Strengthening Bereavement Support Following Miscarriage and Stillbirth in Abakaliki, Ebonyi State, Nigeria

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ABSTRACT

In Nigeria, two major reproductive health problems are miscarriage and stillbirth which are common but not given adequate attention. Grief in relation to miscarriage and stillbirth is dealt with inconsistently, inadequately and is frequently approached with practices that miss the lived experience of the culturally constructed nature of pregnancy loss. The present article is concentrated on the access to bereavement services for mothers who miscarried and/or had a foetal demise in Abakaliki, the capital of Ebonyi State. The objective of this paper is to create an interdisciplinary bereavement model of care for a PPH setup in a limited resource setting with emphasis on the sociocultural nuances of the South-Eastern region of Nigeria. This is through a situational analysis of the management of miscarriage and stillbirth in Abakaliki tertiary hospital and literature review of evidence-based bereavement care interventions and Igbo cultural competencies on bereavement and loss. The study identifies that the current treatment of miscarriage and stillbirth in the study context is mostly clinical with a 'business-as-usual-and-leave-quickly' attitude towards women's grief. The draft bereavement model of care created, encompassing the continuum of care that is shaped by a stepped approach to postpartum grief, incorporating existing institutional care structures for obstetrics and mental health services, and using psychological counselling, social work and faith-based care as part of the continuum of bereavement intervention. The recommendation to implement a bereavement care coordinator in tertiary, secondary and primary hospitals in Ebonyi State was found to be an effective method for institutionalizing the bereavement care model and provide improved access to the multi-professional grief support, given the limited human resources in public hospitals in Ebonyi State. Implications of the draft model for policy and professional education and research are also considered in this manuscript.

KEYWORDS

Miscarriage, stillbirth, perinatal bereavement, interdisciplinary care, Abakaliki, Ebonyi State, Nigeria, disenfranchised grief, maternal mental health

I. INTRODUCTION

A. Background to the Study

One of the most prevalent, yet least talked about poor reproductive outcomes is miscarriage, defined as the spontaneous termination of a pregnancy prior to twenty-eight weeks of gestation (before the time of viability) or as a stillbirth. Worldwide, two million babies are stillborn each year and this is disproportionately high in SSA compared to its population size. Despite overall improvements in some maternal health indicators, Nigeria has experienced

a relatively small reduction in 20 years in its stillbirth rate, and has been among the countries with the largest absolute number of stillbirths in the world. Studies conducted in hospitals across South-East Nigeria have consistently reported high stillbirth rates (20–>60 per 1,000 total births) in these settings, depending on the time and type studied.

The burden is evident in Ebonyi State and its capital Abakaliki in particular. The study at the Federal Teaching Hospital, Abakaliki (FETHA) of four-year stillbirths revealed that the rate of stillbirths was 41.4 per 1,000 total births over the study period, and most women who had stillbirths were from low economic households, while a large proportion of those with stillbirth did not attend any formal antenatal care before the stillbirth occurred. This trend is confirmed in the Nigerian multi-centre data which linked uncooked pregnancies or late-referred pregnancies, high parity, previous still birth and delivery complications with stillbirth. These are numbers of clinical incidents, but each stillbirth and each miscarriage represents a process of grief for a mother as well as a partner and extended family, a process which, at this time, is only superficially supported by Nigerian hospitals.

Pregnancy loss bereavement is different from other bereavements, which have implications for care organisation. This loss is often hidden from the broader community, not marked by the rituals surrounding death and, in many cultural contexts, actively denied or silenced (as reported in perinatal bereavement care literature. In South-East Nigeria, such a silence may be exacerbated by an Igbo cosmology and popular explanations of recurrent pregnancy loss, such as the belief in a ‘spirit-child' that dies and is reborn to torment its parents, thus giving it a medical appearance that is also blameworthy or suspicious, or explained through a spiritual lens. In the bereavement literature, those who have experienced a miscarriage or stillbirth, whose grief is not recognised and accepted by their community and who who cannot mourn openly, have been described as having disenfranchised grief and there is emerging qualitative evidence that this is the case for Nigerian women who lose their babies (as found in qualitative studies of women's experiences of pregnancy loss).

Over the last 20 years, health systems worldwide have shifted to more structured, interdisciplinary approaches to perinatal bereavement care, with the input of obstetricians, nurses, psychologists, social workers and chaplains, and often a designated bereavement lead. Hospital-based evidence on the implementation of such protocols, including memory-making practices, structured psychological screening and staff education in communicating with parents in a compassionate manner, indicates that they enhance the parent experience and may lower complicated grief and subsequent mental health morbidity – although implementation is not consistently effective even in well-resourced settings (as cited in scoping review literature on perinatal bereavement guidelines – Toller’s Erausquin et al). The model that would be comparable and formally documented does not exist in the tertiary or secondary facilities level in Nigeria, and in particular not in Ebonyi state in Nigeria's health system and culture.

