness. In recognizing human experiences as the basis for knowledge (Drucker, 1999), narrative phenomenology is defined as “the science of pure consciousness” (Earle, 2010). It is important to understand that in these definitions, the reference to consciousness is as a form of all human experiences. This is also why narrative phenomenology is a good fit for this study.

Narrative allows the participant to describe their everyday experiences for us to understand the embedded knowledge of the meaning in their narratives. To understand the experience and meaning of grief in perinatal loss requires an in-depth exploration of the women as individuals, each person describing her own knowledge of her loss experience as she understood it in the natural cultural environment, while uncovering the shared meaning and cultural influences (Ruthellen, 2011). In the analysis section of this document, I will be discussing the elements from the participants' narratives such as: the religious setting of Nigerian culture, God as the master narratives within the stories, community support, sharing of similar grief stories and experiences, and acceptable consoling words within Nigerian culture.

Procedures

Design. This exploratory study used semi-structured narrative inquiry interviews of a convenience sample of Nigerian women who experienced perinatal loss in Enugu State, Nigeria teaching hospital. (See Appendix E)

Sample and sample size. The study recruited a convenient sample of 21 voluntary respondents to general advertisement in the clinics of ESUT Teaching Hospital Parklane, Enugu. Enugu State and the capital city of the same name is in east central Nigeria and is mostly populated by local traders and government workers with low income. This hospital provides access to a typical population of women experiencing perinatal loss (See Appendix F). Data was collected from 21 women meeting the inclusion criteria of the study; 20 participants were selected for the research, but saturation was reached at 21, at which point the decision was made to conclude data collection. Consent was obtained from participants following explanation of the study. There was no attrition, and all the consenting participants completed the study. Allowance was made for any drop-outs, including decision to withdraw due to family or work

responsibilities, or unforeseen family emergencies, for which there were none. The target for completed interviews was 21 participants, which is congruent with the sample size for similar qualitative studies. The number was achieved due to saturation. Which means that the proposed number of sample of 20 was completed, after the 21st participant there were no more volunteer, so sample collection was closed.

Inclusion criteria. The requirements for participation in the study include being: a married woman of child-bearing age (18 – 45 years), a Nigerian of any ethnicity residing in Enugu state, and experienced pregnancy or child loss within the past three months. Loss includes miscarriage, abortion, intrauterine fetal death, stillborn, or neonatal death. Other requirements included willingness to share painful memories or experiences, ability to read and understand English at a minimum of fifth grade level, have access to a phone and additional reliable contact information such as a family member or a friend, and a willingness to be contacted after the interview for data clarification.

Exclusion criteria. A participant will be excluded from the study for any identified or suspected severe mental illness or severe physical illness. There was no need for implementation of the exclusion criteria. All participants met the inclusion requirements.

Data collection. Volunteers identified through a contact in Nigeria (senior matron, Mrs. Evelyn Umebuani), were contacted for participation in the study. Advertisement and recruitment posters were displayed in the gynecology clinics and doctors' offices on the hospital campus for fair participant opportunity to all interested in the study (See poster sample, Appendix D). The researcher approached prospective participants for disclosure, screening, collection of demographic data (See Table 1), and consent signing. The participants were informed of their rights to withdraw their consent and participation in the study at any time they wished. The

interviews were always scheduled for a mutually agreeable date and time at participants' convenience. The semi-structured interview generally last 20–30 minutes, with a compensation of \$10 (about 5,000 Naira) in the local currency for participants' time and effort. The compensation was disclosed at the end of the interview to control for bias in participation. Participants did not know each other and are not related to any employees of the department.

Interviews. At the beginning of the interviews, a brief explanation of the purpose of the research was given to the prospective participants. The interviews were conducted individually. Based on a review of the demographic questionnaire, the researcher used the interview guide (Appendix B) to elicit the story of the participant's most recent perinatal loss. The interviews were open, participants led, and the interviewees asked clarifying questions as needed. The interviews were audio recorded using a small portable digital recorder. Field notes were also collected and kept during and after the interviews to add details not presented on the audio recordings, such as body language, gestures, and demeanor, and to document initial reflections on the process and content of the interviews and the environmental context. Participants were allowed to talk until they exhausted their recollections and thoughts about their loss. Follow-up phone calls were made during transcription and analysis for clarification of data and confirmed participants' validity of data analysis through "member checking."

Data analysis. Collected data was analyzed using categorical-content perspectives in narrative research as described by Lieblich, Tuval-Mashiach, and Zilber (1998). This is the method of processing narrative materials of life stories analytically by breaking the text into relatively small parts of content and grouping them into either descriptive or statistical grouping. This type of content analysis is considered a classical method for doing research with narrative materials in psychology, sociology, and education.

In narrative analysis, the interpretation of the story form can either be a holistic-content perspective, holistic analysis of form, categorical-content perspective, or categorical-form analysis. The holistic-content perspective has five steps of reading the story material several times, describing your initial global impression, deciding on special foci of the content or themes to follow in the story, using colored markers to mark the various themes in the story, and keeping track of your results in several ways and for each theme to the end for conclusion. The holistic analysis of form is focused on the analyzing the narrative as a whole, the goal being to demonstrate how narrative story may be used to learn about variations presented in the story structure. From the structure of the participants' stories, emerged a theme of God as their master narrative. This theme will be further explored and explain in the findings. The categorical-form analysis is focused on learning aspects of a narrative that might have been missed in examination of the content alone; an example is that the form can demonstrate how emotions are reflected in the shared narrative of significant events in the participant's life. Categorical-content perspective analyzes narratives by breaking the text into small units of content and submitting them as descriptive or statistical contents for analysis (Lieblich, Tuval-Mashiach, and Zilber, 1998).

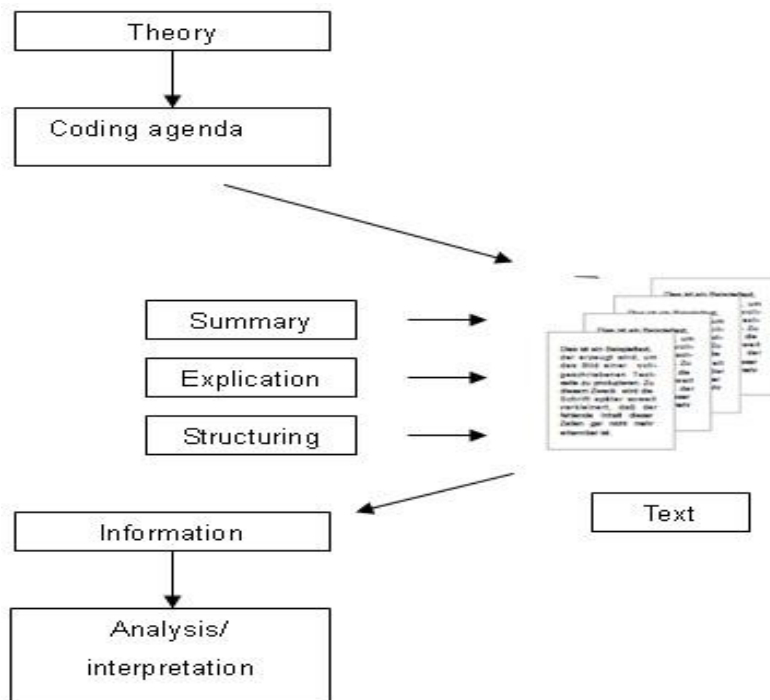
Categorical-content descriptive analysis method of form recognizes the importance of the story context. It allows for incorporation of exact words in analysis to help make sense from the perspective of the storyteller. This method makes it is easier to appreciate the narrative elements as a structure of beginnings and ends to correspond with the cause and eventual consequences, including identification of matter narrative that helped make meaning to the storyteller.

The categorical-content perspective has two types of generalization:

- Generalizations about people – participants might make claims that characterize the women of the culture.

- Generalizations about cultural law — which the participants' claim is always true. The context in the categorical analysis is stressed as important; speakers' linguistic styles in telling their grief stories are essential for analyzing sections of their life grief stories.

Figure 3 **Categorical-Content Perspective in Narrative**



The categorical-content perspective in narrative research analysis will be employed to determine the key elements of the women's stories of their grief experience. The categorical content perspective in narrative research is a good fit for analysis of this data because it will impact the report of the data for important research findings from the participants' lived experiences. Exact words shed light to help understand the meaning of grief in the culture and to answer the posed research question. It is also a good method to help answer the third aim question of appropriateness of the multicultural model of coping after pregnancy loss for understanding grief after perinatal loss in Nigerian women. According to Van, in this model the

difference in grieving and coping for women of color is culturally based, a finding in her qualitative interview study of 20 women of color in their eighth month of pregnancy after pregnancy loss. She discovered that the three prominent themes that explained the coping tools used by the women were: relying on self, connecting with others, and avoiding and pretending. The main tool the women used was “being with others” in religion or spirituality, which she defined as connectedness, for effective coping and better recovery after pregnancy loss. When any of these mechanisms are lacking, it leads to disconnectedness, which inhibits effective coping. This finding is contrary to grief response reports in articles on European American women after similar experience (Van, 2002). Van stated that the multicultural model of coping is a better tool of evaluation for women of color after perinatal loss (Van, 2002). The model is newly developed and has been tested in a limited number of research studies, also a reason behind the decision to test this theory and model for fit with Nigerian women dealing with grief after perinatal loss.

Experts in the fields of maternity nursing and midwifery and bereavement such as my committee chair (Dr. Kantrowitz-Gordon), and my content expert (Dr. K. Swanson) were consulted during the data analysis process for confirmation and accountability to the strictness of the research guidelines.

Rigor and coherence. The maintenance of rigor and coherence of the study were considered based on whether study concerns have been answered (Packer and Addison, 1989). Five criteria directed on how to proceed in the interpretive process: coherence, external evidence, consensus, practical implications (Packer and Addison, 1989). Coherence was judged based on whether the report represented themes and exemplars. The transcripts were double-checked by a

content expert in qualitative research, Dr. Ira Kantrowitz-Gordon. These processes were maintained all through the data collection and analysis proceedings.

Validity. Validity was maintained by checking findings with my committee content expert. Several participants were contacted during transcription to validate transcription accuracy of captured meaning. During data analysis, proceedings were coordinated with Dr. Kantrowitz-Gordon, for validity of findings in the transcripts. This was done independently, then notes were cross checked for developed codes that were independently derived for agreement. These steps were taken to confirm the credibility and of information gained from the data analysis. I kept a journal that documented specific observations and memos on the participants' interviews. Detailed descriptions of research setting and the participants involved in the study and findings are shared so that readers can ascertain the credibility and transferability of findings to similar context and setting in Nigeria or similar cultures.

