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THE EXPERIENCES OF MISCARRIAGE AMONG SUB-SAHARAN AFRICAN WOMEN

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Summary

Miscarriage which is also known as spontaneous abortion is defined as the process which occurs naturally when a foetus is birthed before the foetus has developed enough to live independently during pregnancy. The aim of this academic study is to describe the experiences of miscarriage among women of Sub-Saharan Africa and to identify the kind of care received after miscarriage. Research questions were; What kind of experiences do Sub-Sahara African women face after miscarriage? What kind of care do they receive after miscarriage? **Method:** A qualitative content analysis method was utilized to examine data. Content analysis was applied because of its ability and theoretical framework to discover and expose the contradicted human-side in this academic discourse. Collection of data was done using four electronic platforms. Six personally told stories of women affected by miscarriage were selected for analysis. Swanson`s theory of caring was used to scientifically aid in understanding the research subjects, in pursuits of answering the research questions and achieving the aims of this thesis. **Findings:** Findings from this study pointed out different experiences women of Sub-Sharan Africa faced. Experiences such as emotional trauma, self-blames, guilt, depression, sadness, devastation, bodily stress, and physically enduring pain. Findings also revealed lack of quality care and support from health-care professionals. **Conclusion:** At the end of this academic thesis, there is a deafening silence surrounding miscarriage in Sub Saharan Africa. Women who were affected by miscarriage crave for shoulders to lean on after being emotional traumatized and physically drained under the circumstances of miscarriage. There is a need for emotional support and medical follow up from health-care professionals.

Language: English Key words: Miscarriage, Pregnancy Loss, Spontaneous abortion, Sub-Saharan Africa, Experience of miscarriage, Qualitative Study.

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1 Introduction

The innate joy of some pregnant woman is to physically see and carry a living, healthy and wholesome newborn. The feelings are quite comparable to the heavenly idea of joy, happiness and of utmost fulfilment for some mothers. Indeed, the joy of childbearing begins after getting a positive pregnancy test result. On another note, it is rather heartbreaking to see or witness how the joy of an expectant motherhood is cut short by unexpected events, circumstances, health related issues, or uneventful accidents that lead to miscarriage. (Batool & Azam 2016, 37)

Motherhood in an African context is a powerful, sacred and mysterious journey of bringing another human to life only a woman can naturally undergo. Motherhood attract automatic bunch of reactionary attitudes, emotions and behaviors that are switched by the declaration of a positive pregnancy result. Akujobi (2011, 2)

Inevitably, within the African contextualization, it is noteworthy that the news of a positive pregnancy result from a pregnant married woman brings smiles to the faces of the expectant couple. Particularly viewed from this perspective, Africans see positive pregnancy result as future wealth, a wealthy addition of another human being and future hope of the family. They (Africans) believe children attract unseen blessings such as riches, love and procreation of life. Unfortunately, the uneventful occurrence of miscarriage cut short these beautiful experiences, hopes and desires from pregnant women awaiting delivery. (Abboud & Liamttong, 2003)

A tribe from the Western region of Africa known as the Yoruba descendants in Nigeria describes motherhood as a symbol of fruitfulness and fertility. There is an old time adage used by Yoruba descendants in expressing the importance of a motherhood in Nigeria. It is expressed as "*iya ni wura, baba ni jigi*" meaning "*mother is gold, father is mirror*". They greatly believe that the act of "*kunle abiyamo*" which means the "kneeling prostration" done by individuals or group of people after a child is born. This traditional saying and practices further epitomizes the degree of social importance, societal relevance and cultural value attached to motherhood and childbirth in the Western part of Africa. (Akujobi 2011, 3)

Akujobi (2011, 2-5) expressed that motherhood is embedded in different practices of religion, belief and culture due to the variety in culture and traditional beliefs practised in different countries in Sub-Saharan Africa. Different societies culturally put a meaning to

what a motherhood should be, how mothers should behave, live, carry themselves, be treated or elements associated with motherhood. In terms of religion, motherhood has been religiously shaped and linked to the kind of faith that is practiced by a particular society. Meanwhile, Africans perceive motherhood as the moral transformation whereby a mother is to come to terms with being different compared to other people in the society. In this instant, a mother is categorically ranked differently from single women because of the societal value placed on her as she is now a mother, who is fully engaged and responsible to another individual, which is her baby.

Akujobi (2011, 2-4) went further in explaining that when a woman is pregnant, she is greatly pampered, praised and glorified by her mother-in-law, husband, neighbors, immediate family members, passersby, peers and friends. The pregnant woman receives all manner of goodwill messages from people around her. She is always told that she is *“glowing and shining”* because she is pregnant and expecting the radiance from the birth of a new life.

Surprisingly, in the African perceptive, no matter the levels of talent, skills, educational background, knowledge or financial acquisition of an African woman, her primary function and focus is in motherhood because having a child as a woman is seen as a “God-giving role” and “gift”, hence, the thought that every African woman aspires to get married someday in life to bear a child(ren) of their own. Therefore, African mothers encourage their daughters to get married to enable them express their abilities of womanhood in full and quite early enough too, especially when they are still young. (Akujobi 2011, 3-5)

According to an African belief, it is conceived that the basis of marriage is for a woman to successfully transfer her fertility to her husband’s family lineage. Thus, when a woman is having problems with reproduction such as infertility or miscarriage, such is seen as the worse misfortune a married woman would face in her marital life. Traditionally, a barren woman is regarded and seen as *“incomplete”* while a woman who is experiencing reoccurring miscarriages is called a *“womb eater”, “bleeding womb”* or *“baby eater”*. Miscarriage can also lead to dissolution of marriages. Which can result to a coercive removal of the affected woman from her matrimonial home by her spouse or in-laws. (Akpan 2019)

Quite unimaginably, a large number of these women who suffered miscarriages during pregnancy lose hope in themselves especially the ones who have had to wait for a very long of time in expectation of conceiving and birthing a child. As a matter of fact, so many

of these women are emotionally unsettled (Swanson, Connor, Jolley, Pettinato & Wang 2007; Corbet-Owen, 2003, 20-22).

It is important to know that, information and awareness concerning women`s experiences of miscarriage are not quite developed and widespread in Sub-Sharan Africa (Akpan 2019). A lot of women experience miscarriage during their lifetime, and the majority of these women experience miscarriage during or before twentieth (20th) week of pregnancy (Adolfsson, Arbhebe, Markland, Larsson, & Berg 2015, 106).

Experientially, I have seen a few number of African women who have experienced miscarriages, particularly Nigerian women living in Nigeria. I have also come to the realization that these women are ashamed to discuss about the. Some of them are afraid of being stigmatized and publicly fenced off, and in most cases, the experiences of their ordeals are not heard, voiced out, momentarily written in a diary, detailed or documented for the positive benefits of future medical uses, academic references or preventative measures. This is a sad reality in our society hence, I feel motivated to utilize this research opportunity to find out more about these women personal experiences and how they cared for. Lastly, World Atlas (2018) and United Nations (2019) documented that Africa continent is divided into five different regions which are Eastern Africa, Middle Africa, Northern Africa, Southern Africa and Western Africa. With the exemption of North Africa, four out of these regions are located in Sub-Sharan Africa. Africa consist of 54 countries while 46 countries has its location in the Sub-Saharan region of Africa.

Sub-Sahara Africa (SSA) consist of 46 countries which partially lies in the southern part of the Sahara. It comprised of countries, namely Burundi, Comoros, Eritrea, Djibouti, Kenya, Malawi, Mayotte, Mauritius, Madagascar, Ethiopia, French Southern and Antarctic Lands, Zimbabwe, Uganda, Zambia, South Sudan, Tanzania, Somalia, Somaliland, Seychelles, Rwanda, Reunion, Angola, Cameroon, Chad, Gabon, Sao Tome and Principe, Equatorial Guinea, Democratic Republic of the Congo, Nigeria, Benin, Burkina Faso, Cape Verde, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Mauritania, Niger, Senegal, Sierra Leone, Togo Botswana, Eswatini, Lesotho, South Africa, and Namibia, according to the United Nations. (World Atlas, 2012)

2 Aim

The aim of this research is to identify and describe the experiences of miscarriage among Sub-Saharan African women who experienced miscarriage on or before week twenty-two (week 22) of gestation. The firsthand closures, personal times and physical experiences I had with sub-Saharan African women who suffered the ills of miscarriage in Nigeria necessitated the desires of this academic discourse and made up the rationales behind the aim and topic of this thesis.

There is an insufficient awareness, suffrage and discussion regarding the personal experiences of women who have miscarried their pregnancies in Africa. This is why I aim at focusing on finding out more about their personal experiences and the kinds of care received after miscarriage. My findings will serve as a kind of knowledgeable guide for individuals in public and private spheres, academic reference for future studies and could be a form of professional framework for health care practitioners especially nurses, who give care.

Research Questions:

What kind of experiences do Sub-Sahara African women face after miscarriage?

What kind of care do they receive after miscarriage?

3 Background of miscarriage

Scientifically, WHO (2013) defined miscarriage *"as the loss of a pregnancy during or before the 22-weeks period of pregnancy and fetus weighing up to 500g."* In the field of medicine, medical practitioners utilize the term spontaneous abortion to refer miscarriage.

Ojule and Ogu (2019) academically defines miscarriage as the process which occurs naturally when a fetus is birthed or terminated before the fetus has developed enough to live independently during pregnancy. Miscarriage occurs in about 10% to 15% global gestation. Every country has its own age of fetal viability which solely depends on the country level of development, use of technology and fetal surviving rates. For example, the fetal age viability in Nigeria is 28 weeks of gestation. While in Norway and Australia it is 20 weeks. Therefore, it is important to state that this study focuses solely on miscarriage which occurred within or before 22 weeks of gestation.

Volgsten, Jansson, Darj, & Stavreus-Evers (2018) give the meaning of miscarriage as the common medical complication of pregnancy which tends to occur during the beginning stages of pregnancy. Most of these miscarriages occurs during first trimester as a result of embryonic chromosomal abnormalities which accounts for approximately 60% of all forms of miscarriages. This set of abnormalities happens to be the most common cause of miscarriage (Qin, Pang, Li, Xu & Zhou, 2013).