B. Statement of the Problem

At present, the bereavement care after miscarriage and stillbirth in the health facilities of Abakaliki is predominantly provider-dependent, informal and limited to the clinical encounter. There is usually no clear transition between the woman and her family leaving

the hospital and finding psychological, social work and spiritually/culturally appropriate bereavement support before they go home after the physical management of a pregnancy loss (whether by evacuation, induction or delivery). Nursing and midwifery staff, who are most directly involved with bereaved families, typically report little or no formal training in bereavement communication and they report discomfort, avoidance, and inconsistent practice when caring for a family after a loss, as has been found in other low and middle income hospital settings, and, indeed, in high-income hospital settings as well (see, e.g., the qualitative findings of a Spanish tertiary hospital implementing a perinatal bereavement protocol, reported in Healthcare, 2025). Meanwhile, the sociocultural context around pregnancy loss in South-East Nigeria, in which individuals are expected to be silent and accept the loss of their child as a spiritual matter, prevents many parents from receiving any recognition of their loss as a true bereavement and fails to make any onward referral to community, faith-based or mental health support, when needed. The situation is one in which the scale of the clinical problem (repeatedly documented in Ebonyi State hospital data) is not matched by a formal, interdisciplinary response to the human consequences of that clinical problem.

C. Aim and Objectives

This article aims to examine the current state of bereavement support following miscarriage and stillbirth in Abakaliki, Ebonyi State, and to develop an interdisciplinary model of care suited to the clinical, organisational, and cultural realities of the state's health system. The specific objectives are to:

- Characterise the burden and clinical pattern of miscarriage and stillbirth in Abakaliki and comparable South-East Nigerian tertiary hospital settings;
- Examine the psychological, social, and spiritual dimensions of parental grief following pregnancy loss, with particular attention to Igbo cultural beliefs and practices that shape how such grief is expressed, recognised, or suppressed;
- Review existing interdisciplinary and stepped-care models of perinatal bereavement support developed in other health systems, and assess their transferability to a resource-constrained Nigerian tertiary and secondary care setting;
- Develop a culturally responsive, interdisciplinary model of bereavement care appropriate for implementation across Ebonyi State's tertiary, secondary, and primary health facilities; and
- Propose an implementation, training, and policy framework to support adoption of the model, together with an agenda for future evaluative research.
- What is the documented burden and clinical profile of miscarriage and stillbirth among women attending health facilities in Abakaliki, Ebonyi State?
- How do cultural beliefs and social practices in the Ebonyi/Igbo context shape the experience, expression, and recognition of grief following pregnancy loss?
- What components of existing interdisciplinary bereavement care models are most relevant and feasible for adaptation to the Ebonyi State health system?
- What structure of interdisciplinary bereavement care would be both clinically sound and culturally congruent for Abakaliki's public health facilities?
- What institutional, workforce, and policy conditions are required to implement and sustain such a model?

D. Significance of the Study

In this article I extend the relatively sparse body of knowledge on miscarriage and stillbirth in Nigeria into a more productive model of intervention for the human consequences of these deaths which goes beyond the epidemiological data on the prevalence of miscarriage and stillbirth in Ebonyi State and the South-East. The proposed model provides a concrete and flexible design for the clinicians and hospital administration of Abakaliki, without making any assumptions about the staffing ratios or equipment found in affluent hospitals. The article offers a scientific foundation for policy and practices in bereavement care for maternal and new-born health policy, quality-of-care measures, and pre-service and in-service training curriculum for policy makers in the Ministry of Health (MoH), Ebonyi State and the Nigerian health system. In the broader scholarship of perinatal bereavement in Africa the article serves as a model example of a culturally based approach to the development of models, in which local belief systems are not seen as barriers to be overcome but as structures to be respected when designing the bereavement care model.

II. LITERATURE REVIEW

A. The Global and Nigerian Burden of Miscarriage and Stillbirth

The estimated incidence of miscarriage (defined as the loss of a pregnancy before twenty to twenty-eight weeks of gestation, depending on the country) is a significant proportion of all known pregnancies worldwide, with an estimated two million stillbirths, a proportion of which is also concentrated in low and middle income countries. In Nigeria, the estimated stillbirth burden was considered to be a significant proportion of the overall burden, with estimates of approximately 317,700 stillbirths in 2015, or approximately 12% of the global burden for that year. The national stillbirth rate has been found to be regionally variable in Nigeria, with rates in the South-East, South-South and in the north being different, as a consequence of variations in obstetric services availability, antenatal coverage, and referral system availability throughout the country's varied health systems.