Human subjects protection. Study procedures, consent forms, and questionnaires were approved by the Institutional Review Board of the University of Washington, Seattle, and the Ethics Committee for Research of Enugu State University Teaching Hospital (ESUT) Parklane, Enugu, Nigeria. Digital audio recordings were securely stored in a password protected network location through the University of Washington. Audio recordings were transcribed by a master's prepared Nigerian nurse and by the researcher in consultation with the contact person who knows the culture. After review for accuracy the audio recordings were destroyed. Initials only were used for participants' identification for protection of privacy. Any inadvertent identifiers in the interview transcripts were masked.

Positionality of the researcher. I am of Nigerian descent, born in England, United Kingdom. I was taken back to Nigeria at age 4 during the country's civil war, which lasted for

three years. From age 9 to 23, I have lived in and out of Nigeria until I immigrated to the United States of America when I was 24 years old. The majority of my life and life experiences have been outside Nigeria. My professional growth and experiences in obstetrics and women's health have been in the United States of America. I went into this research with a Nigerian name but very little knowledge of the subject matter and minimal understanding of the culture. In the Nigerian context, I am not considered a true Nigerian because of the above stated facts. So, I went into the research in a neutral position, which is important for my research, since I am seeking to learn from my participants' stories.

My position as a researcher was at the very front of my actions. Granted that my interest in this research arose from my interaction and dealings with Africans in the United States and from observing discord and shift of the equilibrium of the unit when nurses have to deal with patients who are outside the mainstream culture or who had different views or were not accepting the routine care per unit protocol. I had no idea how these cases are managed in Nigeria, and made no assumptions. I found myself understanding that I am an outsider, viewed as not belonging to the community, but because I am a nurse, there was that allowance of having the interest of the participants (patients) at heart. My novice status in research made me more aware and cautious of maintaining the integrity of the study.

The need to develop trust was always in perspective in my dealings with the participants and contact person, and I believe that I maintained "the balance needed to establish a sufficient distance between me as a researcher and the nurses, to make sense of the research data being collected," as expressed by Ann Bonner and Gerda Tolhurst in their personal accounts of conducted research through participant observation and the advantages and disadvantages of nurse researchers as insiders and outsiders (Bonner and Tolhurst, 2002). From the standpoint of

postmodernism as an appropriate table to the view of insider research, the epistemologies and perspectives view the research process and outcomes (results) as ‘co-constructions’ between the researcher and the participants in the research, regarding the research participants as active informants to the research and attempting to give “voice” to the information within the research domain (Denzin and Lincoln, 2000; Patton, 2002). These perspectives allow the researcher to conduct research ‘*with*’ rather than ‘*on*’ the population of interest. While these perspectives contrast greatly with the outsider research perspectives, the researcher’s position and awareness of not favoring a permanent position as an insider or outsider in the research is very important.

Chapter 4. Findings

Chapter 4 describes the study findings, beginning with the context of the interviews. Findings are then organized around the three aims of the study. In the first aim, I describe the narrative of grief in Nigerian women. These narratives shared common elements such as foreshadowing of the loss, grief felt as physical pain, and a master narrative of “God is in Control.” In the second aim, I examine the cultural influences on grief among Nigerian women. Examples of cultural features included the meaning of children and childlessness in Nigeria, survival of the mother is more important than the child, the importance of consolation in Nigerian culture, and the belief that God is in control is an alternative to grief. In the third aim I demonstrate the power of the multicultural model of coping after pregnancy loss to explain Nigerian women’s grief narratives. This was demonstrated by the connectedness from sharing of loss stories and the importance of community support to these women.

Participant Characteristics and Context

Findings include some general observations about the study population. Most of the participants were not very talkative in telling their stories; some stated that what they said is how it happened and did not understand why I was asking the same questions. Identified communication challenges included difficulties communicating in English, and the lack of English words to capture culturally important expressions in their native dialects. Some participants therefore requested to speak in their indigenous language with interpretation by a Masters prepared Nigerian nurse. The participants were eager to talk and shared freely once comfort in communication was established. The resulting transcripts are detailed narratives of their pregnancy, perinatal loss, and near-death experiences.

Demographic characteristics. Participant age ranged from 20 to 42. Occupations included civil servants, petty traders, seamstresses, teachers, a nurse, and homemaker. Gestational ages at time of loss ranged from 8 to 40 weeks. Participants' parity ranged from 0 to 7. All women identified as Christians. Participant demographics and obstetric status is described in Table 1.

Table 1. Participants' Demographic Data (n = 21)

Characteristic	Category	n
Type of Perinatal Loss	Miscarriage	7
	Stillbirth	12
	Neonatal death	2
Age	Range: 20 – 42 years	Mean 31.8 yrs.
# Pregnancies (Gravida.)	G1	4
	G2	3
	G3	4
	G4	2
	G5	3
	G6	2
	G7	3
# Deliveries (Para.)	0	1
	1	7
	2	4
	3	2
	4	2
	5	4
	6	0
	7	1
Previous Losses	Yes	18
	No	3
Duration since this loss	1-3 days	19
	3 months	2
Gestational age at time of loss	1 month	1
	2 months	3
	3 months	1
	5 months	1
	7 months	8
	9 months	5
	3 days post birth	2
Any living Children?	Yes	15
	No	6
Marital Status	Married	20
	Engaged	1
Ethnicity	Igbos	21
Religion	Catholic	11
	Protestant	4
	Pentecostal	6

Educational Background	Grade school	2
	High school	11
	Teachers college	4
	College graduate	3.
	Nursing	1

Interview timing and grief. Data collected was from July 20th to August 21st, 2017 at the ESUTH teaching hospital, Enugu in Eastern Nigeria (See Appendix E). Interviews were done at convenient locations preferred by the participants, ranging from the hospital grounds to nearby restaurant spaces. Availability of a central location for interviews was problematic during the data collection period (See Appendix F). On the day of the interview, the majority of the participants were still in the hospital and 1 to 3 days after the loss. Despite this brief period, the field observation of their state of mind and countenance was rather surprising. Most of the participants seemed cheerful, in good spirits, and very accepting of their losses. Each attributed a quick recovery to their faith, God’s love, and community support. The only participant who showed continual strong emotional reactions said she was sad because of the economic burden that her losses had placed on her family, stating: “We have used up all the money we saved on my pregnancy problems, I cannot help with pregnancy because I have to rest” (Participant #007). Most of the participants seemed eager to continue with their lives; most responded directly to the effect of “I have to think about the ones here,” referring to their children. The analyzed responses of the participants’ stories seemed to echo the goals of the research, which is to understand the meaning of grief after perinatal loss to Nigerian women. Details of the participants’ responses showed the meaning attached to their losses from their cultural lenses.

The context of medical care. The role of medical cultural context in the lives of the participants is important for understanding their experiences of loss. The medical practice culture in Nigeria should be in viewpoint to understand the challenges women and their families have to

deal with. The society have to routinely navigate the system for those who depend on government establishments for health care. Health insurance is not an option at this time, except for those working in big companies or federal government employees, none of the participants had insurance. The general state of health care in a government teaching hospital was a noticeable contrast to teaching hospitals and practice of medicine in developed countries like the United States. It took a considerable effort to adjust my thinking and orientation to the culture, including the state of the units and the burden placed on the patients. The teaching hospital serves the under privileged of the society, but with financial burden of hospital costs. One can easily view this practice as an oxymoron of the concept of serving the disadvantaged. Patients has to grapple with financial decisions and travel time to the hospital for care

Most of the participants in the study were transferred from other private or community hospitals and maternity homes, where service cost is cheaper for the patient. When these hospitals could no longer handle the patients' conditions, family members are asked to take their loved ones to a teaching hospital for a higher level of care. Most of the participants were transferred with hemorrhagic complications. On arrival, the family had to deposit some amount of money, had to be given a long list of all medications, intravenous infusions, blood and blood products, anesthetic medications and such needed before proper intervention could be initiated.

According to the information from personal conversation with a nurse from the institution, a procedure like D & C costs about 25,000 naira (\$70) after completing the medication list (Personal conversation, August 15, 2017). This is a huge amount to people in low socio-economic class, the primary constituency of the hospital. The hospital's regulations are due to no fault of theirs since the government, both state and federal, have not made health care a priority in the country, and hospital management must keep their doors open somehow. The rich

can afford to get private care at any cost or seek health care outside the country. The importance of financial difficulty was demonstrated by a mother who lost her newborn. She responded to the question of what helps her bear her loss and move on with life with: “People wey do more na gburugburu.” This statement was clarified by the local contact person for the research study. Gburugburu was the nickname for the state governor, Ifeanyi Ugwuanya. The meaning was “He discharged us. He cleaned our bill and that help” (Participant #003). This response indicates that she has shifted from thinking about her loss to dwelling on every day survival matters. She was just happy that the governor settled her hospital bill, there was no residual grief feelings. This showed how she was moving away from her feelings of distress acknowledged earlier in the interview.

Transferred care. Most of the participants were transferred from another health care facility for a higher level of care. Most had cesarean section delivery with bleeding complications; the participants included in their narratives the bleeding problems encountered following their pregnancy loss, delivery, or before transfer to the teaching hospital. Most required blood transfusion and others still looked very pale as seen in cases of anemia.

Participant 001 tells her story of near death experience as related to her by her family:

The next thing that happened was that I was in a bed and they started their story, which I knew nothing about at the time. I was told that I almost died, that they gave, were giving me blood, that was what people said. I knew nothing about at the time. I was told that I was almost dead and that they were giving me blood, that was what people said.

This participant was not transferred to a higher level of care until it was almost too late. She told the story of her bleeding and lethargy/unconsciousness, receiving blood transfusions and heard about all that happened from other people who witnessed it.

Participant 014, was also transferred to the hospital in critical state with bleeding and loss of her baby. She narrated:

When we got there (meaning labor ward at good shepherd hospital), they examined me. The water following baby burst, by then bleeding followed that. And the bleeding continued to flow. They checked and saw that it was not what they could handle and asked me to go to Parklane, that Parklane could handle it.

The participants were all transferred to the teaching hospital for a higher level of care. Due to socio-economic challenges, women in Nigeria will seek health care at low cost facilities to meet their family's financial needs. This practice leads to their transfer of care in emergency situations, which was what happened in the cases of the participants in this study.

