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Research Article

Examining the Grief Levels on Postpartum Mothers' Psychological Wellbeing Following Perinatal Deaths in Tharaka Nithi County, Kenya

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Abstract

Introduction: Perinatal death refers to the loss of a fetus or neonate between 28 weeks of gestation (or weighing 500 g) and 7 days after birth. Globally, 3.3 million stillbirths and 2.8 million early neonatal deaths occur each year, with 98% reported in low and middle-income countries. These losses significantly impact maternal mental health, often resulting in grief, depression, and anxiety. This study explored grief levels among postpartum mothers in Tharaka Nithi County, Kenya, following perinatal loss and how this grief affects psychological wellbeing. *Methodology:* Anchored in Kübler-Ross's Stages of Grief theory, a randomized controlled trial (RCT) was implemented in three phases: baseline, intervention, and post-intervention. A total of 53 mothers and 10 counselling staff were selected using census and purposive sampling from hospital mortality records respectively. 2 data collection instruments were used-Perinatal Grief Scale (PGS) and structured questionnaires. SPSS was used to analyze data quantitatively. Descriptive statistics summarized participant data, while correlation, regression and independent and paired t-tests assessed relationships and intervention impacts. *Results:* Most respondents reported low to moderate grief (82.6%) post-intervention, compared to 71.4% in the control group, with a significant correlation between higher grief scores and depressive symptoms ($p < 0.01$). *Conclusion:* There was reduced mean scores among the experimental group, compared to higher scores in the control group substantially in despair, indicating that counselling helped reduce unresolved grief. Difficulty Coping also declined significantly suggesting an increase in emotional regulation and resilience, and decrease in Active Grief scores reflected a reduction in intense emotional reactions such as intrusive thoughts on the baby. The study recommended integrating psychosocial support and culturally sensitive and structured grief counselling through community-based systems to enhance awareness, reduce stigma, and improve maternal psychological wellbeing.

Keywords

Sociocultural Factors, Coping Mechanisms, Psychological Wellbeing, Postpartum Mothers, Perinatal Deaths, Grief Support

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1. Introduction

Mother-child attachment begins early in pregnancy, deepens in the second trimester, and continues after birth. When this bond is abruptly severed by perinatal death-defined as loss occurring from 28 weeks of gestation to seven days post-birth-it results in one of the most traumatic pregnancy outcomes [1]. The psychological impact on mothers is severe, often leading to grief, depression, anxiety, or post-traumatic stress disorder (PTSD). Despite available care protocols, many bereaved mothers' express dissatisfaction with post-loss care, particularly the lack of emotional and psychological support [2].

Globally, 2.7 million stillbirths and 1.5 million early neonatal deaths occur annually, with 99% in low- and middle-income countries [3]. In Kenya, the 2022 neonatal mortality rate was 21 per 1,000 live births, higher than global targets [4]. Perinatal death remains a major public health issue in countries like Nigeria, Ghana, and Malawi due to poor healthcare access and cultural stigma that limits grieving and social support [5, 6].

Grief responses vary among mothers depending on individual and cultural factors [7]. In many African contexts, grieving mothers are often denied culturally appropriate mourning practices, increasing isolation. Complicated grief affects 25-75% of mothers after perinatal loss-significantly higher than the general bereaved population [8, 9]. Associated challenges include sleep and eating disorders, chronic stress, strained relationships, and diminished maternal confidence.

Studies conducted in Sub-Saharan African and South Asian countries identified three themes; mothers' reaction to child loss, care and support after perinatal death, and coping strategies in the absence of care and support. Perinatal death was not appropriately acknowledged therefore care and support was inadequate and, in some cases, non-existent. Consequently, mothers resorted to adopting coping strategies as they were unable to express their grief [1, 20].

In Kenya, although tele-mental health guidelines exist, structured psychosocial care following perinatal loss is lacking, and individualized grief counselling is not standardized [10]. These gaps highlight the urgent need for integrating culturally appropriate mental health and grief support into maternal care services to support affected mothers' emotional wellbeing.

