UNIVERSITY FOR DEVELOPMENT STUDIES

LIVED EXPERIENCES OF WOMEN WHO HAVE LOST THEIR CHILDREN THROUGH MISCARRIAGES: AN EXPLORATORY STUDY IN THE SAGNARIGU MUNICIPALITY IN THE NORTHERN REGION OF GHANA

BY

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UDS/CHD/0026/19

SUBMITTED TO THE DEPARTMENT OF SOCIAL AND BEHAVIORAL CHANGE, SCHOOL OF PUBLIC HEALTH, UNIVERSITY FOR DEVELOPMENT STUDIES, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

NOVEMBER 2022

DECLARATION

Student:

I hereby declare that, this thesis is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere."

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I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of the thesis laid down by the University for Development Studies.

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ABSTRACT

Women who lose their babies through miscarriages are mostly shocked; and feel guilt and emptiness. Most women plan their future with their child during early pregnancy and when they miscarry, they feel they are the cause through something they have done or consumed which makes them sense a lot of sorrow. This study sought to discover the experiences of mothers who have experienced miscarriages in the Sagnerigu Municipality in the Northern Region of Ghana. Participants were carefully chosen through purposive and snowball sampling techniques to capture the diverse experiences of mothers who had suffered miscarriages. Structured observation was also employed to gather additional information to supplement the data collected. Responses were captured using a tape recorder. Notes were also taken and later transcribed and coded. Data were analyzed thematically to identify recurring themes and patterns in participants narratives.

The study was conducted on 15 women who were purposively sampled and interviewed using a well-designed interview guide to collect purely qualitative data and made use of the Phenomenological research design to describe participants' lived experiences concerning pregnancy loss. The data collected from participants in this study were thematically analyzed highlighting all the main themes the study sought respond to. The main themes that were identified from the experiences of the 15 women included: The lived experience of miscarriage, The uniqueness of pregnancy after loss, Support systems and Post miscarriage care. The analysis revealed that, the educational level, age of a woman, place of residence, marital status, occupational type and income variant were important factors that contributed to pregnancy loss experience among ever-pregnant women. It was therefore recommended that, the Ghana Health Service should equip midwives and nurses with skills on how to care for women who miscarry.

ACKNOWLEDGEMENTS

I am thankful to the Almighty Allah for blessing me with good health and a sound mind to work on this project. The success of this study could not have been possible without the support and guidance of my Supervisor Dr. Abukari Salifu. I am thankful for his support and guidance. I also wish to thank my family for their patience and support during the period of this study.

Finally, I wish to express my earnest thanks to all the participants who supported me during the data collection process.

DEDICATION

This piece of work is dedicated to my parents, Mr. and Mrs. Abukari Ibrahim, my kids and all those who have contributed in one way or the other to the success of my education.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACOG	The American College of Obstetricians and Gynecologists
ASRM	The American Society for Reproductive Medicine
CES-D	Center for Epidemiologic Studies - Depression scale
GHQ	General Health Questionnaire
GSS	Ghana Statistical Service
HIV	Human Immune Virus
HREC	Human Research Ethics Committee
IPA	Interpretative Phenomenological Analysis
KNUST	Kwame Nkrumah University of Science and Technology
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PSE	Present State Examination
PTSD	Post-traumatic stress disorder.
TSH	Thyroid-Stimulating Hormone
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Overview

The study's topic is examined more broadly in this chapter before being condensed to a few key problems. By identifying topics crucial and pertinent to the research subject, it critically examines the study's scope, substance, major aims, particular objectives, and importance. The chapter's introduction, study background, issue description, primary and secondary goals, research questions, importance of the study, and study structure are all included.

1.2 Background of the study

Reproduction is an ultimate result of unrestricted natural sexual activity, which is what the majority of people want to happen. For many women who are making plans for the future, being pregnant is an exciting time. Unfortunately, roughly 25% of pregnancies result in miscarriage (Cunningham et al., 2005). Every male and female of reproductive age looks forward to the milestone of a woman becoming pregnant and the ensuing extension of their selves, their relationship, or their family. In many cultural contexts, becoming pregnant both establishes a woman's capacity for reproduction and gives her a new identity as a mother. 15–25% of all clinically confirmed pregnancies result in miscarriage (Todd, 2019). It affects about 50% of all pregnant women and is the most frequent pregnancy problem. Miscarriages are common in the first three months of pregnancy which account for more than 80% of cases (Todd, 2019). Its effects can be devastating to people on an individual and family level and can have a lasting impression on social actors.

Unwanted abortion is an inaccurate term for miscarriage and is disrespectful to both the partners and the women who experience miscarriage, adding further stress to their already

fragile sensitive states. The stated incidence is likely higher than real rates since not all pregnancies are clinically verified and not all women seek treatment after a miscarriage. (Todd, 2019; Van den Akker, 2011; Sejourne, Callahan, & Chabrol, 2010). Unexpected discomfort and considerable blood loss can occur during a miscarriage. As a result of the discomfort and bleeding, a woman experiencing a miscarriage may become sensitive to the treatment she receives from her medical professionals (Van den Akker, 2011). “

The precise definition of a miscarriage is a topic of significant controversy in the literature. "Fetal death during early pregnancy is referred to as a miscarriage up to the gestational age of around 20 weeks, with any fetal loss beyond the 23rd week being called a stillbirth" (Rowland & Lee, 2009). For instance, according to Australian health policy, a miscarriage is defined as a spontaneous loss of pregnancy before to the 20th week, 24th week in the UK, and prior to the 28th week in certain but not all-American States (Van den Akker, 2011). Because it can be difficult to reconcile a loss at ten weeks of pregnancy, before tangible signs of pregnancy are evident, with a loss at 25 weeks, when the carrying mother is typically visibly pregnant and has sensed the baby movement, it is helpful to have some universal consensus on the defining time scales for miscarriages and stillbirths.

In recent years, stillbirth and miscarriage have become major global problems. For instance, according to the World Health Organization’s (2016) estimate, "there were more than 7178 deaths every day in 2015, there were 2.6 million miscarriages and stillbirths worldwide." According to Nonglak (2013), “98% of miscarriages occur in low- and middle-income nations including Ghana, Nigeria, and Haiti.” The World Health Organization (WHO, 2016) came to the conclusion that stillbirths and miscarriages have remained a major worldwide concern for public health and development across time.

In Africa and Ghana, the issue is compounded by socioeconomic, cultural, and healthcare factors. Miscarriages are unfortunately common, affecting about 10-20% of recognized pregnancies globally (Aghajanova et al., 2017). In Africa, determining the precise number of miscarriages is difficult because many cases go unreported and healthcare access varies widely. Some studies suggest that miscarriage rates may be higher in sub-Saharan Africa than in wealthier countries (Say et al., 2014). In Ghana, reported rates are also influenced by similar challenges. For instance, research by Tagoe and Asante (2017) indicates that miscarriage rates in some areas might be as high as 15%, though this is likely an underestimation.

Many studies in Ghana on mothers losing their babies in the early days of pregnancy focus on stillbirths. For instance, Attachie (2013) and Samson (2018) only study the experiences of mothers who lost their babies during delivery (Stillbirth). However, these studies paid little attention to mothers losing their babies before 24 weeks of pregnancy. Again, few studies that relate to miscarriages only focus on the psychological and social consequences of unsafe abortion in Ghana (Emelia, 2013). Existing studies in this area are disproportionately focused on the developed world than on the developing world, such as Africa (Todd, 2019; Van den Akker, 2011).

The causes of miscarriages are complex and varied, involving genetic, anatomical, hormonal, and immune factors, as well as lifestyle and environmental influences (Rai & Regan, 2006). In Africa, and particularly in Ghana, several additional factors contribute to the high incidence of miscarriages:

1. **Infections**: Diseases like malaria and HIV are common in many parts of Africa and can increase the risk of miscarriage (Muehlenbachs et al., 2015). For example, malaria

during pregnancy is linked to higher miscarriage rates due to the effects of the infection on the placenta (Desai et al., 2007).

2. **Nutritional Deficiencies**: Many African populations suffer from nutritional deficiencies, particularly in iron and folate, which are crucial for a healthy pregnancy (Allen, 2005).

3. **Healthcare Access**: Limited access to quality prenatal care contributes significantly to higher miscarriage rates. In Ghana, there are notable disparities in healthcare services between urban and rural areas, with rural women often lacking essential maternal health services (Gbogbo, 2020).

4. **Socioeconomic Factors**: Poverty, low levels of education, and high stress levels can negatively impact maternal health and increase the risk of miscarriage (Granja et al., 2002).

In many African cultures, including those in Ghana, miscarriages carry a significant stigma and are often surrounded by cultural misconceptions. These attitudes can influence how women seek and receive care after a miscarriage. In some communities, miscarriages are attributed to supernatural causes or curses, discouraging women from seeking medical help (Nwankwo et al., 2013). Additionally, the psychological impact of miscarriages is profound. Women who suffer miscarriages often experience depression, anxiety, and post-traumatic stress disorder, but these issues are frequently overlooked in healthcare settings (Lok et al., 2010).

Stress is a well-documented risk factor for miscarriages. In the Northern Region, various stressors, including economic hardship, gender-based violence, and limited access to healthcare, exacerbate the risk. Women in this region often face multiple layers of stress due to socio-economic challenges and cultural expectations. Research indicates that high stress

levels can lead to hormonal imbalances, adversely affecting pregnancy outcomes (Hobel et al., 2008).

In Sagnerigu, women's roles are traditionally centered around household responsibilities and childbearing, which can create additional pressure, particularly when there are difficulties in conceiving or maintaining a pregnancy. A study by Dole et al. (2003) found that women experiencing high levels of psychological stress were more likely to have a miscarriage compared to those with lower stress levels. The physiological mechanisms behind this include increased cortisol levels, which can impair placental function and fetal development.

Trauma, both physical and psychological, is another significant factor contributing to miscarriages. The Northern Region has seen instances of domestic violence, which can lead to direct physical harm and psychological trauma, both of which are detrimental to pregnancy. Physical trauma can cause uterine contractions or placental abruption, while psychological trauma can induce stress-related hormonal changes, further increasing miscarriage risk (Seng et al., 2001).

In the Sagnerigu Municipality, the prevalence of domestic violence is concerning. According to the Ghana Demographic and Health Survey (GDHS, 2014), a significant percentage of women in Northern Ghana have experienced some form of domestic violence. The trauma from such experiences can have long-lasting effects on women's reproductive health, including an increased likelihood of miscarriage.

Belief systems play a critical role in how miscarriages are perceived and managed in the Northern Region. Traditional beliefs and practices can influence women's health-seeking behavior and their response to miscarriage. In many communities, miscarriages may be attributed to supernatural forces or curses, which can discourage women from seeking medical care and instead lead them to rely on traditional healers (Nguyen et al., 2013).

In Sagnerigu, these belief systems are deeply ingrained. Studies show that cultural interpretations of miscarriages often involve spiritual or moral explanations, such as the woman's failure to adhere to cultural norms or taboos (Bleek, 1987). These beliefs can result in stigmatization and a lack of social support for women who experience miscarriages, further exacerbating their emotional and psychological distress. Moreover, the reliance on traditional remedies instead of biomedical treatments can delay proper medical intervention, potentially worsening health outcomes (Aborigo et al., 2012).

While substantial research exists on the incidence, causes, and socio-cultural consequences of miscarriages globally and in various African contexts, there is a notable gap in the literature regarding the specific experiences and psychological impacts of miscarriages on women in the Sagnarigu Municipality of Ghana. Most studies focus broadly on factors like infections, nutritional deficiencies, healthcare access, socioeconomic conditions, and cultural beliefs, but they do not delve deeply into the personal narratives and lived experiences of the affected women in this particular region. Additionally, there is limited research addressing the aftermath of miscarriages and pregnancy terminations due to fetal abnormalities, especially in the context of Sagnarigu.

It should also be noted that not a lot of research has been done explicitly on loss following miscarriage and pregnancy termination due to fetal abnormality. Therefore, it is crucial to research the actual experiences of moms in Sagnarigu Municipality who have had miscarriages.

1.3 Statement of the problem

Reproduction is a natural and cherished part of life for many, but sadly, about 25% of pregnancies end in miscarriage (Cunningham et al., 2005). For many women, the joy of expecting a child is suddenly replaced with grief and emotional pain. Miscarriages, especially

those that happen in the first three months, can be heartbreaking and leave lasting emotional scars (Van den Akker, 2011). Beyond the physical loss, miscarriages deeply affect a woman's sense of identity and social status, especially in cultures where motherhood is highly valued.

Miscarriages are a significant global health issue, with noticeable differences in how they are experienced and managed between wealthy and poorer countries (WHO, 2016). In places like Ghana, the problem is made worse by infections, poor nutrition, limited access to quality healthcare, and socio-economic hardships (Aghajanova et al., 2017; Gbogbo, 2020). The stigma and cultural misunderstandings about miscarriages make it even harder for women to get the care and support they need (Nwankwo et al., 2013).

In Northern Ghana, including Sagnarigu Municipality, women face extra challenges like poverty, gender-based violence, and cultural pressures that affect their reproductive health (Hobel et al., 2008). Despite how common miscarriages are and the severe emotional impact they have, there's a lack of research that focuses on the personal experiences and emotional aftermath for these women. Most studies discuss general issues but don't delve into the personal emotional and psychological toll on women who go through miscarriages.

Moreover, traditional beliefs in Sagnarigu play a big role in how miscarriages are perceived and handled. Many communities believe miscarriages are caused by supernatural forces or curses, which can lead to stigmatization and a lack of support (Bleek, 1987). These beliefs can prevent women from seeking proper medical care, pushing them toward traditional remedies instead, which might not be effective and could worsen their health (Aborigo et al., 2012).

There is an urgent need to listen to and understand the personal stories and emotional journeys of women in Sagnarigu Municipality who have experienced miscarriages or pregnancy terminations due to fetal abnormalities. We need to know how they cope, what

support they receive, and how cultural beliefs shape their experiences. Understanding their real-life experiences will not only add to the global knowledge about miscarriages but also help create better support systems and interventions to improve the well-being of women in Sagnarigu and similar communities.

According to Todd (2019), "up to 50% of pregnancies result in miscarriage, most frequently before a woman misses a period or realizes she is with child." More than 80% of miscarriages happen in the first trimester of pregnancy, accounting for about 15–25% of identified pregnancies (Todd, 2019). After 20 weeks of gestation, miscarriages are less common.

Family members and mothers are seldom prepared for the feeling of miscarriage. According to Leonard, Bower, Peterson, and Leonard (2000), common expressions of these emotions include being unprepared to confront the terrible truth of loss, denial and the perception that their world no longer makes sense. Losses cause psychological and social issues, and moms have a hard time adjusting during grieving (Human, Green, Groenewald, Goldstein, Kinney & Odendaal, 2014). Before assistance is sought for them through support groups, mothers who have lost their babies to pregnancy are sometimes incorrectly classified as having mental illness (McCreight, 2008).

At the time of any pregnancy or childbirth-related fatality, supportive care is crucial (De Bernis et al., 2016). However, there is no established strategy or guideline for treating women who have miscarried and their families within the Ghana Health Service. Additionally, a lot of experts and regular people continue to foster the idea that miscarriage is a minor occurrence. Women are believed to heal without experiencing any long-term psychological or social repercussions on their own, their partners, or their families (Van den Akker, 2011).

Therefore, a gap in the literature needs to be filled. Hence, this study aims to examine the lived experiences of women who have lost their babies through miscarriages and the immediate and long-term psychosocial effects on miscarried mothers and their families.

1.4 Research Questions

i. What are the problems encountered by women who have had miscarriages in the Sagnerigu Municipality?

ii. What are the lived experiences of women who suffer miscarriages in the Sagnerigu Municipality?

iii. What support systems are available to the bereaved women who suffered miscarriages in the Sagnerigu Municipality?

iv. How do women who suffer miscarriage recover or cope with the social and psychological trauma?

1.5 Research Objectives

1.5.1 Main Objective

The main objective of this study was to explore the experiences of mothers who have experienced miscarriages in the Sagnerigu Municipality.

1.5.2 Specific Objectives

i. To explore the problems encountered by women who have experienced a miscarriage.
ii. To investigate the lived experiences of women who have experienced miscarriages in the Sagnerigu Municipality.
iii. To ascertain the social support system available to women who experienced miscarriages in the Sagnerigu Municipality.

iv. To investigate the recovery procedure and coping mechanism for women who experienced miscarriages in the Sagnerigu Municipality.

1.6 Significance of the Study

In order to address the short and long-term psychological repercussions of miscarried mothers, the study evaluates the lived experiences of women who have lost their infants due to miscarriages. This information will aid in describing bereavement management, social, and psychological therapies for women experiencing loss.

The results of this study will also help medical professionals assist moms who have miscarried with holistic care that will help them heal from their loss. The study's findings will inspire more research into the phenomenon and considerably improve the body of literature already available on the psychological and social experiences of moms who have miscarried. The study's findings will also persuade decision-makers in the health sector, including the Ministry of Health, Ghana Health Service, Nursing and Midwifery Council of Ghana, and other pertinent institutions, to examine the country's post-miscarriage care regulations.

