Psychosocial Burden and Quality of Life Among Women Experiencing Neonatal Loss Post-Cesarean Section in Gboko, Nigeria

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ABSTRACT

Introduction: Giving birth is an empowering experience for women and their partners when they have the opportunity to make choices that influence the outcome of this significant life event. Despite efforts made by Nigeria to improve antenatal and postnatal care provision, the perinatal death rate remains high. Consequently, many women continue to experience intense, long-lasting grief, and poorer physical and mental health outcomes due to the loss of a baby after birth. This study assess the psychological and social burdens experienced by women who delivered through Caesarean Section (CS) and lost their infants, while also assessing their Health-Related Quality of Life (HrQoL).

Methodology: A mixed-method research design was adopted. A purposive sampling technique was used to recruit 31 women in Gboko who lost their babies after a CS within six (6) weeks post-partum. Data were collected using semi-structured interviews and structured questionnaires. Qualitative data were analyzed thematically, while quantitative data were analyzed descriptively using frequencies, percentages, mean, and standard deviation.

Results: The findings revealed high levels of psychological distress, significant social challenges, and poor HrQoL among the participants. Thematic analysis identified core themes of emotional pain, trauma, abandonment, hopelessness, and self-harm. Social burdens included isolation, relationship strain, and emotional distress. Physical domains such as mobility, self-care, and pain/discomfort were also negatively affected. Furthermore, moderate to severe depression and anxiety were reported by the majority of respondents. While support from spouses, families, peers, and healthcare providers was acknowledged, significant gaps in care remain.

Conclusion: Recovery for these women requires educational interventions combined with a holistic supportive approach. It is insufficient to heal the surgical incision alone; healthcare systems must provide active lactation suppression support, grief counseling, and family therapy to address the strain on marital relationships and the fear of future pregnancies.

Keywords: Caesarean Section, Health-Related Quality of Life (HrQoL), Social Support, Perinatal Death, Psychosocial Burden.

INTRODUCTION

Giving birth is generally regarded as a positive and empowering experience; however, adverse outcomes such as neonatal loss can result in profound psychological distress and long-term mental health consequences (Sun et al., 2023). Evidence suggests that childbirth experiences significantly influence psychosocial outcomes and health-related quality of life among women (Zhang et al., 2023).

Perinatal loss, particularly following Caesarean section (CS), is associated with severe emotional trauma, including depression, anxiety, and post-traumatic stress disorder (PTSD) (Berry, 2022; Flach et al., 2023). Recent population-based studies indicate that women who experience stillbirth or neonatal death have

significantly higher risks of long-term psychological morbidity compared to those with live births (Flach et al., 2023).

Globally, Caesarean section rates continue to rise, particularly in low- and middleincome countries, where the risk of adverse maternal and neonatal outcomes remains high (World Health Organization [WHO], 2023). In such settings, inadequate healthcare systems and sociocultural stigma further exacerbate the psychological burden experienced by bereaved mothers (Kuforiji et al., 2023; Zhang et al., 2023).

The loss of a child during the early postpartum period disrupts maternal bonding and may lead to complicated grief reactions, characterized by persistent emotional distress and functional impairment (Alvarez-Calle & Chaves, 2023). Studies also show that lack of social support significantly worsens psychological outcomes, while strong support systems improve coping and recovery (Chen et al., 2024; Thomson et al., 2024).

Social support plays a critical role in mitigating the adverse psychological effects of perinatal loss. Women who receive adequate emotional, familial, and professional support demonstrate lower levels of depression, anxiety, and PTSD symptoms (Chen et al., 2024).

However, evidence from low-resource settings indicates that many women experience inadequate support, social isolation, and stigmatization following infant loss (Zhang et al., 2023; Kuforiji et al., 2023). Cultural beliefs and societal expectations may further intensify feelings of guilt, shame, and self-blame among affected women.

Additionally, relationship strain and reduced social functioning are commonly reported outcomes. Studies show that bereaved mothers often withdraw from social interactions and experience difficulties in marital relationships following perinatal loss (Thomson et al., 2024).