In contrast to the facility-based studies, which offer a more detailed, but not necessarily generalizable, view of the problem in the specific hospital context, these studies look at a particular issue in detail. A five-year review of a university teaching hospital in Lagos reported that the five year incidence of stillbirths was 61.8 per 1,000 total births, and that the majority of women with stillbirths had not been booked for their pregnancy beforehand. The Federal Teaching Hospital, Abakaliki review revealed that in South-East Nigeria, the rate of stillbirths was 41.4 per 1,000 births over four years, the mean age of mothers who gave birth for the first time was 28.8 years, and more than two-thirds had not registered for ante natal (ANC) services at any healthcare facility. Similar findings have been reported in studies in Anambra and Imo States, with stillbirth rates being high at the facility level and factors such as uncooked status, late presentation and prior adverse pregnancy outcome, and reduced access to timely obstetric interventions being reported repeatedly as determinants in the South-East region. In a more recent multicenter study of general hospitals and teaching hospitals in the south and north of Nigeria, the mean stillbirth rate was 39.6 per 1,000 births, with referral status, parity, prior stillbirth, birth weight, and gestational age,

and mode of delivery, being significant stillbirth rate predictors after adjustment for confounding.

These are important numbers for two related reasons. First of all they show that pregnancy loss is far from being a rare and peripheral incident in the health system in Ebony State, but a common occurrence in obstetric practice, which should warrant a systematic institutional response rather than individual improvisation by the clinical personnel. Secondly, the high prevalence of association between unbooked pregnancy/lateness pregnancy and stillbirth may indicate that many of these families are already in some kind of disadvantage (financial, geographical, informational etc.) before the pregnancy goes untouched and go without any psychological or social support after the pregnancy loss, unless such support is actively moved to their direction within the health facility.

B. Psychological and Social Consequences of Pregnancy Loss

The international perinatal bereavement literature is rich in evidence for the link between miscarriage and stillbirth and increased risk of depression, anxiety, post-traumatic stress symptoms, and complicated or prolonged grief in bereaved parents, especially mothers. These effects are not only felt in the immediate postpartum period, but have been seen to last for years after the loss of a baby and may impact subsequent pregnancies, parenting of surviving children, and partner relationships in other societies around the world. In Nigeria specifically, some cultural risk factors for the psychological consequences of pregnancy loss have been identified such as negative cultural perceptions of pregnancy loss, stigma surrounding perceived reproductive failure, and fear of consequences for violation of perineal rites (perinatal depression review, PMC5392941). Pregnancy loss is usually not recognized in the community by funeral rites alone or, or by the social organization that normally helps parents to grieve in other situations of loss, and this lack of community recognition often hinders parents from the mourning process.

C. Cultural Beliefs, Disenfranchised Grief, and the Igbo Context

Grief is expressed in different ways and sometimes even forbidden by culture. An extensive account of death and mourning expressions, beliefs, and expectations has been documented among the Igbo peoples of South-East Nigeria where the ancestral world and reincarnation are so interwoven with moral behaviors of the living and the dead that to discuss one without the other is impossible. Mourning by the Igbo people for a known death, whether adult or child who once lived, normally involves some sort of ritual observance that is clearly defined, community involvement, and, in earlier ethnographic descriptions, a series of funeral ceremonies that publicly symbolize the death of the deceased and the communal experience of bereavement. The loss of a child, miscarriage and in many communities, even of a stillbirth, does not fit into this picture: the child was not born into the family, was not named, was not presented, and was not born to walk, so the death may not be recognized at all as a formal mourning event.

In addition to structural sources of disenfranchised grief, there is also the set of explanatory beliefs which may attribute blame to the mother who has suffered a miscarriage or infant loss. The belief of the Igbo people and other South-Eastern Nigerian communities that a

spirit-child can be sent to torment a family through multiple births and deaths has been employed in them to explain spousal losses. The child's death is therefore situated in "spiritual space" and is interpreted based on the mother's spiritual condition, rather than biomedical terms as the health care provider would like to do. Qualitative research among women who have suffered a miscarriage, stillbirth or infant loss in Nigeria has revealed that culturally accepted explanations are often associated with disenfranchised grief, laughter and ridicule, blame and identity loss for the mother, and marital difficulties and social isolation at the time when the mother most desperately needs support and care. Studies on gender and traditional religion in South-East Nigeria have also shown that patriarchal structures may interact with traditional beliefs to exacerbate the social burden borne by women in similar circumstances, and increase their isolation.

All of this does not mean that Igbo cultural structures have no resources for support of their grieving people, however; the ethnographic literature documents abundant communal support systems for the bereaved in the event of a "factual" death, with examples ranging from extended families that mourn to communal labor that is shared to ease a mourner's burden of labor. The issue with the current clinical and policy interventions is not that they were based on an incorrect understanding of bereavement theories from the western world or that they need to disregard the potentially negative impact of these ideas on the bereaved mothers. It is that they should have been designed as interdisciplinary plans of care, that cater to the bio psychosocial needs of the bereaved, and that are cognizant of the community and family support systems already available for the Igbo people.