2. Methodology

2.1. Research Design

The study adopted a randomized controlled trial study design to evaluate the effects of individualized grief counselling on postpartum mothers' psychological wellbeing following perinatal deaths. This design was most suited to collect data that would define the differences between two treatments [11] and also measure effectiveness of a new intervention [12], while meeting the study objectives.

2.2. Study Population

Table 1. *Target Population Size.*

Hospitals	Number of Mothers
Magutuni	11
Kibung'a	5
Marimanti	7
Chuka	30
Total	53

The target population of this study consisted of 53 mothers who voluntarily agreed to participate and provided informed consent, had experienced a perinatal death within the three-month study period and those assessed to be in stable mental health. This data was from the hospital's postnatal registers and the perinatal mortality registers. The study also targeted 10-counselling staff working in the selected hospitals with maternity wards in Tharaka Nithi County.

2.3. Sample Size Determination and Sampling Procedure

Sample Size Determination

The study employed the Chan (2003) formula for sample size calculation. The formula is as follows:

Total sample size = C - 16. 58 or 80% power of the study (from statistical tables).

δ was the standardized effect size (0.6) - considering a clinical significance of 30%

According to [13], a clinical significance of 0.2 units and an SD of 0.5 units of a normal distribution was acceptable for interventional studies. The researcher would consider a 30% (0.3) clinical significance with an SD of 0.5.

Therefore, =0.6

An effect size of 0.6 was considered in this study.

=46 + 2=48 participants

An attrition rate of 5% was considered to accommodate nonresponse.

0.05 x 48 = 23 i.e. 2 participants

48 + 2 = 50

25 patients were sampled for each study group hence a total sample size of 50 participants.

2.4. Sampling Procedure

According to [12], a sample is a representative of the large population. In this study, the target population consisted all postpartum mothers who experienced perinatal deaths within selected public hospitals in Tharaka Nithi County, over a three-month period; November 2024-January 2025. This ensured comprehensive coverage and reduced selection bias; thus, the study employed a census sampling method. The researcher applied purposive sampling to sample 10 counsellors in selected public hospitals in Tharaka Nithi County who were working in the maternity unit. They posed the required information and would enhance standardization of the intervention thus maintaining the internal validity.

2.5. Data Collection

This study utilized three data collection instruments: the Perinatal Grief Scale (PGS), an interview guide, and semi-structured questionnaires. The PGS, administered before and after the intervention, measured grief levels among perinatal mothers across three subscales-Active Grief, Difficulty Coping, and Despair. Scores ranged from 33 to 165, with scores above 90 indicating the need for psychological intervention.

Structured in-depth interviews were used to gather qualitative data from mothers on post-loss coping strategies, developed based on the study objectives and literature. Semi-structured questionnaires with both closed and open-ended questions collected data from counsellors, enabling strategic insights.

Baseline data collection focused on adherence to grief counselling procedures and explored emotional, psychological, sociocultural, socioeconomic, and facility-related factors affecting post-traumatic stress management. Following baseline analysis, mothers received education on coping strategies. Using simple randomization, participants were assigned to either control or experimental groups.

Both groups were monitored for three months to assess coping mechanisms, and after six months, baseline tools were re-administered to compare changes in grief and recovery outcomes.

2.6. Data Analysis

Data was analyzed using SPSS v.29.0. Descriptive statistics including frequencies, percentages, mean, median, standard deviation and weighted means were carried out for quantitative data.

2.7. Ethical Considerations

The researcher obtained authorization and approval to conduct study from Chuka University Institutional Ethics and Research Committee. A research permit to carry out the study was sought from National Commission for Science, Technology and Innovation (NACOSTI). The study was conducted in the facilities after permission was obtained to conduct the research from relevant administration and institutions. Informed consent was sought from respondents and assured of non-disclosure of their identity for any information given. The interview schedules and the questionnaires were serialized for anonymity. The respondents were given freedom to choose to participate or not to participate in the study and were assured that information collected was analyzed and reported objectively to facilitate policy formulation.