Women who experience infant loss often report intrusive thoughts, emotional numbness, sleep disturbances, and persistent grief reactions (Flach et al., 2023). These psychological responses are further compounded by physical recovery from Caesarean section, which may increase vulnerability to postpartum depression (Mo et al., 2022).

Emerging evidence also highlights the risk of complicated grief, which may persist for extended periods without appropriate intervention (Alvarez-Calle & Chaves, 2023).

Perinatal loss significantly affects multiple domains of health-related quality of life, including physical functioning, emotional well-being, and social relationships (Gopichandran et al., 2021; Kuforiji et al., 2023).

Women frequently report difficulties in performing daily activities, reduced energy levels, and impaired emotional functioning following infant loss (Popoola et al., 2022). These outcomes underscore the need for comprehensive postnatal care that addresses both physical and psychological recovery.

The aim of the study is to assess the psychosocial burden, perceived quality of social support, and HrQoL of women who lost their babies after a Cesarean section in selected hospitals in Gboko, Benue State

METHODOLOGY

The design adopted a mixed method using purpose sampling technique, data gathered from multiple statistical techniques were then applied to identify the nature of relationship that exists between two or more variables

The study was carried out in Gboko, Benue State. Gboko is a Local Government Area in Benue state, North-central Nigeria. It was created on the 11th of May, 1970 with a landmass of 2,264 square kilometers. Wielding a population of 358,936 according to 2006 census, it is the largest of the twenty-three local government areas by population in Benue State (Iorkua et al., 2019). Gboko is bordered by Tarka LGA to the North, Ushongo LGA to the South, Buruku LGA to the West and Konshisha LGA to the East with a total area of 1,835km^2 and density of 257.49km^2 and an estimated population of 460 thousand inhabitants. The study area has coordinates 7°35' 0" North, 9°03' 0" East and is characterized by a tropical climate with very thick forests

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The population of study includes women in Gboko, Benue State who had delivered babies through CS and eventually lost the baby within 6 weeks post-partum. There is no record of the statistics of women within this category, thus the population is infinite.

Owing to the uncertainty of the number of women in this category, the sample size used for the study was 31, and 7 participants were interviewed. The researcher filtered through 6 selected hospitals (General Hospital, Myom Hospital, Baki Hospital, TBT Hospital, Bethany Medical Center, and NKST Hospital, Mkar) in Gboko, Benue State, to recruit women who met the criteria for the study and were willing to participate.

Sampling Procedure

Purposive sampling was used for both qualitative and quantitative data, as all women found who met the criteria of study were included in the study. In order to recruit respondents, the data manager at the selected hospitals (General Hospital, Myom Hospital, Baki Hospital, TBT Hospital, Bethany Medical Center, and NKST Hospital, Mkar) provided the researcher with the contact information of all the mothers who had suffered a perinatal death in the last 5 years (n = 53). Once the researcher checked that the potential participants met the inclusion criteria, she telephoned them to explain the study's aim and to invite them into participate. When the potential participants asked for some time to think about the invitation, they were contacted again within the next two days. The researcher made an appointment with those who accepted participation. The inclusion criteria were as follows:

- Having Suffered a Baby Loss Within Six (6) Weeks After the Birth of the Baby Through CS;
- The Death Having Occurred Between One Month and Five Years Before the Time of the Data Collection; And
- Willingness to Participate in the Study.

The exclusion criteria were as follows:

- Not Speaking English or Tiv, and
- Refusing to Participate in the Study (8 Cases).

The researcher let the participants decide where they wanted to be administered the questionnaire so that they felt most comfortable. The copies of the questionnaire were administered on the participants at their preferred location so they did not have to go back to the hospital where their babies' death occurred. The participants did not receive any economic compensation for their participation or deprivation for failing to participate.

To elicit data on the experiences with loss of infant, 7 participants were interviewed on their experiences with psychological and social burden associated with loss of infant following CS. Participants were interviewed in their choice places, the interview was scheduled with the women in their homes or work places as it was convenient for them. In-Depth Interview using semi structured interview guide was used. Interview was captured on tape and transcribed verbatim in 50 pages of transcripts. The transcripts were read severally to get the researcher and coder immersed in the data. Data was categorized into meaningful patterns and coded to represent themes. Excerpts from the interview were included in participants own words.

