

Mothers' Perception of Quality of Services from Health Centers after Perinatal LossManije Sereshti¹, Fateme Nahidi², Masomeh Simbar², Fazlollah Ahmadi³, Maryam Bakhtiari⁴, Farid Zayeri⁵

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Introduction: Perinatal loss is one of the most stressful life events that parents and caregivers experience. Providing an empathetic, caring environment to support mothers who experience perinatal loss is necessary. The aim of this study was to assess mothers' perception of the quality of services received from health centers after perinatal loss.

Methods: This study was conducted in 2014-2015 using qualitative content analysis. Participants in the study were 40 women with a history of miscarriage, stillbirth, or neonatal death who live in Tehran and Shahrekord, Iran. Data were collected from the participants through semi-structured, in-depth interviews, and they were analyzed using qualitative content analysis.

Results: One theme and six main categories were developed, and they indicated the mothers' experiences and understandings of the quality of service received after perinatal loss. The major theme was 'dissatisfaction with the quality of care received.' The main categories included: 1) effective communication, 2) expecting responsiveness, 3) expecting to respect the patient's dignity, 4) expecting better care, 5) tension of medical expenses, and 6) insufficient facilities.

Conclusion: The findings of this study highlighted the weaknesses, inadequacies, strengths, and opportunities in providing health services. They can help reproductive health policy-makers reduce the pain and suffering of the affected families with appropriate measures.

Keywords: mothers' perceptions, perinatal loss, quality of service

1. Introduction

Prenatal loss is a devastating, but common, experience (1). Perinatal loss is defined as any loss, from conception through the first 28 days of life, including miscarriage, stillbirth, and neonatal death (2, 3). Seven million neonatal deaths and stillbirths (4) and 43.8 million abortions occur each year worldwide (5). In Iran, stillbirth and neonatal mortality rates have been reported as 13 and 12 per 1,000 births, respectively (6, 7). The exact number of abortions in the country is unknown, but estimates range from 70.54 to 116.9 per 1,000 (8). Parents have vivid memories of the events of their child's death. They can always recall details of what happened. Laakson et al. also found that mothers who had lost their children considered the moment of birth very important and significant and remembered the details of moment of death and the events surrounding it (9). If parents feel that appropriate care is not provided for them, great and unnecessary distress will be imposed on them (10). Despite the high prevalence of perinatal loss, bereaved parents experience these problems in silence and isolation due to lack of sufficient understanding and

