

ORIGINAL ARTICLE**Coping with Maternal Deaths: The Experiences of Midwives****Dartey Anita Fafa^{1*}, Phetlhu Deliwe Rene², Phuma-Ngaiyaye Ellemes³****OPEN ACCESS**

Citation: Dartey Anita Fafa, Phetlhu Deliwe Rene, Phuma-Ngaiyaye Ellemes. Coping with Maternal Deaths: The Experiences of Midwives. *Ethiop J Health Sci.* 2017;29(4):495.

doi:<http://dx.doi.org/10.4314/ejhs.v29i4.11>

Received: January 6, 2018

Accepted: April 8, 2019

Published: July 1, 2019

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Funding: Nil

Competing Interests: The authors declare that this manuscript was approved by all authors in its form and that no competing interest exists.

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ABSTRACT

BACKGROUND: *Life is said to be meaningful only when the individual is able to cope with challenges associated with it. Challenges at the workplace, whether physical, psychological or social, all contribute to occupational trauma. Coping with the challenges of work is an important part of achieving occupational wellbeing, irrespective of how difficult the job may be. Midwives are trained to be responsible for safe motherhood. However, when faced with maternal deaths, work becomes difficult as they have to cope with trauma resulting from their encounters with these deaths. Thus, the aim of this study was to explore and describe the coping challenges of maternal deaths among midwives in the Ashanti Region of Ghana.*

METHOD: *An exploratory descriptive qualitative design was used in the study. Data were collected by means of semi-structured interviews (18) and focus group discussions (8) with inclusion criteria of being a midwife with at least one year working experience and having witnessed maternal death while on duty. Data were audio recorded, transcribed and analysed using thematic content analysis.*

RESULTS: *Four themes emerged from the study: difficulty accepting maternal death, exhibition of grief reactions, difficulty forgetting the deceased and lack of concentration.*

CONCLUSION: *The study concluded that since the midwife's ability to cope with maternal deaths is challenged, occupational workplace programmes, for example, Employee Assistance Programme (EAP) should be employed in Ghanaian hospitals to help midwives get debrief after maternal death occurs.*

KEYWORDS: *Coping, challenges, experiences, maternal death, midwives*

INTRODUCTION

Occupational challenges that workers face all over the world and across various fields of work are related in one way or the other (1). Health and safety measures have become a growing concern in our work settings to create sound and healthy work environments that induce desired productivity and worker performance (2,3). Healthcare delivery is highly associated with nerve-wracking psychosocial problems owing to the sensitive and relational nature of hospital work (4). In 1996, the International Labour Organization

(ILO) commissioned a stress-prevention manual which could guide coping with stress, grief, anxiety and depression experienced by nurses and midwives, in recognition for the importance of managing harmful occupational exposure (5,6,7). For these reasons, advanced countries have developed support programmes that facilitate the operation of occupational healthcare practices, which offer employees' services like psychosocial counselling to mitigate cognitive work-related challenges of health workers (1,2).

The development of this manual is evident that nursing and midwifery, by nature, and in practice, are very stressful professions associated with many occupational health challenges (8,9,10). Additionally, given that midwives are women and are familiar with birth trauma creates natural bonds between them and their clients (4). This relationship, integral to midwifery practice, may certainly make midwives, especially vulnerable and sensitive to psychosocial hazards that result from untoward events of maternal death (11). A midwife's continuous exposures to these challenges interfere with her mental wellbeing, thereby threatening her ability to cope (12). This may also lead to low performance, and lack of mental attentiveness, thereby affecting healthcare services provided to other pregnant women (13,14) and personal problems such as low self-esteem and the portrayal of negative attitude (15). The findings of (14) show a global representation of the little attention to the severity and prevalence of maternal death distress among midwives.

Literature suggests that midwives need support to develop coping abilities relating to maternal death challenges (12). As such, it is important to identify with the phenomena of maternal deaths, particularly, challenges with coping, to develop possible approaches to managing them. This study, explored coping challenges associated with maternal deaths among midwives in the Ashanti Region of Ghana.

MATERIALS AND METHODS

The study applied qualitative research approach with exploratory design. The research setting was Ashanti Region of Ghana, a region that consistently recorded maternal death rate of 139 in

2014; 168 in 2015, 129 in 2016, 162 in 2017 and in 221 in 2018 per 100,000 (16) as compared to 3 per 100,000 women in countries like Finland, Greece, Iceland and Poland of Europe with the lowest maternal deaths (17). The study was conducted in nine health facilities that included a teaching hospital, a regional referral hospital, four district referral hospitals and three health centres. Purposive sampling technique was employed to select fifty-seven (57) ward midwives and supervisors (18). Eighteen (18) semi-structured interviews and eight (8) focus group discussions were conducted. Participants had worked as midwives for at least one year and had experienced maternal death while on duty. Focus groups ranged between four to seven participants. In each facility, the research team explained the objectives of the study to the managers and potential participants. A convenient meeting was scheduled with interested participants individually. All the participants selected hospital offices for the interviews. A thematic content analysis technique by Holloway and Wheeler (19) was used to analyse data. Data analyses considered trustworthiness strategies: dependability, transferability, credibility and confirmability (20). Data analysis started with validation, confirmation and transcription, within 24 hours of data collection to avoid missing relevant information. Data cleaning and coding was done to organize the different data collected. Data analysis computer software, *Atlas ti* version 7.1.7 was used. Participants' privacy and confidentiality were preserved by the use of alphabets and numbers in place of participants' name, [E.g. Focus Group 1 midwife 1 (FG1M1), Individual Midwife 1 (M1)]. Themes were created as recurring patterns were generated. Three people independently analysed the data and results compared and harmonized.