In agreement with the theoretical perspectives of Dellicour, et al. (2016) & Van der Sijpt (2007), it is acclaimed that lots of women of Sub-Saharan Africa are secretive and reluctant when it comes to disclosing the statuses of their pregnancies to people especially during the first trimester of gestation. And this level of secrecy can be attributed to the superstitious or cultural beliefs of the land. A typical feature of those who live in low-income or middle-income countries. Some of these women are mostly scared of attacks of witchcraft during the early days of their pregnancies. Some are scared of gossips while the unmarried and young pregnant girls are scared of social repercussion, judgmental behaviors from people around them and negative parental reaction.

Due the aforementioned levels of secrecy, most pregnant women tend to keep the positive news of pregnancy to themselves without proper care and attention. Some of these women delay or even refuse to seek ante-natal care during the first trimester of pregnancy until miscarriage is experienced or other unwanted health related issues occur. Even when this happens, some women settle for herbal medicine. Hence the reason why some of these miscarriages are not usually documented or recognized by health-care professionals in the society. (Wong, Crawford, Gask & Grinyer, 2003)

According to Adolfsson, et al. (2015) so many early miscarriages go unnoticed because the woman may not medically know she is pregnant. Most probably, because the symptoms of pregnancy are yet to manifest before miscarriage occurred. When a miscarriage occur, pregnant women are worried and scared by the sights of blood dropping out of their vagina and the associated pains they will suffer as a result of the incident.

In addition, miscarriage leads the way for different kinds of experiences to occur which makes the situation very cumbersome, disheartening and worrisome for certain women. After the confirmation and acknowledgment of the reality of miscarriage, great grief is experienced. Most women cry deeply and prefer to be left alone or in the company of their beloved ones such as parents, spouses or in rare cases, closest friends because these women didn’t just lose an embryo or fetus, they practically lost their beloved baby. (Adolfsson et

al., 2004). Women experience various kinds of feelings after miscarriage. These feelings range from an intense period of dysphoria, guilt, anxiety and emotional distress to anxiety, social isolation, rumination, and societal stigmatization (Van den Akker, 2011, 1-4). Miscarriage is not an experience to joke with or laugh about since it involves another human life or lives. Therefore, it is vital for family members, friends, generality of people, society and community to care and sympathize with women who experienced miscarriage rather than shaming, mocking, trolling, or causing them more pain and sadness.

In furtherance, Adolfsson, et al. (2015, 109-110) emphasized that the best antidote for patient's rage, self-blame, guilt and hurts occur when health care professionals sympathetically, wholesomely and honestly give their ears to receive the patient's complaints, openly acknowledge the affected patients' feelings and stories by creating an enabling environment for them to speak and conversationally discuss why the miscarriage happened and provide complete solution, advice and answers to arising questions.

3.1 General experiences of miscarriage

The definition of miscarriage continues to have evolution depending on different practicalities. On a clearer note, pregnancy loss of up to the gestational age of approximately 22-weeks is still considered miscarriage (Rouse at al., 2017). Early loss of pregnancy is dramatically hurtful and can lead to a variety of symptoms of grief such as social isolation, irritation, sadness, yearning and expression of guilt. Nonetheless, perinatal loss is the most painful of all forms of pregnancy loss, especially from bereavement because it is usually not anticipated for. Most times, it comes up as a result of traumatic event or unexplained reasons. (Chan & Arthur, 2009)

In acknowledgement of the postulates of Chan and Arthur (2009), they buttressed that when miscarriage occurs, there is a sense of loss. This loss is commonly seen among every pregnant woman or couples who have experienced miscarriage. For some women, they experience a higher degree of guilt, self blames, emotional feelings of emptiness and worthlessness, hopelessness, sadness, and anger after coming to the realization that they have lost their babies.

However, Jansson, et al. (2011, 105-108) deduced that women express symptoms of depression following miscarriage. These emotional expression and attitude are generally evident even for unplanned pregnancies. Physical distress symptoms can be experienced in miscarriage especially if medical intervention was used in evacuation of the foetus,

membrane and tissues through D&C. Heavy bleeding tends to occur which leads to more distress, pain and stress for the woman involved.

Kulathilaka and de Silva (2016) claims that the natural courses of psychological morbidity in women following miscarriage is still unclear but it was stated that majority of women tends to grief within 3-4 months while some women still display the symptoms of grief and depression for almost one year. With the help and support of friends, family members, spousal partner and society, the awful emotions that comes with miscarriage easily disappear within a short time. Nevertheless, reverse is the case for women who are grieving without relatives or close friends, aside their spouses to console and comfort them. And if their spouse, family members or the society they live in seems to the unsupportive, the tendency of grieving longer is relatively higher compared to women who get support and consolation from loved ones and societal (Adolfsson et al., 2015, 109).

3.1.1 **Symptoms of miscarriage**

Miscarriage tend to occur mostly during the early first trimester of pregnancy. Women experiences vaginal spotting, bleeding, lower back pain, abdominal cramping, tissue or fluid passing out from the vagina. Two out of ten pregnant women experience vaginal bleeding during this first trimester. Vaginal bleeding happens to be one of the commonest and alarming symptoms in early pregnancy, which mostly occur during the first trimester of gestation. Half of these women who reported to have experienced early vaginal bleeding while being pregnant ended up in miscarriage because the bleeding continued. (Wieringa-de waard, Ankum, Bonsel, Vos, Biewenga, & Bindels, 2003)

Pregnancy bleeding that occurred before 20th-week of gestation is approximately 21%. About 12% of these pregnancies ends in miscarriage. Pregnancy bleeding is associated with low birthweight and preterm birth. Women who experienced heavy vaginal bleeding during their first trimester are at higher risk of miscarrying during the second trimester as a result of heavy vaginal bleeding. (Hasan, Baird, Herring, Olshan, Jonsson-funck, & Hartmann, 2009)

Hasan, et al. postulated in their report (2009) that women who experience light vaginal spotting without pain that last only for couple of days during gestation have no risk of miscarriage. In contrast, women who experience brightly colored vaginal bleeding for days with little or severe pains are at high risk of experiencing miscarriage. They further explained that pregnant women who experience heavy bleeding with pains while

menstruating are three times at high risk of experiencing miscarriage when compared to women who had normal menstrual bleeding.

3.1.2 **Classification of miscarriage**

Generally, miscarriages have been clinically discovered to occur in various ways. Miscarriage is divided into two different types which are early and late miscarriage. Early miscarriage occurs before the 13th week of pregnancy while late miscarriage occurs after the 13th week of pregnancy. Typically, a miscarriage is clinically diagnosed by the use of ultrasonography examination (Ultrasound) in the hospital or health centers. Miscarriages are classified by the nature of their occurrence, which include complete miscarriage, delayed miscarriage also known as missed abortion, repeated miscarriage, incomplete miscarriage, threatened miscarriage, inevitable miscarriage, and recurrent miscarriage. (Adolffsson et al., 2015, 106;Volgsten, 2018)

3.1.3 **Missed miscarriage**

Missed miscarriage, also called delayed miscarriage occurs when pregnancy is expelled. It is characterized by the retention of dead foetus inside the uterus. With the aid of ultrasound, a dead foetus is seen inside the uterus and a collapsed embryonic sac is seen. Uterus retention is as a result of the woman`s body which still produce progesterone and oestrogen hormones in the placenta for a long or short period of time. Reduction of oestrogen hormone is observed because oestrogen hormones can only be maintained when there is a living foetus in the uterus. (Sun et al., 2017; Van den Akker, 2011, 2-4; Adolfsson et al., 2015, 107)

Missed miscarriage is usually accompanied by a short episode of vaginal discharge that are brownish in colour which can disappear rapidly. The discharge may not be noticed quickly by some women. Women quickly sought for medical support when they begin to experience pregnancy symptoms such as; fatigues, nausea and breast pain or when they continuously notice dark discharge from the vagina. (Adolfsson et al., 2015, 107) Also, women who experienced missed miscarriage tends to live with the baby loss guilt in a short period of time than when compared to those women who experienced other types of miscarriage (Volgsten, Jansson, Svanberg, Darj & Stavreus-Evers, 2018).

3.1.4 **Complete miscarriage**

Complete miscarriage is experienced when the entire pregnancy is completely aborted from the uterus. This process indicates that the membranes, fetus and placenta have concurrently expelled. In complete miscarriage, vaginal bleeding slowly decreases and vanishes within a week. An ultrasonography is used to visualize the uterus and cervix to confirm its state (Tamizian & Arulkumaran, 2004).

3.1.5 **Incomplete miscarriage**

Incomplete miscarriage refers to an incomplete or partial ejection of foetus, which is noticeable during and after week 10 of gestation. It is diagnosed with the aid of ultrasound, utilized to properly picture the uterus Incomplete miscarriage is accompanied by heavy bleeding, and lower abdominal pain. The vaginal bleeding is usually expelled in stages and naturally empties itself from the uterus without aid. (Nielsen & Hahlim, 2010).

Nonetheless, sometimes, some parts of amniotic sac, placenta, tissues, or foetus may be retained in the uterus, thereby making it very important for the woman to medically seek for help to treat incomplete miscarriage, so as to ensure that the uterus is adequately emptied and free of debris and infection. This is a necessary procedure to prevent infection and complications. A midwife or doctor might need to perform dilatation of the cervix and curettage of the uterus (D & C) to adequately empty the woman's uterus. (Adolfsson, et al., 2015, 107; Tamizian & Arulkumaran, 2004) Notably, incomplete miscarriage to a certain degree, is the commonest type of miscarriage in the western region of Africa (Adeniran, Fawole, Abdul, & Adesina, 2015).