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support from family members, friends, and healthcare providers. In addition, there is generally insufficient understanding of the psychological consequences of such a loss. Providing a proper atmosphere for empathy and care based on specific guidelines for patients is considered part of the standard care in most obstetric units of developed countries (11). Despite the care protocols that support grieving families during and after delivery in these countries, unfortunately, parents frequently report abusive behaviors of staff members. These behaviors and incorrect advice can cause additional trauma for the parents, inhibit their recovery process, and diminish the level of confidence between staff and patients (12). In Iran, there is no information about mothers' experiences in this field, and there is no existing protocol to support women after perinatal loss. Healthcare providers are at the front line of supporting bereaved families, where they provide comfort, help parents say goodbye to their children, and educate family members on the grief process. Studies showed that about 20% of women who had a stillborn baby were dissatisfied with their care during pregnancy and 10% were dissatisfied with the care they received during labor and delivery (13, 14). Swedish researchers have reported that women who feel lonely and alone during the labor and delivery experience more intrauterine deaths than women who do not have these feelings (13, 15). Swanson stated that proper care is effective in reducing emotional disturbances, anger, and depression, as well as increasing self-confidence in these mothers (16). Proper management of parental grief after prenatal loss is crucial, as it helps to reduce the risk of psychiatric side effects (11). Paying attention to grieving mothers in obstetrics centers is a complex phenomenon and has various aspects that require the close collaboration of different specialists to design proper policies and detailed care programs based on the individual values of their clients (17). But, various factors, such as diversity in specialists, extensive use of equipment, poor communication, uncertainty, fear of litigation, and low acceptance of errors in this area have caused increases in errors, negligence, and their consequences more than in other specialized fields (18). Healthcare providers share the bereavement experience of stillbirth (19). The findings of Farrow's study revealed that 53.7% of obstetricians reported intense grief in cases of stillbirths (20). Involvement of employees in the process of grief increases the complexity of such mothers' care (21). When a pregnancy ends in the death of the fetus, it is the personnel's duty to help the family live past the harsh reality. This is a task that most employees are not prepared for, and it is one of the hardest scenarios that personnel in the maternity ward face (10). Understanding how mothers perceive the received care after perinatal loss is of critical importance for their care, treatment, and health (22). Quality of services is the differentiator, and they are a powerful competitive weapon for many service organizations (23). Today, customers' requests define service quality, and their perceptions and expectations are the main determining factors of quality (24). Patients' expectations are formed by their different physical, mental, and social needs. The resulting agreement between them and service providers, coupled with receiving appropriate services, leads to satisfaction (25). Patient satisfaction is recognized as an important tool for assessing the quality of health care. Identifying, developing, and maintaining the quality of services is one of the main concerns of healthcare providers (26). In fact, one of the current challenges of health systems is how to respond to the patients' expectations (23). Quality of health services must be evaluated continually to be able to make improvements by determining and implementing proper strategies (27). Women's expectations and their experience from obstetrics' services are progressively important to healthcare professionals, health administrators, and policy-makers, and they can contribute to informed decisions for the organization's service delivery (28). Mothers' health is one aim of the Millennium Development Goals. Therefore, paying attention to the performance of the obstetric system is of particular importance. Knowing the expectations of mothers experiencing perinatal loss is particularly important for optimal and effective decision-making. To date, few studies have comprehensively evaluated patient's expectations after perinatal loss, and no study has been conducted in this regard in Iran in terms of the dynamic nature of the expectations or to assess the clients' perceptions of service changes over time or from one person or culture to another (29, 30). Moreover, assessing patient's experiences about the quality of care with constant and selective questions is not entirely possible (31). Therefore, it seems to be necessary that we conduct qualitative studies aimed at determining the experience of women who have incurred prenatal loss with respect to their perception of the quality of services received from health centers.

2. Material and Methods

2.1. Design and setting

In order to detect the perception of mothers from the quality of services received from health centers after prenatal loss, the content analysis method was used. The method was chosen because of the need to describe the phenomenon and explain the emotional reactions of patients (32). Participants for the study were selected from health centers and hospitals in cooperation with the Departments of Health at Shahid Beheshti and Shahrekord Universities of Medical Sciences. Tehran has 20% of Iran's population, and we selected different ethnic, socioeconomic, and racial groups as a sample of Iran's population. For example, Bakhtiary ethnics live in Shahrekord, and mourning is very important to them, and it involves special ceremonies.

2.2. Selection criteria

We recruited women for the study who had experienced perinatal loss at hospitals in Tehran and Shahrekord. The inclusion criteria included the following: Muslim Iranian women, not pregnant, with no known history of mental illness, drug abuse, or opiate and sedative dependence. Women who experienced extreme discomfort during the interview were excluded.

2.3. Data collection and interviews

The participants were contacted by phone. Data were collected through individual, in-depth, semi-structured interviews with 40 women selected using purposeful sampling (20 from Tehran, and 20 from Shahrekord). The interviews were conducted in a quiet environment from May to September 2014. The interviews varied in length, ranging from 14 to 140 min (mean of 32.45 ± 60.85). Most interviews were conducted in parks near the participants' residences. The interviews began with general questions about the mothers' experience of the quality of care received, and it gradually progressed to specific questions based on the interview guide. During the interview process, non-verbal signals, such as tone of voice, silence, emphasizing, and crying were noted. With the permission of participants and their being previously notified, 39 of the interviews were recorded using a digital recorder.

