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Support Systems and Coping Mechanisms among Mothers After Perinatal Loss in Kitwe District, Zambia

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ABSTRACT

Background: *Perinatal loss is a significant public health concern. It disrupts the maternal roles and expectations. Parents who have suffered a perinatal loss have reported intense sadness, anxiety, guilt, anger, and experiences of stigma, shame, and marginalisation of their grief. This study aimed to examine the support systems and coping strategies among mothers following perinatal loss in Kitwe District, Zambia.*

Methods: *An interpretive phenomenological design was used. In-depth interviews using a semi structured guide were conducted between January and June 2025 with twelve mothers. Participants were recruited through Kitwe Teaching Hospital and Buchi Clinic. Data were analysed using reflexive thematic analysis and a deductive approach.*

Results: *The study showed that there was stigma and lack of counselling within the healthcare settings. Community norms often discouraged mourning while religious and peer support played a significant role in coping with the loss. Professional help, faith, and self-care were some of the coping mechanisms employed. The spouse emotional disconnection, in-law conflict, and maternal support influenced coping among mothers. Spiritual beliefs and concerns about future fertility shaped acceptance of the loss and recovery experiences.*

Conclusions: *This study highlights the complex relationship of emotional distress, sociocultural barriers, and available support systems in perinatal loss recovery. While religious and peer support were crucial coping resources, the presence of stigma, lack of professional counselling and certain family factors negatively impacted coping. There is need for multi-level interventions and the integration of culturally sensitive professional supportive care into healthcare services and community structures to comprehensively address the needs of bereaved mothers in Zambia.*

Keywords

Support systems; Coping mechanisms; Perinatal loss.

Background

Perinatal loss, encompassing stillbirth and neonatal death, is a psychologically distressing experience that disrupts maternal

roles and expectations, with significant consequences for physical and mental health [1-3]. Mothers who experience such loss often report sadness, anxiety, guilt, anger, and feelings of stigma and marginalisation [4,5]. These emotional responses frequently lead to social withdrawal, strained relationships, and prolonged or complicated grief [6].

The World Health Organization (WHO) defines perinatal loss as the death of a foetus after 28 weeks of gestation or the death of a newborn within the first seven days of life [7]. Globally, one in ten women will experience foetal loss in their lifetime, making it a significant public health issue [8]. In Zambia, perinatal mortality remains a major concern despite ongoing efforts to improve maternal and newborn care [9]. The country's stillbirth rate was 14.8 per 1,000 total births in 2019 and neonatal mortality was reported at 17/1000 live births in 2024 [8,10,11].

Social support is a critical factor in maternal adjustment following perinatal loss. Families require structured support systems to buffer against adverse emotional outcomes [12]. Studies show that individuals with prior experience of perinatal loss are better equipped to provide meaningful support [13]. However, healthcare professionals often fail to meet emotional needs, particularly in cases where no living baby is present, leading many mothers to feel unsupported [14]. The quality of spousal relationships and attachment also influences the duration and intensity of grief [15]. Coping strategies vary and are shaped by personal, cultural, and societal factors. Mothers may adopt endurance, avoidance, or spiritual acceptance as mechanisms to navigate grief [16,17]. Cultural beliefs in some communities discourage open mourning, which may suppress emotional expression and contribute to long-term psychological distress [14]. Although most women adjust within six months, 15–25% experience chronic complicated grief, highlighting the need for comprehensive bereavement care [9]. This study aimed to qualitatively explore, the support systems available to mothers following perinatal loss, and the coping mechanisms employed in response to their experiences.

Materials and Methods

This study employed an interpretive phenomenological qualitative study design. The study was conducted in Kitwe District, Zambia, at Kitwe Teaching Hospital and Buchi Clinic. Kitwe Teaching Hospital is a tertiary referral facility offering specialised maternal and neonatal services, while Buchi Clinic provides primary healthcare services to the surrounding community. These sites were selected for their accessibility and relevance to maternal health care as the sites record incidences of perinatal mortalities. Participants were selected using purposive sampling based on their experience of perinatal loss and their willingness to share their experiences. The study population comprised mothers aged 18 years and above who had experienced a stillbirth or early neonatal death within the previous six months and had received care at Kitwe Teaching Hospital or Buchi Clinic in Kitwe District. Recruitment was facilitated in collaboration with healthcare personnel at the maternity departments of both facilities, who assisted in identifying eligible participants through records. Potential participants were approached either during their hospital stay or contacted by phone after discharge. Those who met the inclusion criteria and expressed interest were provided with detailed study information and invited to participate in an in-depth interview. Mothers were excluded if they were unavailable during the data collection period, declined participation, or were assessed to be in poor mental health. A total

Table 1: Sociodemographic characteristics of mothers who had perinatal loss (n=12).