1.7 Conceptual Framework

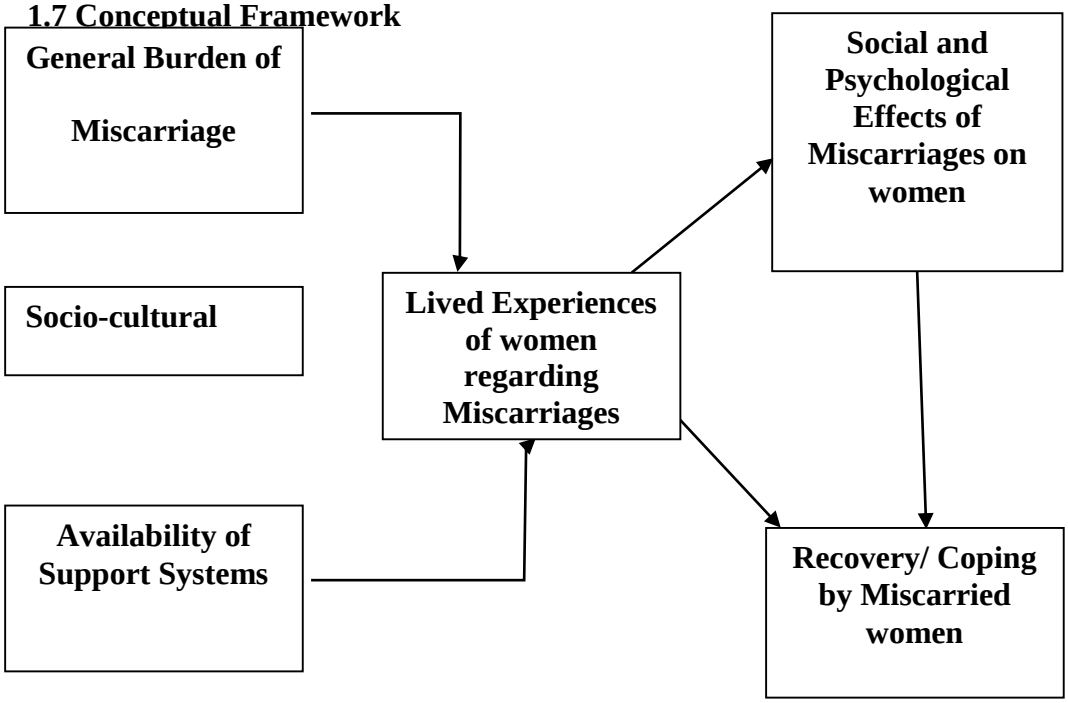

Figure 1.1 Theoretical framework: Phenomenology of women's lived experiences on miscarriages.

Source: Author's own construct

The Phenomenological study is the theory that guides this investigation. Phenomenology investigates perceptions and connects with how people think back on the events they consider important in their life (Smith et al., 2009).

Researchers who employ this approach recognized that experience is subjective and can only be understood through interpretation (Biggerstaff et al., 2008). The ideographic technique of phenomenology enables the researcher to carefully examine how these experiences may affect a person (Biggerstaff et al., 2008). Due to the fact that its ideographic methodology allows researchers to carefully examine how particular events may affect a patient and subsequently have an influence on their care, it has become more and more popular in healthcare research (Biggerstaff et al., 2008).

According to the diagram above, depending on the cultural and societal value systems that women who have experienced miscarriages live in, their lived experiences will either be positive or negative.

The entire burden of miscarriages cannot be overstated because it puts a strain on women and their ability to deal with unforeseen occurrences.

The experiences of such miscarried women will also be improved by the existing support networks. All these will either lead to quick recovery and less effects or vice.

It explores how women experience and interpret miscarriage within the broader social, psychological, and cultural contexts. Here's a breakdown of the key elements:

1. **Social and Psychological Effects of Miscarriage on Women**: This aspect of the framework addresses the emotional and mental health impacts of miscarriage, such as grief, anxiety, and depression. It reflects how women process their experiences both emotionally and in relation to the reactions of those around them.

2. **General Burden of Miscarriage**: This refers to the overall weight or toll that miscarriages have on women, potentially considering the societal stigma, personal guilt, and the often-hidden nature of these experiences.

3. **Lived Experiences of Women Regarding Miscarriages**: Central to the framework, this theme emphasizes the direct, subjective experiences of the women themselves, incorporating their personal narratives and how they navigate the aftermath of pregnancy loss.

4. **Socio-cultural Values**: This section highlights the influence of cultural norms, beliefs, and practices on how women perceive miscarriage and their role within the community. Cultural factors can shape the grieving process and social responses to miscarriage.

5. **Recovery/Coping by Miscarried Women**: This part of the framework explores how women recover, both physically and emotionally, from miscarriage. It includes the coping mechanisms they develop to handle the trauma, such as seeking support from family or religious or cultural rituals.

6. **Availability of Support Systems**: This component focuses on the external resources available to women who have experienced miscarriage, such as healthcare, emotional support from family or community, and counseling services.

This framework connects the subjective, personal experiences of miscarriage with broader social, cultural, and psychological factors, offering a comprehensive view of how women navigate this deeply personal yet socially influenced event.

1.8 Organization of this study

There are six (6) chapters that make up this thesis. The research is briefly summarized in Chapter One. The chapter discussed the degree of the problem and addressed the study's relevance. It also discussed the research objectives and questions.

The second chapter presented very important literature concerning the aims of the study. It incorporates the explanation of terms related to miscarriage and other practical published studies of managing miscarriages and its determinants to the World, Africa and Ghana, thereby providing a concluding summary of the critical matters obtained in the literature collected.

Chapter Three intensely describes the methods used to conduct the research. It covers the research study area, the research design, techniques and data collection tools, and the methods of analysis of your data.

The Fourth chapter also presents the results and analysis of the research results.

In chapter five, the study's findings are critically reviewed and compared to those of previous studies and other significant insights generalized.

Chapter Six concludes by summarizing the research findings, the inferences drawn from the study's findings, and suggestions for managing the effects of miscarriages.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

According to Polit and Beck (2017), “literature review is a process that involves revising relevant literature to a comprehensive background or understanding of the information that is available and related to a problem under study”. Polit and Beck (2017) stated to ensure the domains covered by the literature review are pertinent to the research question. A review of pertinent research and literature on miscarriage was conducted. The following databases were examined for relevant peer-reviewed studies on miscarriage: Medline, CINHL, Biomed, PubMed, books, and grey literature. The research was undertaken in both high- and low-resource nations. The following themes were used to organize the review: “Social and psychological effects of miscarriage on women, burden and prevalence of miscarriage, and social support systems available to women who procedure and coping mechanism for women who experienced Miscarriage”.

2.1.1 Burden and Prevalence of Miscarriage.

One of the most joyous occasions a couple can share is “the birth of a child. However, this experience may be frustrating and difficult due to things like fetal abnormalities, abortion, pregnancy difficulties or fetal loss, and pregnancy-related issues. About one-fourth of pregnancies end in abortions” (Chaloumsuk, 2013). Spontaneous abortion, often known as a “miscarriage, is one of the various types of abortion and is considered to be a rather complex problem. A miscarriage occurs when a pregnancy stops on its own before 20 weeks of gestation (Sarah, 2020). When a pregnancy has a poor start, this is typically your body's method of ending it” (Sarah, 2020).

Miscarriage and spontaneous abortion are interchangeable expressions. While miscarriage is the favored term in clinical settings and among the general public, spontaneous abortion is more frequently used in the medical literature. "The removal of an embryo (blighted ova) or a fetus weighing 500g or less" is the definition of spontaneous abortion given by the World Health Organization (WHO, 2017). This fetal weight is usually associated with a gestational age of 20 to 22 weeks. An early miscarriage occurs before 12 weeks, while a late loss occurs between 13 and 22 weeks following conception. In a “complete miscarriage”, the entire fetus and all of its components are ejected, whiles on the other side, in a “incomplete miscarriage, not all the fetuses are ejected. In a “missed abortion,” the pregnancy dies but nothing has yet been discharged; Geographical and historical differences can sometimes affect what should be considered the right definition of a missed miscarriage (missed abortion). When the woman felt no "fetal movement" or when the symphysis/fundus measurement gradually dropped, suggesting the fetus's lack of growth, the phrase "missed abortion" was used in the past. This could result in a prolonged and uncertain wait on the side of the woman. In current clinical practice, a missed abortion is often identified when an ultrasound reveals a fetus lacking viability. The woman frequently experiences nausea, breast strain, and lack of appetite with no or just moderate vaginal bleeding symptoms” (Hart, 2004; Brody & Frank, 1993). Recurrent spontaneous abortions are defined as three or more consecutive pregnancy losses before 22 weeks of gestation, and they usually occur around the same gestational week (Jablonowska, 2013). It is the most typical kind of miscarriage, according to the American College of Obstetricians and Gynecologists (ACOG). An estimated 10% of clinically confirmed pregnancies and up to 26% of all pregnancies may result in a miscarriage (Kanmaz et al., 2019).

When a pregnancy is terminated either intentionally or spontaneously, it is referred to as an abortion. Different stages of pregnancy loss are described using a range of words. They include the terms "complete," "missing," "threatened," and "inevitable." Early-stage vaginal bleeding puts the pregnancy in peril, but a pelvic exam shows that the cervical Os has closed, and a transvaginal ultrasound confirms the existence of a live baby (Kanmaz et al., 2019). On the other hand, if the pelvic exam reveals an open cervical Os and there is vaginal bleeding, it is anticipated that the baby would pass through the cervix shortly, leading to an inevitable termination. The viability of a pregnancy can be assessed via a transvaginal ultrasound (Birch et al., 2017). Complete abortion refers to "when there is early vaginal bleeding, the transit of sperm and eggs through the cervix, and on transvaginal ultrasound, there would not be any fetal remnants in the uterus". When there was vaginal bleeding and potentially some sperm or tissue passing, but on a pelvic exam, the cervical Os would be closed, and on a transvaginal ultrasound, there would appear to be retained fetal tissue but no viable fetus, which is considered to be a missed abortion. For first-trimester spontaneous pregnancy loss, chromosomal abnormalities are the most common cause. For the most part, "it is yet too early to determine the particular cause of the anomaly. After 15 weeks of pregnancy, the risk of early pregnancy loss in a genetically normal fetus diminishes as pregnancy age increases and is relatively low (Wyatt et al., 2015). An intended normal pregnancy could be unintentionally terminated if it is mistakenly diagnosed as a miscarriage. Widespread public concern over this issue prompted multiple public inquiries that provided advice on how to avoid similar diagnostic mistakes (Regan, Braude & Trembath, 2019). A systematic analysis recently revealed the dearth of high-quality, prospective data on which to base guidelines for the exact diagnosis of early fetal demise (Sarah, 2020).

A number of cut-off levels for the gestational sac or embryo's size above which embryonic heart activity should be detectable should be apparent in a typical early intrauterine pregnancy, according to research (Sarah, 2020). The greatest cause of misdiagnosis, despite the fact that all tests have a certain margin of safety, is operator error, which can occur regardless of the chosen cut-off value. Therefore, according to the most recent National Institute for Health and Care Excellence (NICE) recommendations, all women who have an ultrasound that suggests an early fetal death should have the diagnosis verified either by a second observer or during a follow-up visit seven to 14 days later (Regan, Braude & Trembath, 2019).

2.1.2 Epidemiology of Miscarriage.

Miscarriage is a common and stressful occurrence for women on a psychological and physical level. In general population research, the reported "ratio of clinically discernible miscarriages to known pregnancies ranges from 12% to 15% (Regan & Rai, 2016). In a Finnish study, 3,000 women from the population registry, randomly selected to be between the ages of 18 and 44, received a questionnaire in the mail. The questionnaires that were completed and returned made up 73% of the total. There were miscarriages in 13% of confirmed pregnancies (Hemminki & Forssas, 2019). Women (n=634 272) from the national discharge register, civil registration register, national record of induced abortion, and medical birth register were included in a prospective population-based register-linked study from Denmark that was conducted between 2008 and 2012. A miscarriage occurred in about 13.5% of the 1 221 546 identified pregnancies (n=1) (Nybo-Andersen et al., 2011). The most current known statistics on spontaneous abortions in Sweden is from 2013. There were 521 women in the research, and the miscarriage rate was 10.7% (Selbing, 2013). A research by French and team found that miscarriages occur in 13.6% of confirmed pregnancies (French & Bierman, 2012). According to Kline and colleagues, 50% of eggs created will not result in a

child that will survive, and 22% of these early losses will occur before the pregnancy has been clinically established (Kline et al., 2019; Wilcox et al., 2018).

In the UK, there are about 125,000 miscarriages per year, resulting in 42,000 hospital hospitalizations (Bernis et al., 2016). Although severe maternal "morbidity and spontaneous resolution" of most miscarriages are rare, the high incidence of sickness and associated costs for diagnostic testing, hospitalization, surgical intervention, and follow-up, the burden of illness is nevertheless enormous. Losing a pregnancy is often distressing for women and their spouses, which is bad for their social and psychological welfare. From 1985 to 2008, reported UK maternal death rates following miscarriage ranged from 0.05 to 0.22 per 100,000 births (Bernis et al., 2016). The most frequent causes of death were hemorrhage and infection, and they tended to occur more frequently after second-trimester losses. In an outpatient setting, women who have miscarriages are frequently treated conservatively". Women frequently contact general practitioners for guidance on their management options and help during follow-up.

According to Todd (2019), "15–25% of all clinically recognized pregnancies have miscarriage". About 50% of all pregnant women experience it as the most frequent pregnancy problem. Over 80% of miscarriages occur in the first three months of pregnancy (Todd, 2019). It can be hard to accept the loss of a pregnancy. One may blame themselves or ask why it occurred. A miscarriage, however, cannot be prevented and is not anyone's fault. Miscarriages happen frequently. A miscarriage occurs in roughly 1 in 6 pregnant women. Another usual occurrence is for a woman to miscarry before realizing she is pregnant (Sarah, 2020). In addition, the chance of miscarriage diminishes after 12 weeks, with the first trimester accounting for 80% of early pregnancy losses" (Wilcox et al., 2018).

2.1.3 Etiology and risk factors of Miscarriage

In most cases, the reason for a miscarriage is unknown. Despite numerous research, there is no agreement regarding the significance of environmental causes. There are some risk factors known (Cramer & Wise, 2010). There are several differences and similarities between the etiologies of spontaneous miscarriage and recurrent miscarriage. In cases of recurrent miscarriage, some medical factors are more common (Jablonowska, 2013). However, in specific instances, it is impossible to pinpoint the exact cause. More than half of cases still have unidentified reasons after excluding all recognized causes (Cramer & Wise, 2010; Regan & Rai, 2016). Congenital uterine structural anomalies like the bicornuate or septate uterus can result in miscarriage (Cramer & Wise, 2010). Even intramural or submucosal myomata can result in an early miscarriage (Cramer & Wise, 2010). “

The risk of miscarriage is multifactorial, despite the fact that some maternal risk factors appear to be more significant than others; there is no single predictor of "future pregnancy loss." Age of the mother is a strong predictor of miscarriage risk. In women aged 20 to 30, the likelihood of miscarriage occurring before 20 weeks of pregnancy is 8.9%. This increases to 74.7% for women over 40 (Nybo- Andersen et al., 2011). A significant indicator of the likelihood of losing an early pregnancy is prior obstetrical history. There is a 20% chance of another miscarriage following the first, a 28% chance following two consecutive miscarriages, and a 43% chance following three or more consecutive miscarriages (Regan, Braude & Trembath, 2019). Comorbidities in the mother, including as antiphospholipid antibody syndrome, thrombophilia, hypertension, and abnormally high or low body weight, significantly raise the chance of miscarriage.

The most “researched immune response-related potential causes of miscarriage include anticardiolipin antibodies, antiphospholipid antibodies, and lupus anticoagulants, but any correlation is still unknown. If these antibodies are found in the mother, there may be a 70%

chance that the pregnancy would end in miscarriage (Clark et al., 2011; Cramer & Wise, 2010). The antibodies may cause thrombosis in the placenta later on and can already be detectable at implantation" (Regan & Rai, 2010). "Chromosome abnormalities," which are detected in 50–85% of prenatal tissue samples after spontaneous miscarriage, are the main cause of first-trimester losses (Kanmaz et al., 2019).

According to Kajii et al. (2010), miscarriage can occur for a variety of reasons, especially before nine weeks of pregnancy when chromosomal abnormalities are present. Anomalies in cytogenetic makeup were present in 54% of all fetal karyotypes. Triploidy and 45X are the two most common chromosomal aberrations, with autosomal trisomy coming in second. Trisomies make up about two-thirds of these, and their probability rises with the age of the mother. The majority of trisomies are chromosomes 16, 21, and 22, respectively (Kajii et al., 2010).

The incidence of miscarriage is 15% or less up to the age of 34, but increases to 25% between the ages of 35 and 39, 51% between the ages of 40 and 44, and more than 90% in women over the age of 45, per a substantial prospective epidemiological study from Denmark (Birch, Gulati & Mandalia, 2017). Other, less common causes of miscarriage include inherited thrombophilias (antithrombin deficiency, factor V Leiden mutation, protein C and protein S deficiency, as well as moderate hyperhomocysteinemia) and congenital structural abnormalities of the uterus (Kanmaz et al., 2019)(Nybo-Andersen et al., 2011).