3.1.6 **Threatened miscarriage**

About 50% of threatened miscarriages end up in miscarriage. Medical diagnosis is carried out by seeing the foetus with the use of vaginal ultrasound examination, which determines the state of the miscarriage. In doing so, there is a presence of closed and intact cervix, and the cervical canal which shows that the pregnancy is feasible. The symptoms of threatened miscarriage are lower back pain with non-severe vaginal bleeding. (Adolfsson et al. 2015, 106-107)

3.1.7 **Inevitable miscarriage**

When inevitable miscarriage occur, vaginal exam reveals an open cervix of about 3cm. It is diagnosed with the use of ultrasound. Inevitable miscarriage can also occur after a woman have suffered from threatened miscarried without any prior signs. The tendency of keeping a pregnancy is low due to open cervix. The woman is most likely to experience abdominal cramps if there is a presence vaginal bleeding (Adolfsson et al., 2015, 106-107)

3.1.8 **Reoccurring miscarriage**

Repeated miscarriage is defined as two or more consecutive miscarriages in a row which happened during the same period of pregnancy. Reoccurring miscarriage affect about 1% couples who are reproductive active. In reoccurring miscarriage, the cause of pregnancy loss may be due to genetic related disorders, from maternal or paternal. If no proper attention and investigation is done after three miscarriages in a row, the tendency of another pregnancy loss if there is another positive pregnancy result is 50% higher. (Rai & Regan, 2006)

Therefore, it is greatly recommended for women or couples experiencing a reoccurring miscarriage to quickly seek for medical intervention, proper investigation, examinations and testing. Proper medical assessment such as X-ray of the uterus and Fallopian tubes. A pelvic ultrasound and hysteroscopy to properly visualize the pelvic and uterus. Hysteroscopy is a test done by a doctor to enable him/her visualize the inside of the uterus while using a telescope-like device which is inserted through the cervix. (Van den Akker, 2011, 1-4)

3.2 Causes of miscarriage

Causes and risk of miscarriage include chromosomal abnormalities, overweight, chronic medical conditions, blighted ovum, pre-existing history of miscarriage, maternal and paternal complications, trauma, maternal age, infertility, alcohol consumption, smoking and caffeine intake. (Maconochie, Doyle, Prior & Simmon, 2007).

In accordance to World Health Organization, WHO (2017) research, women with untreated malaria and malaria in a placenta are at risk of having miscarriage. Concomitant diseases, environment factors such as domestic violence, accidental fall, road accident, depression, overweight, gestational diabetes, organic, solvents, ionizing radiation, chronic

diabetes mellitus and thyroid disease/abnormalities can make a woman prone to miscarriage. In addition, women older than forty (40) years are three times at higher risk of miscarrying than women who are under twenty-five (25) years old.

Rouse, et al. (2017) indicates that genetic defect of egg fertilization, chronic medical disorder, constant ingestion of alcohol and tobacco before and while pregnant can cause miscarriage. Chronic medical disorders and post traumatic disorder, immunological related issues, for example: Rhesus factor, antiphospholipid. Traumatic related issues can result to miscarriage for example, pelvic surgery. Reoccurring miscarriage and toxins such as cytotoxin medicines (methotrexate) can also cause miscarriage. Meanwhile, Maconochie, et al. (2007) opinionated that during the first twelve (12) weeks of gestation, women who are very stressed, worried and restless are at higher risk of miscarrying compared to those women who are less worried and relaxed.

3.2.1 **Malaria**

Malaria happen to be one of the leading causes of mortality and morbidity in the world, especially in developing countries. In Africa, the dangers of malaria cannot be overly stated as the nature of the environments support the breeding of mosquitoes. The poor and broken drainage system breeds mosquitoes. The term "Malaria" is understood as a systemic infection of human erythrocytes by plasmodium protozoa, transmitted through infective bites on the skin of the human body by the female anopheles' mosquitoes. (Fried & Duffy, 2017) Record has it that pregnant women are three (3) times more likely to be suspected to have malaria infection than other adults. Surprisingly, about half of the world population are at risk of malaria infection. In 2007, human immunodeficiency virus which is known as (HIV) and malaria resulted to approximately 3 million deaths. (WHO, 2017)

In the opinion of Sayolu, Fabenro-beyioku, Oyibo, Badaru, Onyeabor, & Nnaemaka (2013) Nigeria happen to be one of the countries in Sub Saharan Africa with stable transmission of malaria infection. Areas with low immune pregnant women are more likely to develop malaria and malaria related complications which can lead to miscarriage or even death. Ugwu, Iferikigwe, Obi, Ugwu, Agu, and Okezie (2013) specified that untreated severe malaria has led to lots of miscarriages in West Africa especially in Enugu state, a south-eastern state in Nigeria. Malaria is diagnosed for both pregnant and non-pregnant individuals with the use of Microscopy.

On the report of WHO (2017), the commonest symptoms of malaria include nausea, vomiting, fatigue, abdominal discomfort, elevated body temperature, cold, headache, and abdominal discomfort. Infection with plasmodium falciparum and plasmodium vivax can result to placental malaria infection and chronic anaemia. Which can be followed with a reduction in low birth weight, maternal anaemia, preterm birth, intrauterine growth restriction, maternal death and pregnancy loss. In most cases, they are linked to plasmodium falciparum and plasmodium vivax for women who are having their first-time pregnancies.

It is also observed that pregnant women with malaria infection in Gambia happen to experience low-birth weight and other symptoms. Uganda is also one of those African countries with high transmissions of malaria. Therefore, pregnant women are advised to get long-lasting insecticidal nets for sleeping to avoid falling sick as a result of mosquito bites. (Takem & D`Alessandro, 2013; WHO, 2017)

3.2.2 **Chromosomes**

Farquharson & Stephenson (2010) described chromosomes as genetic building blocks that guide and protect a developing foetus after fertilization has occurred. If a baby has too much or not enough chromosomes, he/she is at risk of not developing properly.

Qin, Pang, Li, Xu, and Zhou (2013) agreed with Farquharson and Stephenson (2010) that approximately 50% of first trimester miscarriages among pregnant women occur due to abnormalities during the foetal development of foetus, which is the natural and commonest way of pregnancy loss. They also agreed that the largest single category of chromosomal anomalies is known as autosomal trisomy, which accounts for about ninety percent (99%) of miscarriages. The chromosomal anomalies, autosomal trisomy has its origin more in maternal meiotic errors and less in paternal meiosis. For example, there is hundred percent (100%) of monosomy X which is known as Turner's syndrome and approximately fifty percent (50%) of XXY in early miscarriage which occurs before week twenty-two (22).

3.2.3 **Ectopic pregnancy**

On the report of Rouse, et al. (2017) ectopic pregnancy happens to be one of the commonest causes of early pregnancy loss amongst pregnant women. Ectopic pregnancy is defined as a pregnancy located and implanted outside the uterine endometrium. Up to 97% of ectopic pregnancies occur in the fallopian tube while other pregnancies can also occur in

other areas of a woman body such as abdomen, ovary, cervix or in the cornua of the uterus. The uterus is the normal place for the development and maturity of pregnancy but, during ectopic pregnancy, the uterus is not biologically useful for its original functions.

Ectopic pregnancy might be life-threatening to the women due to the location of the pregnancy. Ultrasound examination is needed for procedural investigation and evaluation when pregnancy is in an unknown location. The symptoms of ectopic pregnancy begin to visibly manifest from 6-8 weeks after the pregnant woman's last menstrual circle. The symptoms include lower abdominal pain in one quadrant of the abdomen with no sign of vaginal bleeding. More so, some of the risk factors of ectopic pregnancy may include the use of contraceptives like intrauterine device (IUD), risks of infertility and previous fallopian tube surgeries. (Adolfsson, et al., 2015, 108)

3.3 Treatment of miscarriage

Miscarriage as a medical condition can be medically analyzed, diagnosed and treated. Nevertheless, the medical treatment of miscarriage solely depends on the nature and type of miscarriage. As discussed above on section 3.1.2, there are several types of miscarriage and these various types of miscarriages determine the type of medical solution that is utilized to treat it.

3.3.1 Expectant treatment (waiting)

Adeniran, et al. (2015, 107) described expectant treatment as a process whereby an affected woman choose to allow her body to naturally expel its content due to pregnancy loss. This is evident for pregnancy that lasted shorter than week-12 after conception. In this type of treatment, the woman experiences several days of bleeding which is accompanied with abdominal pain. With the help of pain relievers such as Ibuprofen or Panadol, the pains are gradually alleviated. Waiting treatment requires bed-rest, antibiotics against infection and ultrasound examination. (Nanda, Lopez, Grimes, Peloggia, & Nanda, 2012)

Furthermore, the woman who received waiting management treatment are medically advised to temporarily or momentarily stay away from bathing and engaging in sexual activities for two (2) weeks. This is highly recommended to help prevent further complications such as infections or inflammations. (Tamizian & Arulkumaran, 2004; Nanda at al., 2012)

3.3.2 **Medical treatment**

Allen and O`Brien, (2009) explained that medical treatment is the administration of medicines to women affected by miscarriage. The medication given contains prostaglandin such as misoprostol and mifepristone to help in induction of labour, to enable contraction of the uterus and to effectively pass-out the remaining tissues of the pregnancy loss. (Neilson, Gyte, Hickey, Vazquez & Dou, 2010) Uterine muscle relaxant are given to aid the process of ejection of threatened miscarriage. Pain medication that contains Ibuprofen and Paracetamol are generally given to reduce pain associated with bleeding. (Lede & Duley, 2010)

In practice, just as soon as the medical treatment is over, Shelley, Healy, and Grover (2005) suggest that an appointment should be scheduled within 14th day of the medical administration. This is done as a procedural follow-up, to further examine and confirm that the pregnancy was completely removed without any remnant. A urine test or human-chorion-gonadotropin (hCG) is usually be done to eradicate chronic malignancy and ectopic pregnancy.

3.3.3 **Surgical treatment**

According to Adolfsson et al. (2015, 106-108) surgical treatment is done under general anaesthesia after the cervix has dilated with externally given prostaglandin medication. In this type of treatment, the tissues are completely emptied out with the use of a vacuum aspiration or by performing dilatation and curettage (D and C) in surgical theatre. Surgical treatment can be suggested or recommended depending on the type of miscarriage experienced. Especially for incomplete miscarriage. It is important to be aware that surgical treatment can cause infection, uterine perforation, haemorrhage, cervical damage, heavy bleeding or trauma. It is more expensive than expectant management treatment (Nanda, et al., 2012: Neilson et al., 2010).

Shelley et al. (2005) expressed that health care attendants should professionally advised women who were surgically treated to temporarily stop or abstain from sexual activities for at least two (2) weeks after surgery. Adolfsson et al. (2015, 106-108) further states that after surgical intervention, women experience less pains and less bleeding for a couple of days when compared to those women who selected the expectant management treatment or other forms of treatment after miscarrying.

4 Theoretical framework

The Theory of Caring by Swanson Kristine is utilized in this academic work to scientifically aid in discussion and understanding of the research subjects, in pursuits of answering the research questions and achieving the aims of this thesis. The stipulates of the theory will help to find out the kind of care that was given to women affected by miscarriage.

Swanson (1991) defined caring as "*a nurturing way of relating to a valued other towards who feels a personal sense of commitment and responsibility*". The middle range theory consist of five basic caring models which consist of the following: knowing, being with, doing for, enabling, and maintaining belief.