Instrument for Data Collection

For this study, a structured questionnaire and a semi-structured interview guide were used in collecting data from the participants.

A structured questionnaire was used because it permits greater depth of response, is economical in terms of time and money, and is easy to analyze. In this questionnaire, there exists low level of involvement of the researcher and high level of involvement of the respondents; hence, the results can be extrapolated to make empirical statements that help in decision making. The questionnaire was developed from literature review based on the

objectives of the study, and was divided into six (6) Sections: Section A to F. Section A consisted of the socio-demographic profile of the respondents designed using multiple choice questions and has 6 items. Sections B adapted the EQ-5D-3L descriptive system to assess the physical and mental QoL of women who lost their babies in the first 6 weeks after birth through caesarean section. The EQ-5D-3L descriptive system is an interviewer-administered questionnaire which comprises the following five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 3 levels: no problems, some problems, and extreme problems. It is a standardized health-related quality of life questionnaire developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal (EuroQol Group, 1990). Applied to a wide range of health conditions, it provides a simple descriptive profile, a self-report visual analogue scale and a single index value for health status that can be used in the clinical and economic evaluation of health care. Each dimension has three levels: no problems, some problems, severe problems, and unable to. The respondent is asked to indicate her health state by ticking (or placing a cross) in the box against the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number expressing the level selected for that dimension. The digits for the five dimensions can be combined in a 5-digit number ('profile') describing the respondent's health state.

Section C was depression questionnaire designed to assess depressive symptoms among women who lost their babies in the first 6 weeks after birth through caesarean section. The depression questionnaire is a 60-point 20-item questionnaire test format adapted from Beck Depression Inventory (BDI), a widely used self-reported questionnaire designed to assess the symptoms and severity of depression, as well as its behavioral manifestations, with responses ranging from "Rarely or none of the time (less than 1 day)" to "Some or little of the time (1-2 days)", and then "Occasionally or moderate time of the day (3-4 days)" to "Most or all of the time (5-7 days)", rated as 0, 1, 2, and 3, respectively. The participant is asked to indicate how she felt few days after losing her baby. Depression level scores of 0 to 9 indicate no depression, 10 to 20 indicate mild depression, 21 to 40 indicate moderate depression and depression level scores of 41 to 60 indicate severe depression.

Section D was anxiety questionnaire designed to assess symptoms of anxiety in women who lost their babies in the first six weeks after birth through caesarean section. The anxiety questionnaire is a 60-point 20-item questionnaire test format, adapted from the Beck Anxiety Inventory (BAI), with responses from "Not at all" to "Somewhat", and then "Moderately so" to "Very much so", rated as 0, 1, 2, and 3, respectively. The participant is asked to indicate how she felt few days after losing her baby. Anxiety level scores of 0 to 9 indicate no anxiety, 10 to 20 indicate mild anxiety, 21 to 40 indicate moderate anxiety and depression level scores of 41 to 60 indicate severe anxiety.

Finally, Sections E and F were designed to identify the family support resources and health professional support resources, respectively, available to the women who lost their babies in the first 6 weeks after birth through cesarean section. They are made up of 6 and 8 items respectively, most of which are close-ended questions and others open -ended questions, and the participant is expected to tick as many options for each item as applicable to her

The items in the questionnaire were translated to Tiv language by a certified English and Tiv teacher.

However, semi-structured interview guide was used to collect qualitative data that explored objectives 1, 2 and 8. It consisted of 21 items that explored the experiences of women who lost their babies following CS. This instrument allows for in-depth exploration of the topic while maintaining some structure, and builds rapport and trust with participants.

Validity & Reliability of the Instrument

Instruments were validated by a midwife expert, Mental health Nurse expert and public health nurse expert to

ensured the face and contents on the instruments are in lined with core aims of the study. Instrument were test and retest using Cronbach's coefficient alpha of 0.735.A pre-test of the instrument was conducted in order to get the reliability of the adapted version using 10% of the sample size.