Poorly managed type 1 diabetes or thyroid conditions increase a woman's risk of miscarriage, according to research (Regan, Braude & Trembath, 2019). Obese women who successfully conceive following fertility therapy are likewise more likely to miscarry; however, the risk is not higher in those who conceive naturally (Bernis et al., 2016). Miscarriage is something that could happen. Having Chlamydia trachomatis or Mycoplasma hominis infected genitalia

has been found to increase the chance of miscarriage (Cramer & Wise, 2010). A late miscarriage is more likely in women who have bacterial vaginosis (Oakeshott et al., 2012). When lactobacilli are absent, anaerobic bacteria, such as Gardnerella vaginalis and mycoplasma, overgrow, causing bacterial vaginosis. There are several signs of bacterial vaginosis, including the presence of "clue cells," a high pH (>4.5), and a positive "whiff test" result (fish smell when potassium hydroxide is applied to the smear sample) (Larsson et al., 2015). Pregnancy-related primary genital herpes increases the chance of miscarriage (Cramer & Wise, 2010). There have also been reports of rubella, listeria, CMV, toxoplasmosis, and other infectious disorders as potential causes of miscarriage (Jablonowska, 2013).

Studies have shown no conclusive link between socioeconomic status, smoking, caffeine use, or light to moderate alcohol intake and the incidence of miscarriage (Rowlands & Lee, 2009). Atypical thyroid function, including hyperthyroidism and hypothyroidism, can lead to decreased rates of conception, an increase in early pregnancy loss, and poor pregnancy and neonatal outcomes. Thyroid-stimulating hormone (TSH) values above 2.5 uIU/ml are regarded as being outside the normal range and need therapy, reference to the statement from American Society for Reproductive Medicine (ASRM) recommendations from 2012. There are established reference ranges for thyroid function tests during pregnancy, with the first-trimester reference range being 0.1-2.5 (mIU/L), the second-trimester reference range being 0.2-3 (mIU/L), and the third-trimester reference range being 0.3-3.5 (mIU/L) (French, 2018).

The signs of a miscarriage include vaginal bleeding and pregnancy loss. Based on the clinical history and results of a speculum and digital pelvic examination, miscarriage is typically categorized as unavoidable, imminent, complete, or incomplete (Birch, Gulati & Mandalia, 2017). There is a absence of information regarding the clinical history and examination's diagnostic usefulness in the diagnosis of miscarriage. A prospective investigation of general practices in Amsterdam found that "clinical diagnoses of miscarriage based on clinical

symptoms and findings on vaginal digital and speculum examinations were inaccurate in more than 50% of instances" (Birch, Gulati & Mandalia, 2017).

Retrospective research revealed that “40% of women with a clinical diagnosis of total miscarriage have products of conception in their uterine curetting (Bernis and others, 2016). The results demonstrate that the clinical diagnosis of miscarriage is incorrect and that a pelvic examination, including a speculum investigation, may be omitted in clinically stable women who have a history of mild to moderate vaginal bleeding in the first trimester. The major test to establish the viability of the pregnancy in these circumstances should be ultrasonography because it is more useful. A scope examination is still required for female patients who present with severe bleeding and signs of cardiovascular instability. In these situations, a speculum examination can find retained objects that are protruding through the cervix and allow for quick removal.

2.1.4 Types of Miscarriage.

- **Silent Miscarriage (Early fetal demise)**

When an intact gestational sac is still present inside the uterine cavity during the early stages of a miscarriage, this is referred to as early fetal demise. It is also known as a quiet or delayed miscarriage, an empty sac, or a blighted ovum. The diagnosis of early fetal death is supported by either the absence of an embryo within a gestational sac or the absence of heart activity in a visible embryo. The main difficulty in diagnosing early embryonic demise is avoiding the incorrect diagnosis of a healthy, early, normal intrauterine pregnancy. The ultrasound diagnosis of early fetal death depends on insufficient evidence, which increases the risk of diagnostic error. This is particularly true for women whose due dates are ambiguous, who have irregular cycles, who became pregnant while taking hormonal contraception, or who have experienced less than three menstrual cycles since their last pregnancy.

Women with congenital uterine abnormalities, uterine fibroids, retroverted uterus, intra-abdominal adhesions from earlier cesarean sections, or pelvic procedures affecting uterine position are also more likely to have a false-positive diagnostic (Wyatt et al., 2015).

- **Incomplete Miscarriage.**

An incomplete miscarriage is "one that lacks a clearly defined gestation sac but yet has retained fetal tissue. There is no universal agreement on the most appropriate diagnostic standards for the difficult ultrasonography diagnosis of incomplete miscarriage. This diagnosis has been supported by endometrial thickness, which is calculated as the anterior-posterior diameter of the uterine cavity. The cut-off levels examined in separate investigations ranged from 5mm to 25mm (Wyatt et al., 2015). But a recent prospective observational study revealed that none of these indicators can reliably determine if chorionic villi are present in the uterine cavity (Wyatt et al., 2015). It has been suggested that the constraints of employing cut-off measurements can be solved by combining a subjective assessment of the morphological qualities of the tissue within the uterine cavity with a color Doppler assessment of its vascularity" (Wyatt et al., 2015).

- **Complete Miscarriage**

When a woman has an ultrasound but there is no sign of pregnancy tissue in the uterine cavity, the diagnosis of complete miscarriage is made. This diagnosis can only be made with certainty in women who showed a definite evidence of intrauterine pregnancy on earlier ultrasound scans. When a pregnancy is not confirmed by a scan, it is referred to be a "pregnancy of uncertain location," and biochemical indicators are then examined (Wyatt et al., 2015).

Therefore, miscarriage is not only a health issue that "places a heavy burden on society and costs a lot of money but it is also seen as a social issue in all communities since it ultimately

jeopardizes the health of families and societies (Mander & Miller, 2016). The findings of numerous research highlighted a number of issues surrounding abortion that may have an impact on women's daily lives. They came to the conclusion that psychological alterations in women occur six weeks following abortion and pregnancy termination (Sejourne, Callahan & Chabrol, 2020). For instance, abortion badly affects women's minds and makes them feel empty and guilty" (Adolfsson et al., 2014). Additionally, women who experience spontaneous abortion face a doubled chance of developing significant depression, which typically starts one week after a miscarriage and gets worse in situations of recurrent miscarriages (Wolman, 2014).

Women with miscarriages experience "greater familial and social issues than males do since miscarriage is typically seen as a female disease. So, miscarriage can result in psychological suffering, danger to the family, separation, remarriage, and divorce (WHO, 2015). Miscarriage is one of the most traumatic and disastrous pregnancy problems, yet only affects 15% of couples (Rai & Regan, 2016). The experience of women who lose a pregnancy has received less attention despite the above-mentioned negative effects, and there is little research on the experience of women who miscarry in the northern region". More research is therefore required to shed light on the more sinister facets of miscarriage-affected women's lives.

2.2 PROBLEMS ENCOUNTERED BY WOMEN WITH MISCARRIAGE EXPERIENCES

2.2.1 Psychological Distress: Navigating Emotions

One of the most significant challenges women face after miscarriage is coping with intense psychological distress. Research consistently shows that women experience a range of emotions such as grief, anxiety, and depression. Studies by Cumming and Klein (2017) reveal

that about 20% of women may experience significant depressive symptoms following miscarriage, which can persist long after the physical recovery. Additionally, many women grapple with feelings of guilt and self-blame, despite medical evidence indicating most miscarriages are due to chromosomal abnormalities (Brier, 2008).

2.2.2 Social Stigma and Isolation: Facing Silence

Social stigma surrounding miscarriage contributes significantly to the isolation experienced by women. In many cultures, miscarriage remains a taboo subject, making it difficult for women to openly discuss their pain. Bardos et al. (2015) highlight how societal misunderstandings often lead to insensitive remarks and a lack of support from friends and family. This silence can leave women feeling ashamed and unsupported during a time when they need empathy the most.

2.2.3 Inadequate Support Systems: Seeking Compassionate Care

Women frequently report dissatisfaction with the medical care they receive after miscarriage. Often, the focus is primarily on physical recovery, neglecting the emotional turmoil women endure. Meaney et al. (2017) emphasize the need for improved emotional support and information about miscarriage and subsequent pregnancies. Support groups can play a vital role in healing, as noted by Rowlands and Lee (2010), yet these resources are not always readily available or accessible to those in need.

2.2.4 Impact on Relationships: Navigating Together

Miscarriage can strain intimate relationships, as partners may struggle to understand each other's grief. Studies by Gold et al. (2007) and Armstrong and Hutti (2007) illustrate how differing grieving processes can create tension and communication barriers between couples. Open communication and mutual support are crucial for couples navigating this difficult experience together.

2.2.5 Long-term Effects and Subsequent Pregnancies: Fear and Hope

The impact of miscarriage often extends into subsequent pregnancies, where women may experience heightened anxiety and fear of another loss. This anxiety, termed Pregnancy After Loss (PAL) anxiety, can overshadow the joy of a new pregnancy and affect maternal attachment (Côté-Arsenault et al., 2011). Addressing these fears with appropriate medical and emotional support is essential for helping women navigate subsequent pregnancies with confidence.

Miscarriage is a complex experience with profound implications for women's emotional well-being, social interactions, and relationships. By understanding and addressing the challenges highlighted here — such as psychological distress, social stigma, inadequate support systems, and the impact on subsequent pregnancies—healthcare providers and society can better support women through this painful journey. With increased awareness, compassionate care, and accessible resources, we can create a more supportive environment for women coping with miscarriage.

2.3 LIVED EXPERIENCES OF MISCARRIED WOMEN

2.3.1 Effects of Miscarriage on Women (Social and Psychological well-being).

Although many pregnant women are happy in the early stages of their pregnancies, they also often feel conflicted about them, especially if the pregnancy was expected and planned. The mother is the intended parent's nurturer and the defender of the pregnancy (Berry, 2019). A pregnant woman may benefit personally from a romantic social environment and parenting. There is no room for suffering, sorrow, or demise (Austin-Smith, 2018). The “fetus and the pregnant woman have a symbiotic interaction within the early stages during pregnancy. One-third of pregnant women have nicknames for their unborn children and have dreams about

their futures by the time they are twelve weeks along in the pregnancy (Madden, 2014). For both women and their spouses, miscarriage is frequently an upsetting and stressful experience. Many people associate it with the demise of a child, even at the earliest stages of pregnancy, and previous issues with infertility or pregnancy can make this feeling worse. Grief and loss are widespread, yet they usually self-regulate. In cases where it is clinically feasible, treat all women who miscarry with care and sensitivity, explain all steps, alternatives, and decisions in clear terms, and give them time to decide. Give women informational flyers, website addresses, and helplines for support groups. After losing a pregnancy, some women may experience anxiety and depression. These people may find extra counselling and psychological support helpful" (Bernis et al., 2016).

A miscarriage is an eventful "life experience that has a great impact on a person's sense of self, competence, and fulfillment" (Frost et al., 2007). A miscarriage causes a woman without children to lose the sometimes long expected "mother" title and job. Women claimed that they regularly felt "forgotten as mothers" and "abandoned between the worlds of motherhood and non-motherhood" (Harvey et al., 2011). A miscarriage symbolizes several losses, including the loss of power, self-worth, and a child (real or imagined), as well as the loss of future goals, dreams, and expectations" (Adolfsson, Larsson, Wijma, & Bertero, 2014; McCreight, 2018). Lack of understanding and support for the invisible loss brought on by a miscarriage exacerbates feelings of social isolation, guilt, and a broken sense of identity (Frost et al., 2017; McCreight, 2018).

Women must deal with a "growing vulnerability and feelings of failure when the purity of motherhood is permanently damaged (Harvey et al., 2011). According to Miller (2015), after a miscarriage or other pregnancy loss, women frequently lack confidence in their capacity to produce children. When engaging with pregnant women or young children, feelings of jealousy and remorse also appeared, as well as an obsession with becoming a mother" (

Ockhuijsen et al., 2014: Frost et al., 2017). It is also imperative to consider the effect on subsequent pregnancies.

Due to the possibility of a "recurrence, attributing personhood to a past loss may hurt emotional connection and increase anxiety with a subsequent pregnancy (Wood & Quenby, 2010). Gaudet et al. (2010) talked about the anxiety, worry, hypervigilance, and demand for control that frequently accompany postpartum pregnancies. Due to the worry of experiencing another loss, difficulties also emerged in the emotional investment and degree of connection to a new infant (Gaudet et al., 2010). A miscarriage leaves a void that is not filled by a subsequent pregnancy or the presence of a subsequent child" (Adolfsson et al., 2014). Studies "suggest that early pregnancy loss can generate a mourning reaction as big as that to loss of any loved one" (Neugebauer, 2017). The ambiguity surrounding miscarriage, however, adds to grieving being marginalized since societal acceptance and support do not match the intensity of the emotional reaction to the physical and emotional loss" (Lang et al., 2011).

Miscarriage is a significant occurrence for the woman who miscarries, although medical staff may consider it ordinary (Moulder, 2014). Nevertheless, recent research on the psychological implications of such an event, especially early loss, has been reported. One of the first studies to look at how people feel after a miscarriage was carried out by Simon, Rothman, Goff, and Senturia (2009). He said that over a third of the women he talked to acknowledged grief and had depression-like feelings, which subsided after a few days. In contrast, interviews were conducted in this retrospective analysis between one and seven years after the miscarriage. Using a self-report adjective checklist, Seibel & Graves (2018) discovered that "53.7% displayed symptoms of despair, 51.2% anxiety, 41.5% anger and 44.1% dissatisfaction" in women awaiting a dilatation and curettage procedure (D&C). Similar findings were found by Berry (2019) when women were questioned in the hospital before discharge: "76% of

depression, 57% of irritability, 93% of tearfulness, 38% of sleeping problems, and 26% lack of appetite. “

Friedman & Gath (2018) published one of the first comprehensive studies on the emotional effects of miscarriage. To evaluate the psychiatric “caseness,” they utilized the Present State Examination, a standardized psychiatric measure (Wing, Cooper & Sartorius, 2014). At four weeks after a miscarriage, they discovered that "48% matched the criteria for depressive symptoms and disorder." This number is four times higher than the usual range of 10–12% detected in population samples (Gath et al., 2017; Surtees et al., 2019). When Prettyman, Cordle, and Cook (2013) used the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 2013) at one, six, and twelve weeks after the miscarriage, they discovered results that were similar to those of Friedman & Gath (2019), but their main response was anxiety. "A week after miscarriage, 41% of women were deemed "cases" based on anxiety symptoms, and 22% had major depression symptoms. Significant anxiety instances dropped to 18% by week six, but by week twelve, they had risen again to 32%. At weeks six and twelve, respectively, depression reduced to 8% and 6%, both levels that were below the overall population. It was speculated that the rise in anxiety cases at 12 weeks may be related to the woman getting her first period and realizing she is no longer pregnant, or it may be a time when the woman and her partner are debating whether or not to try to get pregnant again given that medical advice frequently suggests waiting three months (Prettyman et al., 2013). Additionally, depressive symptoms may peak later, perhaps around the time the baby should have been born (Berry, 2019).” “

Women's depressed ratings were higher three months after a miscarriage, returned to normal levels at six months, and then rose above the threshold for "cases" once more a year later, according to Robinson, Stirtzinger, Stewart, and Ralevski's (2014) research. Women who experienced an early miscarriage were followed up for two years, and the results showed that

68% of them were still bothered by miscarriage thoughts (Prettyman, 2013). Miscarriages had an impact on decisions about subsequent pregnancies in 64% of women. According to Friedman & Gath (2019), four weeks after a miscarriage, 18% of women still worried about miscarriages and weren't sure if they would try to get pregnant again." "

"Cecil & Leslie employed the State-Trait Anxiety Inventory (STAI) to analyze the psychological impacts of early miscarriage in a study conducted in Northern Ireland," according to the report (Spielberger, 2013). Women who had miscarriages were checked at the hospital two to three weeks, three months, and six months afterwards. There was "an initial rise in concern immediately post-miscarriage, which declined swiftly, and indicated that just a few women remained worried at six months post-miscarriage," according to their findings. The sample size did, however, significantly decline over time, making it challenging to generalize the findings. The General Health Questionnaire (GHQ) and the HAD scale were used by Frost & Condone (2012) to "evaluate psychological morbidity at 24 hours and six weeks after a D&C procedure following a miscarriage (Goldberg & Hillier, 2009). According to Madden (2014), early in pregnancy, there is a greater risk of depression. This is why Frost and Condone utilized an antenatal control group. The miscarriage group had increased somatic symptoms at six weeks and had higher levels of anxiety at both 24 hours and six weeks post-miscarriage". Since depressed symptoms were more severe as measured by the GHQ but not the HADS, the results for depression were less apparent.

About two weeks, six weeks, and six months after the event of miscarriage, Neugebauer et al. (2012) examined psychological morbidity and contrasted the results with both prenatal controls and community samples. To gauge psychological morbidity, they employed the "Center for Epidemiologic Studies - Depression scale (CES-D)" (Radloff, 2017).

Women who had their initial interview at six weeks or six months after a miscarriage had depression rates that were three times higher than those of the population sample. "At two weeks after a miscarriage, women were 3.4 times more likely to develop depressive symptoms than pregnant women and four times more likely than community controls". Women were re-interviewed at six weeks and six months, however neither time revealed any greater symptom levels. Investigations into factors connected to pregnancy, though, have yielded conflicting results. While some studies using standardized measures have shown a higher chance of reports of melancholy, depression, or anxiety when the pregnancy is planned (Simon et al., 2009), other studies using the same measures have not established a link to these emotions (Friedman & Gath, 2019). Additionally, Prettyman et al. (2013) discovered that women whose births were unplanned have higher anxiety levels. There could be guilt and ambivalence issues causing this. It's not always a sign that a baby is unwelcome if it's unplanned. If the pregnancy was unintended, Garel et al. (2012) showed lower levels of despair just after a miscarriage."