Swanson (1991, p.163) defined the knowing model as *"striving to understand an event as it has meaning in life of other by avoiding assumptions, centering on the one cared-for, assessing thoroughly, seeking cues, and engaging the self of both"*. The **knowing** model practically signifies the ability of the health-care professionals or anyone caring for women who were affected by miscarriage to understand the cause of event and the feeling that comes with it. The knowing model expresses the important of giving ears to know how they would love to be cared for without assumptions. It also lay emphasis on health-care providers and individuals caring for the sick or vulnerable peoples to seek out for possible cues on how to help out, while focusing and engaging patient through the processes of the event.

According to Swanson (1991, p. 163), she states that the model of **being with** *"Is more than understanding another`s plight; and becoming emotionally open to their reality"*. The model of being with is about being present emotionally for a woman who were affected by miscarriage and every other patient undergoing one health related condition or the other. By showing concern, being readily available for them, sharing in their pains, consoling and engaging in a healthy conversation that will not be a burden to them rather a healing-based interaction that will uplift them. (Swanson, 1993)

The **doing model,** was characterized by Swanson (1991, p. 164) *as "comforting, anticipating, protecting of the other needs and performed competently and skillfully"* this simply means where one can sincerely do for individuals suffering or patients as they would do for themselves if they were not physically and emotionally vulnerable. This also includes "*preserving dignity"* of the patient while caring for them. Doing for also entails

changing or washing the affected woman`s linens especially if they are bleeding. Covering them up to avoid being cold. Showing concern by getting them food and water. Helping them with daily activities until they are fit to care themselves. (Swansson 1991, p.163)

Enabling model, Swanson (1991, p.164) explains that model as a means of *"facilitating the other`s passage through life transitions and unfamiliar events"*. In practice the enabling model comes into existence when supporting with helpful and applicable information that will help alleviate pain and suffering from women who has miscarried. This model facilitates health-care professionals, families and individuals to think things thoroughly before saying them to individuals who are suffering to avoid adding to the already existing pain. Which also includes facilitating and helping patients and individuals to transit through the unpleasant situation and emotional state they find themselves in until they are in a good and stable state of mind. (Swanson 1991)

Finally, Swanson (1991, p.162) described **maintaining of belief** as *"sustaining faith in the other`s capacity to get through an event or transition"*. Maintaining belief model, is specifically about sustaining faith in the grieving moments of the affected person. Helping them in finding meaning to life again. Offering attainable and realistic hope at every point in time. It also implies to family members and health-care professionals in that, they should be able to standing strong for women who were affected miscarriage by believing in their capacity to see a light at the end of the tunnel while maintaining a hope filled behavior to enable easy transition to a better state of mind.

5 Methodology

Qualitative content analysis methodological researching method will be used to aid the unraveling of my research aim which circles around finding out the experiences of women of Sub-Saharan Africa after they suffered miscarriages. This methodology will form a foundation of theoretical studies which will be utilized to academically answer the research questions. The various processes of the methodological approach for this research will at the end, serve as a framework to proffer solutions to the societal problems in discourse.

Denzin and Lincoln (2005, p. 2) agrees that a qualitative research *"can be multi-in-focus because it involves an interpretative, naturalistic and meaning-giving approach to its research subjects or objects"*. Thus, with the idea of research subjects in this research, a qualitative method of research is ideal. Therefore, content analysis of qualitative

researching method will be utilized in analyzing all forms of data collected and collated in this academic study. The selection of content analysis technique of qualitative researching method meets the scholarly requirements of a research of this nature because it can handle descriptive and experiential data of the experiences of women of Sub-Saharan Africa who suffered miscarriages (Hesse-Biber, 2014).

According to Elo and Kyngäs (2008), qualitative content analysis methodology can qualitatively or quantitatively useful in gathering and collecting data from research objects or subjects. The research methodology can be succinctly utilized in finding out helpful or new information about a phenomenon, either outdated, recent or continuous. It is used in creating insights, understanding of a communication and situation. In addition, qualitative content analysis research technique is theoretically necessitated in identifying vital processes, providing solutions, collecting practical and applicable guides to a course. Qualitative content analysis can be inductively or deductively used in extracting information. Its unit of analysis for studies can be in form of sentences, words interview, textual declaration or interactive discussion.

A study by Kalof, Dan and Dietz (2008, p. 79) shows that qualitative content analysis has the ability to expose the contradicted human-side in a given situation by showing their full emotions, behaviors, relationship and opinions. It provides a textual description of how people experience a particular phenomenon. Its effectiveness in identifying people's faith, gender, relationship, and social background are one of the reasons this method is chosen to explore the feelings of women of Sub-Saharan Africa after miscarriage. All of these personal experiences aforementioned bear-out cultural meanings and other phenomena, thereby forming empirical indicators for qualitative data collection, sampling and categorization.

Conclusively, Lauri and Kyngäs (2005) clearly opinionated that an *"inductive method of content analysis should be used in areas where there is insufficient knowledge and informative background about a phenomenon"*. Therefore, since there is an insufficient study about miscarriage in countries of Sub-Saharan Africa, an inductive approach of qualitative content analysis is suitable for collecting, collating and analyzing raw data materials required for this study.

5.1 Data collection

Data search, collection and selection were electronically done through different non academic databases. Data search was specifically done in search engine of Females in Africa (FIA) Organization, Google search, Daily Nation platform, World Health Organization (WHO), Huffington platform, Mummy Tales platforms and Still A Mom organization.

During data searching processes, certain keywords were utilized in narrowing down parameters to my desired result. The used keywords include the following: “miscarriage”, “pregnancy loss”, “spontaneous abortion”, “miscarriage in countries of Sub-Sahara Africa”, “stories of pregnancy loss in Africa”, “experience of miscarriage” and “ miscarriage stories in Africa”. After searching and accessing a considerable number of online platforms for relevant information that will be beneficial for this study, six (6) stories were retrieved from four (4) platforms.

The used platforms includes Still A Mom organization, Huffington platform, Mummy Tales platform and Word Health Organization (WHO). The final six (6) cherry-picked stories were used for data analysis. These stories were originally told in details by the affected women themselves.Their stories were published in already mentioned platform above.

Criteria for Inclusion

- Well detailed stories originally and personally told by the women who experienced miscarriage were selected.
- Stories selected were only written in English Language.
- Stories chosen applied a reasonable level of ethical consideration.
- Stories published within year 2010 - 2020 were selected.
- The focal points of the stories were on miscarriages from women who live in Sub-Sharan African countries.
- The stories were all referring to miscarriages within week-22 of gestation.
- Stories chosen were readily available and accessible electronically.

Criteria for Exclusion

- Stories written in other languages were not selected.
- Stories from unreliable electronic sources were not selected.
- Stories about miscarriage after week 22 weeks of gestation were not selected.
- Inaccessible platforms were not used for data collection.
- Platforms that were not ethically conscious were not selected.

5.2 Data analysis

When it comes to data analysis, there are actually no specific lay down guidelines given to systematically analyze data aside from the classification of many words and written text into smaller content categories for better understanding (Elo & Kynäs 2008). Organization of qualitative data includes creating of categories, open coding and abstraction. Open coding is defined as process whereby the notes and headings are fully writing in a text format while reading a material. This is why the materials gotten from various platforms were thoroughly read through again and again to get as many headings as possible (Shannon, 2005; Elo & Kynäs 2008).

Open coding lists of categories are grouped under higher order headings and the aim of grouping these data was to specifically help to reduce largeness, ambiguousness of data and number of categories by either merging indicators or breaking or splitting them down to the higher order categories (Elo and Kyngäs (2007). In addition, the main objective of categorization is to provide a means of describing the various situations, which will analytically enhance and increase people's understanding and knowledge about the classified situations. Each indicator or situation were sorted by classifying into words or theme, in order to place them where they rightly belong to in a specific group. (Elo & Kynäs 2008)

Additionally, stories containing the experiences of miscarriage among women living in Sub-Saharan Africa countries were abstracted from four platforms. There were no age or gender restriction, no option of signing up before entry as these electronic platform. They all has free public access, including free accesses to its contents. Six (6) different stories about miscarriage during or before week 22 were selected from the needful stories. The

stories were copied from each platform to a Microsoft Word document for extensive reading, colour coding and easy access. The stories were thoroughly read, from the beginning to the end. This was done multiple times to grasp all the vital information in each story.

Colour coding was utilized in marking the unit of analysis which serves as a way of filtering vital information out from the so many available data collected. Each colour used in the unitary level of analysis had something it represented. For example; the colour red indicates the vital experiences of miscarriage in each story. Pink colour was used to denote cultural believes and expectations. Light blue turquoise colour depicted physical stress experienced during miscarriage. Black color was used to denote health care professional support. While yellow colour was used everywhere in the stories that has something to do with emotional stress.

Finally, data were categorized and sub-categorized using the examples proposed by Polit and Beck (2004), including those of authors Elo and Kynäs (2008), which described abstraction of data as a way of formulating a general description from the already available research-based or non-academic knowledge, which entails conducting to summarize and generate categories by naming each of the categories using words that suits the content while sub-categorizing them by grouping similar incident, experiences and event together as categories.

5.3 Ethical consideration

Polit and Beck (2010) defined ethics *as "a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligation to/of the student participant"* (p.727). The necessity of ethical consideration can never be overemphasized hence, platforms that ethically considered women who has miscarried were selected for analysis. It must therefore be recognized, and importantly stated that the identity and location of women who narrated their real-life experiences with miscarriage were concealed throughout this study.

The Finnish advisory board on research integrity (2012, 32-35) rules on thesis writing were strictly adhere to by making sure that all acquired knowledge from material used were properly cited and authors adequately referenced accordingly. All materials collected at the end of the data collection from various websites were analytically utilized only for this

academic study, and with complete adherence to the various clauses of confidentiality (ARENE 2018, 7-11).

University of Minnesota (2003, 11) idea on plagiarism, is on the same level as “stealing” because it is an illegal act that is punishable. It is therefore informative to fact-fully state that no ounce of unacknowledged collecting or borrowing of another individual’s work, ideas, or pictures without acknowledging the original owner of the property in this academic thesis, in conformity to the stipulates of TENK (2012, 33).