2.4. Data analysis, reliability and validity

At the end of each interview, a short report on the interview process and its important points were prepared and used in the data analysis. Data analysis was performed concurrent with data collection using conventional content analysis by the constant comparison method. Graneheim and Lundman's method was used for data analysis (33). Thus, in this study, the interview text was transcribed and typed immediately after the interview and was read several times. Primary codes were extracted, and then they were merged and classified based on similarities; in the end, the concept and content of the data were extracted. Concerning the accuracy and reliability of the data, four criteria, i.e., validity, conformability, reliability and transferability, were used according to Lincoln and Guba's criteria (34). Member check and peer debriefing were used. The researcher had a long-term involvement (15 months) that included interactions with the subjects, acquiring data, persistent observation, and reading of the transcripts to ensure accurate diagnosis of the unit. The research team and a peer evaluator reviewed the process of data collection as well as the fourth and fifth stages of analysis. An appropriate number of participants were involved with maximum diversity, and simultaneous data collection and analysis were performed.

2.5. Ethical considerations

The study was approved by the Ethics Committee at Shahid Beheshti University of Medical Sciences, Iran, (Ethics Approval Number: 1000/1234). For data collection, a license was obtained from Shahrekord and Shahid Beheshti University of Medical Sciences. The objectives of the study, including voluntary participation and the confidentiality of the information gathered, were explained to the participants by a phone call before initiating the interviews. The time and place of the study were determined by the participants. Written consent to conduct the interviews and to record them was obtained before the interviews. Participants were notified of their right to stop the interview at any time if they felt upset or did not want to continue.

3. Results

Forty women with histories of perinatal loss participated in the study. The interviews were conducted two weeks to 13 years after the loss. Five of the participants had terminated their pregnancies for medical reasons. Other characteristics of the participants are presented in Tables 1 and 2. After determining the concepts, basic codes were extracted from the interviews. The codes were reviewed, summarized, and classified according to similarities and appropriateness, and, then, the primary themes were identified by revising and comparing the internal meaning of the classes. The primary themes were termed as either conceptual or abstract, depending on their nature. According to the mothers' perception of quality of services received from the health centers, the theme entitled "dissatisfaction with quality of received services" and six other categories were created (Table 3) as follows, i.e., sections 3.1. to 3.6, below.

3.1. Expecting effective communication

Perinatal loss is an unexpected, devastating, and very sad reality for most parents. The patient's discomfort, confusion, shock, and denial, in addition to the lack of understanding of the mother's situation and poor communication of the treatment team in the obstetrics and gynecology departments, worsen the mother's problems and add to her difficulty and distress. The participants expected better and more appropriate emotional support from

the treatment team. For example, one mother, a (35-year-old woman with one ectopic pregnancy), said: "When I came, the doctors threatened me, saying that, if you go home, you'll have internal bleeding, and you will not make it back to the hospital." Another 35-year-old woman who had one spontaneous abortion said, "I did not tell them due to the fear that they would do the opposite. Many are like me. I have asked many, and they have said the same. They fear that they won't provide the needed care for her. Some are afraid for their lives. I would tell them if I didn't have fear." Some participants were very dissatisfied about the hopelessness induced by the healthcare providers. In this regard, one 28-year-old woman, who had experienced two early, spontaneous abortions, said, "One of them (a nurse) told me that I was now like a cracked bowl and that the probability of abortion is high in the next pregnancies. I felt totally hopeless. She said that there was no more certainty and validity." Despite most participants' dissatisfaction with the staff's communications, a few participants were satisfied with the emotional support of the staff. For example, a 34-year-old participant who had two earlier abortions said, "The doctor told me decisively that I had an abortion, but, she said it very kindly." She said, "My daughter! My Dear!" "She even called me by name, and she said that the hard part was over and there was not much left; she spoke so calmly that I did not dislike her reaction."