	Variable	Indicators	Frequency(n)	Percentage (%)
1	Health Facility	Kitwe Teaching Hospital	11	91.7
		Buchi clinic	1	8.3
2	Marital Status	Married	8	66.7
		Not Married	4	33.3
3	Highest Educational Level	Primary	1	8.3
		Secondary	7	58.3
		Tertiary	4	33.3
4	Employment status	Unemployed	11	91.7
		Employed	1	8.3
5	Gravidity	Primigravida	4	33.3
		Multigravida	8	66.7
6	Parity	Primipara	4	33.3
		Multipara	6	50.0
		Nullipara	2	16.7
7	Mode of Delivery	Spontaneous Vaginal Delivery	8	66.7
		Caesarean Section	4	33.3
8	Gestation age	Term (≥37 weeks)	2	16.7
		Preterm (<37 weeks)	10	83.3
9	Birth Condition	Live birth	9	75.0
		Still Birth	3	25.0
10	Number of Perinatal Deaths	1death	11	91.7
		>1death	1	8.3

of 12 participants were interviewed, with data saturation reached by the tenth interview.

Individual, semi-structured in-depth interviews using a semi-structured interview guide were conducted between January and June 2025. Interviews were held in private spaces within the mother's home to ensure confidentiality and comfort. Interviews were conducted in English or local language, depending on participant's preference, and lasted between 30 and 45 minutes. All interviews were audio-recorded with the mother's consent. Translations were performed by bilingual research assistants and verified for accuracy.

A reflexive thematic analysis approach was used to analyse the data, recognising the subjectivity of the research team in interpreting participants' experiences. Starting from a deductive approach, the socio-ecological model served as a guiding framework through which the analysis was conducted, with each level of the model (individual, interpersonal, community, institutional, and policy) considered an a priori domain under which findings were organised. However, the development of themes within these broad domains employed a combined deductive and inductive approach, allowing responsiveness to the data and flexibility in identifying and interpreting participants' coping strategies and support systems following perinatal loss.

This approach enabled the study team to explore how mothers navigated grief and accessed support across multiple layers of influence, while allowing emergent patterns to shape the thematic structure. Coding was conducted manually and refined through iterative discussion among the research team. Themes were developed to reflect both direct coping mechanisms and broader contextual factors influencing maternal adjustment after perinatal loss.

Results

Twelve mothers who had experienced perinatal loss within the past six months of the study were interviewed. Participants were aged between 20 and 42 years, and 11 were recruited through Kitwe Teaching Hospital and one through Buchi Clinic. Most (75%) of the mortalities were early neonatal deaths (Table 1).

Support systems and coping strategies following perinatal loss

The results have been presented according to major and subthemes

Table 2: Thematic analysis based on the social ecological model focusing on mothers' support systems and coping strategies following perinatal loss.

Socioecological Model Level	Common Theme(s)	Sub themes/ Codes	Representative Quotes
Individual Level (Microsystem)	Grief and Emotional Pain	Acute Emotional Pain/Heartache, Depressive Episode/Emotional Hiding, Intense Bonding Trauma, Constant Visual Trigger (e.g., job)	*"I feel powerless and really wish someone can take away this pain, I couldn't save my own baby and now it feels like I can't save myself too" (P3)*
	Coping and Recovery	Coping through Professional/ Peer Seeking, Faith as Coping Mechanism, Self-Care/Time Off (Grief Validation)	*"I've reached out to my friend who's a guidance counsellor and the therapist." (P12) "It's okay not to be not okay, and if you need time off... it's good." (P12) / "I'm trying to engage myself mostly in my studies... to keep me distracted." (P10)*
Relationship Level (Microsystem)	The Nature of Support Systems	Spousal/Partner emotional disconnection, In-Law-Induced Marital Strain, Mother's Side Validation (Shared Experience), Shared Grief	*"My mother-in-law was very, very bitter... She's feeding him a narrative of I've killed our child." (P12) / "He's been a bit distant." (P12) / "My mother was very supportive because she told me she's faced similar situations." (P12) / "My husband was hurt so much... he cried a lot." (P12)*
Community Level (Mesosystem)	Normalization and Minimization of Loss	Discouragement/Prohibition of Crying, Comparative Loss/Survival	*"don't even cry" (P4) / "You don't mourn twins, our culture doesn't allow it." (P4)* *"someone who hasn't experienced... is* going to feel like they are just *poking in your wound." (P10) / "My friends have been, even the fellow teachers I work with." (P12)*
	The Nature of Support Systems	Community/Religious Outreach, Advocacy for Therapy/Support Groups	*"most of all, therapy... We also need uhh support groups for women." (P11) "A lot of people have come through... From church." (P2) / "Student Nurse Compassion" (P6)*
Societal/Policy Level (Macrosystem & Exosystem)	Experience with Healthcare System	Blaming/Uncaring Staff Attitude (Stigma), Medical Negligence/ Delay, Absence of Counselling, Call for Staff Empathy/Training	*"They said you waited too long and you didn't push hard enough." (P12) / "The doctor sent us back... I guess they just didn't care." (P11) "The health workers were very mean... a young person is having a child." (P10) "nurses should also be taught how to handle people who've lost children." (P10)*
	Spiritual Acceptance and Fatalism	God's Will/Sovereignty, Divine Giver and Taker	*"leave everything to God because death is written… life is not ours, it's God." (P2) / "God himself gives and again he takes away." (P5)* *"Don't get any injection until you get pregnant again." (P1) / "I didn't know the big problem that caused them to take the baby out." (P8)*
	Post-Loss Advice and Concerns	Focus on Future Conception, Unanswered Health Questions (Diagnosis/Future Fertility)	