Lastly, this academic work was executed by adhering to the ethics of misappropriation as described by TENK (2012, 33). Every possible situation whereby an individual’s work, research or result was unlawfully presented or misappropriated without permission from the owner was completely and ultimately avoided and eliminated. There was never a situation for falsification of data, collection of incorrect and inadequacy of record keeping and data manipulation in order to mislead folks or the research community as whole. And these high standards of research were obeyed and strictly adhered because they are in alignment with the criteria of ethical integrity, proper accuracy and research guidelines as dictated by the Academy of Finland (2003).

6 Presentation of findings

After the processes of sourcing and collecting out the data for this research work, six (6) meticulously sorted true-life stories about miscarriages were found, documented, reviewed and analyzed for this scholarly thesis. The findings from these stories strongly pointed out and acknowledged the several experiences women from countries of Sub-Saharan Africa experience after miscarriage. The findings from the reviewed and analyzed data are categorically presented below as headings and subheadings. The subheadings are placed under the headings which are verified with quotes from the originally told stories used for analysis.

6.1 Cultural influence affecting healing after miscarriage

In countries of Sub-Saharan Africa, women shows that the culture in practice promote and encourage having many children. This is strongly so because children are seen as wealth, hope, strength and gifts from God. The prevalence of this culture practice has created a norm by which the generality of people hold the opinion or societal belief that women are

supposed to have as many children as possible, especially when they are married or living with their partners.

6.1.1 **Cultural believes and expectations**

Findings in story 4 revealed that in Africa, miscarriage is viewed and described as a taboo which only occur to promiscuous women, to women who are cursed or have something to do with witchcraft. Based upon the cultural beliefs of Sub Saharan Africa, women expressed that a pregnant woman is expected to carry her child to full term without miscarrying. Only pregnant women who safely put to bed their living new-born without miscarrying are find worthy. Therefore, when a woman miscarries a pregnancy in whatsoever manner, she is seen as less, downgraded, stigmatized, or verbally abused:

> "In Africa, people think you can lose a baby because of a curse or witchcraft. Here, child loss is surrounded by stigma because some people believe there is something wrong with a woman who has had recurrent losses, that she may have been promiscuous, and so the loss is seen as a punishment from God." (Story 4)

"In most traditional African cultures, these feelings are exacerbated because the worth of a woman is often determined by the children she carries to term."(Story 4)

Story 3, further revealed how discouraging and unkind people are towards women who miscarried. The silent, withdrawn and resentful attitudes from neighbors, workmates, friends and relatives make mourning and healing disturbingly, longer than expected. Women indicated in the stories that people are easily unwilling to comfort or console them after miscarriage without looking for a way to cynically fault them for the unfortunate situation of miscarriage.

"The healing process was not easy. I could see the many questions on our neighbor's faces and other people who knew I was pregnant. The first three days were particularly unbearable" (Story 3)

6.1.2 **Societal pressure**

Findings in Story 5 shows the amount of pressure mounted on married women to have children especially is unimaginable. Women are seen as the bringer of children. They are expected to be fertile, energetic in childbearing and always ready to get pregnant again, in most cases, even, immediately after miscarriage. When these women are tired, fatigued-out

or worn-out of being pregnant due to repeated miscarriage, it is almost certain that peace will be elusive in their families and homes.

The descriptions from women in story 5 and 6 shows that homes become very chaotic and uncomfortable for everyone due to their momentary refusal or restraint from wanting to be pregnant again. In some cases, as a consequence, some partners of these women result to excessive in-takes of alcohol and adulterous acts, thereby transferring aggression to their wives. Aside from faulting their women for miscarrying, they continuously display actions or attitudes that clearly epitomizes their disapproval or rejection of women who decided to momentarily take a break from becoming pregnant just immediately after suffering miscarriage.

> "I informed my husband that I was over with trying to get another child. Things only got worse from then on. I have tried to make things work to no avail. The only thing he does is drink, drink and drink; then he comes home to create chaos." (Story 5)

"I had him so much that by the time I realized he was having an affair outside our marriage, I was so affected that I eventually developed hypertension. I am on medication to date." (Story 6)

6.2 Women experiences of miscarriage

After miscarriage, women go through difficult experiences such as physical pains and distress, emotional stress. Findings from the collected and analyzed data revealed that experiences after miscarriage varies from one woman to another and there are various aspects or factors that determined and underlined these sets of experiences for different women after the suffrage of miscarriage. The experiences also depended on the frequency or number of miscarriages.

6.2.1 **Emotional experiences**

Based on the findings from the six stories analyzed, women showed they experienced several emotional breakdown as a result of miscarriages. They expressed different kinds of emotions ranging from feeling emotionless, disappointment, hopeless, confusion, devastation, guilt, anger, self blames, frustration, to gut wrenching feelings, depression, to the feeling of incompleteness due to miscarriage. They felt devastated and heartbroken for coming into the hospital with pregnancy and going home empty-handed with a hefty hospital bill which took half a year to pay.

Women who miscarried at home started by noticing droppings of blood which increased day after day were terrified. Those women who suddenly started experiencing miscarriage at home expressed lots of fear, anxiety and worry when compared to those who knew they miscarried in the hospital. Some women revealed that when told they were left with an empty embryonic sac without a living baby in it, they became pained, traumatized and devastated:

> "My week was filled with dread, worry, anxiety, sadness, frustration, not to mention I was a hormonal mess.The pretense that everything still might be okay ate away at us both. With every day came more bleeding, more reasons for us to believe we were losing our baby. Knowing there was nothing we could do to stop what was happening, nothing we could do to hold onto him/her and say please don't leave us, you will be so loved here. Unfortunately, no one was listening. About half way through this week came the moment where it was difficult to deny what was happening, the gut wrenching moment I knew our baby had left me, had left us" (Story 1)

> "Our son's death crushed us. We were hurting from penetrating pain. We were young and didn't know how to deal with the loss. The pain was and is still immense. We were left with a physical scar and hefty bills (it took one and a half years to fully pay it) as haunting reminders of our dear son. The trauma was too much. In 2013 we tried for a baby again but at six weeks, a heartbeat could not be located. At nine weeks we were painfully told there was no baby, just an empty embryonic sac; a condition called blighted ovum. The sac had to be taken out. It was devastating to hear that." (Story 2)

Findings in story 6 showed how depressive and traumatic miscarriage make woman feel. Especially for women who received fertility treatment with a hope of get pregnant after the treatment. Findings in story 6, further showed that the feelings were weakening and deeply exhausting. It pinpointed that the feelings leaves one uncoordinated, making everything around them feel very unpleasant including the things that normally give them joy:

> "I had a year of fertility treatments before I got pregnant again, but I lost the baby again. I was so depressed, I couldn't go to church or do anything that previously gave me joy. My husband couldn't comfort me. Coping with my miscarriage was traumatic. My baby boys were both buried at a cemetery in town. I couldn't be at any of the funerals and that still hurts. But whenever I pass those places I whisper a prayer in my heart for them." (Story 6)

The emotional distress expressed in writing in story 3 and 5 was second to known as women demonstrated how hurtful and worrisome it can be for a woman to go through labour pain and back without seeing, feeling or touching her baby. Women who were affected by repeated miscarriage and blighted ovum felt empty, broken and depressed. They emphasized on how stressful going through labor pain felt. Story 2 and 5 also described the level of emotional torture, soberly expression, brokenness and suffrage women had to undergo immediately after miscarriage and devastating it was to go home empty-handed:

> "I was in pain and was bleeding heavily. Unknown to me, I was experiencing labour pains. That was my third miscarriage. The baby was gone. My strength was broken. I was broken. "I am sorry," I whispered to the baby. I could not even call my husband to break the news that night. I waited for him until the following morning. I will never forget the look on his face when I told him." (Story 5)

> "I didn't get the chance to see her because I fainted after the push. My husband saw her though. We left her in the hospital and went home the following day, empty-handed. Preeclampsia had taken the life of our baby. We were devastated." (Story 3)

After miscarriage has occurred, women blamed themselves for being the reason behind the pregnancy loss. They took responsibility for the loss of their baby. They blamed themself for not trying enough to protect their pregnancy. They blamed the nurses for not caring for them enough and for paying very less attention to them and their needs. They blamed the gynaecologist for not checking their blood pressure properly during the periods of their pregnancies. They blamed their boss at work for not giving them work-leave, knowing fully well that they were experiencing pregnancy complications. They blamed their partner for not understanding them enough.

Everyone around them was blamed for miscarrying. They wanted to be left alone to cry and die. The emotional impact comes with loss of appetite to eat, not willing to drink or even keen to communicate with people who are trying to reach out due to the sense of sadness and anger over the loss. They showed a big sense of guilt and blames toward self and everyone else for being a victim of miscarriage:

> "The first three days were particularly unbearable. I would wake up, sit on the couch and cry the whole day. No food. No talking. Nothing. I couldn't stand seeing my phone ring. I blamed everyone for my loss.I blamed my boos at work I blamed hubby for not understanding what I was going through, I blamed everyone and everything around me. I blamed my gynecologist for being ignorant and not paying attention to my blood pressure I wanted to be left alone. I just wanted to die." (Story 3)

6.2.2 **Physical experiences**

From the six stories analysed, women revealed different kinds of physical stress, bodily pressure, discomfort and pains following their experience of miscarriage. Story 3 was an example of the amount of bodily stress and pain women suffering from pregnancy complications:

> "I was in hospital for three tough weeks; swollen beyond recognition, constant epigastric pain, frequent blurry vision among other complications. I ended up in theatre with a near-death experience. I had lost so much blood (remember that I have a rare blood group). As I lay there, I prayed fervently, asking God not to take me. Our first born son and my husband needed me. I may never overcome the trauma of staring at my pool of blood and our daughter who I wouldn't ever hold, hug, kiss, hear her cry or laugh. I would look down and think I saw her move. so difficult to recount." (Story 2)

Women pinpointed in story 2 and 3 the amount of pain they went through while in the hospital. The stress of labor induction and labouring to till the vagina is ready for ejection was straining and exhausting. Women also expressed the extent of bodily pressure they had to go through just to deliver a lifeless foetus was a painful experience to live with:

> "Sadly, they informed us that our baby was no more. Meanwhile, the doctor came in as usual at 9.00pm and said that the loss was expected. That survival was either for me or the baby. It was a hard time for us, but I was yet to hear the worst. I was told I had to deliver my dead baby. Imagine my mental agony. I was induced that night but nothing happened. I was induced again at noon the following day, and I labored till midnight. I was induced again at noon the following day, and I labored till midnight. I just remember doing one push and the baby was out." (Story 3)

> "The baby's heartbeat had slowed dramatically and all the amniotic fluid had drained out. I was in agony and had to be induced for three days before I expelled the foetus of my baby boy. It was such a painful experience." (Story 4)

Nevertheless, story 6 described in writing how women who were affected by miscarriage were domestically abused by their partner as a result of miscarriage. Unfortunately, some women were disrespected, beaten, and money starved for a long time following pregnancy loss. They became even more stressed and frustrated while trying to adjust, live with, tolerate or even try to reciprocating to their partners abusive deeds towards them:

> "Whenever I try to ask about money, the end result is a quarrel. I don't respect him anymore. I find myself returning his abuses with the same and hit him back if he hits me. If I get mad about something and ask or quarrel, he tells me I don't respect him and that he has to marry another wife" (Story 6)

6.3 Care and support after miscarriage

From the stories analysed, women explained in writing the importance of showing care and support as they go through different kinds of emotional distress and physical pains during and after miscarriage.