Table 1. Individual characteristics of the participants

Variable		F (%)
Age at time of interview (year), (mean years \pm SD)	34.88 \pm 7.41(19-51)	
Marital status	Married	40
Education level	Praimery	2
	Middle school	3
	High school graduate	13
	College graduate	22
Job	Housewife	18
	Self-employed/freelance	2
	Employees	20
Insurance	Medical insurance	40
Hospital	Private hospital	5
	Teaching hospital	29
	Governmental non-teaching hospital	3
	Charity Hospital	3

Table 2. Reproductive profiles of the participants

Variable		Numerical findings
Gravida (mean years \pm SD)		3 \pm 1.53
Parity (mean years \pm SD)		1.57 \pm 1.06
Perinatal loss (mean years \pm SD)		2.02 \pm 1.56
Gestational age (week) (mean years \pm SD)		16.91 \pm 10.93
Perinatal loss	One (n)	19
	More than one (n)	21
Types of Perinatal Losses	Abortion	23
	Ectopic pregnancy	2
	Neonatal death	10
	Stillbirth	5
Reason for termination of pregnancy	Sever polyhydraminosis	1
	Severe pre-eclampsia	1
	HELLP Syndrome	1
	Fetal anomalies incompatible with life	3
Wanted or unwanted pregnancy	Wanted	33
	Unwanted	5
	Unplanned	2

Table 3. Main categories and sub-categories of the theme ‘dissatisfaction with the received services from health care system’

Categories	Sub-category
Expecting effective communication	Fear of negative feedback from healthcare providers
	Expecting emotional support in critical conditions
	Stress induced by healthcare providers
	Hopelessness induced by healthcare providers
Expecting responsiveness	Need for more opportunity to get information
	Expecting them to explain the cause of loss
	Expecting to be informed
Expecting to respect patient’s dignity	Respecting personal privacy
	Paying attention to maternal feelings
	Discrimination among patients
	Expecting to be valued
Expecting better care	Expecting follow-up of patients’ condition
	Paying attention to the patient's conditions in research centres
	Appropriate action in emergency situations
	Being left alone
	Tension caused by errors in diagnosis and treatment
	Not receiving proper services during holidays
	Expecting to be visited by one specialist
Tension of treatment costs	Tension of unnecessary costs
	Lack of understanding of patient’s financial situation
	Suffering from high cost of diagnostic and therapeutic measures
Inadequate facilities	Lack of equipment
	Difficult access to medication
	Expecting physical spaces in the obstetric ward

3. 2. *Expecting responsiveness*

Most participants believed that healthcare providers should give convincing information about the cause of their loss, but most of them did not receive the necessary information from doctors other members of the treatment team. Also, some participants were dissatisfied with not being informed of their infant’s condition before the baby died. They expected to receive adequate information about their infant’s condition, but they did not know who the responsible person was. For instance, in this regard, one participant, a 34-year-old with one premature neonatal death, said, "There was no pediatrician to explain the situation to us. When the pediatrician came out of the NICU, a lot of anxious parents surrounded him. He was answering the parents as he was walking away, “Whose mother are you? She is OK. Whose father are you? I do not know whether she would stay or not; I do not know if it is normal for them; at least they should give us the right information." Another woman, a 19-year- old woman who had one premature neonatal death, said, "When I was hospitalized, a woman came that was called ‘Professor,’ and she was saying that if I became pregnant again, they would stitch my uterus; I just could not understand what they were saying, as she was speaking with her students. Then, she started to leave, and I wanted to ask someone a question, but I couldn’t find them, and I did not know where to ask."