D. International Models of Interdisciplinary Perinatal Bereavement Care

In the last 20 years, health systems in North America, Europe and a portion of Asia-Pacific have designed a more formalized plan for perinatal bereavement. In most of these models, the clinical team (comprising obstetricians and nurses) is explicitly interdisciplinary, with the other disciplines (chaplaincy or spiritual care, medical social workers and psychologists or psychiatrists) functioning as standard rather than exceptional aspects of care, typically organized around a named care coordinator and/or a perinatal bereavement programmer (Wool, 2018). Some components of comprehensive programmers that have been reported involve respecting parents' preferences and choices related to their baby's vision, touch and name; the establishment of tangible reminders (e.g. photographs, handprints, memory boxes); access to specialist equipment (e.g. cooling cots) that provide families with the opportunity to spend more time with the baby in the acute hospital environment; formal psychological screening; and organized remembrance activities that extend the support beyond the acute hospital stay.

In the community, a stepped-care approach to interdisciplinary bereavement support is proposed: community-based psychosocial support is initiated for all bereaved parents, and structured screening instruments are used to identify those experiencing more severe bereavement distress, depression, anxiety or post-traumatic symptoms for referral to specialist psychological or psychiatric interventions, alongside pathways to non-governmental and community-based organizations for practical bereavement support, including funeral arrangements (stepped-care model, Hong Kong Medical Journal, 2025). Likewise, a qualitative assessment of the nursing care received by families after a structured

perinatal bereavement protocol had been introduced into a Spanish tertiary hospital revealed that whilst formalized aspects of the protocol, such as memory boxes and a psychological referral pathway were appreciated, successful implementation required the training of staff and the acceptance of the protocol by the institution, and that some nursing professionals without such training continued to have discomfort and avoidance behaviors towards the families post-bereavement (Healthcare, 2025). A scoping review of the perinatal bereavement guidelines implemented in health facilities also identified that social workers, chaplains and nurses were frequently included in interdisciplinary teams in western guidelines; however, the practice of routinely offering to see and hold a deceased baby, when not actually wanted by the parents, has been reviewed in the context of evidence that this practice is associated with higher rates of maternal depression and anxiety.

The above leaves two lessons for Nigeria. The general design of bereavement care that proved effective in this context – which focused on a coordinated approach to obstetrical, psychotherapeutic, social work, and spiritual care through the use of a coordinating position – may be replicated in that context as well, because the general design has nothing to do with expensive resources, but with organizational mechanisms. Secondly, the nature of such care and the choices it affords parents in interacting with their stillborn children and the timing and nature of disclosure to the parents should be framed in relation to cultural dimensions and informed by what such parents might want or need, as it was proposed and then illustrated that good intentions behind procedures may have negative consequences if those are imposed on persons without regard to their wishes and beliefs.

E. Gaps in Bereavement Care within the Nigerian and Ebonyi State Health System

Although there is a vast amount of Nigerian epidemiological research about the mere clinical consequences of miscarriage, the literature that focuses on the hospital's bereavement services is quite limited. To date, just few facility assessments have been conducted in hospitals of South-East region of Nigeria, Abakaliki and others, which has mainly concentrated on perinatal risk factors, cause of death, and the socioe motional outcomes of mothers, with limited attention paid to socio emotional outcomes. In general, Nigeria's hospitals do not seem to have an appropriate framework in place to support the extended families of pregnant women. Both maternity wards and gynecological departments in teaching hospitals offer inadequate bereavement support, information and training, and nursing and midwifery schools do not prepare their students to offer bereavement counselling to the bereaved mother. Medical social workers and pastoral care workers for whom the nature of such cases is only a small proportion of their workload are not typical of the majority of caregivers who have no formal specific training or institutional support to access or provide bereavement care. Because of this, the family members who experience a prenatal loss must seek informal support from one physician or nurse, receiving no follow-up or referral beyond that.

F. Theoretical Framework

This article considers three complementary theoretical approaches to inform the proposed model. The dual process model of coping with bereavement. Describes healthy grieving as a cycle of loss-oriented coping behaviors – confronting and processing the loss reality and

emotional pain – and restoration-oriented coping – dealing with secondary life changes, tasks, and roles that the loss has disrupted. This model can be helpful because it does not dictate a specific order of stages, but rather works as a framework that can address culturally different expressions of grief that do not fit into a Western normative sequence. Within the model proposed here, it might be useful to structure counselling and social work interventions in light of Worden's (2018) task-based approach to grief, where grief is seen as the process of undertaking a set of identifiable psychological tasks: accepting the loss of the loved one, experiencing the pain of the loss, adjusting to the environment without the loved one, and finding a lasting connection to the deceased person while also moving forward. Lastly, an ecological systems perspective, that emphasizes the individual, family, community, institutional, and policy levels at which bereavement support should be available, makes the article's focus on the importance of having an effective model that is not limited to the clinical encounter, but that must address extended family, community and religious structures, hospital systems, and state health policies all at once.