Moving quickly through grief. Generally, the participants demonstrated an approach to handling the loss of the pregnancy or infant that focused on moving forward, despite the seriousness of events. They were not dwelling on feelings of grief, they showed strong faith in God, displayed total trust in God as being in “control,” and using community resources. These common approaches will be explored further in analyses for the three-specific research aims. The participants were open to the perceived usefulness of the resources of faith, community support, and words from wise women and other mothers who had gone through worse experience than they were experiencing. The Nigerian women who participated and shared their stories did not believe in dwelling in the past or what might have been.

These Nigerian women, 2-3 days after their loss, were ready to move on with their lives. They had these to say: “I have to forget, forget it, it is up to God. Something I say is that God gives and God who gave me that baby will me another to stay. Here they treated me and that is

how things happened” (Participant #001). Her statement showed resolution and acceptance of what happened, and that she was already thinking how God would give her another baby.

Their affirmed quick recovery did not take out the painful fact of losing a baby or pregnancy, but the women of this culture, represented by the participants of this study, chose life, faith and a grateful heart. This did not make their loss any less significant than the loss of another woman from a western culture where grief may last longer.

Aim 1: To Describe the Narrative of Grief in Nigerian Women

The narratives of the participants captured the essence of their stories through their pregnancies and their losses. The participants were able to share their stories starting with the pregnancy, plus precipitating events that, to them, contributed to their loss or a reason for going to the hospital. The participants all talked about the birth of their babies, whether the baby was born alive or dead. They shared their initial reactions to the loss ranging from disbelief, crying a lot, questioning, and trying to understand and their process of acceptance. The women spoke about their resources for their grief resolution, which is mostly centered on their faith, family support, and community support of learning from other women who have gone through similar experiences. They were able to utilize the cultural resources in place for dealing with demanding situations.

Their narratives showed the structure of a story with a beginning, middle, and end. Narratives, as a form of interpretive phenomenology, have the aim of using the participants’ stories to uncover naturally occurring meanings and understand the embedded meaning (Benner, 1994). The participants’ narratives included the following features: causes for the loss; events that foreshadowed the traumatic loss; processing their grief; and resolution of their grief. Below are some of the identified features.

The participant shared the cause of their pregnancy loss as they understood it from the medical staff; an example shared by participant #007 was: “The period did not show, until I found out that I was pregnant. Two weeks later I now started bleeding, so I rushed to the hospital, I explained to them...”. It was important to this participant that she shared her story from the point of recognition of being pregnant, which was marked by her missing her period. Missing the menstrual period is a general understanding of conception in healthy women of child bearing age and was the beginning of her story; the other steps and explanations all come together to make sense when she started bleeding as a sign of impending loss, just as the missing of her period marked the presence of pregnancy.

A common narrative element was foreshadowing the death earlier in the story. For example, participant #016 shared:

Mmmm...before I lost the baby I didn't have any problem of ill health or all that but somehow I was ...I was having something like spotting. So I complained to my husband I even showed him what happened. Sooo...that was just it; the next day I was preparing to go to work, on my way to the office, it now happened.

The participant shared her perceived forewarning of what was going to happen. She clarified the signs that clued her that something is wrong with her pregnancy/baby and she compared it to her state of wellbeing. Vaginal bleeding or spotting are considered danger signs of pregnancy. Similarly, Participant #001 shared her traumatic experience of perinatal loss and near-death experience from severe hemorrhage: “I was lying there and I don't remember anything else happening. I was told that I almost died, that they were giving me blood, that is what people said.” It was important to this participant that the gravity of her near-death experience be

recognized as part of her perinatal loss story. She was unaware of her situation at the critical time; this part of the story was told to her by others who observed her in her critical state.

Perinatal loss as pain. Over half of the participants responded to the guided prompt on the meaning of grief related to their pregnancy/baby loss as “pain.” This description was made with the gesture of placing their hands over their hearts. They had this to say: “To me ... I see it as ... pain ...”, “Heart break, very bad pain.” “It means loss to me and can be painful.” “It is painful” (Participants # 005, 006, 018). They used physical symptom of pain as a metaphor in expressing an emotional/psychological feeling to express the degree of the feeling. There was no mention or use of the word grief in their stories and expression of perinatal loss, just as there were no references to their lost pregnancy or baby as a child. All the participants stated: “Grief means pain,” “grief is painful,” “the kind of pain I would not wish on my enemy” (Participant #008).

The wide ranges of response showed that the participants are not using the term “grief” as associated with their pregnancy loss. There is a lack of language for grief. I had to use more a descriptive word to help them understand the term. The research liaison explained that the Nigerian term “Iruuju” is generally associated to the loss of adults, such as a husband, wife, parent, grandparent, or grown children. The observed lack of language or term for perinatal loss seemed to be consistent with the scarcity of articles on perinatal loss in Nigerian because of the absence of attention to death of children. Participants also explained that nothing specific is done when babies or children die. The husband is expected to go bury the child, and a friend or two might volunteer to accompany him. The women generally have no idea where their babies are buried. This might be viewed as not being appropriate by other cultures, but it is an acceptable practice and behavior for Nigerian women. This practice and might be considered a protective

cultural mechanism. As can be seen from the example given about women having no idea of where their babies are buried, cultural beliefs and patterns were important in the narratives of grief. The cultural influences will be discussed in greater detail in Aim 2.

A Master narrative for perinatal loss. It is necessary to discuss the concept of ‘master narrative’ as an identified feature in the grief response of Nigerian women after perinatal loss and how this feature is important to their grief resolution. The concept of master narrative is an abstract idea that is meant to be symbolic in comprehensive explanation of historical experience or knowledge as shared in narratives. Jean-François Lyotard (1979) introduced the term in his series from tribal to feudal to modern time up to present. He used it in explaining narrative knowledge as in the form of stories. Narrative explains and authenticates knowledge of existing power relations, customs, and such. It helps as an inner connector to make sense of events in the story (Sage Encyclopedia of Social Science, 2004). Master narrative is also sometimes referred to as ‘emancipated narrative’ — about a story that includes and explains ‘little stories’ within the total structure. It is a global or totalizing cultural narrative schema that orders and explains knowledge and experience.

God is in control in the narratives of the participants is the identified master narrative. It is the mediated constructed realities in the participants’ stories to simplify the complex issues in their grief as the absorber of their pain, and reason for them to move on with their lives. The women in their faith have transferred the responsibility of life and death to God as the one in control for the unexplainable events of their lives. This total transfer and surrender of power makes the burden of loss and grief easier to bear.

God being in charge as the supreme being bringing order to all chaos was an unshakeable belief of all the participants. Even when the story started with how heavy their hearts were and

their grief reactions, they cheered up by their conviction that the God who gave them the baby that did not stay will give them another. Repeatedly, this idea gave them hope and unshakeable acceptance and took away any and all needs to question this event in their lives. Some participants stated that at the news of their loss they asked, “God why”, but they also ended their statements with “you cannot question God.... God knows best...He does not do anything without a reason” (Participant#014). They remained optimistic about the future and continued to believe that God was benevolent:

Then about my baby that died, I am deeply hurt but “what can I do.” I have to forget, forget it, it is up to God. Something I say is that God gives and God who gave me that baby will me another to stay (Participant #001).

Relinquishing to God’s control also could indirectly benefit the woman by reducing stress and blood pressure: “I’m controlling myself. Asking God to take my mind off... from remembering it, because it is the one causing my BP up again.” (Participant #017).

A summary of the narrative elements of the perinatal loss grief stories with exemplars is presented in Table 2.

Table 2. Narratives Elements in Perinatal Loss Experience

Narrative Elements in Perinatal Loss Experience	
Descriptive of Story	Sample Quote
Precipitating factors	The women, telling their stories from the beginning of their pregnancy is a characteristic of a starting point in a narrative, “what happened was, when I took in...as my pregnancy got to two months, I started having raised BP” (participant #021)
Cause of Pregnancy/Child loss	This feature of their story focused on their child loss; “because my baby is not positioned well, I was told that I could not deliver vaginally but through operation...they examined me...the water following the baby burst, then the bleeding follow

	that...when they operate I was hearing what they were saying there...the placenta on its own and the baby on its own..."(Participant #008)
Use of descriptive words to help understand their loss story	Some of the participants used expressive words to help in understanding their grief story, example is "I was expecting to have a baby...after 9 months" (Participant #018). "I thought that I would live with him like others live with live with their babies too" (Participant #014)
Perinatal loss as pain	The participants used physical symptom to express their psychological and emotional state at their loss. "Grief...it's something like sorrow, when someone is in pain" (Participant #016), Participant #020 stated "It was painful experience that...I had to lose her". Similarly, participant #006 shared, "...painful. It means pains".
Master Narrative for Perinatal loss	Master narrative identified in the participants' stories is "God is in control". God seen as the supreme overseeing all events of their lives is given the responsibility of their loss too. "God is in control, God knows best" (Participants #011, 018)

Aim 2: To Understand the Cultural Influence on Grief in Nigerian Women

Culture is a very complex part of any society, it is also an important part of life, culture is in everything. The aspects of culture shared in the participants' stories will be discussed here. Data analysis revealed the many ways that culture played a role in the women's experience of perinatal loss: importance of God, and belief in God, the value of community support, the meanings of having a child and childlessness, and appropriate methods for consolation.

Importance of God. Church and prayers are important in the participants' grief journey. This was found consistently in the participants' stories and responses to the research prompts, God is in control; God does not do anything without a reason; God knows best. It was important to all the participants that they had someone or group praying for them. In their own words it "comforted" them and "helped" them move on with their lives.

The women's faith in God was another identified grief survival tool of the participants. This participant said, "Na God, only God. I pray a lot. I just remember God and the advice some people that come use to tell me, so I just used that to hold myself together and come back" (Participant #004). Another said that "God will bring another one, that's what I said that this one is not all, this one have come and go, that another one will still come. So that's all..." (Participant #008). This participant summed up the way the women dealt with their loss through faith, community and family support, and cultural expectations. From the women's perspectives, this is their story of perinatal loss and what it meant to them.