that emerged from the transcribed data using the Socioecological model levels. Relevant quotes have also been presented to support the themes (Table 2).

Individual-level themes

Grief and emotional pain

The theme "Grief and emotional pain" elucidated the mother's acute emotional distress following perianal loss and what often intensified the emotions. Most participants stated that emotional distress experienced was mainly due to heartache, depressive episodes and feelings of helplessness. Mothers experienced overwhelming grief and often felt like they were failures, which led to them having shattered expectations and a loss of motivation to engage normally in daily activities. In addition, they stated that they felt trapped in their emotions, unable to find meaning and unable to change their circumstances. This is how some of them expressed herself;

"I feel powerless and really wish someone can take away this pain, I couldn't save my own baby and now it feels like I can't save myself too" (P3).

Further they also reported that these emotions were often intensified by visual reminders, such as returning to work in a child centred environment, internalised guilt of not being able to give birth to a live baby and the confusion that follows after the loss.

"I had to take some time off from work because I couldn't bear seeing other children in my class." (P12) "I try to hide that I'm depressed from my kids." (P12) "The fact that I bonded with my child has been very difficult." (P11).

Coping and recovery

The theme "Coping and Recovery" illuminated the adaptive mechanisms that mothers employed to reconstruct meaning of life following perinatal loss. It also reflected a gradual shift from experiencing overwhelming emotional pain towards regaining balance and psychological stability. Most participants reported that some coping mechanism that they saw helpful included seeking support from professionals and peers, relying on faith, and engaging in distraction through studies or routine activities. They also stated that these activities often helped them to manage distress and restore a sense of normalcy. For some mothers, time off from work was also used as a form of self-care and grief validation. This is how some participants expressed themselves.

"I've reached out to my friend who's a guidance counsellor and the therapist." (P12) "It's okay not to be not okay, and if you need time off... it's good." (P12) "I'm trying to engage myself mostly in my studies... to keep me distracted." (P10)

Interpersonal-level themes

Nature of support systems

The theme "Nature of support system" explicated how healing following perinatal loss is a social process depending on empathy, understanding and relational support. In addition, it also reflects the complex interpersonal relationships for mothers following perinatal loss and explains how the responses significantly influence the grieving and recovery support. Participants reported that support varied from some experiencing mutual grieving where partners were very concerned about the mother's experience and grieved with them empathetically to others witnessing emotional disconnection and withdrawal from their partners. This reflection showed that mother's interpersonal relations can either help them recover or worsen their situation.

Further, some mothers expressed feelings of comfort and empathy, while others experienced blame particularly from in-laws who felt mothers were being lazy to push or did not do much to protect the babies. Maternal figures often provided validation through shared experiences. This is how one expressed herself;

"My mother-in-law was very, very bitter... She's feeding him [my husband] a narrative of I have killed our child." (P12) "He's been a bit distant." (P12) "My mother was very supportive because she told me she's faced similar situations." (P12) "My husband was hurt so much... he cried a lot." (P12)

Community-level themes

Normalization and minimization of loss

The theme "Normalization and Minimization of loss" reflected how cultural beliefs and societal expectations shaped emotional expression and grief behaviour following perinatal loss. Most participants reported that in the communities where they came from, people thought and regarded perinatal loss as a normal or inevitable event rather than a profound tragedy. They also showed no much remorse or seriousness to the loss of a baby in this manner as it was regarded a taboo. In addition, mothers were not allowed to cry or speak about the loss or know where the baby had been buried as it was regarded as way of bringing bad luck to herself and lowering the chances of getting pregnant in the future. This shows that most of the mothers are coming from environments were emotional restraint is valued over healing expression. This is how they expressed themselves;