III. METHODOLOGY

A. Research Design

In this article the model developing design method was used. The design comprised a narrative literature review of the epidemiology, clinical and socio-cultural evidence relevant to the study. In addition, a framework was developed using the principles of intervention science during the process of model building. The design was selected because the aim of this article was not to test a hypothesis but to create a model of care – integrating quantitative facility based data on the epidemiology of pregnancy loss, with qualitative and ethnographic data on pregnancy loss and associated grief. In addition, the data collected were drawn from various facilities, but most of the data were collected in hospitals in Abakaliki and South-East Nigeria where the majority of the study was conducted. This information was not gathered for this study, but was a component of the published peer-reviewed literature by the researchers on pregnancy loss.

B. Study Area

Abakaliki is the capital of Ebonyi state in the South-East geopolitical zone of Nigeria. The city is the home of the state's main tertiary referral hospitals such as the Federal Teaching Hospital, Abakaliki and Ebonyi State University Teaching Hospital, as well as secondary general hospitals and a series of primary health centres both in urban and predominantly rural communities of the local government areas of the state. Ebonyi State is overwhelmingly Igbo speaking; it shares this broader South-Eastern Nigerian cultural context, specific to customary beliefs of death, ancestry and reproduction and has a high Christian religious affiliation which exists alongside traditional belief systems, often syncretic ally. Like many areas of South-East Nigeria, maternal health care seeking is a combination of formal antenatal/obstetric care and informal or traditional birth attendance; in the tertiary hospitals of Ebonyi State, previous studies have reported that unbooked pregnancy status is a significant risk factor for adverse perinatal outcomes including stillbirth.

C. Sources of Evidence

This paper has been based on three main forms of evidence. The first group are the epidemiological studies done in tertiary and secondary hospitals in Abakaliki and South-Eastern Nigeria on miscarriage and stillbirth (in Pregnancy outcomes). These were used to gain a broad overview of the size, composition and nature of the phenomenon in the area. The second category is made up of qualitative, ethnographic and review literature on the subject of grief and mourning practices, and cultural perception of miscarriage, stillbirth and pregnancy loss generally in the Igbo ethnic groups and Nigeria in general. This body of work was to scope out the social and cultural aspects of the subject. Thirdly, there is international literature on bereavement interventions that involve multiple interdisciplinary approaches, bereavement interventions that involve stepped-care, and health-care provision in general. It was employed to highlight some of the relevant components, principles, and lessons learnt from similar services that could be related to the context of Ebonyi State. All three categories were obtained by searching for keywords (miscarriage, stillbirth, perinatal loss, bereavement care, and interdisciplinary care) and bibliographic database mining (Nigeria, Igbo ethnicity, Ebonyi State, Abakaliki). Also, some of the articles in the first two categories were found through citations from other articles.

D. Model-Development Approach

The interdisciplinary model presented in section 4 was developed in an iterative synthesis process. The model components identified in the literature search were assessed for the applicability of models to the resource situation in the typical Nigerian public tertiary and secondary hospital, which includes the Ebonyi State model. The components that might be adapted with comparatively little extra investment were then compared with the sociocultural aspects based on the evidence of Igbo attitudes and approaches to miscarriage, to look for potential areas of tension and/or adaptation requirements. The last phase of creating a stepped care model involved identifying the essential bereavement care elements for all families, and the more intensive elements for those who have greater care needs, based on the principles of stepped care found in the interdisciplinary bereavement care literature.

E. Ethical Considerations

As this is a literature-based study where development of the model was not done using patients' primary data, the report did not require ethical approval from the institutional ethical review board. However, the article was written with ethical considerations of the topic taken into account. I have been careful to mention the occurrence of such phenomena without passing judgement on it and without propagating any negative beliefs about the cause of the illness, as is the case in describing the practices involved in the Ogbanje. Further, consensus on the results was obtained by removing all identifying information from the data and only providing data that have been previously published by others. Ethical approval from the relevant State health research ethics committees would need to be obtained if the proposed model was to be put to any practical test with bereaved parents, health care providers or community and religious leaders. Ethical issues to consider when working with bereaved parents are ensuring informed consent of participants and offering emotional support in the event of triggering of any past trauma and related distress.

F. Limitations of the Approach

There are significant limitations to the model-development process used in this approach that should be taken into consideration when using the resulting model. It is based on secondary synthesis of the existing literature and does not include new empirical data from the Abakaliki health workers, bereaved parents, or community leaders, but is instead a structured and evidence-informed starting point for local co-design and piloting of the proposed model and not a completed or validated intervention. The figures for stillbirths obtained from facilities represent a snapshot of the situation, in particular time and place, and may not be exactly representative of the situation today or in other facilities in Ebonyi State. This limitation is directly tackled in Section 6 with a call for a phased programme of local consultation, piloting and evaluation before wider implementation.