3. Results

Table 2. *Response Rate Analysis.*

Instrument	Category	Pretest		Post test	
		Response F (%)	Non response F (%)	Response F (%)	Non response F (%)
Perinatal grief scale	Intervention	23 (92%)	2 (8%)	22 (88%)	3 (12%)
	Control	23 (92%)	2 (8%)	22 (88%)	3 (12%)
Questionnaire	Intervention	10 (100%)	0	10 (100%)	0
	Control	10 (100%)	0	10 (100%)	0
Interview	Intervention	23 (92%)	2 (8%)	22 (88%)	3 (12%)
	Control	23 (92%)	2 (8%)	22 (88%)	3 (12%)

Out of the targeted 50 participants, 46 (92%) mothers consented and completed the pretest assessment across public

hospitals in Tharaka Nithi County. By the end of the study, 44 completed the post-test, reflecting a 4% attrition rate. All sampled healthcare workers (100%) participated fully in both the pretest and post-test phases.

Demographic Characteristics

The study examined participants' demographic characteristics including age, marital status, education level, and occupation to understand the studied sample. This information provides the context of the study population as well promoting assessment of the sample's representativeness. Table 3 below shows the age of the respondents.

Table 3. Age of the mothers.

Age of Respondents	Frequency	Percentage
20 years and below	2	4.3
20-25 years	4	8.7
25-30 Years	6	13.0
30-35 Years	9	19.6
35-40 Years	24	52.2
40 years and above	1	2.2
Total	46	100.0

The majority (52.2%) of perinatal loss cases occurred among women aged 35-40 years, likely due to age-related health risks such as hypertension or diabetes. In contrast, only 4.3% were aged 20 or below, possibly indicating fewer cases or underreporting among adolescents due to stigma or limited access to care or underreporting.

The study further sought to establish the marital status of the respondents, and the findings obtained are presented on Table 4.

Table 4. Marital Status.

Marital Status	Frequency	Percentage
Single	27	58.7
Married	8	17.4
Divorced	2	4.3
Widowed	9	19.6
Total	46	100.0

Over half of the respondents (58.7%) were single, with fewer being widowed (19.6%) or married (17.4%), highlighting the potential impact of limited spousal support, contributing to deeper emotional trauma and prolonged grief.

The study further sought to establish the education levels of mothers as shown in Table 5.

Table 5. Education Level.

Education Level	Frequency	Percentage
Primary School Level	26	56.5
Secondary School Level	10	21.7
College/tertiary level	6	13.0
University Level	4	8.8
Total	46	100.0

The educational attainment of respondents shows that 56.5% had completed only primary school, and a combined 21.7% had reached secondary level. Only 8.7% had attained university education. Lower educational levels may correlate with reduced awareness of prenatal care, limited access to reproductive health services, and poor health-seeking behavior. These factors likely contribute to increased risk of perinatal complications and loss.

Additionally, the study sought to establish the occupation of the mothers and the findings obtained are presented on Table 6.

Table 6. Occupation of Mothers.

Occupation	Frequency	Percentage
Student	7	15.2
Peasant Farmer	12	26.1
Unemployed	14	30.4
Employed (informal sector)	3	6.5
Employed (Civil Servant)	10	21.8
Total	46	100.0

In terms of occupation, the highest proportion of respondents were unemployed (30.4%), followed by peasant farmers (26.1%). Only 6.5% were engaged in the informal sector, while 21.7% were employed as civil servants. Economic vulnerability is clearly evident and may affect a mother's ability to access quality maternal healthcare services, contributing to adverse pregnancy outcomes.

Maternal Obstetric Characteristics

The study examined several obstetric characteristics to contextualize the levels of grief among postpartum mothers. Among the variables studied include the number of previous pregnancies, previous live births, type of perinatal loss, ex-

pectations surrounding the loss, and the nature of care received at the health facility. The variables provide important background information on maternal reproductive history and healthcare experiences, which are known to influence how mothers perceive and cope with perinatal loss. The distribution of these characteristics among the study participants is presented below.

Table 7. Responses on Number of Previous Pregnancies.