3.3. *Expect to respect patient's dignity*

Some participants were dissatisfied with the personnel’s not respecting their dignity and rights while receiving health care. In this regard, one of the participants, a 39-year-old woman who had an ectopic pregnancy after 11 years of infertility, said, "When my doctor came, I expected her to understand my emotional state since she had so many years of experience, but she did not care when I asked my questions, she would do her own job and spoke with her nurse." Another woman, a 23-year-old woman whose baby died seven days after birth, was concerned about the staff’s not respecting her personal privacy. She said, “The mother is in severe pain and does not understand. Many people come around her, so when the delivery is over, you know what has happened, it's so bad; so many people around you are watching you, as if it is an exhibition, while they were doing nothing." Another 46-year-old woman, who had three recurrent abortions, said the following about discrimination among patients, "I could not do my work myself and my husband was not allowed to come into the room, but there was another woman in the bed beside me

whose husband was with her. But the staff said that her husband was a doctor, but he was not. When I understood, I felt so bad." However, some other participants expressed satisfaction with regards to their dignity (respecting personal privacy when declaring news of fetal malformations): For example, a 28-year-old participant who had terminated her pregnancy due to Down's syndrome said, "My husband went to her (the obstetrician's) clinic; her attitude was good. She sent everyone out, and my husband was alone with her in the clinic, and she spoke with him."

3.4. Expecting better care

Many participants were dissatisfied with the care provided in the hospital during pregnancy and afterwards for the following reasons, i.e., being left alone, not being referred to centers with better equipment, no follow-up visit after loss, and lack of appropriate action in emergency cases. They expected better care; one participant, a 28-year-old woman with one abortion, in this regard said, "I went to this hospital rather than a private hospital; I waited for a long time until they came to do the ultrasound; I was very hurt. I bled a lot until it was my turn. It was too late. After that examination, the doctor told me that the placenta had separated." One of the causes of distress and anger for some of the participants were errors in diagnostic procedures, but doctors trust these tests, and this caused physical and psychological harm to the participants. One of the participants, who had two early spontaneous abortions, said in this regard, "When I underwent ultrasound, they told me that the fetus, gestational sac, and everything were inside uterus and that there was no problem, but I had taken methotrexate, which was for mothers who were treated in teaching hospitals, where healthcare providers told them that the reason for their being neglected was the crowded nature of the hospital. One of the participants, who had intrauterine death at 40 weeks of gestation, said in this regard: "They would not come to visit me, they were impatient, and they said that they were busy and they asked if I could not see that there were other patients needing their attention and asked me what I thought they could do. Ten patients were hospitalized with only two care providers. They cannot jump from one patient to another." One of the most important complaints of many participants was the absence of doctors during holidays. They considered the absence of doctors as one of the factors that caused them to lose their babies. One 40-year-old mother who had one premature neonatal death and one spontaneous abortion in this regard said, Why should there be no doctors in hospital on the holidays? All were midwives. I don't want to say midwives do not do good work, but the surgeon knows some issues better; I was so annoyed; I had stress because my doctor was not there; later I thought the doctor could keep the baby alive. "

3.5. Tension of high medical expenses

High medical expenses or imposition of unnecessary costs by physicians or the lack of attention to patient's economic situation by physicians were some of the causes of dissatisfaction of participants with the healthcare system. One participant in this regard, a 39-year-old woman who had an ectopic pregnancy after 11 years of infertility, said, "I was told that, if I undergo IVF, its only 20% likely to get pregnant, so the doctor suggested I should do it 2 to 3 times. I told them I did not have the financial ability, but they still said I should do it 2-3 times to get the result. I think the doctor did not understand." Another mother, a 34-year-old woman with one premature neonatal death), in addressing the imposition of unnecessary costs, said, "They told my spouse that if he wanted the doctor to be his wife's private physician, he would have to pay 900 thousand Tomans. In the end, it had no outcome; she did the delivery and went away, I never saw her again." A 24-year-old woman with a history of two premature neonatal deaths, said, "Because of my financial situation, I postponed the ultrasound, but then I regretted it and felt guilty. " But some of the participants appreciated the doctors for paying attention to their economic issues. For example, a 45-year-old woman with history of eight recurrent perinatal losses and had used a private hospital's facilities said, "The morning I went to visit the doctor, she even told me that my costs will be high in this hospital and that she will come to another low-priced hospital, if I wanted."