6.3.1 **Support of family and friends**

Women in the stories below, pointed out how powerful and helpful it was to receive physical and spiritual support, empathy, love and care from family members and friends. Some women made mentioned of their mothers being available for them and how the availability of their mothers helped them coped and healed from the loss. Immediate family are likewise, a great source of strength. Making themselves available to help women walk is such a support anyone can beckon upon. Women with supportive partners felt safe. They expressed so much gratitude towards the availability of their partners. Their partners gave

them shoulders to lean on, which helped them heal. Story 6 showed that women had supportive friends who gave them a reason to smile again:

> "My husband tried to help me, but at some point he had to call my family to come and pick me because he didn't know what else he could do to assist me. A call I received from my mother one week later changed everything. She told me to wake up from that couch, take my Bible and read it. She said that I was too young to give up on life. I heard her, and started opening up to my husband and pouring my heart out. That began my healing processes." (Story 3)

"One pregnant friend used to take walks with me, and was a great source of encouragement. She appeared to have no fears, and this made me strong." (Story 2)

"We had supportive friends. They walked with us, prayed with us. One of my friends bought my unborn baby gifts early in the pregnancy."(Story 4)

Interestingly, Story 1 specifically displayed the feeling of togetherness, hope, safety and comfort due the availability of her partner which uplifted her moods and lightened her emotional burdens. Family members were great source of strength that motivated and helped the affected women:

> "The hug I received from my love was the most raw and loving moment I have ever experienced.He held me on the bathroom floor while I cried, and cried, and howled in utter pain and shock at what was happening. I have never felt so safe, loved and lucky. Yes, in this horrible moment. But I was, I am, to have someone who would forgo their own pain and sorrow to comfort me. To have those same feelings as me and just worry about mine. We just held hands, no tears, no words, just that look of "we have got this" and the touch reminding each other there is love which will get us through this." (Story 1)

Although not every women had access to supports from family members or friends. Story 6 disclosed some unfortunate experiences women had to live with after miscarriage. It reveals how unsupportive and unsympathetic some partners were:

> "When I had the third miscarriage, trouble started in my house. My husband started seeing other women. Abuses became the order of the day. Each time he returned from the bar, he would become verbally abusive, calling me a dog and complaining how I was unproductive, useless, and stupid, and that all I could do was to excrete dead babies. The abuses turned into bitter exchanges between us, and later developed into fights." (Story 6)

6.3.2 **Need for support from healthcare professionals**

Women pointed out that health care professionals play an important roles when it comes to supporting women affected by miscarriage. Thus, the things they do or say has a colossal impacts in either uplifting or negatively affecting women`s emotional state. Unfortunately, story 2 and 4 revealed that the level of unprofessionalism and unfriendliness from medical staffs towards affected women greatly contributed to their pains and healing.

On another situation, women expressed how hurtful and unforgettable it was to live with the thought of not seeing, feeling or touching their children before they were taken to be buried. They couldn't see their babies due to the kind of medical culture practiced at the hospital. Women explained that the culture practiced after delivery is to hand over the lifeless body of a baby to the father with or without the woman's consent and when the father or relative are unavailable, the child was dumped beside them without any form of communication. Although some women who miscarried at home had a fill of all the memories needed, while some women saw, felt and beheld their babies at the hospital:

> "My husband called the nurses but they ignored his calls. After a long wait, about 45 minutes, one of the nurses came by and said "Haijatoka yote, bado tu itabidi ungoje" (you need to wait for more time for the baby together with placenta to be out) and she walked away. Mark you this is in one of Nairobi's top private hospitals. I was in that position for about one hour bleeding, tired, broken, shake. in the company of my husband and our long awaited baby who was no more. It was a girl." (Story 2)

One of the major heart-breaking and hard-to-forget moments for these concerned African women, was how nurses wrapped their babies in plastic bags, dumped the body by their bedsides, only for them to pick up the bags with the assumption that the contents were sanitary garbage. Story 4, described the act as mind-torturing and sickening. Seeing their lifeless baby in an unkempt manner left them broken and further worsened their conditions:

> "The medical staff contributed a lot to my grief, despite the fact that I am doctor too. They put my first baby in a plastic bag and left it beside my bed thinking it was my sanitary equipment I picked it up, only to see my baby. The practice here is to hand the dead baby to the father to take away for burial but my husband and relatives were not allowed to be with me, I picked my baby myself and took him to his father. It was the most sickening feeling I have ever had. The nurses were so unfriendly towards me, and made the ordeal worse." (Story 4)

Nevertheless, women expressed they were administrated fertility medications while they were already pregnant. While some women uncovered how they were prescribed with polycystic ovarian syndrome (PCOS) medicine known as clomid, while they were already four (4) weeks pregnant. They pinned down their health-care provider for being the reason for their pregnancy misfortune. They blamed their gynaecologist for not being thorough with medical diagnosis. Some women also narrated how their blood pressure wasn't monitored during their pregnancy visitations, even though they were pre-diagnosed with preeclampsia at week twenty. Story 2, and 3 conspicuously showed how most of the affected African women wished they were adequately informed about medical complications that could arise during the journeys of pregnancy:

> "In 2014, I started suspecting I was pregnant but then I had an unusual bleeding. I went to see a gynaecologist in one of the leading and most reputable private hospitals. He advised that we should ignore the bleeding. He administered Clomid to aid conception. Four weeks later I confirmed I was

> pregnant. I decided I wasn't going to see a gynecologist until after 10 weeks. I wanted to be sure that on my first visit, a heartbeat will be detected. When I went, at 10 weeks, the scan estimated my baby's gestation at 14 weeks! Now a new worry set in; I had taken Clomid while already pregnant!! I became paranoid! Clomid shouldn't be administered to a pregnant woman! Talk of nature conspiring with misfortunes to throw the worst at you" (Story 2)

"I blamed my gynaecologist for being ignorant and not paying attention to my blood pressure." (Story 3)

Findings in Story 2 shows that healthcare professionals were acting unconcerned and unperturbed after kick starting the induction process. They indicated that there were no follow-up plans to monitor the progress of vagina preparedness. They complained that they were left alone in the hands of their partners or family members to eject the lifeless foetus without any monitoring or show of concern.. Story 2 further explained that the medical personnel attached to them for support were not helpful in whatsoever manner during and after miscarriage:

> "I cannot describe the pain. I was admitted to a medical unit rather than maternity to save me the trauma of seeing mothers with healthy babies. My experience at the hospital was traumatic. I was induced but the nurses did not monitor my progress. I had no experience of a vaginal birth but the nurses were not bothered. I delivered my baby alone with my husband in the room" (Story 2)

6.3.3 **Carefully chosen words and respect**

Women indicted the importance of respecting and supporting them through skilful communication. Story 1 made mention of carefully chosen words while conversing because context of communication is vital. It revealed that offering unsolicited and unhelpful advice can worsen affected women`s emotions. Thus, it is consequently necessary to ensure that communicative words are seasoned before utterance. Women also pointed how hurtful dismissive commentaries about the loss of their baby can be especially when people starts making comments like *"But you are not that far gone"* while consoling them. Women urge people through their stories to stop focusing on the number of weeks the pregnancy was before miscarriage. Because the number of weeks the pregnancy was before miscarriage holds no water and shouldn't be considered before respectful, sympathetic and encouraging words are offered.

The written expressions of women in story 1 also revealed that women would like to discuss about their loss and feelings without being judged, blamed, mocked or verbally abuse by sympathizers. However, women craved for ears that are willing to listen to their

stories. Therefore, women see it as important when asked about their experiences or well being as it helps them in opening up to somebody. They want people to acknowledge their loss and feel their pains too. Story 1 also expressed that being fearful and keeping quiet entirely about the situation can make things worse for them:

> "Please don't say you weren't that far along anyway. He was still our baby. Please just say sorry if you don't know what else to say.Please don't feel like you can't ask us how we are. Please don't feel guilty for bringing it up to see how we are both doing. Please don't think that by choosing to tell you what has happened, that we want you to feel awkward. Please don't make us feel awkward and change the subject. Please give us a hug if that is what you feel like doing.Please know we are grateful for your worry, your sadness, your kind words, your hugs and your love." (Story 1)

6.4 Self-healing strategies

Having faith in God was one of the healing strategies women utilized in healing. Findings from story 2 and 5 showed that the affected women accepted that miscarriage had occurred and devised their own mechanism of healing and coping. More than half of these women strongly had faith and hoped in God for quick recovery. Story 5 and 2 shows that women started feeling signs of relief after reading the praying by themselves or with the help of their partners or mothers, helped a lot:

> "There were many days and nights when I would wake up to find my husband kneeling and praying. He found me doing the same a number of times. We also prayed together as a couple. I still have not lost hope that God is preparing me for more blessings." (Story 5)

> "At 22 weeks, I wouldn't feel the baby actively moving (imagined or real, I am not sure). I really cried and told my husband that I was not ready to have the baby delivered rather than carry her and risk losing her. He, together with other friends prayed with me and encouraged me. I was visiting my doctor regularly filled with lots of panic but God is faithful." (Story 2)

6.4.1 **Expectation of another pregnancy**

Quite expectantly, after miscarriage women cried bitterly and hope to get pregnant soon. They explained how they had faith in God to bless them with a fruit of the womb. Some women verbalized how they were encouraged and advised using the word of God by their mothers to get pregnant again. Story 2 and 3 shows that, women who later got a positive pregnancy result penned down how healed, happy and wholesome they felt afterwards:

> "On January 19, 2016, our precious daughter was born. She has been a blessing. I look at her and just see God. God came through miraculously. I encourage any mom currently trusting on God for a baby to keep trusting Him. He will come through." (Story 2)

"*I drew closer to God and prayed every day. I am now pregnant again 17 weeks. So far so good and I am praying for the best. To God be the Glory*."(Story 3)

7 Discussion of study findings

Scientifically, the art of completing a theoretical study emphatically requires a section which allows the researcher to emphatically express his or her opinions, while comparing and contrasting the discoveries and theoretical frameworks of the research. In conformity with this, this discussion part of this academic study consists mainly of summary of the result found in this study and the postulates of the “Theory of Caring” by author Swanson Kristine. In relation to this thesis, the stipulates of the theory was used to investigate and understand the kind of care that was given to the women who were affected by miscarriage. The six stories analysed for this study succeeded in revealing the experiential extents of miscarriage these women underwent and the type of care they received.