Number of previous pregnancies	Frequency	Percentage
1	18	39.1
2	10	21.8
3	12	26.1
4	2	4.3
5 and above	4	8.7
Total	46	100.0

The study further sought to establish from the mothers, the number of previous live births they had. This is a significant variable because there is a close link between maternal identity, parity, and coping mechanisms. Table 8 below illustrates the results of the mothers' previous births.

Table 8. Number of Previous Live Births.

Number of Previous Live Births	Frequency	Percentage
1	27	58.7
2	8	17.4
3	3	6.5
4	2	4.3
5 and above	6	13.1
Total	46	100.0

A majority (58.7%) had one previous live birth, while 13.0% had five or more. This mix of primiparous and multiparous women highlights that perinatal loss is not confined to maternal experience level and may recur across pregnancies if root causes, such as healthcare access or pre-existing conditions, are not addressed.

The nature of loss is critical in shaping the depth and expression of grief among mothers. As a result, the study considered it important to establish from the mothers, the type of perinatal loss they had. The findings are presented on Table 9.

Table 9. Type of Perinatal Loss.

Number of previous pregnancies	Frequency	Percentage
Miscarriage,	14	30.4
Ectopic pregnancy	6	13.1
Termination of pregnancy,	3	6.5
Stillbirth	11	23.9
Neonatal death	12	26.1
Total	46	100.0

The most frequently reported perinatal loss reported was miscarriage (30.4%), followed by neonatal death (26.1%) and stillbirth (23.9%), highlighting vulnerabilities in both early and late stages of pregnancy. Miscarriages were often linked to poor antenatal care or maternal illness, while stillbirths and neonatal deaths were associated with delivery complications and infections. Ectopic pregnancies, though less frequent (13.0%), remain critical due to their life-threatening nature. Pregnancy terminations (6.5%) were attributed to various medical, social, or economic reasons.

The perception and preparedness for loss among mothers influences their grief processing and therefore the grief outcomes. The researcher sought to establish from the mothers, if the perinatal loss was expected or not. The findings obtained are presented on the pie chart below.

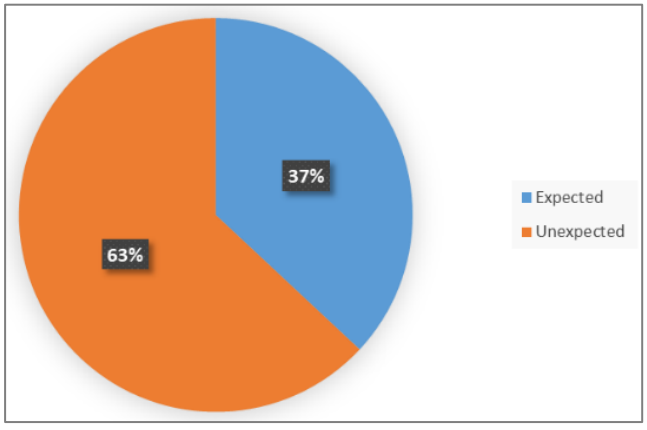

Figure 1. Expectation on Loss.

The findings reveal that the majority (63%) of the respondents indicated that they did not expect the loss, whereas 37% indicated that they had anticipated that child loss. This revealed unexpected losses among more than half of the mothers which could indicate heightened emotional distress due to lack of preparedness for the losses.

It is the role of the healthcare system in shaping the grieving experience among mothers. The study sought to establish from the mothers if they received care at the hospital imme-

diately after losing a child. The findings obtained are presented in the bar graph below.

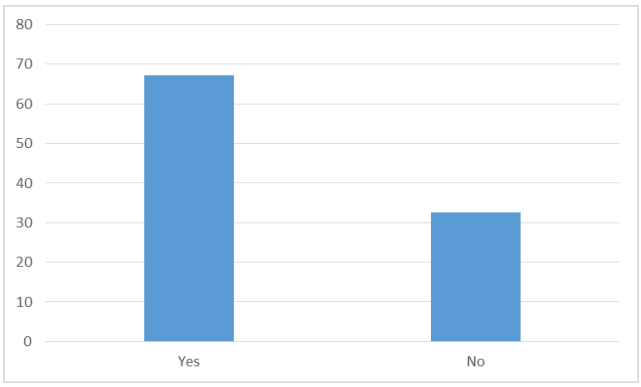

Figure 2. *Care at the health facility.*

The study established that 67% of the respondents indicated that they received care at the hospital immediately after they lost their child while 33% indicated that they did not receive care. This may be partly because they may not have experienced the loss while at the hospital, or as a result of other factors.