3.6. Inadequate facilities

Some participants considered the inadequate health facilities and equipment in health centers to be the cause of their perinatal loss. Mothers with a history of perinatal loss were dissatisfied with several conditions, such as inappropriate heating and cooling systems, health status of the hospital, inadequate equipment and drug, and discomfort due to being in a room with patients with completely different physical or mental conditions; for instance, being placed beside mothers who have just given birth to a healthy, live child. For example, one participant, a 46-year-old woman who had three recurrent abortions, said, "My roommate gave birth to her child; her relatives were happy and laughing, looking for a name for the child. The room they gave me really bothered me." Another mother, a 24-year-old woman who had two premature neonatal deaths, said, "I had great pain, but could not find a suppository; they told me that I should go out to buy it. In this situation, my husband was nervous. They were telling him to go buy this rare injection for the kid. Well, at that time when you are nervous, who can go

and come?" However, some of the participants who were taken to other wards by healthcare personnel (to reduce discomfort and avoid confrontation with postpartum mothers) also declared their dissatisfaction due to the violation of their personal privacy and discrepancy of other patients' conditions. One participant, who was a 34-year-old woman who had just experienced the death of her newborn baby, said, "After giving birth, I was mistakenly taken to the internal medicine ward where some men were hospitalized on the other side of the ward. One of roommates was an old woman who was very sick with urine and feces incontinence, and she smelled really bad. The other one was an old woman who had a heart attack; there was no one in that ward like me, and I did not like it at all. I was not in a good mood, and I got bored. The bedlam would start telling you the story of her heart."

4. Discussion

This is the first study on the perceptions of women with a history of perinatal loss about the quality of health services in Iran. The results of this study indicate that the expectations of most participants were not fulfilled. For most quantitative studies on women whose pregnancy had resulted in live birth, the mothers' satisfaction with the quality of services received during pregnancy, during and after delivery was reported high. Possible reasons for the difference between the results of this study and other studies may be due to the following:

- 1) The qualitative nature of the study provided more opportunities for others to express their problems and expectations of the quality of received service, while quantitative studies with closed questions do not provide such opportunity for patients;
- 2) Most of these quantitative studies were conducted during hospitalization. As some participants declared in this study, they would not complain due to fear of inappropriate behavior or being deprived of required health care services. Maybe in other studies, patients refused to express their real views about the services received, because of their concern about the hospital staff's being informed of the results of the research and showing inappropriate behaviors towards them. The current study was conducted outside the hospital and without any association of the researcher to the health centers. For instance, Karimian's study showed a high level of satisfaction with the services provided, despite the lack of quality of care at different stages of labor (35). In this context, McKinnon (36) and Farmahini (37) stated that patients may report higher satisfaction with medical services because of fear or negative feedback that can deprive patients of needed services;
- 3) It is argued that women tend to assess their birth experiences more favorably (36, 38). Positive assessment of the services received might be because of birth of a live and healthy baby; thus, losing the fetus or neonate could be the cause of reporting dissatisfaction with health services in this study;
- 4) Studies have indicated that psychological disturbances can affect a person's perception of care, as patients with experience of reproductive loss, maybe they focused on the loss itself rather than other characteristics of care after the loss (39). Studies have shown that parents often remember that they received emotional care rather than clinical and technical care (40, 41).