IV. TOWARDS AN INTERDISCIPLINARY MODEL OF BEREAVEMENT CARE FOR ABAKALIKI

A. Guiding Principles

This model is based on five principles that guide its development, which were taken from the literature examined in Section 2. First, bereavement care should be regarded as a normal part of the maternity/gynaecology service, not as an additional responsibility on the goodwill of individual staff members. Second, care should be interdisciplinary in its design, based on the coordinated, not the ad hoc, inputs from obstetric, nursing and midwifery, psychological, social work and spiritual or chaplaincy perspectives. Third, the care needs to be stepped and matched – providing a compassionate baseline to all bereaved families whilst ensuring that highly specialised input is given to those families with distress or risk profile, with the limited number of staff in public hospitals in Nigeria. Fourth, care needs to be culturally congruent, respecting and working with the Igbo family and community arrangement, extended kin support and religious practice, but not replacing them, and ensuring that bereaved mothers are not blamed or stigmatised due to explanatory beliefs like ogbanje. Fifth, support needs to be continued beyond the acute inpatient phase after a miscarriage or stillbirth, as the acute inpatient phase after a miscarriage or stillbirth is often short and grief and its psychological and social effects are long-lasting, occurring over months and years.

B. Structure of the Model: A Four-Tier, Interdisciplinary, Stepped-Care Framework

The proposed model provides for four levels of increasing intensity of care, and reflects the stepped care models reported in the international literature (as cited elsewhere, e.g., the stepped care pathway reported in the Hong Kong Medical Journal 2025) and adjusts the staffing assumptions to match the realities of the tertiary, secondary and primary facilities in Ebonyi State.

1. Universal Compassionate Care (all bereaved families, all facility levels)

All women and families who suffer miscarriage or stillbirth should have a clear minimum standard of compassionate and respectful care at the point of loss, from PHCs to the teaching hospitals in Abakaliki, Ebonyi State. This involves clear, honest and gentle communication about what has happened, in the woman's preferred language (English or Igbo or a

combination of both), by a trained member of staff; clear recognition of a loss and the fact that grief is a natural and expected response, from any gestation; private space, wherever possible, away from the women with healthy babies or ongoing healthy pregnancies; and a basic, standardised information leaflet, produced in both English and Igbo, highlighting common physical and emotional responses to loss, warning signs for return to hospital, and how to access Tier 2 and Tier 3 support. This tier is the most readily implementable aspect of the model as it does not need new infrastructure but just training.

2. Structured Psychosocial Support (facility-based, all bereaved families offered access)

Building on Tier 1, all bereaved families should be offered the opportunity to have a structured contact with a trained nurse, midwife or medical social worker working in a bereavement support role prior to discharge but this should not be a requirement. This contact should include practical arrangements in relation to seeing and where desired holding the baby as well as any memory making arrangements – such as a lock of hair or simple keepsake – in place, but all framed as an offer and not an expectation, and a brief, low-burden screening using simple and validated indicators adapted to local use, and a warm referral (a named contact and proactive follow up call/message rather than a leaflet only) to Tier 3 services for any family who would like additional support. This tier should also contain practical guidance on the aspects of registration, burial and, where appropriate, hospital chaplaincy or family's own religious leaders since this is a common additional cause of distress in settings with no formal perinatal bereavement pathways.

3. Specialist Psychological and Social Work Intervention (facility-based, need-driven)

More intensive specialist support should be made available to bereaved women and families that have been identified through Tier 2 screening (or self-referral) as having experienced significant depressive symptoms, anxiety, traumatic stress reactions or complicated grief or experiencing severe social problems (e.g. marital conflict due to the bereavement, blame on the family or financial difficulties arising from hospital expenses). This level should rely on the level of clinical psychology, psychiatry and medical social work already found in tertiary hospitals like the Federal Teaching Hospital, Abakaliki or Ebonyi State University Teaching Hospital and should be established as a formal referral system with maternity and gynaecology services instead of having every family navigate the hospital bureaucracy alone. This tier should be established at secondary and primary facilities without mental health specialists, and should be available in conjunction with a designated referral pathway with the nearest tertiary facility and, if possible, with telephone or telehealth contact to minimise the transport burden on the bereaved families who are already under financial pressure.

4. Community, Family, and Faith-Based Integration (extends beyond the facility, ongoing

Another aspect of the model is the clear recognition that the psychological impact of pregnancy loss is not just about the loss, but also about the social stigma and exclusion that often occur in this context, particularly within the community and family; and the fourth tier is intentionally beyond the hospital limits, because the process of mourning is by nature a communal and family-based one. The community-based psychosocial layer described in the Hong Kong stepped-care model includes partnership with local churches and traditional and community leaders, where these are appropriate and welcomed by the family, to provide accurate, blame-free information about the medical nature of the loss, directly challenging

stigmatising explanatory narratives, and links with community-based women's groups or peer-support networks which the international literature has identified as valuable in extending bereavement support beyond the acute hospital encounter – when the bereavement woman consents. The success of this tier is reliant on the ability to work with and not assume the role of existing community and/or religious organization structures in the various local government areas of Ebonyi State, as outlined in Section 6, and so relies heavily on the principle of true local co-design.