Women who endure miscarriages often experience a variety of contradictory emotions. Sometimes, a woman's first encounter with a more serious loss in life is a miscarriage (Friedman,2018). For some mothers, losing the fetus is equivalent to losing their first child (Bansen & Stevens, 2012). The mother is unable to give a lost child a name, is unaware of the gender, is without an image, and has nothing to bury or hold. Therefore, she lacks a cause for sorrow. The fetal demise is the loss of herself (Rosenfeld, 2011; Frost & Condon, 2016). This element has been overlooked in the study literature, but the suffering of miscarriage might also be physically distressing occurrence (Neugebauer et al., 2012; Prettyman et al., 2013). Sudden discomfort, blood loss, quick hospitalization, and an operation can all be symptoms of miscarriage. Surgery-related stress and emotional reactions have been studied (Levy, 2017), and for most women D and C might be their first procedure. The woman frequently

feels discomfort in her body. It is possible to explain the pain as varying from mild cramping to excruciating pain. When a miscarriage occurs, the bleeding can be so intense that the women may fear for their lives.

The D&C might be a woman's first surgical procedure. Miscarriage can occasionally result in emergency hospitalization (Lee & Slade, 2016). The knowledge that the woman may get pregnant again resides in the emotional sorrow of miscarriage. Some women wondered how having another child would affect their confidence. Women sought information about raising children well before becoming pregnant again (Bansen & Stevens, 2012). Four weeks following a miscarriage, women were afraid of having another one and unsure about whether they would try to get pregnant again (Lee & Slade, 2016; Friedman & Gath, 2018). Women were unhappy with the kind of information they received on when they could become pregnant again (Friedman, 2019). Women experience regret over their miscarriages and feel guilty (Bansen & Stevens, 2012). Guilty feelings are experienced by more than two-thirds of women (Moulder, 2014). Losing a pregnancy, a baby or unborn child, motherhood, or one's self-esteem is represented by miscarriage, which can also cast doubt on one's capacity to have children (Friedman, 2018; Lee & Slade, 2016). Following a miscarriage, people frequently report feelings of emptiness, humiliation, helplessness, and low self-esteem (Frost & Condon, 2016). Even the psychologically distressing miscarriage occurrence has been linked to desperation, agony, and listlessness (Alderman et al., 2018). Miscarriage is a life event and a crisis for many women. For several months, some women experience despair and anxiety symptoms (Bansen & Stevens, 2012). The women are unable to express their emotions or dread. Every day they reflect on the miscarriage and believe they will never feel normal again (Friedman & Gath, 2018). After a miscarriage, the majority of women experience a severe period of grief, anxiety, and guilt. After the miscarriage, the more substantial portion of the reaction begins to fade after four to six weeks and eventually stops (Brier, 2009). After a

miscarriage, sentiments are described as being grieved (Friedman & Gath, 208; Lee & Slade, 2016).

According to several research, women have depressive symptoms after a miscarriage (Lee & Slade, 2016). Also, according to research, major depressive illness after miscarriage occurs at varying rates. One week after a miscarriage, 22% of people scored depressed on the Hospital and Depression Scale (HADS) (Prettyman et al., 2013). Ten days later, Broen et al. (2014) reports a 47.5% rate with a frequency of 10-12%, this is four times greater than the general population (Lee & Slade, 2016). Another study found that depression was 3.4 times as prevalent in women two weeks following miscarriage than it was during pregnancy (Neugebauer et al., 2012). A British study found that 48% of women who took the Present State Examination (PSE) standardized exam four weeks after a miscarriage showed evidence of depression, which is four times greater than the rate for the general population (Friedman & Gath, 2018). In Prettyman's study, the frequency was 6% after six weeks (Prettyman et al., 2013). The prevalence of depression two months following miscarriage is 51%, compared to 6% in the general population (Judd et al., 2014). Depression is more common than in the general population by three to four times even six months following a miscarriage (Neugebauer et al., 2012). After six months, 32% of cases developed despair, according to Jacobs (Jacobs et al., 2019). Even anxiety was noted to occur at various intervals: “41% after one week, 18% after six weeks, and 32% after three months” (Prettyman et al., 2013).

Last but not least, social support may be necessary for the emotional adaptation following miscarriage, according to Garel et al. (2012). Numerous studies have linked a lack of support from spouses, family, and friends to a higher risk of psychiatric morbidity after miscarriage and other traumatic events (Golberg & Hillier, 2009; Forrest et al., 2012). The results of studies that considered factors that could predict psychiatric morbidity post-miscarriage have generally been contradictory. The only factors that have been demonstrated to agree are the

mental history and professional and non-professional help. Slade (2014) stated that despite numerous considerations, it is difficult to comprehend the significance of the event. Robinson et al. (2014) argue that it's crucial to consider the cognitive mediators that influence how people adjust psychologically following miscarriage. Also, according to cognitive theories, people's interpretations of events and accompanying ideas, not the actual events themselves, impact how people feel (Slade, 2014).

2.3.2 Emotional and Social support given to the Women

Women frequently struggle to go through the grieving process and engage in common coping mechanisms after a miscarriage (Lang et al., 2011). The grieving process is negatively impacted when loved ones' expectations of unconditional support aren't satisfied (Rowlands & Lee, 2010). Activities of daily living and participation in worthwhile activities may be impacted by difficulties coping with the physical, mental, sociological, and psychological repercussions of a miscarriage (Neugebauer, 2017). Rather than recognizing the particularly individual implications that arise following the loss of a baby, many people typically regard miscarriage simply as a sad aspect of pregnancy (Frost et al., 2017) or as a medical event (McCreight, 2018).

Findings show that inadequate medical care is provided for physical and emotional requirements both during and after a miscarriage as a result of medical staff members' insensitive remarks, inadequate educational resources, and a lack of empathy, all of which may exacerbate parental grief (Rowlands & Lee, 2010; Lang et al., 2011). Lack of training, time restraints, and perceived differences in medical professionals understanding the importance of loss are among the causes of inadequate medical treatment (Olson, 2013). Additionally, women's feelings of vulnerability may heighten perceptions of bad situations, hinder coping mechanisms, and endanger their health and wellbeing (Lang et al., 2011).

Women are frequently left trying to deal with the devastating event of a miscarriage while also questioning why there is a lack of compassion and support from family members and medical professionals (Harvey et al., 2011). Miscarriage must be seen by families, community members, and health care professionals as a personal and meaningful experience requiring timely and empathetic support in order to promote and sustain the well-being of women who have had one (McCreight, 2018; Olson, 2013). Miscarriage parents should be seen as a particularly vulnerable group in need of better psychological, physical, spiritual and emotional support (Olson, 2013). Partners provide assistance to women (Johnson & Puddifoot, 2016). Women are aware of their emotions and willing to express them to their partners (Alderman et al., 2018). For the husband, a miscarriage may be an unfamiliar and new scenario. In one of Johnson's examples, the husband was paralyzed and was at a loss for what to do when his wife began to bleed profusely. The woman had to assume command of the circumstance (Johnson & Puddifoot, 2016). It appears that the family is oblivious of what has happened. They are confident that she will heal fast and psychological consequences won't linger (Friedman, 2019; Frost & Condon, 2016).

The fact that everything related to miscarriage is kept so secret and that women as a result do not receive enough support has drawn some criticism from women. A sense of loneliness is created by the silence. Women discover that they are not alone in their miscarriage experiences when they talk about them. Some women get assistance from others (Bansen & Stevens,2012). Although talking about pain, especially the anguish of women, has become increasingly acceptable in today's culture, miscarriage still remains to be a taboo subject. As a result, recovering from a miscarriage can feel lonely.

According to a national survey on the general public's impressions of miscarriage, 41% of respondents reported feeling isolated immediately following the miscarriage. Even when the loss is acknowledged and freely discussed, others might not know what to say. Even close

friends and family members have the potential to unwittingly say unpleasant things that further isolate the woman and her spouse. Others in a woman's society might be getting pregnant and giving birth safely at the same time. Even if it cannot be avoided, witnessing others celebrate life during a time of loss can be extremely upsetting. Women, their spouses, and their loved ones can all benefit from creating healthy boundaries and open places for grieving. Women going through miscarriage recovery may find a sense of camaraderie and understanding in a support group. Women might find help by joining a social media "miscarriage support" group online.

Patients need to be informed about things like the timelines for investigations and treatments, the evolution of diagnoses and potential treatments depending on diagnoses, the likelihood of term pregnancy given the frequency of prior miscarriages, and known versus undetermined causes. Briefly put, the patient needs to be aware of the decision-making process for her care, particularly the time delays she might anticipate between each stage. This information should be repeated at regular intervals. It will reduce frustration, link the patient's expectations of care with what is medically realistic, and help to ensure a good working relationship between the patient and her physician. It is also valuable to enquire whether the patient has been given alternative explanations for recurrent Miscarriage as those explanations may have no scientific basis but may be causing emotional distress. It is not unusual for patients with recurrent Miscarriage to question the psychological etiology, a likely reflection of the degree to which the psychoanalytic work of the 1940s filtered into lay knowledge.

The need to understand why miscarriage occurs is paramount that many patients construct causality out of personal nonmedical events if no scientific medical explanation can be provided.

2.4 SOCIAL SUPPORT SYSTEMS AVAILABLE TO MISCARRIED WOMEN

2.4.1 Three Approaches to Support Women who Experience Miscarriage

In order to discuss the construction of a uniform national care package for recurrent miscarriage, 83 significant stakeholders from throughout the UK gathered in December 2019 for a UK-wide consensus conference on miscarriage care. Without any participation or support from any commercial entities, Tommy's Charity paid for the conference. Along with a description of the available data and recommendations, important questions about treatments, tests, and care organization were given for discussion. Consensus was used to reach agreements.

Worldwide, three primary strategies are used to assist women who experience recurrent miscarriages. Until they have experienced three miscarriages, women in the first model receive little to no care. This method leads in the loss of preconception counseling and treatment options, such as the chance to address body weight, alcohol use, smoking, and food, especially vitamin intake like folate. Couples who endure miscarriages may only receive the advice to try again. Miscarriage-related mental health is rarely recognized or handled, and complaints about the treatment are common. Although the UK National Health Service (NHS) use this tactic frequently, the UK consensus conference came to the unanimous conclusion that this model is ineffective. “

The basis of the second concept is a graded technique. Women who have their first miscarriage will be guided toward resources for meeting their physical and emotional health needs as well as methods for enhancing their health in order to become healthier in the future. Patient support groups, weight control, online mental health self-help tools, drug and alcohol addiction services, preconception counseling, vitamin D and folate supplementation advice, referrals to essential services for the management and optimization of chronic maternal

medical conditions (such as diabetes, heart disease, hypertension, and epilepsy), and mental health screening are some of the components of this plan that may be included. Women who miscarry again will be referred to a miscarriage clinic, which may be staffed by a midwife or nurse and offers thyroid function and full blood count tests in addition to lifestyle counseling (Van Dijk et al., 2020). If test results are abnormal, or if you have a persistent medical condition, mental health issue, or both, arrangements will be made to refer you for specialized care. In subsequent pregnancies, women will have access to prenatal reassurance screenings and support programs.

When a woman has her third miscarriage, she will be given permission to visit a doctor-run clinic where a wide range of diagnostic methods and treatment choices are available. For genetic testing, pregnancy tissue from the third miscarriage and onward will be sent. Antiphospholipid antibody blood tests and a pelvic ultrasound scan (preferably a three-dimensional transvaginal scan) will be scheduled. Depending on the clinical history and the findings of the genetic study of pregnancy tissue from prior losses, parental karyotyping may be provided if appropriate. Couples having a history of recurrent miscarriages will need their care pathway to include appropriate screening and treatment for mental health disorders as well as significant obstetric dangers, such as stillbirth, fetal growth restriction, and particularly preterm birth.

In the third model, a medical professional visits women who have had two miscarriages in a clinic. Oftentimes, a whole panel of investigations is provided right away. This model is common to some UK NHS institutions and private recurrent miscarriage centers both domestically and abroad. There are several problems with this paradigm. The third model leaves women who have experienced two miscarriages vulnerable to asking for and receiving therapies that may be ineffective or even dangerous, even though these women are highly likely to become pregnant again in the future and do not require substantial research or

treatments. Furthermore, this may not be the most efficient use of the scarce healthcare resources available. Following consideration of the three options at the UK meeting, 80 (96%) of the 83 participants selected the graded approach (Van Dijk et al., 2020).

2.5 RECOVERY PROCEDURES AND COPING MECHANISMS FOR MISCARRIED WOMEN

2.5.1. Recovering Procedure and Coping Mechanism for Women.

Coping refers to deliberate reactions to traumatic circumstances. By adding the process of handling stressors (external or internal) that are perceived as strenuous or beyond the resources of the person," Folkman (1984) went on to further define coping. He distinguishes between two basic types of coping: problem-oriented coping, which involves modifying how an individual interacts negatively with their environment. By taking immediate action and addressing the anxiety's underlying source, this could be accomplished. An illustration would be if a lady who was pregnant overheard two doctors discussing a child who would be born severely damaged and went to the doctor to ask about the child in question. The alternative type of coping, known as emotion-regulating or palliative coping, relates to managing the problematic relationship without addressing its root causes, which are typically intrapsychic processes like defense mechanisms and denial. This coping mechanism is demonstrated by the mother who was discussed above telling herself, “They are not talking about my child.” The latter type of coping, is more relevant for our research because it is seen as management rather than mastery (Zigmond et al., 2013). The majority of white women's experiences have been used to build the existing literature on coping with miscarriage. Most publications focus on the disparities between the women's and their husbands' or partners' coping styles, with the men being typically less communicative (Madden, 2014). Women in this research have

discussed both successful and unsuccessful coping mechanisms. The number of useful techniques vastly outweighs the number of ineffective ones. According to Austin et al. (2018), 73% of their sample felt religious views to be convincing following a loss. In order to cope with their miscarriages, study participants, according to Frost and Condone (2016), engaged in self-improvement activities like fitness, weight loss, pampering, as well as other pursuits like shopping and house renovation. Common themes in these reports included discussing the loss experience with others, staying busy at work, reading about miscarriages, crying, attending therapy or support groups, and spending time with close relatives, including taking trips with spouses and cherishing special moments with small children (Slade, 2014). Ineffective coping mechanisms included avoiding discussions about the loss, overeating, refraining from expressing grief, thinking of suicide, spending excessively, or abusing drugs (Bansen & Stevens, 2012). The miscarriage research does not address whether there are racial/ethnic differences in these helpful and ineffective techniques.

Even while miscarriages are frequent, they can still be difficult to deal with if you recently lost a loved one. After a miscarriage, many women are shocked by how intense their feelings are. The emotions range from astonishment and sadness to unreasonable guilt and concern over upcoming pregnancies. Men can experience sentiments of loss and inadequacy, too. This is particularly true if they don't know how to support their partner during this trying time. Such emotions are quite normal. After a miscarriage, the emotional healing process could take some time. It frequently requires considerably more time than physical recovery does. Long-term acceptance of the loss may be aided by allowing yourself to grieve the loss. Generally speaking, men and women react to miscarriages differently. Men frequently enter problem-solving mode in times of stress. When they are unable to “cure” their partner's suffering, they may feel inadequate and helpless. Another typical issue is miscommunication. Men frequently witness their partners crying when they discuss the baby, so they learn to

avoid the topic. In addition, if he doesn't mention anything, the lady might assume he doesn't care even though he does. Experts encourage males to demonstrate their concern and to be vulnerable and transparent with their partners in order to assist couples recover from the impact of a miscarriage on their relationships. They may do the dishes, monitor the other kids, or take their partner out for a nice meal, for instance.

Women have described having intense emotions of alienation and isolation after losing a pregnancy. They talked about society did not acknowledge the magnitude of their loss and that there was only a limited amount of time for grieving before people were expected to "move on" with their lives. A wall of silence added to the sense of loneliness and fueled the alienated grieving experience. Discussing the loss or viewing any of the mementos (pictures, hand/footprints) made family members and friends uncomfortable. In order to protect themselves, ladies also refrained from talking about the loss in public. Thus, what was before public has returned to the private sphere. When there is an "elephant in the room" that no one notices, tension might result (Miller, 2015). These silences may be particularly challenging for women whose losses may not be acknowledged by society (such as ectopic pregnancies and nonmedical elective abortions). With the emphasis on the potentially life-threatening situation the woman has just been through (and not the pregnancy that has been lost) or the perceived "choice" that the woman made to end her pregnancy voluntarily (Slade, 2014), the significance of the loss in these circumstances is frequently missed. Many women will become what Spielberg (2013) refers to as "resolute" if they are given little other option. According to him, the idea of resolve alludes to our struggle to understand who we are in the world. We can find ourselves in this situation frequently (for example, after a miscarriage), where everything seems insignificant in comparison to what is "really crucial in the-world" (Wing et al., 2009). According to Miller (2015), people frequently underestimate their capacity for coping with unfavorable life situations, and times of significant difficulty can

frequently lead to personal progress. We would propose that resoluteness offers women who have lost pregnancies the strength to consider getting pregnant again. It seems as though society exhales a unified sigh of relief whenever another pregnancy is started. It appears from the outside that the woman is moving on and has accepted her earlier loss. The truth is frequently extremely different. The new pregnancy begins in the wake of the earlier loss. Fear, remorse, dread, and emotions of treason toward the previous child are all rekindled along with grief (Miller, 2015). Along with this, there is the idea that the new pregnancy somehow takes the place of the lost one, with the hope that as attention turns to the new pregnancy, the previous one would be forgotten. Some women found it challenging to reconcile this presumption with their own experiences. For many women, the weeks following a miscarriage are emotionally turbulent. A woman who has recently miscarried has hormonal changes as her body readjusts to not being pregnant at the same time. Her fluctuating hormone levels could make her feel more intense.