Contextual Support Factors

Psychosocial and socio-cultural factors including religion, cultural practices, and societal support are fundamental in shaping mothers' coping with perinatal loss. These factors influence mother's types of coping strategies and influence stigma or comfort they experience after the loss. Studying these factors was necessary as they provide insight into complications or improvement of grief levels. Therefore, the study sought to establish from the respondents if they had received any support from religion and or society. The findings obtained are presented on figure below (Figure 3).

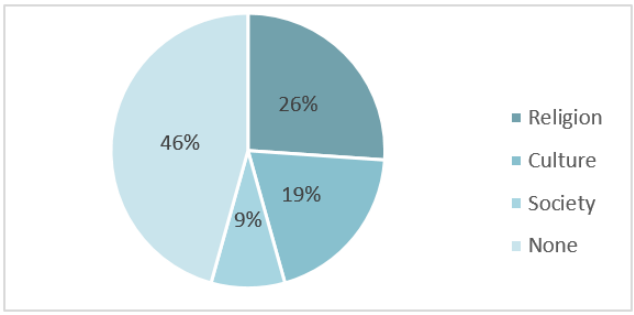

Figure 3. *Support from Religion, culture, and society.*

From the findings, the majority (46%) of the respondents had not received any support from the society and religion, while 26% of the respondents had received help and assistance from religious institutions.

Demographic Information of the Healthcare

The study assessed the demographic characteristics of health professionals in order to provide contextual background for interpreting their perspectives and practices. Variables examined included professional role and length of service. These attributes are essential in understanding potential variations in clinical practice, responsiveness to maternal needs, as these factors shape professional roles, decision-making, and the quality of patient care. The distribution of these characteristics among respondents is presented below (Table 10).

Table 10. *Professional Role and Years of Service.*

Professional Role	Frequency	Percentage
Midwife	2	20
Obstetrician	2	20
Psychologist	2	20
Counsellor/Psychologist	4	40
Length of Service		
Less than 1 year	0	0
1-3 years	1	10
4-6 years	5	50
7-10 years	2	20
More than 10 years	2	20
Total	10	100

The findings show that counsellors/psychologists formed the largest group of participants at 40%, indicating strong mental health representation in maternal care. Midwives, obstetricians, and psychologists were evenly represented at 20% each, reflecting balanced input from key clinical providers. In terms of experience, half of the participants (50%) had 4-6 years of practice, while 40% had over 7 years, including 20% with more than 10 years. Only one participant had 1-3 years of experience, and none had less than a year. This suggests that most respondents were experienced, enhancing the credibility and depth of the reported perspectives.

Grief levels on postpartum mothers' psychological well-being following perinatal deaths

Pretest Results

The researcher did a comparison of grief levels experienced by mothers in an experimental group and a control group following perinatal loss. The objective is to delineate the various facets of grief, including Active Grief (AG), Difficulty Coping (DC), and Despair (D), and their cumulative impact as represented by a Total Grief Score and categorized Grief Level. To provide context for the subsequent analysis, a detailed overview of the demographic characteristics and loss distributions within both the experimental and control groups

is presented. This foundational understanding is crucial for interpreting the observed grief levels and identifying potential confounding factors.

Pretest Scores for Perinatal Grief Scale (PGS) on Control Vs Experimental group

The experimental group comprised 23 participants. The distribution of 'Type of Loss' within this group was as follows: Stillbirth accounted for 10 cases (43.5%), Miscarriage for 7 cases (30.4%), and Neonatal death for 6 cases (26.1%). Regarding the 'Time Since Loss', the most frequent period was 6 months post-loss, observed in 6 participants (26.1%). This was followed by 2 months and 4 months, each with 5 participants (21.7%). Losses occurring at 1 month and 1 year each involved 3 participants (13.0%), and a single case (4.3%) was recorded at 2 weeks post-loss.