4.1. Expecting effective communication

The results showed that most participants were dissatisfied with the health providers' communication. McGee's results were consistent with the results of this study (42). However, the results of Geerinck-Vercammen (43) and Asplin (44) showed that most mothers were satisfied with the care and behavior of medical personnel. The authors have considered this satisfaction due to the care and communication with patients by professionals and trained personnel, which was based on the standard guidelines. While in Iran, in addition to the lack of trained personnel, there are no guidelines in this regard. The current status shows that healthcare providers were not successful in providing emotional and psychological support, proper communication with patients, and listening to their perspectives; it seems that paying attention to patients' desires and enquiries are less achieved by people in the field of reproductive health. Lack of awareness of healthcare providers in the field of communication is perhaps one of the main causes of patients' dissatisfaction, but other factors, such as physical, social, cultural, and economic factors, business density, equipment, and gender, also should be considered. Another very important factor in communication problems can be the involvement of health care providers in the experience of grief of perinatal loss (18). Although the relationship between the doctor and patient is a professional association, it must be acknowledged that this relationship is not neutral. When staff members repeatedly witness the death of babies or the termination of pregnancies, this stressful situation can prevent comfortable conversation, besides sincere and essential empathy between staff and patients (20). Employees' involvement in the process of mourning not only puts the mother at higher risk of pain and suffering, but also increases the complexity of mothers' care (21). Some of the main tasks of healthcare providers include the following: to provide client-centered care, reflect patient's views, and

have empathy and good communication skills (1, 45, 46). Patient-centered care is important during interactions with mothers who have a history of perinatal loss (47). The emphasis of healthcare providers about perinatal death is on medical views and focuses on the physiologic factors, which is in contrast with mothers' view regarding losing their child as an emotional, symbolic phenomenon (1, 48). This conflict of views between healthcare providers and patients could cause non-personalization and mechanical interaction of care and cause health care providers to be perceived as people who take care of patients without compassion and empathy (1). However, one of the other problems reported by participants was the stress caused by their caregivers; the possible cause of this problem cannot be solely attributed to lack of personnel's awareness of how to communicate with patients. Perhaps, one of the causes of inappropriate communication and expression of concern about patients' health is the fear of possible adverse events and patient complaints to the judicial authorities. So, studies of the obstacles of personnel's communication with mothers after perinatal loss seem to be in order.

4.2. Expecting responsiveness

In this study, most participants wanted to know the cause of their loss, and they used different methods to achieve this goal. However, their expectations were not fulfilled by healthcare providers, and this was consistent with studies of Gravensteen, Cecil, and Tsartsara (49-51). Providing information about death assures parents that all necessary measures were taken in the desired shape and without pain and suffering to keep the life of their child. This helps to reduce the parents' feeling of guilt.' It should also be noted that mothers' dissatisfaction with not receiving information and low awareness of mothers who have lost their child might not be because the personnel did not give them the information, but it may reflect disturbance at receiving information during stress time that has caused possible misunderstanding about the method used by healthcare providers to provide information. However, studies have shown that mothers remember the events around their perinatal loss clearly and exclusively, but this should be balanced against the recall bias of women during and after delivery (52, 53). Neglecting this issue may simply cause misinterpretation of the actual data (53).

4.3. Expecting to respect patients' dignity

In this study, some participants reported that healthcare providers disregarded their dignity or apathy and neglected their maternal feelings. The results of Trulsson et al.'s study were similar to the findings of this study (54). The study of Gravensteen et al.'s study showed that the majority of parents reported honorable behavior of healthcare providers towards their dead babies (49). The potential difference between the results of this study and Gravensteen's study may be due to cultural differences and having a support protocol in Norway (49). A significant proportion of patients were dissatisfied because their personal privacy was not respected. This is consistent with the results of Melese's study (55). Although, unnecessary looking or touching another person's genitalia by anyone, including medical personnel, is regarded as sin according to Shia authorities, the presence of students in the obstetrics wards and the necessity of their education is a challenge. This study found that, despite adequate facilities in most university hospitals, patients expressed dissatisfaction with the services rendered and attributed it to lack of respect of health care providers as the reason, while the results of the study show that the majority of mothers who suffered perinatal loss in private and small non-teaching hospitals were satisfied with health services; although they complained of lack of facilities at these centers. The results of Senarath's (56) and Naghizadeh's (57) studies also showed that mothers were more satisfied with health services in small centers. These findings may confirm that the high workload and the presence of students in teaching hospitals are some of the causes of clients' dissatisfaction. Studies show significant reduction in effective communication of staff and patients with enlargement of the system (58). Higher customer satisfactions despite less specialized care may be due to the better interpersonal relationship between mothers and the staff in such institutions, which probably spend more time with them and pay more attention to their problem. Women in Armstrong's study insisted that good results and high quality of services can only be achieved when the healthcare providers spend time to listen to their serious health concerns (3).