The majority of academics concur that a woman who has a miscarriage is likely to suffer grief and that this is both normal and healthy. However, Berry (2019) notes that the response is variable, dynamic, and extremely individualized, with distinctive aspects that might be concealed from both the lady and others (French, 2020). Following a miscarriage, a woman's responses are influenced by numerous unseen circumstances. These include blaming oneself, seeking explanations, giving up on the future, shattering parenting ambitions, not having a physical person to grieve the perceived loss of oneself with, silence from others, and not having the right rituals (Bansen & Stevens, 2012). The experience of grieving is common and unpleasant. People grieve for varied lengths of time, and the intensity of their loss also varies. Some people experience extreme grief for only a short while, while others experience mild grief over a longer period of time, and still others completely ignore their sorrow. Because of this variety, it is challenging to define normal grieving (which is neither excessive nor

insufficient) as well as what complicated mourning looks like. Grief is a common response to a lasting loss. Grief is a common occurrence, and there are various cultural expressions of sorrow and grief behavior (Bansen & Stevens, 2012). The experience of losing a significant person is known as bereavement. Every person experiences death at some point in their lives, whether it be their own or that of their parents, siblings, friends, or children. Grief is a response to bereavement and includes emotional emotions as well as cognitive, physiological, social-behavioral, and physical expression. Sometimes the words “mourning” and “grief,” particularly in the psychiatric sciences, are used interchangeably. Grief is expressed via mourning in a social and cultural setting (Stroebe et al., 2011). Cullberg & Bonnevie (2011) describes a traumatic crisis as an occurrence of such sort and degree that the person feels his or her bodily existence, security, and social identity or other parts of life are significantly threatened. Examples include the death of a close relative or friend (Cullberg & Bonnevie, 2011).

After a miscarriage, regular menstrual cycles normally start up again after a month or two. Once the bleeding has ceased, women can resume sexual activity without risk. For medical reasons, women are not required to put off attempting a new pregnancy. Women do not need to routinely be checked for other less common causes of miscarriage because chromosomal abnormalities account for the majority of losses unless they experience recurrent losses. According to a significant retrospective study from Scotland, women who become pregnant within six months of their first miscarriage are less likely than those whose interpregnancy interval is more than six months to experience a second miscarriage or other pregnancy difficulties (Bansen & Stevens, 2012).

2.5.2 The Scientific History of Grief

One of the first to define mourning as a painful loss was Freud. The thoughts, feelings, and actions associated with the deceased consume all of the griever's energy. According to Freud

(1957; original work published in 1917), there is a risk that the griever may increasingly isolate themselves and become entrenched in the grieving process. Some typical grieving symptoms are described in Lindemann's classic study as follows: “Somatic discomfort, obsession with the death's picture, guilt, an adversarial reaction, and a break from usual behavior patterns” (Lindemann, 1944). Significant attention has been paid to Cullberg's explanation of the grieving process in Scandinavia and Sweden. He claims that there are four necessary steps or phases to the grieving process.

The initial phase is shock, which is characterized by disbelief, shock, and denial of the event. The griever then moves on to the response phase, where they are aware of the loss and experience a range of emotions, including tears, rage, solitude, and denial. The person resumes daily life and gets back to business during the reparation phase. The individual's life situation has changed since the loss, and this is when the reorientation phase begins. To move past the loss, the griever must adapt and shift to some extent on a practical, emotional, and identity level (Cullberg & Bonnevie, 2001). According to Worden, there are four steps in the grieving process.

In order to move past the sorrow of grieving, a person must first understand the significance of the loss. "Finally, emotional transfer of the deceased and return to daily living occur once adaptation to a life in which the deceased is missing occurs" (Worden, 2009). Bowlby underlines that in order to comprehend the loss, the relationship between the person who has died away and the person left behind who is grieving that loss must be taken into account (Bowlby, 1980). A handful of the authors Cullberg (Cullberg & Bonnevie, 2011), Stroebe (Stroebe et al., 2011), Wortman (Wortman & Silver, 2011), and Worden (Worden, 2009) represent recurrent names in the literature since they have investigated grief in various scientific areas.

The account of the grieving process by Bonanno and Kaltman (2011) is a much-appreciated summary of the scientific history of grief and its clinical application. 2011 research by Bonanno and Kaltman defined difficult (chronic) grief as prolonged mourning. The term "pathological grieving" is a synonym. There is a chance of developing pathological grief if the griever hasn't gone through the grieving process appropriately and on their own, if there was a dysfunctional relationship or unsure feelings between the dead and the griever, if the griever has had health issues in the past, or if there isn't any support available (Bonanno & Kaltman, 2011). Depression, anxiety, or post-traumatic stress disorder (PTSD) are all manifestations of complicated grief. Complicated mourning is characterized by repressed emotions, delusions about the deceased's relationship, emotional suffering, destructive yearning, and loneliness. The bereaved stay away from places, things, or people who had a strong connection to the departed. Insomnia, as well as a lack of interest in social and professional activities, are common symptoms of complicated sorrow. Anxiety, including both typical anxiety and panic (anxiety) disorder, can be a very strong indicator of difficult grieving. Younger persons are more likely than older ones to experience PTSD with flashbacks instead of despair after suffering severe losses.

Most women go through a typical grieving process, experiencing a range of emotions (Bonanno & Kaltman, 2011; Frost & Condon, 2016; Worden, 2009). Grief after a miscarriage is distinct from grief after other types of losses. The lack of a tangible item to mourn prevents the ladies, and their sense of guilt outweighs other losses (Frost & Condon, 2016). The prenatal grieving scale has been recommended by the authors of the Handbook of Mourning because it takes into account factors unique to perinatal loss and is valid and reliable (Neimeyer & Hogan, 2011).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The plan or procedure for carrying out a particular study phase is known as research methodology (Burns & Grove, 2009). The research design, as well as the many methods and instruments utilized to collect research data from the participants, are covered in this chapter. It also provides details on the kind of study, study population, variables to be assessed, sampling strategy, and analytical instruments to be employed in the data analysis. Moreover, this chapter discusses the study's ethical problems and implications.

3.2 Study Area

The Sagnerigu Municipal is one of the twenty-six (26) MMDCs that originated from the Tamale metropolitan in the Northern Region of Ghana. The district was created in June 2012 and shared borders with the Savelugu Municipal to the North, Tamale Metropolis to the South and East, Tolon District to the West and Kumbungu District to the North-west. The population of the Municipality at the 2010 population housing census stood at 148099 with 74886 males and 73213 females. However, the Ghana statistical service projected 186,796 for 2020, comprising 93,761 males and 93,035 females. The district is made up of 79 communities, comprising 20 urban, six peri-urban, and 53 rural areas. It is further divided into three (3) area councils: Choggu-Sagnarigu, Kalpohini and Kanvilli. (GSS, 2014).

3.3 Research Approach

In order to empower women to understand pregnancy-related issues, to advance social change by eradicating stigmas associated with miscarriages and raising awareness of the

emotional aspects of dealing with pregnancy loss, and to share this knowledge with the healthcare professionals who treat women, this study aims to gain a thorough understanding of women's miscarriage experiences. Without the women themselves telling their own stories and using their own language, this issue cannot be understood. To help the researcher gather the rich and in-depth data needed, it was necessary to first have a thorough grasp of the problem before deciding on the best research techniques. Therefore, in order for the researcher to provide a thorough explanation of the phenomena of miscarriages via the perspective of women who have experienced child loss, this research must be conducted only using qualitative methods.

Also, given the sensitive and deeply personal nature of miscarriage, a qualitative research approach is particularly suitable for several reasons. The goal of qualitative research is to offer a comprehensive knowledge of complicated phenomena that are frequently subjective and multidimensional. Miscarriage is a deeply emotional and personal experience that varies widely among individuals. A qualitative approach allows for a nuanced exploration of these experiences, capturing the emotions, coping mechanisms, cultural influences, and personal narratives of the women affected. This depth of understanding is crucial for comprehensively addressing the research questions.

The Northern region of Ghana has unique social, cultural and economic factors that influence what women go through whenever they go through miscarriages. Qualitative research is adept at exploring these contextual factors, providing insights into how local customs, beliefs, healthcare systems, and community support structures impact women's experiences Granja et al., 2002). Understanding these contextual elements is essential for developing culturally sensitive interventions and support systems.

Qualitative research methods are adaptable and may be tailored to the particular requirements of the study population. Examples of these approaches include focus groups, in-depth

interviews, and participant observations. This adaptability is crucial when discussing delicate subjects like miscarriage since it enables the researcher to establish a secure and encouraging space where participants can share their tales or experiences. It also enables the researcher to probe deeper into unexpected themes and issues that may arise during data collection.

Qualitative research generates rich, descriptive data that provides a comprehensive picture of participants' experiences (Willig, 2008). Through methods such as thematic analysis or narrative analysis, researchers can identify common themes, patterns, and variations in the experiences of women who have had miscarriages. This rich data is invaluable for developing a detailed and empathetic understanding of the impact of miscarriage on lives of women.

A qualitative approach prioritizes the voices and perspectives of the participants, ensuring that their experiences are at the forefront of the research (Neimeyer & Hogan, 2001). This participant-centered approach is particularly important in studies involving sensitive topics, as it empowers participants to share their stories in their own words and on their own terms. It also helps to build trust and rapport between the participants and the researcher, which can lead to more honest and detailed accounts.

The findings from a qualitative study on the lived experiences of women who have had miscarriages in the Northern region of Ghana can contribute to both theory and practice. Theoretically, the study can provide new insights into the emotional, social, and cultural dimensions of miscarriage. Practically, the findings can inform the development of targeted interventions, policies, and support services that tackle the particular or specific needs of women in this Region. By highlighting the voices of the women affected, the study can also raise awareness and advocate for improved healthcare and support systems.

A qualitative research approach is justified for this study due to its ability to give a detailed, contextualized, and participant-centered understanding of the lived experiences of women who have had miscarriages in the Northern region of Ghana. This approach ensures that the complex and sensitive nature of the topic is adequately explored, resulting in rich and meaningful insights that can inform both theory and practice.

3.3.1 Rationale for a Qualitative Approach

The literature review states that most previous studies concentrated on quantitative data and gave women lived of grieving after miscarriage relatively little consideration. The quantitative technique reveals a relationship between a collection of known factors, but it does not uncover unique processes or provide an explanation for the relationship between the known variables (Hennink, Hutter, & Bailey, 2011; Denzin & Lincoln, 2005). As a result, quantitative statistical data can be used to gauge how deeply a miscarried woman is grieving, but it cannot explain the "how" of the grieving process.

Qualitative research provides a different paradigm for bereavement study, which aims to better comprehend this phenomenon. Instead of generalizing to a larger population and forecasting consequences, qualitative research seeks to better comprehend and describe the “texture of experience and quality” (Willig, 2008). The methodology of qualitative research has the potential to offer detailed and expressive information that makes it easier to grasp the meanings and explanations that people assign to their experiences. It could be feasible to develop a deeper understanding of bereavement using this knowledge. Theoretical understandings of sorrow and mourning must be examined and improved utilizing more quantitative techniques (Neimeyer & Hogan, 2001).

A qualitative research approach was determined to be the most appropriate for the current study, according to Brocki & Wearden (2006), "given the complexity of the phenomena and

the significance of the participants' processes of meaning-making". The rich, in-depth accounts of how participants cope with and grow to understand the lived experience of pregnancy loss were captured using the interpretive phenomenological analysis (IPA) qualitative method. The rationale behind the selection of IPA was its emphasis on the systematic investigation of individual meaning-making through an idiographic lens. This approach allows researchers to compare and contrast the perspectives and comprehensions of many individuals who are involved in the same event (Smith et al., 2009).

3.4 Research Design

The study employs the Phenomenological Research Design to allow the researcher to describe participants' lived experiences concerning pregnancy loss.

Phenomenological research design is a qualitative approach focused on exploring and understanding the essence of human experiences (Creswell, 2014). This method aims to delve deep into participants' subjective experiences, capturing their perceptions and emotions regarding a particular phenomenon. In the context of investigating the lived experiences of women who have had miscarriages in the Northern region of Ghana, phenomenological research design is particularly suitable. This approach allows researchers to gain profound insights into the personal and often deeply emotional experiences of these women, providing a rich, nuanced understanding of the impact of miscarriage on their lives.

Phenomenology is centered on understanding the lived experiences of individuals. (Smith et al., 2009). Miscarriage is a deeply personal and emotional experience, and phenomenology can capture the complexities and nuances of how women in the Northern Region of Ghana experience and make sense of this event.

Phenomenological research seeks to uncover the meanings that individuals assign to their experiences. This is crucial for understanding how women interpret their miscarriage

experiences within the cultural, social, and personal contexts of the Northern Region of Ghana.

This approach allows for the collection of rich, detailed data through in-depth interviews and other qualitative methods. This depth of information is essential for understanding the full impact of miscarriage on lives of these women, in addition to their emotional responses, coping mechanisms, and the support systems they utilize.

According to Creswell (2014), the description offered by the researcher in a phenomenological study "culminates in the essence of the experiences for several individuals who have all experienced the phenomenon." Thus, the researcher will, from the participants' perspective, describe the lived experiences of women who have lost their babies through miscarriage in the Sagnarigu Municipality of Northern Region, Ghana.

Van Manen (2016) and Lester (1999) also asserted that the use of phenomenological design is hinged on a subjectivity and paradigm of personal knowledge, and highlights the significance of interpretation and personal perspective. As such, phenomenological design is decisive for understanding "subjective experience, gaining insights into people's motivations and actions, and cutting through the clutter of taken-for-granted assumptions and conventional wisdom."

The focus of this study is understanding the personal significance that women give to their experiences of miscarriage. The phenomenological approach, which is concerned with a thorough understanding of the human experience, seems to be a good fit for this research perspective (Parry, 2004; Snelgrove, 2014). In order to provide a neutral explanation of the essence of this experience, the study intends to explore, describe, and understand how women make meaning of their lived experience of miscarriage. Our two main objectives were to (a) characterize the miscarriage experience from a human perspective and (b) describe the meaning of caring as experienced by women who had miscarriages.

3.5 Study Population

According to Burns and Grove (2005), "a target population is a group of individuals who meet sampling criteria to which the study findings will be generalized." The target population comprised women who have lost their babies through miscarriage (both incidental and recurrent) and they were drawn randomly from communities in the Sagnerigu Municipality. These communities included Sagnerigu, Wurishe, Gbolo Kpalsi Gurugu and Sognaayili.

However, there is no available data about women who have had miscarriages in the Sagnerigu Municipality, from which a scientific formula could be used to draw a sample size from the population. Thus, all women who have had miscarriages in the Sagnerigu Municipality constitute the study population.

3.6 Sampling Technique and Sample Size

The study made use of the Purposive and Snowball sampling procedures to examine miscarriage survivors' life experiences. Purposive sampling is a non-probability sampling strategy that works best when one has to explore a certain field of individuals who have expertise in a particular phenomenon and are prepared to take part in the study (Gentles, Charles, Ploeg & McKibbon, 2015). Additionally, purposeful sampling picks only those people who are pertinent to the research design and is less expensive, easier to access, and more convenient. Nevertheless, the study also adopted the snowball sampling technique to identify women who had miscarriages. The rationale for using the snowball technique arises from the sensitive nature of the phenomenon, which made most women with such experiences shy away from discussing their ordeal. Snowball sampling was relevant to this study because people with lived experiences like miscarriage are likely to know each other and can direct the researcher to one another for interviews.

The interviewer randomly approached women she taught were of child-bearing age in some randomly selected areas in the Sagnerigu Municipality, where they were asked if they had ever miscarried before. With this approach, these women were purposely picked and interviewed. Most of them referred the interviewer to other women who had miscarried before. By this approach, the interviewer interviewed the women until she attained a point of saturation where she was having similar responses from the women. A target participant of 15 women who had had miscarriages either isolated/ once or recurrent was therefore purposively sampled in the Sagnerigu Municipality.

3.7 Inclusion and Exclusion Criteria

- **Inclusion Criteria**

Women who have lived in the district for 12 months or more, women who have had miscarriages either once or recurrent and mentally sound women, were included in the study.

- **Exclusion Criteria**

Women who were not from the Sagnerigu or had not lived there for 12 months or more prior to the study and women who were not mentally stable were excluded.

3.8 Data Collection

3.8.1 Data Collection Methods/ Sources

Interviews: Interviews were the main data collection method employed in this study. Interviews are a fundamental qualitative research method used to gather in-depth information on participants' experiences, perceptions, and emotions. They are particularly effective for exploring complex and sensitive topics, making them well-suited for studying the lived experiences of women with pregnancy loss in Northern Ghana. Through interviews,

researchers can engage directly with participants, facilitating a deeper understanding of their personal narratives and the meanings they bring to their experiences.

Interviews allow for the collection of rich, detailed data. This depth is essential for capturing the multifaceted and deeply personal nature of pregnancy loss. Interviews offer flexibility to probe and follow up on interesting points, ensuring that researchers can explore the nuances of each participant's experience.This method places participants' voices at the center of the research, allowing them to express their feelings and thoughts in their own words. This is crucial for a topic as personal and emotional as pregnancy loss. Interviews can be adapted to respect cultural norms and practices, ensuring that participants feel comfortable and respected throughout the research process.