The control group consisted of 21 participants. A notable difference in 'Type of Loss' distribution was observed compared to the experimental group: Stillbirth was considerably higher, accounting for 13 cases (61.9%). Miscarriage and Neonatal death each represented 4 cases (19.0%). The distribution of 'Time Since Loss' in the control group showed 2 months and 4 months as the most frequent periods, each with 5 participants (23.8%). This was followed by 1 year (4 participants, 19.0%), 2 weeks (3 participants, 14.3%), 1 month (2 participants, 9.5%), and 6 months (2 participants, 9.5%).

Table 11. *Time And Type of Loss.*

Type of Loss	Experimental Group (N=23)	Control Group (N=21)
Stillbirths	10 (43.5%)	31 (61.9%)
Miscarriage	7 (30.4%)	4 (19.0%)
Neonatal death	6 (26.1%)	4 (19.0%)
Time since Loss		
2 weeks	1 (4.3%)	3 (14.3%)
1 month	3 (13.0%)	2 (9.5%)
2 months	5 (21.7%)	5 (23.8%)
4 months	5 (21.7%)	5 (23.8%)
6 months	6 (26.1%)	2 (9.5%)
1 year	3 (13.0%)	4 (19.0%)

The control group exhibits a higher proportion of Stillbirth cases (61.9%) compared to the experimental group (43.5%), alongside a lower proportion of Miscarriage and Neonatal Death cases. This difference in the distribution of 'Type of Loss' is a critical factor when interpreting the findings. Stillbirth is frequently associated with more intense and prolonged grief compared to early miscarriage, given the deeper maternal-fetal bonding and greater societal recognition often afforded to later-term losses. Therefore, the control group's higher prevalence of stillbirths could inherently predispose it to higher overall grief levels, irrespective of any experimental intervention.

Overall, Grief Level Distribution Comparison

A comparison of grief level distributions between the experimental and control groups reveals notable differences. The results are shown in Table 12 below.

Table 12. *A comparative overview of the grief level distribution by group.*

Grief Level	Experimental Group (N=23)	Control Group (N=21)
Mild	0 (0.0%)	1 (4.8%)
Moderate	10 (43.5%)	11 (52.4%)
High	10 (43.5%)	5 (23.8%)
Severe	3 (13.0%)	4 (19.0%)

The experimental group had a higher proportion of participants experiencing High grief (43.5%) compared to the control group (23.8%), while the control group had more individuals in the Moderate grief category (52.4% vs. 43.5%). Severe grief was slightly more common in the control group (19.0%) than in the experimental group (13.0%), and only the control group reported any Mild grief (4.8%).

These variations suggest that, despite similar overall average grief scores, the grief experience differed in intensity and distribution between groups before treatment. The experimental group had more participants at the higher end of the grief spectrum, indicating a possible concentration of more intense emotional responses. This pattern may reflect the influence of individual differences or the nature of the intervention itself. It highlights the need for further analysis of how grief manifests across subgroups and the potential limitations of grief level categorization.

Comparative Average Total Grief Scores and Components

Table 13. *Comparative Average Grief Scores by Group and Sub-Category.*

Metric / Group	Experimental Group (N=23)	Control Group (N=21)
Overall Averages		

Metric / Group	Experimental Group (N=23)	Control Group (N=21)
Average Total Score	108.4	109.8
Average Active Grief (AG)	35.7	38.0
Average Difficulty Coping (DC)	37.0	36.8
Average Despair (D)	35.7	35.0
Average Total Score by Type of Loss		
Miscarriage	101.0	111.5
Neonatal death	117.7	104.0
Stillbirth	111.7	111.1

The average Total Grief Score was slightly lower in the experimental group (108.4) compared to the control group (109.8), but this small difference is likely not statistically significant. Component scores-Active Grief, Difficulty Coping, and Despair-were also nearly identical across both groups, indicating that the core emotional experience of grief was comparable. Interestingly, despite the control group having a higher proportion of stillbirths (61.9% vs. 43.5%), which are typically associated with more intense grief, the total grief scores between the two groups remained similar. This may suggest that the experimental intervention, if present, did not significantly reduce overall grief intensity or that other factors in the experimental group balanced the impact of grief.