Ethical Consideration

Ethical clearance was obtained from the Head of Department of Nursing, University of Nigeria Enugu Campus and Research Ethics Committee of various Hospitals selected from Gboko, Benue State.).

RESULTS

Demographic Characteristics of Respondents

Table 1: Socio-Demographic Profile of Respondents

Criteria Characteristics	Frequency (f)	Percentage (%)
Age		
18–29	14	45.2%
30–39	14	45.2%
40–49	3	9.7%
Educational Status		
Primary Education	2	6.5%
Secondary Education	17	54.8%
Tertiary Education	12	38.7%
Religion		
Christianity	29	93.5%
Islam	2	6.5%
Marital Status		
Single	4	12.9%
Married	23	74.2%
Separated	3	9.7%
Widowed	1	3.2%
Number of Children		
None	4	12.9%
1–4	23	74.2%
5–8	4	12.9%
Occupation		
Farming	8	25.8%
Trading	9	29.0%
Civil Service	10	32.3%
Full Housewife	4	12.9%

Socio-demographic characteristics of the respondents in Tables 1 shows that 14 (45.2%) respondents were within the age group of 18-29 years, 14 (45.2%) were within the age group of 30-39 years, and 40-49 age group had 3 respondents (9.7%). Two (6.5%) respondents reported having attained primary education as their highest educational level. More than half, 17 (54.8%), indicated that they had completed secondary education, 12 (38.7%) had tertiary education as their highest level of educational attainment.

From this data, the majority have completed secondary education. Most respondents, 29 (93.5%) identified as Christians, while a small proportion 2 (6.5%) identified as Muslims. Four (12.9%) respondents were single, while the majority of respondents, 23 (74.2%) were married; 3 (9.7%) reported being separated, while only 1 (3.2%) was a widow. Majority of respondents, 23 (74.2%) indicated that they had between 1 to 4 children; and 4 (12.9%) had 5 to 8 children. Ten (32.3%) respondents reported being employed in Civil service, 9 (29.0%) were engaged in trading, 8 (25.8%) farmers, while 4 (12.9%) full-time home-makers (housewives).

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Table 2: Experiences with Psychological Burden

Psychological Burden Concepts	Sub-theme	Theme
Feeling empty	Psycho-physiological pain and emotional deprivation	Internal factors of burden
Feeling anger and resentment	Psycho-physiological pain and emotional deprivation	Internal factors of burden
Losing appetite and refusal to eat	Psycho-physiological pain and emotional deprivation	Internal factors of burden
“My sleep was so bad”	Psycho-physiological pain and emotional deprivation	Internal factors of burden
Forgetfulness	Psycho-physiological pain and emotional deprivation	Internal factors of burden
Experiencing flashback of baby at thought of pregnancy	Immediate and residual thought-provoking traumas	Internal factors of burden
Seeing baby while asleep	Immediate and residual thought-provoking traumas	Internal factors of burden
Seeing baby in trances while awake	Immediate and residual thought-provoking traumas	Internal factors of burden
Intermittent waking to check on babies	Immediate and residual thought-provoking traumas	Internal factors of burden
CS scar-induced trauma	Immediate and residual thought-provoking traumas	Internal factors of burden
Full breast and no baby to suckle	Immediate and residual thought-provoking traumas	Internal factors of burden
Seeing children same age as baby	Immediate and residual thought-provoking traumas	Internal factors of burden
Hearing baby cry at night	Immediate and residual thought-provoking traumas	Internal factors of burden
Loss of confidence in motherhood	Hopelessness, defeat, and self-blame	Internal factors of burden
Loss of self in grief	Hopelessness, defeat, and self-blame	Internal factors of burden
Hopelessness about future pregnancy	Hopelessness, defeat, and self-blame	Internal factors of burden
Self-blame	Hopelessness, defeat, and self-blame	Internal factors of burden
Self-harm	Pain-induced self-harm	Internal factors of burden
Feeling hated by God	Abandonment and disappointment	External factors of burden
Questioning God, self, and others	Abandonment and disappointment	External factors of burden
Suspicious of unseen forces at work	Vulnerability	External factors of burden

2 themes emerged from the data and 5 sub-themes. The themes were internal and external factors of burden. The internal factors of burden comprised of subthemes including psychophysiological pains and emotional deprivation, immediate and residual thought provoking traumas, hopelessness and defeat, and trauma induced self-harm; while the external factors of burden had the subtheme, feeling abandoned, disappointed and vulnerable.