A sense of strong belief in God resonated in the participants' individual experiences and stories – God was personal to them. The narratives had a sense of testimonial as each shared the story of their loss and the sense of triumph over what could have been a double tragedy, of losing both mother and baby. By surviving, she can live to see another pregnancy: "Every day I just wake up and I count my blessings...God knows best and I believe that he will give me a boy that will do that" (Participant #010). She is referring to a male child that will keep the husband's name and continue the lineage. Nigerian culture considers the male child more important than female children because female children marry out to another family and change their name, while the male child will marry and bring forth children bearing the father's name. Another participant shared about her recovery: "with prayers, it wasn't easy, but with their encourage... words of encouragement, quoting Bible... and all that... giving me their own experience and... you know, so many other things; I was able to scale through." Another participant on her way to assisted delivery of her dead second twin stated: "So I told them to do me the operation that with the power of God I will come out and Jehovah made it so. I did it in peace and came out in peace." Yet another participant on a question about grief stated: "It is mourning, and it is painful

but with God we can overcome all” (Participant #20). She also had this to say about her fast recovery from described symptoms of clinical depression after her baby’s death: “...So they helped me through prayers and I was able to get over that. It was a difficult time but God had mercy and saw me through.” Similar to other participants, there is a total relinquishment to God of the whole event of death and loss.

Traditional community support. For all the participants, visitation and advice from friends and others with previous experience of loss was a big source of strength, second only to their faith in God. Repeatedly, they shared how they gained strength from hearing the stories of loss told by other survivors. Most of the participants shared that hearing other’s stories helped them put their own loss in a better perspective because comparing the stories they heard to their own loss, made them feel like their loss is bearable in comparison. Some of the participants of them stated: “It was after hearing her story that “I stopped crying.” “I know that mine is nothing compared to her.” “It helped me pull myself together,”(Participants # 001, 008, 016, respectively). Similarly, the sharing of Participant #015, who stated: “...it was how people were saying to me...it was the words people used in talking to me that made me to forget it.” Forgetting here meaning letting go of her grief and moving on with her life. Participant 002 expressed the benefits of community support through shared experiences:

Stories shared by other women helped me. Even like this morning, my mother called me and told me that anything that happens to me, I was not the first person that it happened to and I will not be the last, others have experienced it, other have experienced so, what you need is to pull yourself together. And me, I am like, I don’t like other that will be copying foreigners, if it happens, it happens.

This participant clarified her statement by talking about the uselessness of allowing oneself to get depressed, needing psychiatrist and taking medications, which does not change the event that occurred. She mentioned that none of that changes what has happened and that when one succumbs to depression and seeks psychiatric help, it is comparable to one “acting like you are in control” of what happened” which will be lack of faith in God.

Community support and words of consolation came to the women without needing to ask for support:

I have asked no one, but people came to me, visited me with words of encouragement, that the child that will stay is coming, the child that will be mine to stay is coming, that no one knows how or why this happened, that I should bear it and take heart that it is better that the child goes than me dying, that I am young and will have more children. It is comforting, and it helps me get hold of myself (Participant #001).

She took the advice of others and has accepted her loss. These examples demonstrate how the cultural practices promoted rapid resolution of grief after perinatal loss. This participant did not seek support, but other women visiting patients in the maternity ward heard of her story and visited her bed space to offer her some consolation. She appreciated these visitations; they made sense to and comforted her.

Expectations for husband to provide hospital supplies. Husbands were occupied with making sure that the medical supplies for taking care of their wives were available. With the exception of one participant, all the husbands went out either to buy prescribed medication or tried to find money to settle the hospital bill, so the wife could be discharged. Families must provide all the medications and medical supplies needed for hospitalization of their family

member. Hospital supplies to be provided include; iv infusions, suture, anesthetics, antibiotics, pain medications, and such for the mother's surgery or delivery.

Meaning children and childlessness. Participant responses revealed the meaning of a child ranged from being a helper, to joy, or to carrying on the family name in the cases of male children, revealing the profound influence of cultural practices in the grief response among Nigerian women. Greater emphasis on this finding came mostly from participants with no living children. Participant #001 in response to the prompt question of "Can you tell me what this pregnancy/child meant to you?" said: "A child is very important a child make you happy," and a husband chimed in that meaning of a child in having a helper called your own. Another participant said:

The importance of a child is that, in short, anytime you have a child, when you get home after a hard day's work, you ask the child to get you a cup of water and he will. Anytime you see the child, your heart will be filled with joy, because it is your child, your hope and future (Participant #001).

Participant #010 shared: "Expecting the baby, I feel like other women with children." Expressing the importance of being a mother like other married women. Participant #017 stated: "I thought I would live with him like others live with their babies too." Once more drawing attention to the cultural expectation of a woman to bear children. Another participant expressed her joy and dreams that she will be a mother: "I am the one who will carry a baby in my arms. God, I will have a baby like other women?" (Participant #014), this participant highlighted the importance of feeling fulfilled as a woman by becoming a mother and being accepted in the circle of her peers Participant 017 shared: "It means a lot to me, after my last loss, people are saying that I cannot have another baby but I thank God who gave my lost womb...and I lost this one (baby)." This

participant expressed her feeling of being vindicated from a childless state. A child seemed to make a woman feel complete, fulfilled, and rewarded. Similarly, being childless brings the label of “barrenness” to the woman. Analysis of the narratives identified the meaning of childlessness. Nigerian culture values children as the hope for the future and women in Nigeria measure their worth in their husband’s family with the number of children they have and the mixture of the children (boys and girls). The participants responding to the interview prompt of “What does this pregnancy mean to you” identified the meaning of childbirth and children to women in Nigeria.

To me, a child is a woman’s happiness. It is a woman’s happiness in every home, without a child your home will be (searching for words), like when all this years I had no child, I see my neighbors with their children and I will go inside my home and it will be very quiet and I will be asking God, when will it be my own time to have children so that this quietness will go away? (Participant #011).

This response shows that a woman in Nigeria considers her womanhood and happiness complete with bearing children. Another participant said:

Hei (emotional exclamation), staying for years without any pregnancy, this pregnancy was like (sigh) (in a wistful voice), so I will be a mother, I will carry my baby this year? I was hoping and preparing everything! (stressed), but God knows the best (Participant #012)

There is also the taunt of other women and in-laws that goes with childlessness. Another participant additionally shared:

Before I had my first baby, it was hell for me, it was just one year of marriage, my mother in-law will call me and tell me that she is coming to my house to visit with some

children ... if you cannot give me any grandchildren, I will bring other children to be my grandchildren, all this just to be wicked to me (Participant #013).

These examples are important to help understand the uncomfortable position of childlessness for Nigerian women. It is almost like having a child and losing the child is better than not being pregnant at all. The community is sympathetic to mothers who lost their children but almost unforgiving for childlessness.

My next-door neighbor, she had a small baby about 4 months and I asked her if I could hold the baby, she said no, you are not a mother, you will not know how to hold her; it was not a funny time in my life. Even with this baby gone, I am still happy, I thank God that I have baby at home, nobody can say that I am not a mother. (Participant #017)

The narrative here draws attention to the importance of motherhood. A barren woman is not respected as being a complete woman. For this participant, her lost pregnancy served an important purpose as a proof of her womanhood, for which she is grateful. The community will now be sympathetic with her incomplete motherhood for not yet having a son; her motherhood has been proven even if the child did not survive.

Survival of the mother is paramount. Survival of the mother was seen as more important than the survival of the fetus or infant. As one participant said:

When I heard it I cried so much that I could not be consoled but they consoled me at telling me that God who brought this one will bring another one. That it is better for the baby to go instead of my head going with this one. Understand ... God knows why it happened (Participant #008).

The survival of the mother allows for future opportunities to bear and raise children. Survival of the infant after death of the mother is more problematic because who will raise the child? The

devastating effects of losing a mother were apparent from an incident that happened at the Parklane hospital to a non-participant in the research. I observed the devastation of the death of a mother to her surviving 14-year old daughter. Participants' comments about the comfort from words like "It is better that the baby passed on and you are here," made sense as a mother can always find a way to take care of her family.

The 14-year-old that lost her mother to post-surgical bleeding complications was finding it difficult to make sense of her life, her new baby sister, and a 3-year-old sister who needed care. I witnessed the horror of this young girl's anguish and the terrible confusion of trying to make sense of her shattered life and that of her 3-year-old sister and a newborn. I witnessed the agony of this little girl surrounded by girls her own age trying to console her and talk to her about what she should do to get a message back to their village so that some relatives or good villagers will help her bury her mother. She had lost her father and brother few months earlier. A mother in the culture takes care of everything and everyone. She cried inconsolably, faced with the cruel reality of life and the uncertainty of her future. On reflection, it brought to context the women's repeated shared narratives of gratefulness that they "survived," that they are "alive" to talk about their experiences and that they should channel their energy and effort to taking care of their surviving children. I reflected on their sense of gratitude amidst their loss, and why the reminder of gratefulness made sense to the women and why they were on task about getting on with their lives and taking care of their living children. I wondered what the faith of the young girl and her surviving siblings will be now that they are orphans.

Consolation in Nigerian culture. The observed familiar words of comfort and consolations from the stories show the features of how Nigerians approach consolation. Participants found comfort and consolation from advice given by others, like "... telling me I

should thank God by not me dying... that I should thank the baby that the baby died just because of me... All sort of stories coming.” “They talk to me about people who lost their babies and their big children, telling me that it is better the baby goes than me, that I can have other children who will stay.” “It helps me, it make me hold myself and see that my case is not the worst.”

Another participant stated:

That I should just take it that that is the will of God; I should not even think about it; that since it's here... thank God that we have ehmm ehmm... a baby with us now. We have at least one. There are people that doesn't have, and God is... that has already given you one and gave you another one.... you are still young, you will still have those babies, the babies you want to have. ...words of encouragement, ... I was able to scale through.”

Phrases like “you are young”, “you will still have other babies”, or “God used your loss to remove some things from your body”, “there are people who do not have children”, would be viewed as inconsiderate and insensitive if directed at a woman with perinatal loss in a western culture. This is because of the western cultural perspective and such comments may be viewed as not being helpful to the patient.

In the context of the culture, my findings confirmed that these ways of talking and consolation were indeed useful and consoling to the women. What is considered uncaring words in the context of United States is acceptable to the women of Nigeria. I found that the participants were able to move on with their lives.

Interviewer: Are you saying that these words..., like, “you will have another one” or “this one is not your own, so let it go instead of this one to take your head.” “The one that is your own will stay,” are comforting and consoling words to you at this time?

Participant #016: “Yes, it is comforting because when they say that, it help me hold my self together, sometimes their own make my own look easy.”