4.4. Expecting better care

The results show that most participants had no follow-up after the termination of their pregnancies. The results of Dent's study showed that less than half of mothers with perinatal loss history received post-natal follow-up services, but other studies have shown that 92% of mothers with a history of perinatal loss had at least one follow-up visit after losing their baby, while mothers were not aware of follow-up after loss in the current study (59, 60). The results of this study show that some mothers with history of loss are not visited by a physician after childbirth or miscarriage; they did not even know who their doctor was. The participants expressed that lack of visit to patients after pregnancy termination by doctors was sometimes due to their frequent shifts. Although organizational culture, such as administrative regulations, shortage of staff, staff rotation during education, and professional life, may affect

healthcare providers' ability to communicate effectively with mothers and provide emotional and practical support (36); but concerning the emotional and psychological conditions of these patients, it is necessary that hospital authorities take some measures to ensure that patients can communicate with their doctors after childbirth to reduce its inappropriate consequences of not being visited and increase patient satisfaction. Most participants were dissatisfied with inaccessibility of their doctors during holidays and see this issue as the reason for the loss of their child. It seems that people working in health systems are not interested in working on holidays and usually lower-rated and less experienced staff work on holidays. Although hospitals try to work to their capacity, care and management of emergency situations on holidays is a serious challenge for health care providers (61).

4.5. Tension of medical expenses

Participants in this study tried to receive the best care in treatment facilities when faced with problems during pregnancy; in order to get the best possible care and provide conditions for the birth of a healthy baby, they have experienced high costs. The significant costs to maintain the pregnancy or to help ensure the infant's survival have caused a lot of stress and tension. Participants gave emphasis to healthcare providers paying no attention to patients' financial status and imposing unnecessary costs on them, rather than the costs themselves. Wright also showed that the mothers, who were mourning, also showed concern about treatment costs and financial support sources (62).

4.6. Insufficient facilities

The results of the study show that most participants were dissatisfied with hospitalization ward after childbirth or abortion and hearing the crying voice of neonates and happiness of families who had a healthy child. Also patients taken to other wards were dissatisfied. The results of some other studies also display dissatisfaction of women with perinatal loss experienced in the hospitalization ward (51, 63).

4.7. Strength and limitation of study

4.7.1. Strengths of the study

One strength of the study was that it was not conducted in the hospital, which provided an opportunity for the patients to express their views without fear and concern of feedback of health care providers.

4.7.2. Limitations of the study

The nature of loss and grief might have forced some women with experience of loss to refuse to participate in the study. Thus, purposive sampling from volunteers might not reflect the experience of women who did not participate in the study. This study also relied on the participants' memory and may be associated with recall bias.

5. Conclusions

Problems that most participants expressed in the evaluation of their health care experience were mainly due to poor quality of health care providers' interactions and their lack of empathy. The findings of this study can serve as a guide for healthcare policy-makers to design a customer-oriented approach. Thus, to improve the quality of interactions and mothers' care the following are recommended: 1) staff and doctors who face mothers with experience of prenatal loss should learn skills on stress management and how to communicate with these mothers during their educational courses, 2) develop care and support protocols, 3) standardizing patients-midwives ratio in order to provide more opportunities for effective communication, 4) organized obstetrics wards with proper facilities and equipment, especially in non-training and small hospitals, 5) there must be measures to provide better services on holidays. Finally, more qualitative and quantitative systematic investigations are proposed.

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Conflict of Interest:

There is no conflict of interest to be declared.

Authors' contributions:

All authors contributed to this project and article equally. All authors read and approved the final manuscript.

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