Theme 1: Internal factors of burden

This theme emerged from the data, with four (4) sub themes and described the experiences of mother who lost a baby following caesarean section delivery.

Subtheme 1: Psychophysiological Pains and Emotional Deprivation

Participants expressed that there was feeling of emptiness. "I lost my child two (2) weeks after C/S, I felt bad, I felt like em em, even though I was alive, I felt like my life has gone, you know I felt so empty…" (P.7)

Feeling anger and resentment was felt by participants "… I was always angry, everything got me angry, the anger in me was too much, I would try to pretend but if you open my heart, I was so annoyed within me, honestly I lack words to describe it…." (P.7)

Loosing appetite and refusal to eat was evident in the data presented by all participants. For participant 4 she stated "…I cried the whole time, even I didn't eat for about 2 weeks, I was crying everyday…" (P.4)

Loss of sleep/intermittent waking was expressed among almost all the participants, participants expressed that they lacked sleep. "…My sleep was so bad, anytime I sleep, there is a particular hour that my child always wake up to suck breast ….. and being my first child, I usually wake up to watch my child, she was just my image and then the baby is not there again…" (P.3)

Participants were of the views that loss makes one forgetful. "I usually forget things, up till now, I still forget things. I will be talking with you now and then will forget what I was saying… it affected me mentally…" (P.2)

Subtheme 2: Immediate and Residual Thought Provoking Traumas

Experiences of mothers who lost babies post C/S could be said to evoke immediate traumatic pains and residual pains. This subtheme was evidenced in the data, with seven (7) concepts. Immediate traumatic pains were associated with having full breast with no baby to suckle, waking to feed baby but meeting empty cot, dreaming about babies as if they are physically present, seeing babies in trances and running in to carry baby and faced with the reality of death. Residual thought provoking traumas are events and issues that constantly reminds you of the death and evokes traumatic response. They include: flash back experienced at the thought and mention of another pregnancy, C/S scars and seeing women who were pregnant with you at the time of loss or seeing babies who ought to be child's age mate.

The following excerpts from interview supported these subthemes.

For immediate traumatic events,

Participants described the pains associated with loss as thus, "… I was having my baby and suddenly my breast is full and there is no one to feed…" (P. 6)

Participant 2 stated thus"… I was so devastated, even when I sleep, I usually wake up to breastfeed the baby, play and put her to sleep, so I would eventually wake up and start, " where is my baby, It took two weeks for me to start coming to reality that the child is no more…"(P. 3)

'' …Sometimes if I I saw my child, my child just passed here. Even if I sleep, I would feel baby is asking me mummy why did you allow me to go and leave you…"

For residual traumatic events, participants expressed as follows:

Participant 2 expressed …I felt, em, I felt , I thought my world was gone, because after C/S, when I turn, I look at the mark on my tummy and I turn around and I don't see baby….!

Subtheme 3: Hopelessness and Defeat

Mothers who experienced loss of child following C/S had a feeling of hopelessness and defeat. This theme has three concepts as viz: Loss of confidence at motherhood, loss of self in grief and hopelessness in future pregnancy. Mothers questioned the likelihood of having another live child following supposedly another C/S. "I was not myself, I had no hope in this life … I always think of how my life …is going to look like ..." (P.1)

Subtheme 4: Pain Induced Self Harm

The pain associated with loss as expressed by participants was huge especially when associated with guilt. Participant stated that she was so engrossed in guilt that she hit her head on the floor. There was self-blame at delaying to go for a booked C/S. "…I was booked for appointment but I delayed because I have seen women do normal delivery after C/S. I was waiting for normal labour, I think it was my fault…" (P.6)

Theme 2: External factors of burden

Subtheme 1: Abandonment, Disappointment and Vulnerability

Participants expressed that their experiences with loss after C/S evokes a feeling of abandonment and disappointments. They had feeling of being hated by God, questioning God, self and others. Participants felt abandoned by God; there was anger and questioning of self and the divine. "… I almost ran mad, I was so angry. I was like … ah, is it me that caused the death of the child or what, what happened?..." (P.3)

There was nothing like friends again, I feel like I am just that person that God hates most…" (P.7)

Subtheme 2: Vulnerability

Participants expressed that their experiences with loss after C/S evokes a feeling of suspicion. They were suspicious of unseen forces at work including "the devil" and "village people".