Culture offering the alternative in grief. This section of the discussion ties together the ideas of aim 2 of the research, the cultural features identified among the participants that helped them move quickly through their grief. These features involved shared experience of women who had been through child loss experience, and community support involving direct family or church family and friends. Based on the findings from the narratives of the participants, the assumed normal response to grief as described in the five stages of grief by Kubler-Ross (1969), seemed not to be an option for these women. The participants experienced sadness at the news of their loss but not the defined stages of grief as stated by Kubler-Ross. There was no observed denial, anger, bargaining or depression, the women were all at acceptance and getting to resolution of their grief. According to the Nigerian women, it solves nothing, and helps nothing to dwell on the loss. The alternative to prolonged grief and depression is to learn from people who have gone through similar experiences, focusing on God as the alternative in grief, having a grateful heart for surviving the ordeal of a child or pregnancy loss. The participants responding to the prompt question of “What in your opinion helped you deal with your loss?”, meaning to get on with their lives so soon, responded as follows:

But I believe... Uche chukwu ga eme (meaning, God’s will, will be done) ... and again, sometimes I sit and think... understand? So... all these things... I don’t know...

because... I handed everything into God’s hands. I don’t know what the problem is, only God knows (Participant #015).

Nigerian women showed themselves to be from a praying culture and highly dependent on their faith, belief, spirituality, and relationship with God. Depending on God like the

participant shared: “God’s will be done” has to do with total surrender regardless of the outcome. In so doing the burden of the event is not in the control of the one experiencing the phenomenon. Dwelling on the loss will otherwise be viewed as lack of faith and trust in God. The support of others tends to remind them of the importance of this trust in ‘God’ as the master narrative.

Participant #016 shared that, grief is:

something like sorrow, when somebody is in pains, that’s grief. So I will say I was in pain; I was in pains then, but you know, when you God, and people around you that helps you to pray and support you, encourage you, giving you words of advice, you know, you’ll be able to pass through those pains, but when you’re not with God, when you don’t pray or ask him for direction....

Similarly, this participant showed her total surrender to God even in this painful event and that trust made the burden of pain easier and she is able to move faster through the grief experience. Participant #021 stated “If you don’t have God, you are lost and you need prayer. My pastor prayed with me when the devil was telling me not to read my bible and I was able to overcome”. In other words, grief is a painful event, even unbearable experience, but without God, prayers, or directions the pain will truly be unbearable. Once again, total surrender to God in the outcome of a perinatal loss made the grief easier to bear and the participant could move through grief faster.

Hence, the belief that, with God, nothing is impossible. This belief helped the participant to bear that which can be perceived as unbearable, making faith and belief in God an important feature in the grief resolution technique. Not being in control makes the burden of their loss easier to carry. Giving up responsibility of the event to a higher power helped them through their grief and helped them cope with their loss. Participant #002 said this in explaining to the researcher the importance of God in her life and prayers:

We have the belief that God give and having that believe her in Nigeria, our religion, there are verses that will hold you. Once such thing happens, you will see even people that has gone through it they will give you verse and verse that will help you.

She tried to explain that they drew comfort and solace through the word of God in the Bible and from reading the Bible. Cultural features of the grief response are summarized in table 3.

Table 3. Cultural features in Grief

Cultural Features in Grief	Outcome
God <ul style="list-style-type: none"> • Faith • Belief in God 	Helped them move to grief resolution
Community support <ul style="list-style-type: none"> ▪ Husbands as provider (hospital supplies) ▪ Meaning of child/childlessness ▪ Importance of survival of the moth 	Changes perspective of loss and move to grief resolution
Consultation <ul style="list-style-type: none"> ▪ Other mothers sharing stories of their loss experience. ▪ Listening to words of support from other women 	Reminder to view loss from a different perspective, helps move to resolution

Aim 3: To test the appropriateness of the multicultural model of coping in Nigerian women.

The transcripts were analyzed for elements of the multicultural model of coping with grief looking for attributes of connectedness such as depending on others, religion and spirituality. It was found that connection with family, friends, and church is vital in their coping effectiveness: “My family and church will not let me go there” (Be depressed after loss). “I listen to other women with experience” (Shared past grief experiences). These are the identified responses that showed connectedness in time of grief that help the participants deal with their

loss. Identified use of religion and spirituality in coping with grief after perinatal loss was noted in these responses by the participant; Participant #016 shared.

It was... it was a hard period for me. But thank God, my people were all around me, supporting me, my husband was there when it happened, and I was able to cope with that and ehmm... move on with my life, you know... with ehmm doctor's ehmm advice to calm down, forget everything, that... that everything is going to be fine. I don't have any problem but because it just came like that, and God willing, another one will still come. I believe so. So, I didn't have any issues with that one because I have a good husband who is supporting me too (Participant #016).

The narrative of this participant outlines the importance of connectedness. It took the community support and other women sharing their stories to remind her of her faith and the need to be grateful to God at this difficult hour. Being reminded that others are thankful that she as a mother did not die, helped her put her loss in a different perspective and be grateful that she is alive to take care of her little children, who would have been without a mother if she had died. Similarly, with other participants, the reminding helped the mothers to put things in perspective and not dwell on their loss but appreciate the opportunity they have at life to take care of their living children.

Shared experiences of suffering. All the participants described other women visiting them at the time of their loss for condolences and comfort. Participants repeatedly stated that listening to other women who have gone through a similar experience helped them gain a unique perspective on their own losses. It made their losses not feel as bad. Hearing others' stories helped them become appreciative of their lives and the lives of their living children or their family. They had such comments like the following:

Whoever had an experience or an encounter at the 'OZU', whenever that person enters a forest... That is, whoever had an experience where blood is spilt, when this person enters a forest, and the person sees 'OZU' ... 'OZU' is a red mound that is pure red. ... when you see it in the forest, you take to your heels because something bad has happened to you before. So I learnt from people's experiences. And accepted that I am not the first person who had a baby that died, I am not the second to experience that as well, and I will not be the last (Participant #004).

Thus, the 'Ozu mound' is a metaphor for recognizing a repeating event such as perinatal loss. Someone who experienced bleeding once will recognize a similar future occurrence, as represented by an Ozu mound, and react appropriately. This preparation can come from personal experience or from the shared stories of others. Hence, there is some preparedness for moving on with life after such perinatal loss when it repeats. Thus, there is connectedness within a woman's own experience and across the experiences of other women. This participant alludes to how she will be part of that chain of connectedness in the future because she "will not be the last."

Importance of community support from Women. The participants stressed the importance of community support such as church, family members, and friends, and the women who shared their similar experiences or worse. The two participants still working on returning to some sense of normalcy had no family members or friends to visit them. They both had a visit from their pastor and had only their husbands for support. This can undoubtedly be very lonely since those reported to rally around women with perinatal loss are always women. Additionally, these two women are deprived of the comforting words that can only come from these supportive women. Even in times when these supportive women have not experienced perinatal loss, they

often know someone with similar experience or worse. The participants' shared responses about community support from other women around them;

She said when I was done and came out, so she said I shouldn't cry and I shouldn't think of it, that anyhow it is that God knows everything, that if God wanted her to survive she'll survive and if God doesn't, God knows everything that happened. So I should try my best to keep this one to myself (Participant #019).

The participant narrated the importance of support from others around her as helping her get grounded again in her faith and trust in God and helping her fast move through her grief to a resolution.

Participants repeatedly expressed the notion of having "overcome" their tragedy and a sense of resolution and moving on with their lives while waiting on God for their next pregnancy and child. They seemed to place great emphasis and value to words of "encouragement" and shared experience of others, especially from those who shared similar experiences. The general idea is that babies are not given any funeral rites/services because they have not achieved anything in their lives. Study findings also revealed the general notion of relief that the mother's life is spared instead of the child's. When medical complications surrounded the loss, these feelings were shared by those who witnessed the seriousness of the events. Most of the participants stated that they had to be realistic and at terms with their losses because they are alive to try again or to take care of their child/children.

The observed grief resolution of the participants was largely related to "connectedness," which was shown in their heavy reliance on the cultural role of women sharing their past grief experiences with the women with new loss. This practice seemed to reflect "the structure of caring" as described by Kristen Swanson (1993) in her article "Nursing as informed caring for

the well-being of others.” The supporting women maintained belief in their attitude towards the women with loss. They understood the general condition of the grieving women and the situation; participants reported their words of “encouragement” seemed to convey the message of “being with” in their most vulnerable moments. They were doing for the bereaved what the bereaved could not do for themselves at that time — “give them hope” of survival by sharing a similar hard story that was considered to be therapeutic and “enabled” the grieving women to cope effectively and resolve their grief. The grieving women drew strength from those who have gone through a similar painful journey or worse, and still lived to tell their stories to help others.

The cultural pattern of making meaning and understanding out of their losses and challenging events can clearly be identified in the modified multicultural model of coping after perinatal loss. There were identified reconciliations within the stories exhibiting acceptance and resolution with their losses. The position of the self was demonstrated by the participants’ sense of gratitude for surviving the ordeal of pregnancy or newborn loss. “I thank God that it happened now instead of later.” “I am fine, I have to think about the ones here.” “I thank God it did not take my head” (Participant #011). The shared narratives showed the ease of the participants at relinquishing the burden of their losses to God as the “master narrative”; “God is in charge.” “I am fine because I have God.” “God knows everything and why things happen this way,” and “I thank God that I am alive.” Also, this narrative helps the understanding of the importance of faith and God in the participants’ grief experience: “God who brought this one will bring another...what happened will not make me stop thanking God or believe in God because God is in control... I trust and hope in God” (Participant #008).

In summary, connectedness discussed in the aim 3 section showed how the participants gained comfort through shared experience of suffering with others who have gone through

similar experiences, and the importance of community support of family, friends, and other important contacts in their environment in processing loss and resolving grief. Caring and support after such a traumatic event are crucial to resolution and healing. Connectedness was an important and prominent feature in the participants' grief response and resolution after perinatal loss and the fit with the multicultural model of coping after perinatal loss is shown in Figure 4.