"Don't even cry." (P4) "You don't mourn twins; our culture doesn't allow it." (P4) "Someone who hasn't experienced... is going to feel like they are just poking in your wound." (P10)

In addition, despite restrictive cultural constraints, some mothers received support through religious outreach, peer networks, and compassionate individuals such as student nurses which serve as critical bridges to emotional healing and social validation in the context were mourning is normally not encouraged. A number of mothers expressed concerns on the need to have therapy services where they can easily share their experiences and get help. The participants' desire for mental health interventions signify a growing awareness and acceptance of services which helps to shift from silence to help seeking behaviour consequently fostering recovery and emotional restoration. This is how one expressed themselves.

"Most of all, therapy... We also need support groups for women." (P11) "A lot of people have come through... From church." (P2) "Student Nurse Compassion." (P6)

Institutional-level themes

Societal and policy-level themes

The theme "Societal and policy level" expounded barriers that shape individuals' experiences following perinatal loss. It shows how gaps within health care system such as uncaring attitudes from healthcare staff, medical delays, and absence of routine counselling services and care from the hospitals and clinics contribute to hindering recovery. It is a sign that institutions do not recognise perinatal loss as a sensitive health issue. In addition, most mothers' experiences concern on experiencing stigma especially for the young mothers. This is what some participants said.

"They said you waited too long and you didn't push hard enough." (P12) "The doctor sent us back... I guess they just didn't care." (P11) "The health workers were very mean... a young person is having a child." (P10) "Nurses should also be taught how to handle people who've lost children." (P10).

Spiritual acceptance and fatalism

The theme "spiritual acceptance and fatalism" reflected how the spiritual belief systems provide a framework for understanding and managing perinatal loss. Most participants reported that they interpreted their perinatal loss as part of God's divine will and find comfort in the belief that life and death are according to God's plan. The spiritual meaning attached to perinatal loss acts as a protective coping mechanism which also offers emotional containment in grief and a source of resilience and meaning making. This is what some participants said.

"Leave everything to God because death is written… life is not ours, it's God." (P2) "God himself gives and again he takes away." (P5)

Post loss advice and concerns

The theme "Post- Loss advice and concerns" elucidates the medical information and communication gaps that mothers experience following perinatal loss. Most participants reported that they experienced confusions about medical explanations regarding their fertility as most were not clear, inconsistent, and lacking empathetic communication from healthcare providers which contributes to uncertainty and mistrust leaving mothers unsupported in the hectic and traumatic journey.

In addition, mothers also reported the influence of informal advice received from the communities they came from which was often rooted in cultural beliefs or misinformation and sometimes in conflict with the medical guidance which further complicated the mother's ability to make decisions. This is what some participants said.

"Don't get any injection until you get pregnant again." (P1) "I didn't know the big problem that caused them to take the baby out." (P8).

Discussion

This study explored the support systems available to mothers and the coping mechanisms they employed following perinatal loss in Kitwe District, Zambia, using the socio-ecological framework. At the individual level, mothers described profound emotional pain, including heartache, guilt, and depressive symptoms. Coping strategies included seeking help from professionals and peers, relying on faith, and taking time off work to manage their grief. Similar emotional responses and coping strategies were reported in Iran and Spain, where spiritual framing and self-care were common [1,18]. These findings highlight that while emotional distress is universal, coping is shaped by cultural and religious contexts that provide emotional scaffolding in the absence of formal mental health support.

At the interpersonal level, support systems were shaped by complex family dynamics. While some mothers received empathy and shared grief from their own mothers, others experienced spouse emotional disconnection, and conflict with in-laws. Similar findings were reported in Malaysia and Germany, where peer support and attachment quality influenced bereavement outcomes [13,15]. This reflects how emotional safety, rather than familial proximity, determines the quality of support, especially in cultures where grief is minimized within family structures.

Additionally, we identified factors across all domains of the framework that shaped how mothers experienced grief and recovery. At the community level, cultural norms discouraged open mourning and often minimized the significance of perinatal loss. However, religious outreach and peer support emerged as informal but meaningful avenues of care. Echoing findings from Uganda, Kenya, and Ghana, cultural silence and stigma were prevalent [10,19,20]. These patterns imply that community norms can both hinder and facilitate healing, depending on the presence of empathetic subgroups and evolving generational attitudes.