C. The Interdisciplinary Team and the Bereavement Coordinator Role

The model suggests a Bereavement Care Coordinator position in every tertiary and secondary care facility that participates in the programme, as this is consistent with international evidence that programme coordination is a key predictor of successful implementation of interdisciplinary bereavement care (Wool, 2018). This does not necessarily have to be a new post funded separately; it can be given as a defined responsibility to an existing senior nurse, midwife or medical social worker, who has been suitably trained, with a small interdisciplinary bereavement committee made up of representation from obstetrics and gynaecology, nursing and midwifery, clinical psychology or psychiatry, medical social work, hospital chaplaincy, and, if the facility wishes to include this dimension, a person trusted in the local community. The coordinator's role would be to ensure that ward staff continues to have a Tier 1 training programme, to ensure that offers made in the Tier 2 pathway to specialist services are made and recorded and not assumed, to monitor referrals into Tier 3 specialist services and to be the Tier 4 point of contact for community and faith based partnerships within the facility.

D. Workforce Training and Capacity Building

The model is specifically driven by the need to train, as this has been documented as a prerequisite for implementation, not an ‘add on’ to the process, in the absence of training, even when a formal protocol is in place (Healthcare, 2025). Three tiered training approaches are suggested: a brief mandatory orientation for all staff working with mothers in maternity and gynaecology services and all staff who work in the emergency department; a more intensive certificate level training for staff taking on Tier 2 psychosocial support roles, including staff from psychology, psychiatry and social work, covering grief theory, culturally sensitive communication about pregnancy loss, and basic screening tools; and specialist continuing professional development training for psychology, psychiatry and social work staff in Tier 3 roles, to cover therapeutic approaches related to perinatal grief. As a result of resource limitations, this training can be conducted on a cascade model where fewer members of staff are trained in detail, e.g. in partnership with schools of nursing, medicine and social work of institutions like Ebonyi State University and the Federal Teaching Hospital's training programmes, and pass on their knowledge to their fellow departmental members of staff.

E. Cultural Adaptation in Practice

There are a number of adaptations that make this model different from bereavement protocols undertaken in high income countries. The use of language and framing is done throughout, with a sensitivity to the concepts of loss and mourning within the Igbo cultural

context, and ensuring that the concepts used are not ones that would not translate in a meaningful way from a clinical or western psychological perspective. There is a focus on family involvement rather than it being a problem: in Western hospital models that are based on the individual's right to privacy, this often means keeping involved people out of the bereavement process, not for their lack of involvement, but because they can be a source of pressure or blame in a woman's life after a loss; in this model, husbands, mothers-in-law and other close kin are involved, not as a problem, but as a resource. Addressing explanatory belief systems is not avoided, instead, Tier 3 and Tier 4 support includes respectful conversations with trusted staff or community partners that present accurate biomedical information, and acknowledge the spiritual/cultural world in which many families understand their loss without demanding that families abandon their own beliefs. Lastly, the model is not based on the assumption of Christianization, nor of any single religion; the provision of chaplaincy under Tier 1 and Tier 4 is designed to meet the needs of the variety of Christian denominations found in Ebonyi State and those families who are more heavily reliant on traditional belief and practices.

F. Implementation Pathway within the Ebonyi State Health System

A phased implementation pathway is suggested, starting with a pilot at only one tertiary hospital, which in this case is most likely the Federal Teaching Hospital, Abakaliki as there is epidemiological evidence of stillbirth at the hospital, with the Ebonyi State University Teaching Hospital to be expanded, followed by secondary general hospitals in the various local government areas of the state. Primary health centres, which are not on-site specialist centres, would be integrated mainly as Tier 1 centres and referral centres – with the standardised information leaflet and a clear pathway well communicated about on-site to refer bereaved women to the nearest Tier 2 and Tier 3 centres. This staged process enables the model to be further developed, in parallel with initial implementation, to reflect lessons learned, before being broadly implemented, as recommended in Section 6 for local co-design and piloting.

V. DISCUSSION

A. Implications for Practice

From the development in Section 4, it is suggested that in Abakaliki, a significant improvement in bereavement care after miscarriage and stillbirth does not necessarily require a big capital investment. Many aspects of Tier 1 and Tier 2 can be achieved by training, redefining roles of staff and secondary and tertiary hospitals, and creation of simple standardised materials by existing staff and departments within Ebonyi State's tertiary and secondary hospitals. The more complex components of the model specifically Tier 3 specialist (psychology and psychiatric input) rely on the current (and potentially under-resourced) presence of psychology, psychiatry and social work departments in the state's teaching hospitals; formally connecting them into maternity and gynaecology referral pathways is an organisational rather than financial challenge. This indicates that the hospital administrators and clinical leaders in Abakaliki may start implementing some of the model within the existing budget, if there is enough commitment and investment in training the initial hospitals.