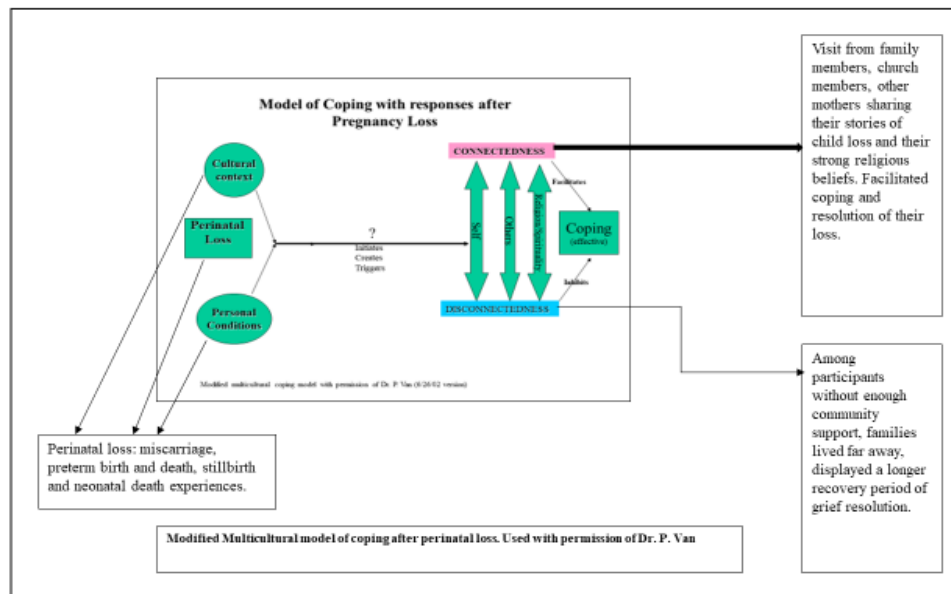


Figure 4: Modified multicultural model of coping after perinatal loss

Conclusion

The findings discussed in this chapter revealed the different factors that can mark the experience of grief phenomenon for Nigerian women. These factors are also significant in the participants' rapid resolution and moving on with life after perinatal loss. The findings also suggest how environmental influences and culture can affect how they process their life experiences. How people learn and gain knowledge of life events including grief will affect their reactions. For the

participants in the study, God and connectedness in the culture played a major role in their grief response and moving on with life.

Information filled narratives of grief from the participants provided need information to understand the narratives of grief among Nigerian women following perinatal loss. Nigeria is noted to be a religious culture, from the analyzed narratives, it is obvious that the Nigerian women have a strong culture that influenced their grief response after perinatal loss. The belief in God, community support in grief, women sharing their loss stories to help those who experienced perinatal loss are some of the identified cultural influences on grief in Nigerian women. From the analyzed participants' narratives, attributes of connectedness like, family support, faith and religiousness were recognized among the Nigerian women. These attributes are consistent with the identified attributes of the Multicultural model of coping after pregnancy which denotes connectedness and consequent effective grief resolution. The multicultural model of coping after pregnancy loss is an appropriate model for use among Nigerian women

Chapter 5. Discussion

The purpose of this research was to understand the grief response of Nigerian women after perinatal loss. The research was also designed to try to understand the impact of cultural influences on their grief response and the validity of the multicultural model of coping as an effective one for these women. In this chapter, I will compare the findings to other studies on grief after perinatal loss to see how the findings fit with theoretical frameworks for loss.

Implications of this research for practice, policy, education, and research will be discussed. The insider/outsider concept in qualitative research will be further discussed including suggested ways of controlling the problem in research.

Observed Grief and Elizabeth Kubler-Ross Grief Model

The observed grieving process among the Nigerian women was very contradictory to the popular grief theory of Kubler-Ross. Participant narratives had no explicit or implicit representations of denial, anger, bargaining, or depression, key elements of the Kubler-Ross stages of grief. The women acknowledged and accepted their loss. In response to question 3 in the interview guide, some people say that they feel regretful, guilt, and such feelings when they experienced loss. How did you feel after your pregnancy or baby loss? — participants denied any of those feelings. The only feeling that was mentioned was regret. Participant #020 responded: “I had some regrets because ehmmm...during the pregnancy, I wasn’t coming to the hospital for antenatal care, I wasn’t taking my routine drugs, so I think that must have been at least one of the causes of what happened.” but they all echoed that God is control and must have a reason for allowing them to go through the loss experience and they are grateful to God for being alive. Participant #008 said:

I do not feel anything like that. Like people say, I thank God that my head did not go with the baby. I miss my baby but the God that give this baby will give me another baby that is my own and that baby will stay. I don't know...this is what I can say.

It is hard to determine if this response was in connection to the suddenness of the losses or just the reality of the Nigerian culture. It was clear that everyone grieves differently, and it is important to consider the cultural context of the individual concerned. The responses to the narrative prompt pointed to the fact that regret, blaming, anger was not part of their grieving process. The participants focused on the identified master narrative 'God' for meaning, strength, and hope in their grief.

The women definitely expressed shock at the news and knowledge of their babies' deaths. They cried, each one of them in their own way, moaning their loss — of motherhood, of holding their baby, or playing with their children. One mother, clenching her heart, expressed that "it hurts here." The pain and trauma of child loss is not lost on these women from a culture that believes that the sun rises and sets on children; rather, they are of a culture that does not believe in dwelling on things beyond their control. Another participant in her narrative asked:

Who do I blame, do I blame myself, what can I do? The doctors and nurses who are trying to help me or my husband, who is trying in his own way? I just know that God is in control and the same God who gave me this one will give me another one that will stay."

From the observed behavior of the participants, there were no observed airs or pretense. These women genuinely believed that the particular incident of their loss is over (resolved). There was no observed anger as in looking for an outlet or someone to pay for their tragedy, nor denial, but there was acceptance. There was an observed attitude of gratefulness that they are alive and survived the ordeal of perinatal loss.

These findings differed from those in western studies on maternal response to fetal and infant loss that reported depression, preoccupation with the loss, crying, sleeplessness, loss of appetite, distress like anger and guilt, and other grief manifestations that need psychological intervention (Peppers and Knapp, 1980; Swanson et al., 2009, and Kersting and Wagner, 2012). The unique experience of the Nigerian women's responses is best expressed through the women's voices to understand how they construct and make meaning of their loss and grief.

Leon (1992) discussed how the dramatic improvements in care of patients with perinatal loss has taken place in hospitals but seemed to have resulted in what he described as possible hazards of these improvements. They are: institutionalization of bereavement, idealization of contact with the dead baby, and homogenization of grief. By institutionalizing bereavement, nurses tend to follow protocols in care of patients instead of care and awareness of the specific contexts/dimensions of their loss. Idealization of contact with a dead baby tends to equate contact with a dead baby with complicated grief and adaptation to the process of mourning, but this practice is not being culturally appropriate as adopted hospital protocol. One example is that Nigerian culture will consider it a taboo. Homogenization of grief refers to the tendency of counselors to denigrate different grief responses from a preconceived grief reaction perspective, which seems to tell parents the "right" thing or way to react, depriving them of that power to grieve in their own way and understanding (Leon, 1992). This article seemed to support the findings of grief response in Nigerian women, which is unique, unscripted with no prescribed pattern, and the women resolve their grief in their own ways. The idea of knowing and how we know therefore becomes important in this cultural context, as what they are familiar with in terms of sympathy and comfort is important in their healing and recovery from their grief state.

This finding also addressed aim 2 of the research, which is to understand the cultural influence on grief among Nigerian women.

Implications for Research

Qualitative and mixed methods studies should be supported to confirm this study's findings and further test the multicultural model of coping after pregnancy loss.

There is also need for development of theories and model to understand the life experiences of Nigerian women, especially following perinatal loss.

This study was conducted using semi-structured narrative inquiry interviews and follow-up phone calls of a convenience sample of Nigerian women who experienced perinatal loss. From the available literature on perinatal loss among Nigerian women, it is clear that very little attention has been given to the women's perspectives of their loss. Further research is needed to explore maternal grief response to perinatal loss in other tribes in Nigeria and other African countries. The use of the multicultural model of coping needs to be employed in these future studies to validate it as a preferred model for women of color. The use of narrative inquiry is also recommended for the future research to allow for consistency and comparability of findings. Narrative was effective in achieving an in-depth and nuanced understanding of the participants' experiences and was culturally congruent because story-telling is a culturally appropriate method of communication and sharing (Stuhmiller, 1994).

Study Limitations

It is unknown whether the findings generalize to other ethnic groups in Nigeria or beyond Nigeria to other cultures in Africa where perinatal loss is as common. Nevertheless, it provides a framework for understanding perinatal loss that can be tested in other groups, and opens the

option of not using Kubler-Ross in these cultures. The limitation of transferability of the study will also affect the ability to develop appropriate training proposals for health care providers.

Insider/Outsider Positionality of the Researcher

In my research described here, and as a qualitative researcher, I found myself fluid on the continuum of insider-outsider concept. I started as an outsider to the institution staff and the participants, so much so that I needed the presence of my contact person for every participant interviewed during the first two weeks of my research. Being an outsider was experienced in the form of: close ended responses, office doors remained closed to me until arrival of my contact. It was difficult to contact any participants or conduct any interviews until the contact person was present. I had to wait outside the doors and was not acknowledged after the initial response that my contact person was not available. I had a feeling of not belonging to the community and not trusted.

The position of the researcher an important consideration in a narrative inquiry. The insider – outsider theory looks at the positionality of the researcher as a privileged position affecting the study results positively or negatively. Lindbeck and Snower first developed the theory as a series presentation in 1984, discussing the effects/privileges of the insider vs the outsider in companies. The concept has been largely applied in labor economics as it pertains to workers who enjoy every opportunity in a company, opportunities that would not otherwise be open to any one considered an “outsider,” and how this practice negatively affects the productivity output of the company (Lindbeck and Snower, 1984). This concept is being applied to nursing and health research, especially of qualitative methodology. The concept assumes that the research is always in one position or the other (insider or outsider) during research, and that the position of the researcher influences the research positively or negatively.

The role of the researcher as a nurse and researcher requires the need to develop a trusting relationship with participants in the research, as well as “fit in” so the researcher’s presence does not disrupt the normal flow of activities in the research environment (Booner and Gerda, 2013). Hellowell (2006) argued that the development of the ability to be reflexive in one’s own qualitative research is not an easy skill or milestone for many research students. It is therefore important that students are cognizant of this pitfall. He used case studies presented by doctoral students to argue his position on the importance of researchers being aware of their position as an insider/outsider. The student participants in the research shared their experience about their shifting positions on the insider/outsider continuum and the value in developing reflexivity in respect to their own research (Hellowell, 2007). Sharan, Juanita, Ming, Youngwha, Gabo, and Mazanah, (2001), in their article on the “Power and Positionality: Negotiating insider/outsider status within and across cultures,” discussed the complexity that accompanies the status of acknowledging that students in the United States interviewing people “back home” in Africa are involved in a complex research effort within and across cultures. Positionality, power, and representation were concepts viewed as useful for explaining the dynamics of the insider/outsider concept (Merriam et al., 2001).