The researcher met all participants individually to discussed the purpose of the interviews. An Informed consent was presented and the participants agreed by signing the informed consent form that was presented and read to them. The interviews were conducted by the researcher herself but sort for professional help during the data transcription, The interviews were held in both the Dagbani and in English.

Secondary Data: Secondary data sources can provide valuable insights when researching the lived experiences of women with pregnancy loss. These sources include existing studies, literature reviews, statistical reports, and qualitative analyses.

3.8.2 Data Collection Instruments

3.8.2.1 Interview guide

An interview guide (Appendix I) with a list of questions and prompts served as the basis for the interviews (Smith et al., 2009). The method was designed to be flexible and provide avenues for the ladies to discuss their experiences of loss. Pregnancy, the mother's relationship to her unborn child, the actual day of the loss, and the experience of receiving

assistance were among the subjects covered. The guide's questions were constructed with flexibility and adherence to the interview's content flow, both in terms of wording and arrangement (Smith et al., 2009). To make sure the participant could share their personal story however they chose, the researcher either clarified things or encouraged them to elaborate when necessary. The questions from Smith et al. (2009) served as the basis for certain inquiries. For instance, some questions were descriptive (e.g., “Tell me more about what you mean by that”), while others probed for feelings (e.g., “And how did you feel about that?) or opinions (e.g., “Did you find that useful?”). In order to avoid seeming presumptuous or leading in any manner, many questions started with "tell me about your experience of..." To make sure the participant had enough time to convey her story, questions like "Is there anything else you would like to add that we have not talked about?" were asked after the interview.

The use of verbal and nonverbal probes, which encourage the interviewee to expand on a description of an experience that requires further explanation, is a crucial component of the in-depth interview process (Sorrell & Redmond, 1995; Smith et al., 2009). Verbal probes in particular can be useful in eliciting more information when asking participants to recall a portion of their experiences (Liamputtong & Ezzy, 2005). They can also assist the interviewer in keeping the subject somewhat consistent (Berg, 2001).

The interviewer may be able to extract hidden meanings or establish the tone of the discussion by using silence or other non-verbal clues (Kvale, 2016). When needed, the researcher spoke with the interview subjects and asked questions such "Can I get an example from you?" and "Can you tell me a little more about that?" She was also perceptive to silences and cognizant of their mental distress. The interview started with a number of

demographic questions before moving into more detail with open-ended questions to learn more about the participants' experiences following their loss.

The analytical procedure was guided by the work of Smith et al. (2009), although it adhered to the Phenomenological framework. In order to generate unique themes that reflected the shared experiences of the participants, a comprehensive interaction with every transcript of interviews was necessary throughout this process. In order to ensure the accuracy of the information, the researcher personally recorded and transcribed each interview. This decision protected participant confidentiality and anonymity and let the researcher to fully immerse herself in the data that was gathered. Interviews were transcribed within a few days of their conclusion in order to preserve the integrity of the data, and data analysis was immediately initiated.

3.9 Data Analysis

3.9.1 Thematic Analysis

The information gathered from research participants was subjected to a thematic analysis. "Thematic analysis allows the researcher to see and make sense of collective or shared meanings and experiences," claim Braun and Clarke (2012). It is also an approach to identifying and elucidating commonalities in the way a topic is written or presented. Women who have experienced miscarriages attribute significance to their loss of a child. When these experiences were discussed, a pattern of mutual understanding would surface, serving as the foundation for this study.

"Thematic analysis enables the researcher to identify patterns within and across data concerning participants' lived experience, views and perspectives, behavior and practices," according to Clarke (2017) once more. Thus, the researcher's choice of theme analysis is

appropriate for this study since it may enable her to find the subtleties and connections in the real-life experiences of miscarried mothers.

The main themes were curved out of the objectives of the study

3.10 Validity and Reliability

As stated by Creswell & Miller (2000), "determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account" is the foundation for the validity of qualitative research. The researcher used data triangulation, which involves utilizing various data sources to establish a cogent argument for the themes developed from data sources, to ensure the accuracy of the study's conclusions. Once more, the supervisor would evaluate the interview guide and the study's following write-up to make sure the questions posed will get the right kind of response from the participants.

3.11 Ethical Consideration

Research cannot be conducted without seeking permission from the relevant authorities. The Head approved this study by the Department of Public Health and subsequently reviewed with the project supervisor. Ethical clearance for the study was obtained from KNUST and the Municipal Directorate of Health Services, Sagnarigu, Ghana.

3.11.1 Informed consent

Two further ethical considerations are facilitating informed consent and safeguarding participant confidentiality and anonymity. Participants must be thoroughly informed about the nature, purpose, and procedures of the research in order for them to offer their informed consent (Byrne, 2001). Before they can voluntarily consent to the research or decline to participate, participants must be fully capable of understanding this information (Walker,

2007). As part of the protocol, which is based on the principle of respect for autonomy, participants are told about the benefits and hazards of the research (Holloway & Wheeler, 2002).

Every participant in the current study was provided with thorough information regarding the purpose, nature, benefits, and possible risks of the study. This happened in writing as well as verbally (over the phone and before to each interview). In line with ethical guidelines, research participants had to sign a consent form prior to any data being collected, attesting to their informed consent. Both the subject and the researcher signed this consent form on the day of the initial interview (see Appendix II). Furthermore, participants were informed of their freedom to withdraw from the study at any time during the whole research process. Informed consent was requested of participants at the start and end of every interview, it is impossible to predict what kind of material the interview would unearth before data collection begins (Walker, 2007). It's possible that details that the participant feels uneasy disclosing or including in the study's conclusions will be revealed. As a result, obtaining informed permission is a continuous negotiation, and the researcher must be mindful of any reasons that can make a volunteer decide not to take part in the study or forfeit from it (Cook, 1995). In the end, the researcher must take all reasonable precautions to safeguard volunteers and lessen the possibility of psychological harm (Byrne, 2001).

Every participant in the current study was provided with thorough information regarding the purpose, nature, benefits, and possible risks of the study. This happened in writing as well as verbally (over the phone and before to each interview). In line with ethical guidelines, research participants had to sign a consent form prior to any data being collected, attesting to their informed consent. Both the subject and the researcher signed this consent form on the day of the initial interview (see Appendix II). Furthermore, participants were informed of

their freedom to withdraw from the study at any time during the whole research process. Informed consent was requested of participants at the start and end of every interview.

3.11.2 Confidentiality and anonymity.

The researcher's obligation to guarantee secrecy and anonymity is another ethical consideration (McHaffie, 2010). All communications between the researcher and her supervisor were kept private and anonymous at all times, as well. For instance, to ensure privacy, all interviews took place in a private space at the participant's home or place of employment.

All participant contact information was painstakingly preserved by the researcher in a secure location to safeguard participants' identities. Password-protected transcriptions and research-related data files were stored on the researcher's hard drive, where they were only accessible by the researcher. Details that might allow the person to be identified were also looked for in thesis quotes (Parkes, 1995). After the study was completed, interview transcripts were stored for five years at School of Psychology and Social Science ECUs in a lockable filing cabinet. These moral dilemmas adhere to the guidelines established by the Human.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter covers a number of topics, including the sociodemographic characteristics of women who suffered from various forms of pregnancy loss, the kind and standard of treatment given in hospitals, and the understanding that these women developed as a result of their miscarriages. It also provides the results based on the study's objectives, which examined the lived experiences of miscarried women, the resources accessible to them, and the coping strategies these women employed in the face of adversity. Four major topics were used to examine the participant's miscarriage experiences:

(a) Lived experiences of miscarriage

(b) The uniqueness of pregnancy after loss

(c) Support systems

(d) Post-miscarriage care.

Main Themes	Sub Themes
Lived experience of miscarriage	How it happened
	Fear
	Level of pain experienced
The uniqueness of pregnancy after loss	Loneliness
	Individual journey
Support systems	Partner support
	Family and friends
	Service characteristics
	Care provision
Post miscarriage care	Utilize coping strategies

4.2 Socio-Demographic Characteristics of Respondents

The history of the respondents who were the study's targets is the main topic of this section. Ultimately, 15 respondents were chosen to participate in the data collection process; all of them were women who had miscarried or lost their pregnancy during the study period. After interview saturation was reached, this figure was attained.

Table 1: Age of Respondents

Characteristics	Frequency	Percentage
Respondents Age		
15-24	0	0.0
25-34	8	60.0
35-44	5	33.3
45-49	1	6.7
50-54	1	6.7
	15	100.0
Marital Status of Respondents		
Married	15	100.0
Single	0	0.0
Divorced	0	0.0
Separated	0	0.0
Co-habiting	0	0.0
	15	100.0
Respondents Educational Level		
Tertiary	8	53.3
Secondary	2	13.3
Primary	1	6.7
No Formal Education	4	26.7
	15	100.0
Ethnicity		
Dagombas	12	80.0
Hausa	1	6.7
Frafra	1	6.7
Kusasi/ Mamprusi	1	6.7
	15	**100.0**
Religion		
Islam	13	86.7
Christianity	2	13.3
African Traditional Religion	0	0.0
	15	100.0
Pregnancy Status		
Pregnant	7	46.7
Not Pregnant	8	53.3
	15	100

Substance Use	1	6.7
Alcohol Consumption	1	6.7
Tobacco Smoking		
	2	13.4
Health Status of Respondents		
No Underlying Health Conditions	12	93.3
Underlying Health Conditions Present	**3**	6.7
	15	100.0
Income Status of Respondents		
100-500	7	46.7
500-1000	1	6.7
1000-1500	1	6.7
1500-2000	5	33.3
Above 2000	1	6.7
	15	100.0
Respondents Occupation		
Retail stores and hawking	7	46.7
No work/ housewives	5	33.3
Government/public sectors	3	20.0
	15	100.0
Type of Place of Residence		
Urban	15	100.0
Rural	0	0.0
	15	100.0

Source: Field Work, 2021

Table 1 above displays the maternal age brackets of participants within the reproductive age groups 15-54. The results revealed that most participants (8) are young and within the age bracket of 25-34. This was closely followed by women within the age groups 35-44 years, representing 5; women within the age brackets of 45-49, 50-54 have one participant each and the age bracket 15-24 had zero (0) participant. This is because they may still be in school or too young to marry, accounting for their almost negligible proportion.

According to the findings of the study, as displayed on the Table 1 above, the number of women by marital status are 15 women who are currently married, and this represents all the respondents targeted by the study.

From the data collected, the highest number of women who had experienced miscarriages (8) had attained Tertiary education comprising a master's degree, first degree and Higher

National Diploma. This was followed by women with no sort of formal education and women who attained Secondary education represented by 4 and 3 respectively."

Ethnicity is mainly related with cultural beliefs and practices influencing how miscarriages are perceived and handled through cleansing practices or special rites. Primary data gathered from this research shows majority of the respondents (12) are Dagombas. The rest of the participants representing the Hausa, Frafra, Kusasi and Mamprusi ethnic groups are represented by one (1) person each. As far as ethnic affiliation is concerned, the Dagomba ethnic group is the dominant ethnic group in the sample size in the Municipality."

The religious affiliation of a person again influences their reproductive decisions and how one perceives miscarriages through the religious beliefs and practices they uphold. It is therefore essential to consider this variable. Primary data gathered from the field shows that, majority of the participants represented by 13 women are Muslims, while 2 are Christians. There was no participant belonging to the African Traditional Religion."

Many studies have shown a link between drinking alcohol and miscarriages (Ford & Schust, 2009; Henriksen et al., 2004; Nykjaer et al., 2014). A high alcohol consumption during pregnancy may be teratogenic for some women, and it increases the chance of preterm birth in women who consume a lot of alcohol (Hadi et al., 1987). Therefore, it is crucial to take this element into account. The results showed that only one (1) participant had ever consumed alcohol.

Based on the data gathered for this study, most (15) women do not smoke, indicating that personal smoking did not contribute to the various degrees of miscarriage they experienced.

The ability to conceive again and the mental state of the pregnancy have a bearing on a woman's miscarriage experiences. From the data gathered for this research, 8 women, the highest number out of the sample size, were not currently pregnant but had a child or

children. In comparison, seven women who had experienced miscarriage were pregnant and expecting to carry full term.

Status of health can affect either negatively or positively the reproductive process for a woman. Underlying conditions play a considerable role in determining the health of a pregnancy and measures put in place in case of an emergency; therefore, it is necessary to understand these women's health status and the level of care they receive before and after a miscarriage.

Primary data gathered from this research shows that, majority (12) of the participants had no underlying conditions whiles three other responses recorded one condition each, namely Hypertension, Piles and Ulcer. This data is critical to understanding the miscarriage pattern in some women and the level of care received to manage these conditions whiles in the reproduction process.

As illustrated in Table 1, from all the monthly income indices, women who belong to the monthly earners between 100-500 cedis and 1500-2000 cedis category represented by five responses each was the highest proportion. This was followed by one woman each for the 500-1000, 1000-1500 and above 2000 cedis categories.

This shows that seven women from the sample size earn well above 1000 cedis every month, while six earn below that gauge.

The table 1 above also describes the various types of occupations of the respondents. This includes those who do not work and those who are engaged in different types of occupations. Primary data gathered from this research indicates that, seven (7) of the women work as entrepreneurs, thus retail stores and hawking. This was closely followed by five (5) women who were not working (those who were basically housewives) and only three (3) women who

worked in the government/public sectors. These were women who worked as professionals and managers and provided clerical services.

The table 1 also describes the number of respondents who lived in urban areas and rural. Primary data gathered in the field showed that, all the 15 women who had ever experienced miscarriage reside in urban areas. This reflects that among the miscarried female sample size, there are more urban dwellers than their rural counterparts in this research.

4.3 General Problems Encountered by Miscarried Women

By employing qualitative research methods, the study sought to understand the general problems these women face and providing a comprehensive overview of their challenges. Data were gathered through in-depth interviews with 15 women who had experienced miscarriages within the past two years. Thematic analysis was used to identify recurring issues and concerns.

4.3.1 Emotional and Psychological Distress

Many participants described profound feelings of grief and loss following their miscarriages. The emotional impact was immediate and intense, often leading to prolonged periods of mourning.

One participant shared, *"The pain of losing my baby was unbearable. I felt like a part of me had died."*

These feelings of grief were often compounded by societal expectations to quickly move on, which added to their distress.

Several women reported experiencing heightened levels of anxiety and fear after their miscarriage. Concerns about future pregnancies and the possibility of recurring miscarriages were common. One woman recounted,

"I am constantly worried that I will lose another baby. It's a fear that never goes away."

This pervasive anxiety affected their overall mental health and well-being.

Depression was a significant issue for many participants. Symptoms included persistent sadness, lack of interest in daily activities, and withdrawal from social interactions.

"I lost all interest in things I used to enjoy. I just wanted to be alone,"

said one participant.

The stigma in the community associated with mental health often prevented these women from seeking professional help.

4.3.2 Social and Cultural Challenges

Stigmatization emerged as a prominent theme. Many women felt judged and blamed for their miscarriages, both by their families and the broader community. One participant explained, *"People would whisper behind my back, saying it was my fault. It made me feel so ashamed." (R1)*

This social stigma exacerbated their emotional suffering and led to isolation.

A significant number of participants reported a lack of support from their spouses and extended families. Cultural expectations often placed the blame for miscarriage solely on the woman, leading to strained marital relationships and limited emotional support.

"My husband dd not understand what I was going through. He just wanted me to get over it,"(R7)

shared one participant. This lack of understanding and support deepened their sense of loneliness and helplessness.

Cultural beliefs and practices surrounding miscarriage also posed challenges. Some women were subjected to traditional rituals that they found distressing. For example, one participant recounted, *"I was made to drink herbal concoctions that made me very sick. But they said it was necessary to cleanse my body."(5)*

These practices, while intended to help, often added to their physical and emotional burden.

4.3.3 Health Care-Related Issues

Inadequate medical care was a common problem faced by the participants. Many women reported receiving insufficient information and support from healthcare providers following their miscarriage. One woman noted,

"The doctors didn't explain what happened or what to expect. I left the hospital with more questions than answers." (R10)

This lack of communication and guidance left them feeling confused and unsupported.

Access to mental health services was severely limited in the Sagnerigu Municipality. Participants expressed a need for counseling and psychological support, which was largely unavailable.

"There are no counselors here to help us deal with the trauma. We have to cope on our own."(R3) lamented one participant. The absence of mental health resources contributed to the prolonged suffering of these women.

Financial constraints further complicated access to adequate healthcare. Many participants struggled with the costs associated with medical treatment and follow-up care. One woman explained,

"We can't afford to see specialists or buy expensive medications. We just have to manage with what we have." (R 6)

This financial burden often led to delays in seeking care and compromised their recovery.

4.4 Lived Experiences of Miscarried Women

The purpose of examining this theme through its subthemes was to uncover and produce fresh perspectives on the experiences of these women and their coping mechanisms following the miscarriage.

Miscarriage is an unfortunate result of pregnancy that causes a mother to suffer greatly emotionally and physically. Additionally, it occurs more frequently than most people realize. It is essential to realize that there is no right or incorrect way to feel following a miscarriage.

What might I feel during a miscarriage is a common question among women. Many pregnant women miscarry early on without even knowing. They might just believe they are experiencing a heavy menstruation. In this case, one might have abdominal cramps, much heavier-than-normal bleeding, pelvic, back and stomach pain, as well as a feeling a sense of weakness.