In the course of this study, I discovered in most societies, miscarriage is a tragic event that is filled with immense emotions, enormous pains, sadness and physical stress. The biggest cause for alarm observed during this study was the dept of lack or the inadequacy of information about miscarriage and its related effects. There were lack of awareness about miscarriage and early pregnancy complications. Mostly, these women barely knew what miscarriage was. They were not prepared for this kind of uncertainty, neither did they know what to expect if miscarriage occurred, or how to handle the situation of miscarriage until they were victims of it.

Swanson`s theory emphasized on the redundancy of information and lackadaisical attitudes towards effective communication. According to Swanson, there is always an utmost necessity for better and usable information sharing, provisions and guidance during care-giving. Quite particularly, as it regards this study, the lukewarmness of the caregivers in information and communication sharing contributed to the suffrage of women who miscarried experienced.

The aftermath experiences of miscarriage presented in the findings were filled with different kinds of emotional distress, feeling of guilt, and physical pains. The result from this study shows that emotional expression are synonymous with women after miscarriage, hence, when the news of miscarriage has been conveyed, most women were in state of shock. Shock that was accompanied by tears, disbelief, numbness, confusion, disappointment and sadness.

The Swanson`s theory of caring consist of five conceptual models: knowing, being with, maintaining belief, doing for, and enabling. Applying the concept of doing as a theoretical

model of Swanson's theory of caring to the above paragraph, it can be clearly seen that these women who were hospitalized and induced due to miscarriage, regained consciousness only to realized their baby was already taken out of the hospital to be buried by their partner without their consent. The premise of nurses not giving them a chance to see or touch their child due to the culture practised at the hospital is practically unbelievable. The Swanson's concept of doing as model to be utilized in caring was not applied, because the women were not involved in the "doing", in that, they were not allowed to "do" anything during the disposal of their lifeless baby.

One of the painful experiences these women had to pass through was the physical pain and bodily stress that came with miscarriage. The amount of bodily pains experienced encompass frequenting the hospital and staying days or weeks on hospital admissions. Upper abdominal pains and cramps, blood loss, and being physically bullied from their partners were also experienced. They were bodily stressed and tired during and after experiencing miscarriage. Some women were frequenting the hospital when they started noticing blood spot from vagina while some were visiting the hospital intermittently due to pre-eclampsia which started during their 20th week of pregnancy. From the result found, pre-eclampsia is a kind of pregnancy complication which made women experience swollen body, headaches, blurred vision and constant pains.

Painfully, women who miscarried had to be medically induced to either begin the miscarriage or complete an already started processes of miscarriage. Labor induction of miscarriage is a means to expunge the dead foetus which as a varying lengths of time. For some women, it was a matter of days for labor induction to be completed, while for other women, the process was a lot longer, far longer than a week depending on the medical situation and implications of the entirety of the process. The process of waiting to achieve vagina birth without any physical support from nurses was such a painful and bodily tiring thing women went through.

Considering the "being with" model of caring described by Swanson (1991, 163) "*Is more than understanding another`s plight; it is becoming emotionally open to their reality".* One can understand that certainly, most African women didn't only experience physical pains and distress as a result of the various and uneventful processes of miscarriage at hospitals. In rarity of times, while in the comforts of their homes and among loved ones, they were tormented, abused, shamed, beaten and made to bear different episodes of domestic violence from their partners without anyone showing them concern and care. Without

mincing words, the plights of these miscarried women weren't understood by caregivers in hospitals and not even by their loved ones while at home.

Quintessentially, as discovered and recorded in the findings section of this academic report, some of the women who miscarried their pregnancies were fortunate enough to avoid home-made episodes of domestic violence, and for this set of women, their bodily pains and stress ended with the medical processes of miscarriage at the hospitals. In other words, it is unlikely to state or show any correlation between how these women were being treated by their spouses and what Swanson postulated in the theory of caring concerning understanding of another plight to aid healing.

In furtherance, Swanson (1991) defined caring as *"a nurturing way of relating to a valued other towards who feels a personal sense of commitment and responsibility".* Applying this definition to this study, it is therefore correct to assert that care after miscarriage is a cardinal process of recovery, an important feature that necessitates pointing out the relativity and methodical approaches utilized in providing the care and support to these women who have suffered miscarriage. Evidently, learning and discovering the kinds of care the research subjects received after their ordeals with miscarriage was important in understanding how healing was achieved. Women from Sub Saharan Africa who were part of this academic thesis expressed a high level of dissatisfaction with the nature, type and process of care-giving they received after their miscarriage.

The quality of care received was considered as emotionally traumatizing, insensitive, unkind and unresponsive. Nurses were unprofessional, unfriendly and unapproachable to these women. Some women lamented on how they were left unattended and timely unchecked while they were heavily bleeding. When the above findings are viewed, compared and contrasted with the models of Swanson`s theory, one can deduce that these women were not properly cared for, examinations were not carefully done. Nurses were not doing for their patients as they would do for themselves, such as making sure patients were pain-free, comforting them in a skilful manner, proper body examinations, medical tests, protecting and providing basic needs while preserving dignity and respect.

The "knowing" model was referring to understanding the cause of the event and being able to assimilate the situation these women were going through at the time of miscarriage. Findings showed that the health-care professionals who attended to these women used a lot of amateurish and unethical terms in describing diagnosis to these women and their spouses. Personally, in agreement to scholarly opinions, terms such as "the loss was

expected" "*we couldn't find the heartbeat of the baby*" and "*the baby is gone"* are unhelpful, unprofessional and very unethical. The level, structure and flow of the communicative discussion of the health-care professionals showed a reasonable level of unpreparedness, poor levels of knowledge in discussing sensitive medical misfortune (miscarriage) and inadequacy of professional skills.

Moreover, health-care professionals would have maintained belief by being available and able to communicate with their patients during the traumatic phase of miscarriage. The obvious physical absence of nurses from their patients during their ordeals was another negligence of the dictates of Swanson's theory of caring. How can care, during and after miscarriage be administered in absentia? Is it even possible to give care to a pregnant woman without being physically present to firstly understand and connect with her pains? These are questions for all to bear in mind as one read to understand the contexts of the misunderstanding some of these women who were affected by miscarriage had with their nurses.

Without putting the "being with" model of Swanson's theory of caring in practice while receiving care, one of the women who suffered from the ills of miscarriage explained that after labour induction medicine was administered to her, she was left all by herself to bleed out the foetus and placenta at the hospital, even though nurses were physically present at hospital or seen to be engaged in flimsy or activities lacking emergency attention. At times when nurses were called upon for help due to pain or for explanation of the situation, nurses responded unsympathetically saying things like "*you need to wait for more time for the baby, together with placenta to be out"* showing no remorse to the patient.

Totally, in consideration to the theoretical stipulates of Swanson's theory of caring, one can understand that in order to truly follow the structure of caring, one should keep in mind the five concepts as tools for maintaining good relations to these women who were affected by miscarriage by communicating skilfully and competently while administering care to achieve the intended outcome of reaching healing and well-being of their patients. It is utmost impossible to efficiently give care without doing, knowing or being with the care receiver in whatsoever way. This further explains why women affected by miscarriage needed their family members and friends to be with them, to importantly help them in their healing and recovery processes.

Kindness of words and concerns were evidently sources of reliefs. Many of the women expressed high feeling of gratefulness when they are being asked "How are you?" or

"What happened?". Some of these women pointed out how appreciative they felt towards people who were kind with words. They are thankful for people who feel sad about their situations. Women demonstrated how much they would want to be hugged and loved without feeling guilty, agitated or tensed-up when having people around them. They wished people would only say "sorry" when they don't know or have something uplifting to say to them. The practice and show of kindness and concerns epitomizes humanity and as humans, it can be of utmost best to be humane to ourselves by showing our humaneness and helpful concerns.

Additionally, even as anyone would expect, some of these women who were affected by miscarriage became more saddened and hurtful when some lame statements were used in attempts to show concerns or console them. Sentences such as *"you weren't that far gone"* or *"another baby will come"* were devastating and mentally debilitating. The lamentations of these women showed these kinds of words were demeaning to their lost child(ren). Even though they miscarried the pregnancy, they still believed that the foetus was still their baby, who will be forever cherished and loved. All this added together were in deformity with Swanson's theory of caring, which emphasized on showing care and support by enabling with kind words, to lift the care receiver off the burdens of miscarriage.

7.1 Critical review of the study

Qualitative content analysis methodology was used for this academic study. This method was explored because of its tenets in describing a phenomenon with limited studies and its unique way of analyzing and interpreting data. The interesting thing about content analysis is that it can be used inductively, deductively or together. These approaches involve three main phases: the preparatory, organization and reporting of study. Inductive approach which was specifically explored for this study involved organization of data, creating of category table and abstraction. (Elo, Kääriäinen & Kanste, 2014)

One of the advantageous parts of using content analysis is the ability to reduce collected data into concepts that best described the study phenomenon by either creating a model or categories (Elo et al., 2014). In the case of this study, the research questions were used in specifying what to analyze and categories to create. During the preparation stage, suitable data were collected from six platforms. These data were read multiple times to make sense out of them as postulated by Elo and Kyngäs (2008). Selection of unit of analysis was done from the stories collected. For the organization phase, categories were created from

voluminous data collected from six different electronic platforms just as already explained in the data collection part of this study.