"…Yeah, I would say that I was suspicious, but that one is supernatural……it is something not physical….when I was pregnant I saw an old man and woman beating me… saying we warned you but you didn't listen, … do you really think you will hold this child…" (P.5).

"…I did not put my mind on a particular person that did, but I know it was village people that did it" (P.7).

Table 3: Social burden associated with the experiences of loss of child following C/S

S/N	Social Burden	Theme
1	Lack of excitement/interest in events; loss of energy and functioning in activities of daily living (ADL)	Self-imposed social isolation
2	Loss of sex drive/libido; fear of losing relationship	Relational handicap
3	Tearing up at gatherings and in social groups; refusal to see or interact with friends; associated loss of self and concentration	Emotional breakdown

Experiences with social burden yielded three (3) themes and 7 subthemes. Participants experienced many social burdens. The following were excerpts as captured from the participants.

Theme 1: Self-imposed social isolation resulting from lack of excitement and interest in events, and loss of energy, drive and functioning at the activities of daily living.

Participants avoided people, lost energy at previously pleasurable activities and the drive to perform activities of daily living. The following represented participants' verbal expressions.

"… I was tired of people telling me sorry, sorry madam; it felt so bad. So, when it happened, I was always avoiding people …"(P.4)

"This loss affected my work performance in many ways even at home. Even to cook for my children, I cannot be able to cook, sweep or do other chores …"(P.6)

Theme 2: Relational Handicapped

Participants related that they felt handicapped in partaking in usually exciting activities. These themes have three (3) sub themes: loss of sex drive/libido, fear of losing relationship with spouse and the extended family system and suspiciousness. Participants expressed that they felt angered, irritated and fear at sexual

relationship and fear of being considered weak and incompetent by families especially husband's family members.

"… I always feel like if I have sex that I will still get pregnant and give birth to a dead child. (P.4)

"… I feel like not having relationship again because it is as if it irritates me,… mmhh I get angry… when approached…" (P.6)

Theme 3: Emotional breakdowns and outburst

Participants expressed that they experience emotional break-downs especially while interacting with peers, families and friends as well as in periods of solitude. The sub themes include: tearing up in social gatherings and groups, refusal to see friends or interact with friends, and associated loss of self and concentration.

DISCUSSION OF FINDINGS

The findings of this study align with recent research indicating that perinatal loss results in profound psychosocial burden among affected women. Consistent with Berry (2022) and Flach et al. (2023), participants in this study reported high levels of emotional distress, trauma, and psychological instability.

The findings of this study are consistent with recent literature demonstrating that perinatal loss is associated with significant psychological distress, including depression, anxiety, PTSD, and suicidal ideation (Berry, 2022; Kwesiga et al., 2023).

The social challenges identified—including isolation, relationship strain, and reduced participation in daily activities—are also supported by findings from Zhang et al. (2023) and Thomson et al. (2024), which emphasize the role of inadequate social support in worsening outcomes.

Furthermore, the study highlights the importance of structured psychological interventions. Evidence suggests that counseling, peer support, and healthcare provider engagement significantly improve coping mechanisms and emotional recovery (Chen et al., 2024; Thomson et al., 2024).

Overall, the findings reinforce the need for a holistic approach to maternal care that integrates mental health services, social support systems, and culturally sensitive interventions.

CONCLUSION

Perinatal loss following Caesarean section is associated with significant psychological and social burden, leading to reduced health-related quality of life. Effective social support systems and structured psychological interventions are essential in mitigating these adverse outcomes. Healthcare providers must adopt a comprehensive, patientcentered approach that addresses both the emotional and physical needs of bereaved mothers to promote recovery and long-term well-being.

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