At the institutional level, participants reported uncaring attitudes from healthcare staff, medical negligence, and a lack of counselling services. Spiritual beliefs and unresolved medical concerns further shaped post-loss decisions and emotional adjustment. Similar experiences were documented in Australia and high-burden countries, where bereaved mothers felt unsupported by healthcare professionals [14,21]. These findings underscore institutional neglect as a barrier to recovery, likely stemming from limited training in grief counselling and systemic underinvestment in maternal mental health.

Our findings revealed a nuanced interplay between emotional responses and the support systems that shaped how mothers coped with perinatal loss. Rather than relying on a single coping strategy or support source, mothers navigated a multifaceted experience influenced by personal grief, relational dynamics,

community expectations, institutional responsiveness, and broader policy silence. Similar complexity was reported in Spain and South Africa, where coping strategies were layered and shaped by both internal resilience and external influences [4,16]. This demonstrates that coping is not linear but adaptive, reflecting the absence of structured grief pathways.

At the individual level, mothers described acute emotional pain, including sadness, guilt, and depressive symptoms. These experiences were compounded by constant reminders of the loss, such as returning to work environments involving children. Coping strategies varied, with some mothers seeking professional or peer support, others relying on faith, and a few engaging in distraction through routine activities. Spiritual acceptance was common, though not always sufficient to alleviate emotional distress, echoing findings from Spain [1]. This indicates that spirituality offers comfort but may not fully address the psychological complexity of grief.

Interpersonal relationships played a central role in shaping maternal adjustment. While some mothers received empathy and shared grief from their own mothers, others experienced emotional neglect, spouse emotional disconnection, or conflict with in-laws. These dynamics often intensified feelings of isolation and self-blame. Notably, support from trusted confidants such as friends or neighbours was often more emotionally impactful than that from immediate family, reinforcing the value of peer-based support in bereavement care [12]. These insights reveal that emotional validation from peers may be more effective than obligatory family support in contexts where grief is stigmatised.

Community-level influences were shaped by cultural norms that discouraged open mourning and framed perinatal loss as taboo. Participants described stigma, silence, and judgment, particularly among young or unmarried mothers. These findings align with research from Uganda and Kenya, where cultural beliefs often suppressed emotional expression and contributed to long-term psychological distress [19]. However, some participants noted that community attitudes may be slowly evolving, with increased empathy and openness emerging in certain circles, similar to observations in South Africa [4]. This points to the possibility that stigma is not static and may be shifting due to increased awareness and dialogue.

Institutional-level findings revealed significant gaps in healthcare responsiveness. Most participants felt that providers failed to offer emotional support, and bereavement care was rarely integrated into routine maternal services. These experiences mirror those reported in other low-resource settings, such as Uganda and Zambia, where healthcare workers often lack training in grief support and may unintentionally dismiss maternal suffering [1,9]. Access to mental health services was also limited, with barriers including cost, distance, and lack of awareness. These findings emphasise that institutional neglect reinforces emotional isolation and delays recovery.

At the policy level, participants described systemic gaps in post-loss care and communication. Many mothers received inconsistent or unclear advice regarding future conception and medical follow-up, which contributed to confusion and anxiety. For instance, some were told to avoid medical interventions until conceiving again, while others expressed frustration over not understanding the cause of their loss. These findings reflect broader gaps in reproductive health literacy and the absence of standardised post-loss protocols, similar to findings in Ethiopia [22]. Spiritual beliefs also shaped emotional adjustment, with many mothers framing their loss within religious narratives of divine will. While this offered comfort to some, it also reinforced fatalistic attitudes that may discourage help-seeking or emotional expression. These insights call for attention to the need for clearer post-loss counselling and culturally sensitive communication.

Conclusion

This study highlights the complex relationship of emotional distress, sociocultural barriers (stigma and restricted mourning), and available support systems in the recovery of mothers experiencing perinatal loss in Kitwe District. While religious and peer support were crucial coping resources, the presence of stigma, lack of professional counselling in healthcare settings, and certain family factors (spouse emotional disconnection, in-law conflict) negatively impacted coping.

These findings highlight the need for multi-level interventions and the integration of culturally sensitive professional counselling and supportive care into healthcare services and community structures to comprehensively address the needs of bereaved mothers in Zambia.

Strengths

This study utilised the socio-ecological framework to explore support systems and coping mechanisms, allowing for a more in-depth understanding of the context in which maternal grief unfolds.

Limitations

The sensitive and emotional nature of the topic may have prevented some participants from sharing their full experiences. However, interviews were conducted in the mothers' home environment. Privacy was ensured and the participants were assured of confidentiality and emotional support should they feel like breaking down.

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