B. Implications for Policy

The Ebonyi State Ministry of Health in collaboration with the hospital management boards of the Federal Teaching Hospital, Abakaliki, and Ebonyi State University Teaching Hospital, is best placed to formally support a bereavement care standard, as part of a wider maternal and new-born health quality of care policy, at the state level. The model's focus on a multi-disciplinary, stepped approach to culturally appropriate bereavement care could be adopted by Nigeria's reproductive, maternal, new-born, child and adolescent health strategy which, to date, has placed greater emphasis on preventing deaths rather than providing post-loss psychosocial care. Finally, pre-service training institutions, such as nursing and midwifery councils and medical and social work training institutes, should think about adding to their existing training programme a core competency that covers bereavement communication, which is currently not being taught in most of the pre-service courses in Nigeria.

C. Strengths of the Proposed Approach

The model's major strength is in its efforts to balance two seemingly conflicting concepts in the literature on culturally adapting health interventions: fidelity to the evidence-based model of effective interdisciplinary bereavement care, and responsiveness to specific cultural, religious, and structural contexts of Ebonyi State. The article seeks to develop a construct that is not just a copy and paste of the Western hospital protocol, but one that can be accepted by the clinical and administrative stakeholders in the state's health institutions as relevant to their respective contexts and patients, as the article is based on facility level data from Abakaliki.

D. Limitations

The model proposed here has not yet been put into practice or tested in the health facilities in Ebonyi State, and its feasibility, acceptability and effectiveness in these facilities has yet to be tested. The literature which supports the cultural adaptation components is based on credible ethnographic and qualitative research literature about the Igbo mourning practice and the experiences of women in Nigeria who have experienced pregnancy loss, but is not specifically associated with the community of Abakaliki or the state of Ebonyi. There are likely to be local variations across the various local government areas, religious groups and socioeconomic groups within Ebonyi State. The assumption that the current psychology, psychiatry and social work departments in the teaching hospitals in Ebonyi State are sufficiently staffed to accept Tier-3 referral without extra staffing should be subjected to specific test during the pilot phase because the fact that there is shortage of staff in these disciplines is a widely documented constraint in the Nigerian health system in general.

VI. CONCLUSION

The psychological, social and spiritual consequences of miscarriage and stillbirth are poorly dealt with by formal hospital systems, despite being common, well documented clinical events in Abakaliki's health facilities. It has been suggested in this article that such a gap can be bridged by the use of an interdisciplinary approach to care, which involves integrating obstetric, nursing, psychological, social work and chaplaincy knowledge and skills into a co-

ordinated, stepped structure while at the same time paying attention to the Igbo cultural context in which bereaved families in Ebonyi State live and where they experience grief. The four levels proposed in this model – universal compassionate care, structured psychosocial support, specialist intervention, and community and family integration – is designed to provide a starting point for Nigeria's public health facilities, which may not have the infrastructure of health systems in high-income countries. However, its ultimate success will rely on authentic local co-design, careful pilots and rigorous evaluation in the local hospitals and communities of Abakaliki. It is a realistic model for the competent clinical care and recognition, support and dignity which bereavement of any kind deserves if adopted and refined in this fashion, the number of families in Ebonyi State that experience the loss of a pregnancy will be met.

RECOMMENDATIONS

On the bases of the above analysis, the following recommendations are suggested to the concerned stakeholders of the health system in Ebonyi State and to future studies.

- All hospital management systems, in particular, the Federal Teaching Hospital Abakaliki and Ebonyi State University Teaching Hospital, should commission a structured local needs assessment involving bereaved parents, staff in maternity and gynaecology, staff from psychology and social work departments, and community and religious leaders in order to validate and refine the four-tier model described in Section 4 before formal adoption.
- Where Tier 1 and Tier 2 components are introduced, a pilot implementation should be carried out at one facility to test the feasibility of the process before being rolled out across the site.
- Bereavement care after pregnancy loss should be formally incorporated as part of the maternal and new-born health care quality-of-care standards with an allocated budget line in the Ebonyi State Ministry of Health.
- There is a need to check on pre-service training of schools of nursing, midwifery, medicine and social work affiliated to institutions in Ebonyi State to see if training on foundational skills of perinatal bereavement communication can be integrated as a core competency.
- Empirical studies should be conducted in the future with the necessary ethical approval, which explore the acceptability of certain components of the model, especially the Tier 4 (community and integration into family), considering the sensitivity of involving directly with beliefs like the ogbanje concept.
- Longitudinal study to follow-up Ebonyi State facilities' maternal mental health outcomes after miscarriage and stillbirth would enhance the existing local evidence base and aid in model refinement in the future.
- There is a need to seek partnership linkage between the participating hospitals and existing community, women and faith-based organisations in Ebonyi State to establish the Tier 4 (community-integration) component on existing structures that are already established with local trust, rather than establishing new and unfamiliar structures.

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