The year of publication of the stories used were limited to 2010-2020 in other to get newly updated data for the research. Although older data might have been filled with vital information which could have been relevant but were unselectable. Literature searches were done through different search engine and electronic databases of Females in Africa (FIA) Organization, Google search, Daily Nation platform, World Health Organization (WHO), Huffington platform, Mummy Tales and Still A Mom Organisation.

Considerably, depending on the angles of observation and interest, there were different limitations in the build-up of executing this academic study. The limitation found in using this method was the limitation of scientific articles which concentrated solely on the aim of this study. There was a huge limitation in getting first-hand primary data via a face-to-face interview with women from regions of Sub-Saharan Africa who were affected by miscarriages during their various times of pregnancy.

A possibility of conducting interviews would have availed me with the first-hand, undiluted information and data. The study could have been more country specific if there were adequate documentation and availability of data, information and empirical reports about the subjects geared towards the research aim of this thesis. Unfortunately, my desire was cut short due to the distance of the subjects' continent of residence and countries of study interest.

The sensitivity of the research topic and aim of this study would require a lot more, the utmost option of travelling to these African countries in order to acquire and source adequate research subjects and required amount of first-hand data. Adversely, this path would have costed a lot of money, consumed time and the processes of data collection would have taken longer time, thereby making the workload cumbersome. In addition to lengthy data collection time, data protection and privacy of the research subjects might be tampered with in the process.

In addition, being the sole-researcher of this study has some pros and cons. There might have been some vital information that were overlooked as a result of working alone. This limitations reality would have been prevented when researching with partners or with group of fellow researchers. The abilities, capabilities and capacities of being more than one researcher would have negated these particular ills of this academic study.

It is also important to assess the trustworthiness of the method used for this study. According to Elo et al. (2014) they explained how Lincoln and Guba offers four criteria to be used in assessing trustworthiness of data a researcher used in a study. Because irreliability and validity are used when assessing the credibility of a qualitative and quantitative content analysis. Thus, the essential of trustworthiness includes: dependability, credibility, confirmability and transferability. Although authenticity has been added to the criterion of trustworthiness and that will be described below.

Credibility refers to accurate identification and description of data and how they are scientifically utilized and discussed in the analytic representation of the study. This study is credible as it accurately identified and described every data used during the study. Dependability was described as the stability of data that is empirically consistent in any given time. Conformability refers to the sole objective of the researcher, about data correctness and representation while transferability refers to relocation of relevant context to other individuals or groups. Authenticity on the other hand, involves the extent of fairness and faithfulness a researcher showed during the conduct of an academic or scientific study. (Elo et al., as cited in Lincoln & Guba, 1989)

The academic process of completing this study revealed a lot to answer the research questions and profoundly provide angles for prospective researches and future academic discourses, by all means, supporting the credibility and transferability criterion which applies to the relevance of the study and making it transferable the other groups or settings.Ethical considered wasn't overlooked at any point in time. The identities of participants were totally concealed.

Lastly, findings in this qualitative content analysis exposed the truest feelings and experiences of women affected by miscarriage. The Swanson theory of care provided the theoretical framework to probe the way women were cared for and how health-care professionals performed while giving care during and after miscarriage. Succinctly, the limitation of scientific articles which solely concentrating on the kind of care women from Sub-Saharan Africa received after miscarriage was uncovered.

8 Conclusion

Miscarriage is as a matter of medical fact, a loss that can be emotionally and physically stressful and painful to any affected woman and her partner. Due to the kind of cultures

and beliefs surrounding miscarriage in Sub-Saharan Africa, women hide their experiences of miscarriage to themselves to avoid being shamed, judged or mocked as miscarriage is culturally perceived as a taboo. They were encouraged not to disclose their pregnancy status until after the first trimester of being pregnant. This is usually advised to avoid fetish or evil people from knowing about the statuses of people's pregnancies. This notion simply means that it is believed that miscarriage mostly occur due to spiritual attack from evil people. In consequence, consciously and unconsciously, women live in fears and feel unsafe having people coming close them to avoid noticing their pregnancies.

And when miscarriage eventually happens, African women feel safe in keeping what has happened to them silent, unreported, undocumented and private. Although, there were previous studies about the silence surrounding miscarriage in well-developed countries. In some these developed countries women are still encouraged to keep the news of being pregnant secret until after 13 weeks of pregnancy. The only difference is that women in developed countries are a lot more at ease talking about miscarriage and their experiences unlike African women. The silence surrounding miscarriage is deafening as African women still find it hard to tell the event of miscarriage.

In furtherance, health-care practitioners were usually the ones pregnant women turn to before and after miscarriage. The findings of this research showed that the idea or practice had its own negative and positive impacts on them. Indicatively, from all observations, women expressed that the gynaecologists were mainly focusing on medical aspects of miscarriage and giving out diagnostic information without monitoring or instead of having and paying the slightest attention to their emotional states.

Furthermore, it is completely incomprehensible how no proper provisioning was arranged for some of these women even after necessary hospital admission requirement was met. Nurses were more fixated on waiting for the ejection of the foetus and placenta. Health-care professionals totally trivialized the physical pains and emotional trauma women underwent during and after miscarriage. There were no form of medical follow up or private meetings for discussing about their wellbeing after miscarriage. Nevertheless, the reactions and actions of health-care professionals might have been as a result of lack of work ethics, incompetence, non-challenge or due to the environmental culture surrounding miscarriage.

In other to add value to life, making frantic effort in knowing the cause of the problem is vital. The use of ambiguous medical terminologies should be minimized to avoid

misleading thoughts and expressions when diagnosing women who are pregnant for the first-time and those who had experienced miscarriages in the past. Having in mind the cultural sensitivity surrounding miscarriage, it is important for nurses and caregivers to practice person-centred care. Most women wished they can be showed some sense of belonging by giving them better care and emotional support. They wished their needs can acknowledged and recognized while going though pains. They wished their situation are better assessed and interpreted while avoiding assumptions that they are knowledgeable enough to deal with the situation. All this should be put into consideration while giving care.

Conclusively, the aim of this study provided an insight on the experiences of miscarriage and to elucidate more on the kinds of care necessarily required after miscarriage. Hence, this study should serve as a form of awareness to further advance the academic knowledge on experiences of miscarriage and its related suffrage to individuals, nursing students and health-care professionals. Including the global professional community. It is quite important that we dissuade from describing people, especially patients by their problems. It is completely unethical and unprofessional, because women who were affected by miscarriage should not be described as “miscarried women”, as their medical health problems do not describe or represent who they are

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Appendix 1 Categorization of data analysis

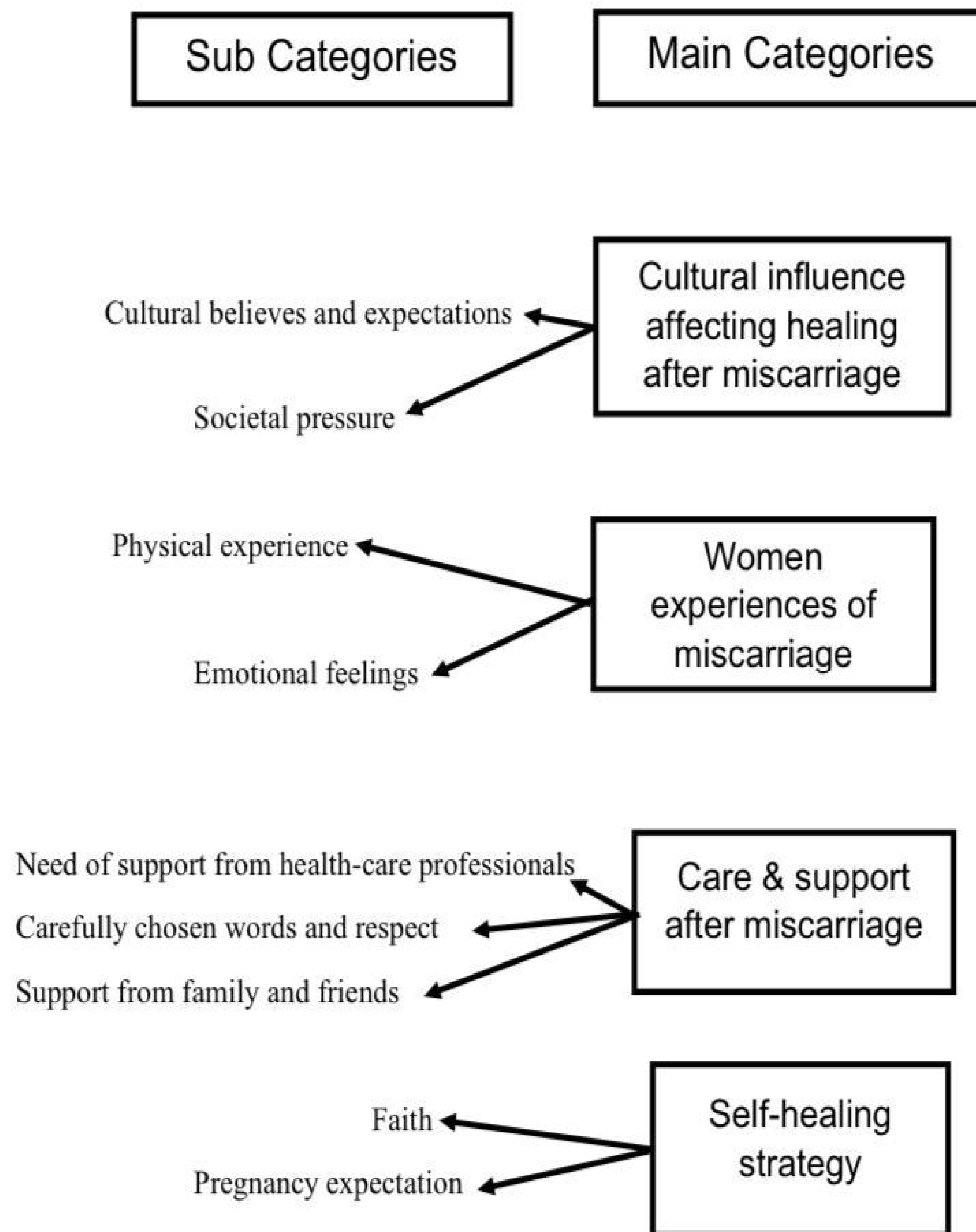

Figure 1 Categorization of data analysis