Some of the participants expressed how the whole experience happened, the uncertainty that came with it, the confusion and not knowing exactly what to do; One participant said thus:

"It was not an easy experience at all because, after going through morning sickness as a pregnant woman, then all of a sudden, the pregnancy dropped, it was not easy at all and unexpected. I felt terrible because I couldn't control the blood that was flowing. (R 2)

Another woman narrates as: *I was unaware; I entered the bathroom to urinate, saw the blood on my panties, and came out to inform my boss at work. She sent to call the driver to come before the driver could arrive, my whole body was hot. The blood was flowing like they have open pipe whiles the clotted blood was also dropping."* (R 1)

She expressed her confusion about the blood flow and inability to do anything about it as a pregnant woman. The physical pain was not what the woman experienced so much but the psychological toucher that she went through.

Another woman also narrated her experience in an in-depth interview;

"I woke up one morning, sitting outside, my legs started hurting me, and suddenly, my stomach started hurting too. The process I went through is similar to giving birth and all the pains that came with it. I felt so sad and bad because, something you expected and prayed for, all of a sudden, you lose it. I just imagine the child being around me. "(R 3)

Those who may have suffered a loss or had trouble getting pregnant may be more likely to feel miscarriage anxiety than others. However, living in continual fear and worrying about "what ifs" just adds stress and consumes valuable, limited pregnancy time.

However, when you speak to those who have had a miscarriage, the emotional toll frequently outweighs the physical toll. Although many find it difficult to recall the cramps or spotting, the emotions of anxiety and sadness are still as vivid as a knife. Many people express the belief that their loss was not considered significant by others and that having a miscarriage was akin to getting a period (and while it is physically similar for some, the emotional weight is much different).

Participants reported feeling worry in relation to things like frequently losing their pregnancies, becoming mothers later in life, and not having any living children. Two women discuss the psychological impact of dread and how it affected their relationships with their spouse's family as well as their general mood:

"The first miscarriage, I was okay, but until second and third miscarriage, I thought it was a fibroid, and I began to research to know the real cause because I could not understand why this was happening, but I could not get exactly what it was in the end." (R 4)

Another participant had this to say: *"My stomach started hurting me, I was told to take paracetamol which I did, and in the evening, it started hurting me again, and I was scared something bad will happen. My husband took me to the hospital; a few minutes later, some smelling blood started dropping badly; then D and C was done on me. One of the nurses inserted something into me which was not supposed to be used, the doctor came to remove it, and it was paining even more, and I did not know what was happening*." (R 11)

Contextually, what would they have listed, if asked to write down the top five fears relating to pregnancy, conception, childbirth or postnatal recovery? Many of these women would have listed hospitals, needles, nurses, surgical intervention, and miscarriage. Others were based on what they had read, heard, or witnessed on television, or, worst of all, hearsay. Some of those were based on horrific experiences.

Their subconscious mind would work tirelessly to find new evidence to support their fears and keep them very much alive, regardless of whether they were based on actual events or the product of an overactive imagination. This caused their survival instinct, or "fight response," to activate with those familiar feelings we associate with fear when we encounter a stressful stimulus.

When a miscarriage happens after you have already gotten a positive pregnancy test, it can be a physically and emotionally painful process. Miscarriages cannot be made any more accessible, but we can all try to understand what happens in the process (Sarah Bradley, 2021). Although abdominal pain is one of the most frequent symptoms of a miscarriage, it is not the only type of pain or discomfort you might feel.

Cramping with a miscarriage is usually caused by the uterus contracting, just like period cramps. Lower abdominal or pelvic cramps on both sides are a common side effect of miscarriage. Additionally, the uterus produces lining during the menstrual cycle to prepare

for pregnancy; when the pregnancy cannot continue, the lining must be shed. Because the body has been preparing for pregnancy, there will be more lining and tissue so that the miscarriage bleeding will be heavier than a period.

Some participants narrated the pain they had as a result of the miscarriage; some were excruciating to the point it felt like pushing out a baby, and others also had different levels of pain. Pain affects anyone psychologically and physically, and this section delves into the individual experiences and how they went through the ordeal.

A participant who had experienced multiple pregnancy losses related her experience, citing the level of pain, the restlessness and uncertainty it came with but hoping for the best out of the situation: she said thus:

"I had a visit to the hospital for a check-up, and they asked me to come back two days later; that night, I could not sleep due to the pain. The next morning, I went back to the hospital, and that was it; they had to extract the clot, and the experience was painful and tragic for me." (R 7)

Another participant narrates thus: "*With that, you cannot sleep at night, nor can you lay down well. I had to lay on one side for a very long time to get some relief; when the pain moved to the side, I had to change position again, and I could not lay on my stomach or my back. Just needed a laying position to relieve the pain, not comforting."* (R 2)

In a thorough interview, one of the participants shared their thoughts:

"I had a headache, and my husband took me to a private hospital; the doctor gave me tramadol. When we got home, I told my husband I was not taking the drugs, but he insisted; 20 minutes after taking it, the blood started flowing. It was painful and sad." (R 12)

Moreover, no matter how far along with a person's pregnancy when they miscarry, it is essential to allow them to feel grief and emotional pain. Miscarriage emotions are primarily

complicated and messy, according to the narrations of these women and other secondary data gathered; it is usually the feeling of sadness and relief that the physical pain is over.

Similar to how menstrual cramps can induce back pain, the uterine contractions that occur during a miscarriage can also produce back pain. This pain is typically felt in the lower back and can range from mild to severe. These women's individual miscarriage experiences corresponded with these levels of suffering.

4.5 The uniqueness of pregnancy after loss

This theme was investigated through two subthemes.

When a parent loses a kid, they are never prepared. Put simply, parents ought not to outlive their children. It's critical to remember that your loss does not depend on how long your child lived. A child's death is tragic at every stage.

Some women find themselves feeling alone in their grief because nobody knew they were pregnant in the first place. It was also revealed that, a woman can also face challenges if other people's reactions to a loss are not helpful or upsetting.

The study also found out that, some couples see their loss has affected their relationship with their partner.

A number of participants reported experiencing feelings of loneliness following the loss of a pregnancy, comparing their situation to the loss of a personal item.

A participant had this to say:

"I felt like am losing a part of me that I desired for so long and yearned for has gone." (R 4)

Another participant narrates her experience thus:

"I feel very relieved because the pain has stopped after the miscarriage and other hands, I felt so bad, tragic and unhappy because I was ready to welcome the baby all of a sudden it turns this way." (R 2)

A woman with four loses had this to say:

"It was not easy for me, and I was thinking a lot when I was alone." (R 6)

According to statistics, couples are probably familiar with someone who has ever experienced a miscarriage. Of women who are aware of their pregnancy, 10% to 20% will miscarry during the first trimester. Since it's typical for women to miscarry before they realize they are pregnant, many experts believe that this number will be high. According to a recent survey, 43% of moms said they had lost a baby in the first trimester or more times.

Several respondents narrated their separate experiences; experiencing the miscarriage at home or work, the amount of time it took before the blood came out, the shock and confusion and the next course of action.

Another participant had this o say in an in-depth interview:

"No, why will you blame me because it was not my fault; I cannot blame myself; it just came. It is only maybe if you want to terminate it. Then, you can try to blame yourself after that, but this one just came by itself. The miscarriage was a medical problem caused by the man (my husband), and I felt terrible seeing the blood coming out and not being able to do anything about it" (R 1)

Another participant narrated thus:

"When we got to the hospital, they received me very well, especially the Doctor on duty that day; he was begging me to calm down and exercise patience. He then removed one sample of clotted blood and showed it to me. He kept telling me to relax because the mess had already

been committed. I was crying, and he held me to calm down; after that, he said we should pray for another baby." (R 3)

Another woman with five miscarriages had this to say:

"With five miscarriages, I was sad and depressed at the time. The blood was still flowing, so I was indoors for a week. The first one, I was okay, but until the second and third miscarriage, I thought it was a fibroid, and I began researching to know the real cause but could not get exactly what it was in the end." (R4)

This cross-section of participants indicates the diverse experiences of all 15 respondents; no one miscarriage is the same for everyone. The striking factor here is that, participants who went for medical care during the miscarriage period were given the answers and prescribed medications needed instead of self-medicating.

4.6 Social Support System Available to Miscarried Women

Most women had positive things to say about their partners, whom they perceived as being their primary sources of support during the miscarriage experience. Most women reported that their spouses were physically and emotionally present throughout this time and in subsequent pregnancies. While most women reported positive experiences with their husbands' support, others felt their spouses did not fully understand the impact the miscarriage had on them or that they were not totally present for them. Similar to what happens often after a family member dies, a few women, especially those with older children, expressed their thanks for friends and relatives who provided practical support. Women appreciated having others feed and watch their children so they could have time to process their miscarriages.

In relation to family and friends support, participants narrated that:

"My family was far from here, my husband was in Tamale, but his main family too was in Bolga. He informed the younger brother, and he came to the hospital. He was doing the rounds for me before my husband arrived in the evening." (R 1)

"Yes, I had support; I realized that, during trying times, there are some people who will be there for you no matter the situation and also, I also observed that I have people that love me much and care for me." (R 2)

"I got support from my husband and family encouraging me that another child is coming up. "(R 4)

"It was my mother-in-law that prepared the herbs for me and cooked for me as well." (R 10)

Miscarriage management was divided into two categories: surgical and medical care. When neither of the codes for the preceding procedures could be determined, women were categorized as being handled expectantly (i.e., other treatments). Participants described the quality of service and treatment provided at the health clinics throughout their difficult times.

Even though some experiences did not go as planned and these women had to endure a low level of care at the health centers, some experienced excellent services, which played a considerable role psychologically and emotionally for these women as well as helping them get through the trauma of miscarriage. As such, the following narrations were gotten from the participants who experienced miscarriages at health facilities:

"When I arrived, the health staff saw blood around me and the thing dropping, they quickly took me to the theatre; I was lucky because they were doing D and C that day, and I was the first person to be attended to" (R 1)

"The hospital environment was good, but the processes in which they did the D and C was not nice. they will open your legs, and put some the tools inside you. You will feel so much pain." (R 1)

Another participant indicated that:

"The hospital treated me well and showed me care and kindness. That particular labor room was perfect because that was where issues concerning blood are treated, and all tools and materials needed for such were available there" (R 2)

Participants had varied views regarding hospital management for miscarriage. A participant had this to say:

"The nursing care was okay. Most of the time, the drips they put me on for the blood to come out fast makes me sleep most often. They took me to the theatre, and I had the D and C."(R 4)

"I was very comfortable, and they gave me a special doctor." (R 6)

Another participant indicated that:

"It was not that good. They did not respect me, and they care so much about the money I will pay them rather than their service." (R 11)

For many people, miscarriage has a detrimental psychological impact. In the first week following a miscarriage, 22-41% of women report clinically significant symptoms of despair and anxiety. (Fernlund et al.,) Even when sadness and depressed symptoms have subsided, the emotional experience of miscarriage might linger. A key gap in miscarriage care has been found as the absence of adequate psychosocial support.

Previous studies have shown that including patients in clinical decision-making and providing them with medical information as well as emotional support increases the quality of miscarriage care.

4.6 Recovery Procedure and Coping Mechanism for Miscarried Women

The participants' realistic and practical strategies for dealing with the stress and uncertainty of the waiting time are collected under this organizing subject. Simple distraction methods and maintaining a busy schedule were frequent pragmatic coping mechanisms for anxiety. This was especially true of participants who had children already; yet, for those who were employed, work frequently served as a significant diversion. Others who took part avoided (namely, not allowing themselves to think about the pregnancy and blocking it out of their thought processes).

The women frequently tried to change their lifestyle to reduce elements that could raise the chance of miscarriage, such as cutting back on vigorous exercise or changing dietary consumption.

Many of the participants cited the need of giving thanks to God in all circumstances and having faith that His will be done as one of the most helpful practical strategies they could use at this time. They believed that the worries and difficulties they encountered could only be fully understood by women who had been in their shoes.

A participant said thus:

"*It was written by Allah." (R 12)*

Another participant said:

"I know it was the works of Allah. If things are beyond your control, you cannot do anything." (R 10)

During the in-depth interview, most participants stated thus:

"There is always a second chance in life." (R 8)

'Islam taught me to have faith and Iman with Allah; all is possible, and there are many blessings to come my way." (R 6)

"It is the consent of God. He gives and takes." (R 4)

Tragically, miscarriage happens surprisingly frequently. According to experts, 20% of pregnancies result in miscarriage. But the agonizing anguish of this loss is not like most losses. Since many people's losses are highly personal, the greater community frequently is unsure of how to react or offer support.

Many women who miscarry may feel depressed, fear, sadness, anger and sometimes jelousy

Due to the fact that his hormones have not been involved in the pregnancy as much as those of his wife, a husband may or may not be able to comprehend all of these emotions. Additionally, women frequently see pregnancies as more "real" than men do before the kid is born. Even men experience grief, but it's different.

4.7 Additional Information - Juxtaposing variables.

4.7.1 Marital Status and Miscarriage

There is little research on the association between women's marital status and their experiences with miscarriage. Researchers in the field of pregnancy loss found that the loss caused significant marital stress. According to studies, married women are less likely than single (never married) women to endure pregnancy loss (Adetunji, 1998a; Eggleton, 1999). A relationship has a chance of becoming unstable once it is not constrained by the vows of matrimony.

Perinatally bereaved mothers have also been found to have low self-esteem, which makes them question their abilities to bring another pregnancy to term or prevent another perinatal loss (Meert et al., 2005; Caelli et al., 2002; Hendrickson, 2009; Wonch Hillet al., 2017;

Meredith et al., 2017). Mothers who have experienced perinatal loss are more likely to experience psychosocial and psychiatric issues, and they are also more likely to die, particularly from cardiovascular diseases (Maciejewski et al., 2007; Prigerson & Maciejewski, 2008; Hvidtjrn et al., 2016).

4.7.2 Place of Residence and Miscarriages

According to studies, miscarriages are significantly more common among rural people than among urban ones (Abebe & Yohanis, 1996; Feresu et al., 2004). The causes offered include, among others, women having fewer pregnancies per year (less than two years) and failing to attend antenatal care facilities.

This condition may be caused by the sedentary labor that predominates in urban areas, such as office and other corporate job that necessitates a lot of sitting and little mobility. Pregnant urban women who work in such positions are more likely to miscarry than pregnant rural women, whose jobs require greater mobility.

4.7.3 Wealth Status and Pregnancy Loss

The level of household affluence may be a significant predictor of pregnancy loss in women. The household's economic index is another factor that demonstrates a complex link with pregnancy loss (Adetunji,1998).

4.7.4 Access to Antenatal Services and Pregnancy Loss

The success of a woman's pregnancy is critically dependent on her ability to access antenatal care. Therefore, the quality of health services offered and received, as well as availability to health facilities in terms of travel time from home to the health center, are critical factors in influencing the outcomes of pregnancies for women.

4.7.5 Alcohol Consumption and Pregnancy Loss

Numerous studies have found a connection between pregnant women's excessive alcohol use and the subsequent loss of their pregnancies. As a result, drinking alcohol in any form has been linked to a higher chance of miscarriage (Lorente et al., 2000; Wilcox et al., 1990; MacArthur et al., 2008; Clavel et al., 2005).

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

The sociodemographic traits of women who suffered from various forms of pregnancy loss, the kind and standard of care they received in hospitals, and the women's subsequent understanding of miscarriage are all covered in this chapter. Additionally, it provides the results derived from the study's aims, exploring the real-life encounters of miscarried women, the resources at their disposal, and their strategies for overcoming obstacles. Four primary themes were examined in the study of the participants' miscarriages: support networks, the special nature of pregnancy following loss, lived experiences of miscarriage, the uniqueness of pregnancy after loss, support systems, and post-miscarriage care.

5.1 Socio-Demographic Characteristics of Respondents

The socio-demographic data reveals critical insights into the population studied. The majority of participants (60%) were between 25-34 years old, a critical reproductive age. This finding aligns with Adetunji (1998a) and Santelli et al. (2003), who noted that both younger and older women are more prone to miscarry, emphasizing the vulnerability of this age group. All participants were married, which reflects the cultural context where childbearing is often within marriage.

5.3 General Problems Encountered by Miscarried Women

The study identified several general problems faced by women who experienced miscarriages, categorized into emotional and psychological distress, social and cultural challenges, and healthcare-related issues.

Grief and loss were profound among participants, in line with the research conducted by Bennett et al. (2005), who defined miscarriage as a serious psychological trauma. There was a lot of concern and fear about getting pregnant again, which is in line with the findings of Farren et al. (2018) that women frequently have increased anxiety following a miscarriage. Depression was also significant, with symptoms of persistent sadness and social withdrawal, corroborating the work of Lok and Neugebauer (2007).

Stigmatization emerged as a significant issue, with participants feeling judged and blamed for their miscarriages. This finding aligns with Murphy and Merrell (2009), who noted that societal attitudes can exacerbate emotional distress. The lack of support from spouses and extended families was another critical issue, reflecting the patriarchal norms identified by Greil et al. (2011). Cultural beliefs and practices, including distressing traditional rituals, further complicated the women's experiences.

Inadequate medical care was a common complaint, with many participants reporting insufficient information and support from healthcare providers. This is in agreement with the findings of Simmons et al. (2006), who highlighted the need for improved communication in miscarriage care. Recovery was significantly hampered by limited access to mental health treatments, which is consistent with Evans's (2012) concerns over the provision of psychological care for miscarried women. Financial constraints further limited access to adequate healthcare, highlighting the intersection of economic and health vulnerabilities (Rowland et al., 2010).