By the third week of my data collection and daily interactions with the unit’s staff community, I felt a shift in my position from the nurses and other employees of the department. I moved from “maybe some acceptance as belonging but not fully trusted,” which fully changed to “belonging to the community and being trusted” as an insider (Loewen and Hiebert, 2013). Attitudes of the nurses and the participants towards me changed. I was invited to the closed unit and given options of where to stay as I waited for the completion of obstetrics team’s rounds before my interaction with my participants. I was updated on potential participants, recognized in

all the units without my contact person, and participants made contact with me for any updates in their status when they saw me in the units' hallways. I recognized this as acceptance and being considered an insider.

I believe that as a beginning (novice) researcher eager to give voice to my population of interest and to ensure the validity of the research, I was able to maintain neutrality of position. In as much as I acknowledge and understand the bases for the insider/outsider contrasts or polarity, I argue that neither term captured my position and role throughout the research, hence my position of neutrality as being neither an insider or outsider but more in-between (in the middle). In my enthusiasm to conduct the research with the participants, I also learned from them. I am certain of my actions and non-positionality in the research, expressed by the suggestion of Pugh, Mitchell, and Brooks (2002), that the research partnership between an insider and an outsider would balance the advantages of both positions while reducing the disadvantages. I truly considered myself to be neither an insider nor an outsider in the context of my PhD research. In as much as I acknowledge and understand the bases for the insider/outsider contrasts or polarity, I argue that neither term captured my position and role throughout the research, hence my position of neutrality as being neither an insider or outsider but more in-between (in the middle).

I found myself balancing my positionality and seeking the assistance of my contact person on occasions of unclear narratives. I found that it was difficult to shift back and forth, or hold both positions simultaneously, as an "insider" or "outsider" all the time. I found that with constant reflexivity, I was open to the social and cultural dynamics. Being away from Nigerian culture for over twenty years, I did not go into the research as an "insider researcher," but neither was I a total "outsider researcher." I believe that this predicament was to my advantage in not losing the "objectivity" and not making any assumptions on the behavior of the participants. I

was not intimately engaged with the research domain, neither will I be described as those who “parachute into people’s lives...and then vanish” (Breen, 2002).

Many strategies have been recommended for the avoidance and control of the insider/outsider position in any research methodology. These suggestions include findings from reviewed literatures and from research experience. It includes practicing reflexivity, being aware of the advantages and disadvantages of each position (insider/outsider) in research, understanding the cultural context of the research, keeping objectivity in perspective and in field experience, and being receptive to learning the unknown.

Practice of reflexivity: Reflexivity is defined as a behavior of attending thoroughly to the effect of the research process, examining self as a researcher and as oneself in the research in terms of one’s assumptions and preconceived notions about the research or the subject matter, and how these assumptions may affect research decisions, especially in selection and wording of research questions (Ping-Chun Hsiung). This effort involves being critical about one’s self and critical of the context of the research environment, dealing with appropriation of social expectations and unscripted contingencies as in deaths, rituals, and ceremonies (Bonner and Tolhurst, 2002; Hellowell, 2007).

A researcher need to be aware of the advantages and disadvantages of each position and work as best to maintain the integrity of the research. Merriam, Lee, Kee, Ntseane, and Muhamad (2001), expressed that what insiders ‘see’ and ‘understand’ will be different from what an outsider understands, but does not make it any less valid. In research, the researcher sometimes experiences being both insider and outsider, but these positions are relative to context as in cultural values and norms of both the researcher and the participants. The intricacies of one position or the other are important and the factors of knowledge, construction, and representation

in research process should always be in perspective. A researcher must try not to view one position as better than the other.

Take time to understand the culture of interest; in so doing avoid alienation of one's self from the culture of research. It is important not to alter the flow of social interaction unnaturally. Having an established interaction between the researcher and the participants will promote both the telling and the judging of truth in the story shared (Bonner and Tolhurst, 2002).

Understanding the culture as an insider will save the nurse researcher the energy of understanding the fundamentals of what is going on in the cultural interactions. On the other hand, being already accepted in the culture as an insider limits the researcher's openness and the possibility of unbiased learning of the cultural perspectives. The familiarity of the culture as an insider leads to taking things for granted and missing behaviors that might add to the research because it is viewed as routine.

It is helpful to keep your objectivity in perspective (avoid assumptions); this should be clear with constant and frequent reflexivity. Know yourself and your role as a researcher (bracketing). This will be useful in avoiding generalizations that can influence biased segregation. It will help the researcher be sensitive to the narrator's voice and experiences and avoid imposing theories and generalizations onto the lived experiences of the narrator. It builds the researcher's understanding and sensitivity in conducting and presenting fieldwork in qualitative research (Sherif, 2001; Breen, 2007).

Additionally, I found the following strategies from this research project helpful. I learned from conducting this research that transparency is important. My first week at the research site, when I was being introduced to the unit staff, I was aware that I was the unknown in the unit's routine and I avoided making any assumptions, even with my contact being the director of the

department. I sought the permission of the nurses for timing of my interaction with the participants to avoid disrupting the flow of work on the unit and responded with respect to the nurses' request to stay out until they are comfortable with me. I gave no airs or made any assumptions. This behavior, I noticed by the second week, quickly enabled me to be accepted by the nurses. I was not viewed as taking advantage of knowing the director. The nurses became more open and will made notes in their report of potential participants whom I can approach, and sometimes already informed the participant of my presence on the unit and what my study was about. This, I believe, prevented the loss of valuable opportunity and prevented participants from being suspicious because they trust the nurse. (Be open and upfront with the population of interest, 'transparency').

Be open to learning the unknown (language of preference or cultural rules of conversation), be curious. My conscious position of neutrality helped me meet potential participants without bias. I was able to adjust myself to the participants' needs. In my first group of participants, I noticed that they were very hesitant responding to the interview prompts. On more conversation, I realized that they were worried about speaking in English and making grammatical errors. By being open and neutral allowed me the flexibility to adjust my plans to what works best for the participants. I was quick to reassure them, but I learned to ask the participants about their language preference for the interview purposes. Making an extra effort to assume a neutral position will help you as a researcher adjust to the participants' need instead of the researcher's needs.

Implications for Practice

The findings of this study might not be generalizable to all 250 ethnic groups in Nigeria, but there are implications that can benefit practice in Igbo tribes. In developed countries, nurses

in dealing with women of other cultures after perinatal loss will benefit from asking the patient what practices will be beneficial to grieving and healing process. Women should be supported after perinatal loss by asking questions to help understand cultural preferences that will emphasize health care workers' support in bereavement. Understanding their loss will influence plan of care for women after perinatal loss in Nigeria, as well as updating of policies for care of to be culturally appropriate and sensitive to women from other cultures. Helping women to connect with available contact person for support will be helpful and therapeutic. These study findings will guide practice of nurses taking care of these women and may be applicable for the care of Nigerian women who have migrated to developed countries like the United States. The study may identify risk factors for prolonged grief in Nigerian women, such as lacking connection through family, friends and church. The study findings will also provide insight for adaptation and development of culturally appropriate assessment tools for postpartum grief for African women. The ultimate goal is the development of interventions to support effective coping after perinatal loss and improvement of mental health outcomes.

The participants in this study indicated that their faith and community support strengthened and sustained them through their experience. Using narrative research investigations is needed to determine the presence of faith influence on grief response of mothers after perinatal loss. Accommodation need to be made for patient that may request the presence of their spiritual leader at the time of perinatal loss. Narratives allow the voice of the storyteller in the analysis. This finding can be incorporated in practice when taking care of Nigerian women after perinatal loss.

Implication for Policy

This research has implications for development of policies to guide practice for Nigerian nurses taking care of women after perinatal loss. The magnitude of perinatal loss in Nigeria is a major public health problem. Studies on women's psychological, emotional, or physical wellbeing after perinatal loss in the Nigerian context are very limited. An informal poll of nurses in obstetric units in three hospitals in Enugu state revealed no procedures or policies for emotional care of mothers after perinatal loss. Women with no available family support might benefit from hospital staff being present and supportive following as a means of promoting emotional healing. This will only be possible with policy or protocol guiding practice in place, the culture nursing unit will also affect practice. This study will also be part of evidence needed to influence public health department in Nigeria to consider health care policies to benefit mothers who experienced perinatal loss. This research will provide evidence for revision of hospital policies to be more culturally sensitive in developed countries like America. The study will provide opportunity for discussions around care management of migrant Nigerian or African women who experience perinatal loss, giving them the opportunity to voice what is culturally appropriate for them in dealing with their loss. It is also important for nurses to be flexible around some hospital policies and guidelines for taking care of women after perinatal loss.

Implications for Nursing Education

Grief and perinatal loss are phenomena often witnessed in all areas of maternal and child health nursing practice. Nursing students must be aware of cultural differences that may exist in their patient population in maternal and child health and learn how to provide care and interact appropriately with patients. Cultural humility should be the guiding rule, it will enable the nurse to ask the patient about what works for them in their care. Nursing educators need to consider

cultural differences in grieving after perinatal loss and must include evidence-based findings in nursing maternity curriculum. Incorporating nursing research into the entry-level nursing curriculum may provide experience that will be built on throughout nursing education and practice, based on increasing knowledge. There should be translational evidence-based care of mothers after perinatal loss.

Findings of this study will contribute to the education of nursing students in cultural sensitivity and culturally appropriate care for mothers of different cultures after perinatal loss. The study will contribute to needed scholarly research in strategies for patients of diverse cultures. The findings from the stories of the women in this study showed that seeing and holding their dead babies has no significant meaning, and naming the dead newborn was not a cultural practice. While appropriate and encouraged in developed countries, this practice should not be imposed on patients from other cultures without confirming its appropriateness in the patient's culture. Nurses and students need to learn how to ask the appropriate question of each patient within the context of their culture and individual preferences.

As in practice, the need to develop trust was always in perspective in my dealings with the participants and contact person, and I believe that I maintained “the balance needed to establish a sufficient distance between me as a researcher and the nurses, to make sense of the research data being collected” — this is according to Bonner and Tolhurst (2002) in their personal accounts of conducted research through participant observation, and the advantages and disadvantages of nurse researchers as insiders and outsiders. From the standpoint of postmodernism as an appropriate platform of the view of insider research, the epistemologies and perspectives, view the research process and outcomes, as ‘co-constructions’ between the researcher and the participants in the research (Denzin and Lincoln, 2000). According to Patton

(2002), the research participants are viewed as active informants to the research, who also attempt to give voice to the information within the research domain. These perspectives allow the researcher to conduct research ‘*with*’ rather than ‘*on*’ the population of interest. While these perspectives contrast greatly with the outsider research perspectives, the researcher’s position and awareness of not favoring a permanent position as an insider or outsider in the research is very important.