The findings challenge the assumption that any intervention will lead to a measurable reduction in grief levels. It highlights the complexity of perinatal grief and suggests that only highly effective, well-targeted interventions can create noticeable change. Further investigation into the intervention's nature and deeper subgroup analysis based on the type of loss are necessary to determine any nuanced or indirect effects of the intervention.

Post test results

Post test results for Perinatal Grief Scale (PGS) on Experimental group Vs Control Group

Descriptive statistics were used to analyze the distribution of grief levels (total scores) across the experimental and control groups after the individualized grief counselling intervention. The descriptive analysis of post-test scores from the Perinatal Grief Scale (PGS) clearly shows that individualized grief counselling had a significant impact on the psychological wellbeing of postpartum mothers following perinatal loss.

Table 14. *Summary of Descriptive Statistics - Post-test Total Scores.*

Group	Mean	Median	Minimum	Maximum	Standard Deviation
Experimental	95.1	97	71	132	16.5
Control	107.9	109	80	149	17.8

The mean total grief score in the experimental group was lower (95.1) than in the control group (107.9) indicating lower grief scores among participants in the experimental group compared to those in the control group. Further, the total mean grief scores for the experimental group decreased from 108. 4 in the pretest to 95.1 during post-test, indicating an overall reduction in grief levels following the intervention. The median scores support this trend, with experimental group's median at 97 and control groups at 109, confirming a shift toward lower grief severity. The standard deviation was slightly lower in the experimental group, indicating more consistent grief reduction across participants, while the control group showed greater variability. The highest score (149) appeared in the control group, suggesting persistent severe grief in the absence of intervention.

Overall, Grief Level Distribution Comparison

Table 15. *Grief Levels by Category (Post-test).*

Grief Level	Experimental Group (n = 23)	Control Group (n = 21)
Low	7 (30.4%)	4 (19.0%)

Grief Level	Experimental Group (n = 23)	Control Group (n = 21)
Moderate	12 (52.2%)	11 (52.4%)
High	4 (17.4%)	6 (28.6%)
Severe	0 (0%)	0 (0%)

The experimental group had a higher proportion of mothers with low to moderate grief (82.6%) post-intervention, compared to 71.4% in the control group. The control group retained a higher percentage of high grief cases (28.6%) than the experimental group (17.4%). No cases of severe grief were recorded post-test, indicating some natural decline in extreme grief over time in both groups, though more pronounced in the intervention group.

Comparative Average Total Grief Scores and Components

Table 16. *Mean Scores by Subscale - Post-test.*

Subscale	Experimental Group	Control Group
Active Grief (AG)	34.2	41.0
Difficulty Coping (DC)	32.1	38.1
Despair (D)	28.8	35.1

Across the three subscales of the PGS-Active Grief, Difficulty Coping, and Despair-participants in the experimental group consistently recorded lower scores than their control group counterparts. Notably: Despair showed the most substantial reduction, indicating that counselling helped reduce hopelessness, emotional numbing, and lack of purpose-common features of unresolved grief. Difficulty Coping also declined significantly in the intervention group, suggesting an increase in emotional regulation and resilience. The decrease in Active Grief scores reflected a reduction in intense emotional reactions such as crying, longing, and intrusive thoughts about the baby. These changes align with findings from studies by [14] and [15], which emphasize that structured grief counselling leads to measurable emotional improvement in mothers dealing with perinatal loss.

4. Discussion

Pretest

The analysis of grief following perinatal loss reveals significant emotional distress among mothers in both experimental and control groups, with existing literature emphasizing the profound psychological burden on perinatal loss [16] with many mothers reporting moderate to severe grief levels. While average grief scores were similar (experimental: 108.4, control: 109.8), the distribution of grief levels varied, suggesting individual factors such as psychological resilience, coping mechanisms and social support influence on grief intensity. The control group had a higher proportion of stillbirths (61.9%), a loss often associated with deeper grief due to stronger maternal bonding, possibly explaining their higher grief levels, regardless of intervention. consistently showed that grief following stillbirth, miscarriage or neonatal death was often prolonged, intense, and resistant to rapid resolution.