5.4 Lived Experiences of Miscarried Women

Themes like the cause of the miscarriage, fear, and coping mechanisms were used to examine the women's actual experiences.

Many women described the physical and emotional toll of miscarriage, with experiences of sudden and severe bleeding and pain. These accounts are consistent with the clinical descriptions provided by Regan and Rai (2000), who noted the physical manifestations of miscarriage. The unexpected nature of the event and the subsequent emotional impact were significant, aligning with Swanson et al. (2007), who emphasized the traumatic nature of miscarriage.

Fear of future miscarriages was pervasive among participants. This fear is well-documented in the literature, with Hutti et al. (2018) noting that women who have experienced miscarriage often face significant anxiety in subsequent pregnancies. The participants' fears about medical procedures and healthcare settings reflect broader concerns about the quality of care, as discussed by Geller et al. (2010).

5.5 The Uniqueness of Pregnancy After Loss

The emotional landscape of pregnancy after loss was marked by heightened anxiety and vigilance. This finding is consistent with Armstrong and Hutti (1998), who noted that women often experience mixed emotions during subsequent pregnancies. The sense of loneliness and the individual journey of each woman highlighted the need for personalized care and support, as suggested by Côté-Arsenault and Donato (2007).

5.6 Support Systems

The study discovered different degrees of healthcare services as well as assistance from spouses, friends, and family.

Partner support was critical but inconsistent. Some women reported strong support from their partners, while others felt misunderstood and unsupported. This aligns with the findings of

Swanson et al. (2009), who noted that partner support can significantly impact the emotional recovery of women after miscarriage.

Support rendered by friends and family varied widely, with some women receiving significant emotional and practical support, while others faced judgment and blame. This dichotomy reflects the findings of Leis-Newman (2012), who stressed the relevance of a supportive social network in mitigating the emotional impact of miscarriage.

The quality of care provided by healthcare services was a critical factor in the women's experiences. The need for compassionate and comprehensive care was highlighted, echoing the recommendations of Simmons et al. (2006) for improving miscarriage care.

5.7 Post-Miscarriage Care

Post-miscarriage care was found to be inadequate for many women, with limited access to mental health services and financial constraints further exacerbating the situation. The utilization of coping strategies varied, with some women finding solace in religious and cultural practices, while others struggled to find effective coping mechanisms. This finding aligns with the work of Evans (2012), who highlighted the diverse coping strategies employed by women after miscarriage.

5.8 Coping Mechanisms

The coping mechanisms employed by the women included seeking help and support from social networks, engaging in religious and cultural practices, and utilizing healthcare services. The effectiveness of these strategies varied, reflecting the findings of Geller et al. (2010), who emphasized the need for individualized coping strategies.

The findings of this study provide a comprehensive overview of the lived experiences of women who have experienced pregnancy loss in the Sagnerigu Municipality. The socio-demographic characteristics of the participants, coupled with the general problems encountered, highlight the complex and multifaceted nature of miscarriage. Emotional and psychological distress, social and cultural challenges, and healthcare-related issues were all significant factors in the women's experiences. The need for improved support systems and comprehensive post-miscarriage care is evident, with personalized and compassionate care being critical to the recovery process. The study's findings underscore the importance of addressing the emotional, social, and healthcare needs of women who have experienced pregnancy loss, ensuring that they receive the support and care necessary for their recovery.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

This study used primary data from participants to examine women's lived experiences with pregnancy loss among women chosen in the Sagnerigu Municipality of the Northern Region. The study sought to identify some risk factors that were connected to pregnancy loss among selected women, including alcohol use, smoking, and underlying conditions these women might have during such pregnancies. Again, to examine the household or social factors like income level, household setting, and so on that influenced pregnancy loss among women. Thematic analysis tends to explore the themes identified that contribute to or are part of the pregnancy loss experiences among women in the Sagnerigu Municipality and their background characteristics, which have been shown to influence pregnancy loss.

All women engaged in this research have at some point experienced levels of miscarriage; some first-timers and others had multiple experiences. Demographic and socio-economic characteristics were related to "pregnancy loss experience and maternal age, educational level of the women, type of place and region of residence all play several roles." Other pregnancy loss was influenced by their ethnicity, religion, maternal occupation, and household wealth.

Transcripts of the qualitative data analysis state that, older women are more likely to lose their pregnancy than younger women. Women with formal education typically have access to prenatal care and can develop an understanding of their pregnancy, whereas women without formal education are typically left to the mercy of any unqualified advice from the local community or family members. As a result, women with secondary and higher education are less likely to experience pregnancy loss than women with no formal education. This tentative statement needs further research into the effectiveness of the local system of caring for

pregnancy and the formal health care system as some indigenous ideas will differ on women with proper education having a lesser rate of miscarriage and acquired knowledge on pregnancy as compared to women with no formal education.

Another finding worth noting is the relationship between place of birth outcomes and residence. Rural areas account for a more significant share of miscarriages internationally, especially in Ghana. The Ghana Health Service database and literary sources, however, reveal that while "rural areas have a more significant absolute number of miscarriages (perhaps because of increased fertility), the proportion of all fetuses' that result in a miscarriage is higher in urban areas than rural areas. Prior research has revealed that women in urban areas are more likely to use hospitals and skilled medical personnel for childbirth and prenatal care.

This study demonstrates that many women who have experienced repeated miscarriages go through a period of great uncertainty and emotional suffering while they wait for a new pregnancy, and that during this time, they are likely to require emotional support. Repeated pregnancy losses can have severe psychological effects on a woman's mind and body, including grief, worry, and despair, which can affect every aspect of her life. Miscarriage that occurs frequently has long-lasting impacts and affects people in profoundly different ways. Supportive care should make up the majority of the treatment provided to women who deal with this upsetting and stressful illness.

For doctors and service providers, it will be challenging to design a program that satisfies these women's requirements given the challenging times the nation's health sector is experiencing. In order to find out what these women are thinking and feeling while they wait to become pregnant again, this study looked at their past experiences.

The thematic analysis of this study revealed four (4) primary themes that were leveraged; lived experiences of miscarriage, the uniqueness of pregnancy after loss, support systems and post-miscarriage care; we are aware that miscarriage is a tragic result of pregnancy that causes a mother a great deal of emotional and physical stress and occurs more frequently than many people realize. The study revealed moments these women started experiencing the miscarriage process and the sudden loss of control over their bodies.

The study also revealed that miscarriage anxiety could be especially prevalent for those who may have experienced a loss or have difficulty in conceiving with the constant fear of the unknown. The level of fear and uncertainty was captured and highlighted as a true reflection of the experiences of these women.

It is recognized that the subconscious mind always strives to find new evidence to verify their concerns and keep them alive, leading the survival instinct to kick in, regardless of whether they are founded on actual events or the product of an overactive imagination.

The study also demonstrated the positive support experiences they received from their partners and family at large; the support they considered as central support figures during their experience. The emotional and physical support offered in their traumatizing moments were primarily highlighted in work.

Characteristically, some women's experiences were nothing to write about when they visited the hospital with their case, while some got good services. Miscarriage is known to have a detrimental psychological impact on many people, with clinically significant symptoms of anxiety and despair occurring in 22 to 41% of women in the first week following the loss. Even when feelings of loss and depressed symptoms have subsided, such emotional experiences can continue.

6.2. Conclusion

This study identified and examined the pregnancy loss among women in the Sagnerigu Municipality of the Northern Region, which set out to explore women's lived experiences of miscarriage, taking into consideration diverse factors, their detailed experiences of the process of losing the fetus, level of healthcare received and coping strategies post-miscarriage. The description developed from the study depicted the adventures of fifteen (15) women in the Sagnerigu Municipal who had experienced different levels of miscarriage. Qualitative data were collected in structured and open communication interviews and then analyzed in a thematic way to understand the process of being pregnant and then losing it suddenly with no prior knowledge. The four main themes were used to establish sub-themes/patterns in the data gathered that has significance and influence these themes had to address in this research.

The challenges that women pass through as a result of the painful experiences of miscarriage are supported by this study. The loss of hope is at the heart of each woman's miscarriage experience, despite the fact that each woman's experience of pregnancy loss is unique. Additionally, all of the women in this study found that religious belief in “God gives and takes” was a major source of assistance in regaining emotional equilibrium.

The women described their varied emotions of astonishment, despair, discouragement, and self-guilt as their psychological and physical responses to responding to the loss of hope. Being a good mother, becoming more self-aware, letting go of painful experiences, and regaining emotional equilibrium are all necessary. Intervention is required throughout the grieving process to assist the women in overcoming their loss of hope and regaining emotional equilibrium.

Finally, this study unequivocally demonstrates that, women have varied experiences (both positive and negative) with the care they got. As a result, it is crucial to improve social support for these women by increasing community understanding of the occurrence and effects of miscarriage.

6.3. Recommendations

Based on the research findings, the researcher wishes to make the following recommendations;

1. The Ministry of Health should increase public education on safe pregnancy practices, especially for young women who are approaching reproductive years. This is crucial because the findings indicate that older women who have reached reproductive age have lost more pregnancies than younger women. This calls for increased focus to be placed on encouraging younger women to adopt healthy habits and refrain from harmful behavior in order to reduce the chance of pregnancy loss due to miscarriages, stillbirths, and (spontaneous or induced) abortion.

2. The Ghana Health Service should take the initiative to train and equip midwives and nurses with more skills on how to care for women who endure miscarriages. This can be done with the help of some Non-Governmental Organizations (UNICEF etc.). Nurses and midwives, who play a critical role in improving the quality of care for women who experience a miscarriage, must get training in communication skills and techniques to handle such occasions in order to boost women's satisfaction and the comfort of healthcare professionals.

3. In order to raise awareness about the causes of miscarriages and their effects on mothers and their families as a whole, the Ghana Health Service should equip and train public health midwives and nurses. This can be done by providing women with informational flyers and helplines for support groups.

4. The Ministry of Health should establish counseling facilities in hospitals where women who have miscarried can be referred for psychological evaluations and counseling because some of the women have admitted that, they were unable to accept the situation and that it was challenging to recover from their ordeals. This can be accomplished by establishing bereavement support groups and facilitating their communication.

5. For women to receive the necessary care and support, the Ghana Health Service should equip nurses and midwives with skills to help educate families and spouses especially, on ways to care for and support women who miscarry.

6.4 Recommendations for future research

Findings from this study suggested that, the matters of miscarriage affected the women and their families more than imagined, therefore, further studies are therefore required to appreciate the phenomena fully.

1. The majority of participants in this study were Dagombas and people from other regions in the Northern belt. Women from southern ethnic groups or key areas cannot benefit from the understanding offered based on their racial backgrounds or geographic places. It is necessary to research other cultures and key areas more thoroughly.

2. The results may reveal the women's experiences at that time because the data collection took place at a certain time period. They are unable to explain their lengthy experiences. Therefore, a long-term study is necessary to fully comprehend the psychological responses of women who have lost children through miscarriage.

3. Even though the results provided a greater understanding of the women's miscarriage experiences, this study was limited to one particular Northern jurisdiction. Therefore, additional study in other regions of the region is required to broaden the existing findings and paint a complete picture of women's miscarriage experiences in Ghana. Building a grief tool

that considers cultural and socioeconomic issues is also crucial to meet the needs of women after miscarriages, as varying socio-cultural circumstances may influence varying points of view.

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APPENDICES

Appendix I: Interview Guide

Introduction

This project is being conducted as an academic study by a student in the Department of Social and Behavioral Change in the School Public Health, to **EXPLORE THE LIVED EXPERIENCES OF WOMEN WHO HAVE LOST THEIR BABIES THROUGH MISCARRIAGE.AN EXPLORATORY STUDY IN THE SAGNERIGU MUNICIPAL.** The information that you provide will contribute to our knowledge on the subject area and will be treated with high confidentiality.

SECTION A: SOCIO- DEMOGRAPHIC DATA

1. Age (years):

A). 15-24 [ ] B). 25 -34 [ ] C). 35-44 [ ] D) 45-49 [ ]

2. Religion

A. Islam [ ] B. Christianity [ ] C. Traditional [ ] D. Other (specify)……..

3. Marital status

A. Married [ ] B. Single [ ] C. Divorced [ ] D. Married but separated [ ]

E. Cohabitating [ ].

4. Educational level

A. Tertiary [ ] B. Secondary [ ] C. No Formal Education [ ]

5. Place of residence: A). Rural [ ] B). Urban [ ]

6. Employment Status:

A). Unemployed [ ] B). Self Employed [ ] C). Employed [ ]

7. Income:

A). Ghc100- Ghc500 [ ] B). Ghc500 -Ghc1000 [ ] C). Ghc1000 – Ghc1500 [ ]

D). Ghc1500-Ghc2000 [ ] E). >Ghc2000 [ ]

8. Ethnicity: _____

9. How many children do you have?

A. 0 [ ] B. 1 [ ] C. 2 [ ] D. 3 [ ] E. 4 [ ] F. 5 [ ]

G. Other (Specify) ……..

10. Pregnancy status.

A. Yes [ ] B. No [ ] C. Don't Know [ ].

11. Length of time in the relationship?

A. Less than 5 years [ ] B. 5−10 years [ ] C. More than 10 years [ ]

12. Do you smoke cigarette? Yes [ ] No [ ] If **Yes**, how many sticks per day? _____

13. Do you take alcohol? Yes [ ] No. [ ] . If **yes**, specify which type of alcohol_____

14. Do you have any of these conditions: Diabetes or Hypertension?

SECTION B. EXPERIENCE OF MISCARRIAGE

1. How many miscarriages have you experienced?

A). Once [ ] B). Twice [ ] C). Thrice [ ] D). More than 3 [ ]

2. At what gestational age did you miscarry?

A). less than 7 weeks [ ] B). 7 – 16 weeks [ ] C). 17 – 26 weeks [ ]

D). Above 26 weeks [ ].

3. At what age did you miscarry/ how old were you? ----------

4. What was your parity before your first miscarriage?

A). Nulliparous / that was my first pregnancy

B) I had already given birth to 1 child

C). I had already given birth to 2 children

D). I had already given birth to 2 children

5. What was miscarrying like for you?

……

6. Lived experiences after pregnancy termination/ Miscarriage?

	YES	**NO**
A. Loneliness	[ ]	[ ]
B. Disappointment	[ ]	[ ]
C. Blame	[ ]	[ ]
D. Avoidance	[ ]	[ ]
E. Guilt	[ ]	[ ]

7. What were your experiences in the weeks that followed?

A). I forgot about it within few weeks

B). I experienced mood or anxiety disorder for months.

C). I had mood or anxiety disorders for years after the loss.

D). Other ……

8. Did you have any underlying condition diagnosed that might cause the miscarriage?

A). Yes [ ] B). No [ ]

9. How did you feel after you had a miscarriage? Will you share your feelings with me?

……

10. What do you think was the cause of your miscarriage? Would you share this with me?

……

11. Did you want to see your baby after the miscarriage? What did you feel when you saw him or her?

……

12. Where did you experience the miscarriage?

A). Home [ ] B At the workplace [ ] C). Hospital [ ] If hospital, when were you discharged? …….

If the miscarriage happened at the hospital, please answer question 13 to 15

13. How do you feel about the nursing care that you received through your miscarriage?

……

14. What was your expectation of the health staff?

……

15. Did you feel comfortable in the room where you had a miscarriage? What kind of room would be best for you while having a miscarriage?

……

16. How would you describe the process of losing your baby?

…….

17. Did you get any support either from your partner or family or any social support system? Can you describe your experience of support during this difficult time?

……

18. Can you share with me your religious belief regarding miscarriage?

…….

19. Did the miscarriage have an effect on your mental health? Can you share with me some of these effects and how you overcame them?

……

…….

20. How do you see yourself now?

Thank you for your response.…

Appendix II: Adult Consent Form

INSTITUTIONAL REVIEW BOARD, UNIVERSITY FOR DEVELOPMENT STUDIES

ADULT CONSENT FORM

TITLE OF RESEARCH: Lived Experiences of Women who have lost their Children through Miscarriage; An Exploratory Study in the Sagnarigu Municipality

PRINCIPAL INVESTIGATOR: Abukari Linah

PRINCIPAL INVESTIGATOR'S DEPARTMENT: Social and Behavioral Change

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

Purpose of the research:

This Research Is Intended to Find Out What Women Go Through During and After a Miscarriage

Study Procedures:

The study is going to be a qualitative study where the study subjects will be purposively sampled and data collected using an interview guide. The data will therefore be thematically analyzed.

Your total expected time commitment for this study is: One Year

Benefits:

This study will help participants have the opportunity to share their experiences and release the burden they had during their miscarriages and help us find solutions to minimize miscarriages

Risks:

Since this is a very sensitive issue, participants may feel uncomfortable to share their experience and might not give the right responses.

Confidentiality:

All records from this study will be kept confidential. Your responses will be kept private, and we will not include any information that will make it possible to identify you in any report we might publish. Research records will be stored securely in a locked cabinet and/or on password-protected computers. The research team will be the only party that will have access to your data.

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3. I understand the information that was presented and that:

   A. My participation is voluntary, and I may withdraw my consent and discontinue participation in the project at any time. My refusal to participate will not result in any penalty.

   B. I do not waive any legal rights or release UDS or its agents, or you from liability for negligence.

4. I hereby give my consent to be the subject of your research.

Participant's Signature…….. Date ……