Conclusion

Based on the findings of this research, the participant Nigerian women responded to the expected reaction of a mother at losing her child, they cried acknowledged the empty feeling of not holding their baby. The observed and shared acknowledgement and resolution of the phenomenon of grief is culturally inclined. The women were able to react to their loss, but generally depended on the culturally available community resources of support from their families, religious affiliations, and shared stories of women who went through similar experiences, to give a different perspective to their own loss and grief experience, some participant shared that in the face of the shared stories from other women, they felt that their loss is bearable in comparison. They were reminded by those around them of the most important outcome of the experience; that they are alive for their family and living children. In the light of their new perspectives, the women chose to refocus their energy and attention with grateful hearts. It is safe to accept that the Nigerian cultural context is integrally connected with the women’s grief response after perinatal loss.

This study shows how important culture is for understanding grief. In response to the guided question of “What in your opinion helped you deal with your loss? Each participant described the different resources that helped her healing after the loss. The master narrative in

the responses of the participants is, God is in control. The responses were as follows: God is in control (Participants # 012, 014); God will give me another one (Participants # 001, 003); Belief and faith in God, shared experiences of suffering by other women were also identified as what helped them recover from their grief and move on with their lives, plus the importance of community support. Nigerian culture offers an alternative to grief. When other women with similar grief experiences share their loss stories (an element of connectedness), it made it easier for the participants to view their loss from a different perspective. The chance of viewing their grief from a new perspective helped the women accept their loss, made resolution, and moved on with life as they know it. These are healing strategies that empowered the women to move on with their lives after their loss. Their greatest strategy is their faith and belief in God. The aspect of religion and spirituality that gave them the most comfort is knowing that God is in charge and in control of all events in their lives. In this belief is also the unshakeable faith that He will give them another baby that will stay with them. The master narrative was strongly identified in the participants' response to what helped them feel better after their loss.

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Appendix A. Kubler-Ross Stages of Grief

Five Stages of Grief – Elizabeth Kubler-Ross	
Stages	Interpretation
1 – Denial	Denial is the conscious or unconscious refusal to accept facts, information, reality, etc., relating to the situation concerned. It's a defense mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death, of course, is not particularly easy to avoid or evade indefinitely.
2 – Anger	Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and /or with others, especially those close to them. Knowing this helps keep detached and non-judgmental when experiencing the anger of someone who is very upset.
3 – Bargaining	Traditionally the bargaining stage for people facing death can involve attempting to bargain with whatever God the person believes in. People facing less serious trauma can bargain or seek to negotiate a compromise. For example, "can we still be friends?" when facing a break-up. Bargaining rarely provides a suitable solution, especially if it's a matter of life or death.
4 – Depression	Also referred to as preparatory grieving. In a way, it's the dress rehearsal or the practice run for the 'aftermath' although this stage means different things depending on whom it involves. It's a sort of acceptance with emotional attachment. It's natural to feel sadness and regret, fear, uncertainty, etc. It shows that the person has at least begun to accept the reality.
5 – Acceptance	Again, this stage definitely varies according to the person's situation, although broadly it is an indication that there are some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind, who must necessarily pass through their own individual stages of dealing with the grief

Based on grief model first published in *Death & Dying*, Elisabeth Kubler-Ross, 1969. Interpreted by Alan (Chapman 2006 – 2013)

Appendix B

Semi structured Interview Prompts.

1. Can you please tell me about your pregnancy and what happened?
1. Could you tell me what that pregnancy meant to you?
2. Some people say that they feel regretful or guilty about various kinds of things when they experience loss. How did you feel after your pregnancy or baby loss?
3. According to you, how has your grief changed over the past months?
4. Are there things about being a Nigerian woman that you think helped you deal with your loss?
5. What in your opinion helped you deal with your loss? (Helped you feel better?)
6. In your opinion what is grief?

Appendix C. ESUT Permit for Research

ESUT TEACHING HOSPITAL PARKLANE

P. M. B. 1030 ENUGU

parklanehospitalenugu@yahoo.com

DR. G. E. NJEZE, BM, BCh (Nig.) FMCS FWACS FICS
CHIEF MEDICAL DIRECTOR



DR. W. O. OKENWA, MBBS, (NIG.) FWACS
CHAIRMAN MEDICAL ADVISORY COMMITTEE

BARR. P. N. MADUCHI, B.Sc. (Pol.Sc.) LL.B, B.L, MHSAN
Ag. DIRECTOR OF ADMINISTRATION

Our Ref: ESUTHP/C-MAC/RA/034/162 Date: 11/1/17

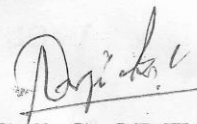
TO WHOM IT MAY CONCERN:

ETHICAL PERMISSION FOR RESEARCH.

Permission is hereby given LAETICIA N. EGESI

to conduct the research on Grief Experience Among Nigerian Women following Perinatal loss

in the ESUT Teaching Hospital. Parklane bearing in mind all the ethical implications.


DR. C. J. G. ORJIOKE
(Chief Consultant Physicians & Enugu State Chairman Ethical Committee)

Appendix D. Research Advertisement Flyer

WE NEED YOUR HELP TO UNDERSTAND THE LOSS OF A BABY



DID YOU LOSE A BABY
BEFORE OR AFTER
DELIVERY IN THE LAST 6
MONTHS?
HAVE YOU LOST A
PREGNANCY?

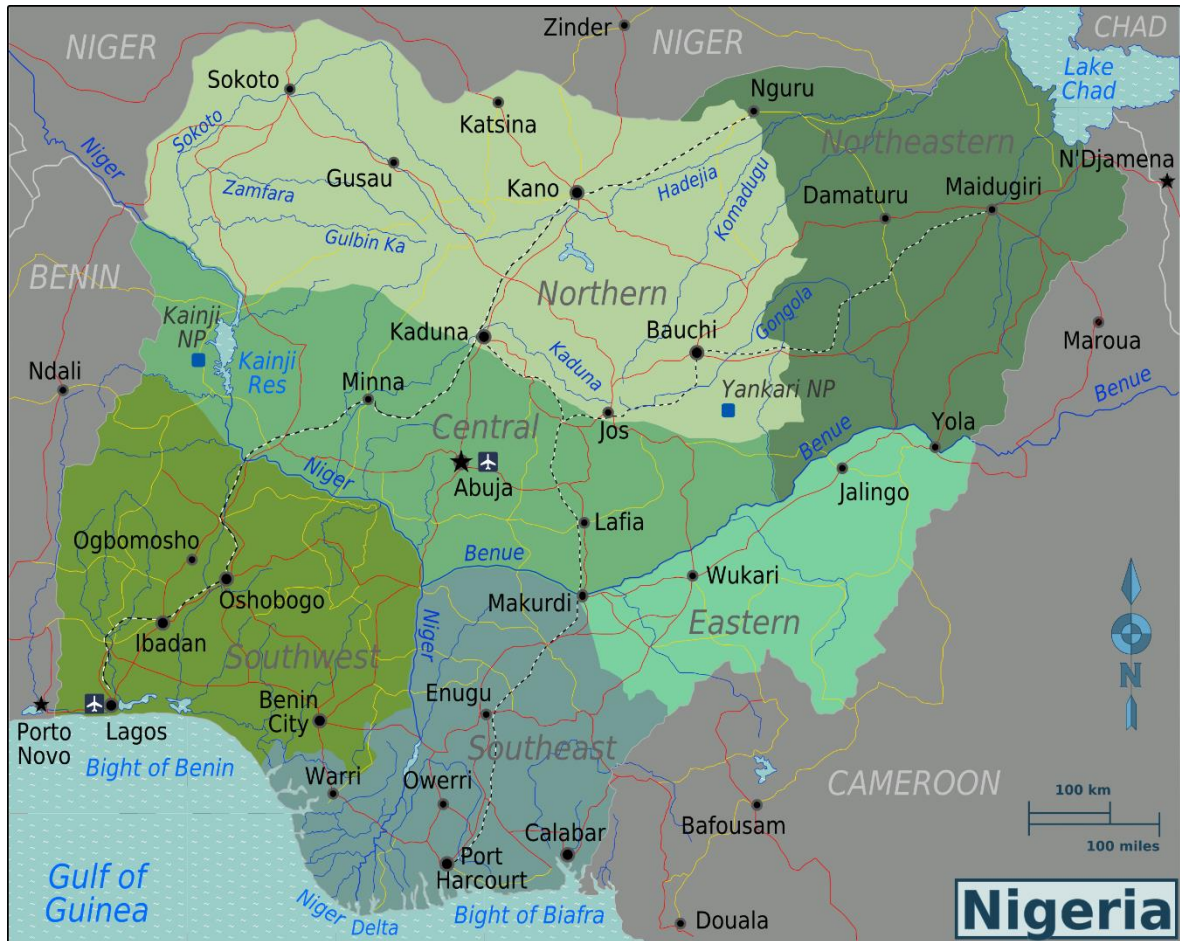


LAETICIA EGESI IS A PhD-C
SCHOLAR FROM UNIVERSITY OF
WASHINGTON SEATTLE, USA.
SHE IS INTERESTED IN WAYS TO
HELP NIGERIAN WOMEN IN
THEIR HEALING AFTER THE
LOSS OF A BABY

WE ARE SEEKING TO UNDERSTAND WHAT IT MEANS TO A NIGERIAN WOMAN TO LOOSE A BABY OR PREGNANCY
YOUR STORY CAN HELP UNDERSTAND THIS MEANING AND HELP OTHER WOMEN GOING THROUGH SIMILAR
EXPERIENCE.

IF YOU ARE WILLING TO PARRICIPATE IN THIS STUDY, PLEASE CONTACT
Mrs. E. Umebuani (ASSISTANT DIRECTOR OF NURSING; LABOR/DELIVERY , OB GYNAE CLINIC) 08063492627,
08183307541

Appendix E. Map of Nigeria, location of Research, Enugu. (Google image).



Appendix F. Enugu State University Teaching Hospital (ESUTH)



Appendix G. Participant Interview

From left to right: participant, researcher, and participants' child.