The persistent high grief levels across both experimental and control groups reflects research by [17], the intervention does not significantly reduce total grief scores, and it remains clinically significant years after loss. Subtle differences in grief distribution imply the intervention might affect specific components of grief rather than its overall intensity. Both groups showed continued high levels of Active Grief, Despair, and Difficulty Coping, highlighting the core dimensions interventions must target.

Importantly, the persistence of severe grief even a year of post-loss challenges societal expectations of quick recovery and underlines the need for long-term, personalized support [18]. The findings support extended mental health care and policy reforms such as prolonged bereavement leave to accommodate the complex and lasting nature of grief after perinatal loss.

Post Test

The study findings show that 82.6% of mothers in the experimental group experienced low to moderate grief levels after receiving individualized grief counselling, with none reporting high grief. A comparable study that supports these findings is [17], who demonstrated that structured grief interventions significantly reduce psychological distress following perinatal loss. In contrast, 28.6% of mothers in the control group continued to experience high grief levels, indicating the significant impact of the intervention. The counselling sessions provided structured emotional support, validation, and coping strategies, aligning with Worden's Task Model of Grieving. This model emphasizes acceptance of the reality of loss through acknowledgement of grief, processing of the emotional pain, environmental adjustment without a baby by encouraging on resumption of social and ongoing needs, and finally, reinvestment in life-all of which were addressed by the intervention. These findings resonate with Kubler Ross Grief Model, where individualized counselling appeared to ease progression through denial, anger and depression towards acceptance. By validating emotions and fostering the coping strategies, the intervention helped navigate the mothers grief, reducing prolonged distress and supporting healthier psychological adjustments after perinatal loss.

While both groups showed some natural decline in grief over time, the experimental group exhibited a much greater improvement, demonstrating the counselling's role in accelerating recovery and preventing prolonged or complicated grief. The reduction in grief subscale scores also indicated

better emotional regulation and cognitive adaptation among counselled mothers. Likewise, [19] concluded that individualized, relationship-centered support significantly improves coping and decreases risk of complicated grief.

These results reinforce the effectiveness of grief counselling and align with [3] recommendations to include bereavement care in maternal health services. In Kenya, where mental health resources are limited, the study highlights the need for culturally appropriate interventions. It also challenges societal tendencies to downplay perinatal loss, affirming the profound psychological impact on affected mothers and the importance of targeted support.

5. Conclusion and Recommendations

Coping mechanisms following perinatal loss among postpartum mothers in Tharaka Nithi County significantly affect their psychological wellbeing. Mothers who accessed individualized grief counselling showed better emotional recovery, reduced grief severity, and improved coping compared to those relying on informal or culturally influenced strategies. However, such counselling services were limited, inconsistently provided, and not integrated into routine maternal care, leaving many mothers to depend on inadequate informal support. Cultural beliefs and gender roles also discouraged help-seeking and reinforced feelings of guilt. The study emphasized the importance of accessible, structured, and culturally sensitive interventions to support bereaved mothers. Integrating grief counselling into postnatal care was found to significantly enhance emotional adjustment and reduce despair, highlighting the need for systemic reforms in maternal health services. Addressing sociocultural barriers and formalizing psychological support within healthcare systems is essential to promote healing and long-term mental wellbeing among mothers affected by perinatal loss in this region.

Abbreviations

AG	Active Grief
DC	Difficulty Coping
PGS	Perinatal Grief Scale
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
SPSS	Statistical Package for Social Sciences

Author Contributions

Doreen Kawira Mbae: Conceptualization, Formal analysis. Investigation, Methodology, Resources, Visualization, Writing - original draft, Writing - review & editing

Lucy Gitonga: Conceptualization, Methodology, Supervision, Validation, Writing - review & editing

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Conflicts of Interest

The authors declare no conflicts of interest.

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Biography

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