The study got ethical clearance from the Senate of the University of Western Cape, South Africa and Ghana Health Service.

RESULTS

All participants were females, ranked from Staff midwife to Director of midwifery. The majority (52.6 %) were junior ranked officers. Their ages

ranged between 22 to 61 years with the majority (56.1%) less than 46 years. Most participants (58%) worked more than 10 years as midwives, meaning most of them had extensive working experiences and possible multiple exposure to maternal death. Four themes emerged from the analysed data: difficulty accepting maternal death, exhibition of grief reactions, difficulty forgetting the deceased and lack of concentration.

Difficulty accepting maternal death: Participants reported it was difficult to accept maternal deaths that occurred in the wards. They testified that most pregnant women who died were not sick and that most presented with normal conditions. Cases were presented as below:

M11: *The woman was pregnant; she wasn't sick. Pregnancy is not a sickness, so she should deliver and go home happily, but why did she die?*

M16: *I personally do not want to hear about maternal death because pregnancy is not a disease; the woman had no pathological condition. The woman came in healthy so why she should die is something that bothers me.*

FG2M3: *A woman who is not sick or does not have any disease whatsoever dies in trying to deliver; it's difficult.*

Participants further explained that pregnant women, who were unwell on admission, did not present deadly conditions in most cases. The majority of pregnant women walked into the wards unaided. The deaths of these women, according to the participants, were unexpected and difficult to accept. This is demonstrated in the following statements:

FG4M1: *The mother came in healthy. Mother was not bleeding, not in any bad condition and the mother died, you will not accept it.*

FG4M3: *When you as a midwife attending to a pregnant woman who walks in healthy, and even if there are risk factors relating to her situation, and you lose her, it is difficult to accept it.*

The participants described it was difficult accepting the deaths of patients who

communicated well on admission and recovering, and those who regularly attended antenatal clinics. Coping was more challenging to midwives as seen in these quotes:

FG6M3: *I don't know what happened, because she was communicating with you. I was talking to her, so why all of a sudden? You will always be thinking about the patient, why the patient died!*

FG1M1: *Sometimes, your disbelief gets worse when the client is a regular attendant of Antenatal Care, has been on the ward for a while and has been managed very well. One gets surprised when such a thing occurs to her.*

FG7M6: *Sometimes, they are recovering or getting better, and they lost their lives at the end.*

Some participants demonstrated knowledge in conditions that killed pregnant women. This prepared them for the worse scenarios, but their anguish didn't wither. The following were said:

FG4M4: *There are some conditions such as Post-Partum Hemorrhage (PPH) which puts pregnant women in danger, but when a mother is not bleeding or nothing of the sort, and a mother dies, it puts you in a bad mood.*

M5: *Normally, maternal mortality cases in this hospital concern those that were referred from other district hospitals, where a woman's condition was not good, yet was not referred on time for further treatment to save her life. In that case, one cannot do much.*

Exhibition of grief reactions: The study found that participants exhibited grief reactions. Denial was reported as one of the main reactions to loss:

FG1M3: *You keep on denying the death because you see a patient on the ward going through a recovery process and unexpectedly, you see the patient's condition deteriorating just like that.*

M6: *When maternal death happens, at times they [attending midwives] have denial and you [supervisor] need to support them. They feel they have not done what they needed to do.*

In some cases, participants were easily angered anytime maternal deaths occurred. This is demonstrated in the following:

FG6M2: *The recording of maternal death comes with tension mixed with anger, surprise and shock from the news.* **FG5M6:** *Maternal death affects me personally; the little thing someone does or says annoys me.*

Similarly, participants reported having to bargain with the pain of loss. Bargaining makes a person linger in the past to escape the pains of loss (21). Self-blame is associated with bargaining:

FG6M3: *Is it that she has to die that she died? Sometimes, you have to bargain, bargain, and bargain, but you wouldn't get answers to why the patient died even though you tried everything you could do for the patient, but she still died.*

M14: *Sometimes, some midwives bargain persistently and question themselves why maternal death happened.*

Difficulty forgetting the deceased: The results of the study also showed that participants had difficulty forgetting the death of pregnant women. Participants explained that numerous circumstances reminded them of deaths that occurred in the past:

FG1M4: *Sometimes, you try so hard, but you can hardly forget especially when you have been emotionally attached to the client.*

FG3M2: *There was this particular client I had become friends with. The next day I came to work, she had died. For that woman's death, coping was very difficult because, every day I will reflect on how she could have died.*

Additionally, the data presented significant time difference individual participant could cope with maternal death challenges. While some midwives coped within a shorter time, others took much longer. Other participants couldn't tell how much time it took them:

M4: *It takes a while for one to forget, but one must still come to work, though you remember when you see a pregnant woman.*

M6: *It takes me some time to forget maternal death when I experience one.*

Some other participants take weeks to forget and cope with maternal death:

M15: *To forget or cope with maternal death, it takes about a week to two for me to forget it.*

FG3M4: *When I experienced one at the theatre, It took me about two weeks before I could stop thinking of it.*

Other participants, who took much longer time to forget about maternal deaths, confirmed their experiences:

FG5M2: *I experienced one two years ago. It took me weeks to recover. Yes, more than a month.*

FG6M1: *I have experienced some before, in 2010 (four years ago) and I still think about the patient, what happened and how the patient died, I don't know!*

After years of experiencing maternal death, this participant could tell exactly what happened that night:

M4: *We were at work, about seven years ago. We were there in the labour ward and then this woman came with some friends that when they were home, they saw her in labour and she had locked herself up in her room so they had to call someone break the door, so after breaking the door, they brought the patient. You could see that the patient had laboured in her room for a long time, so one of her legs was very swollen, very red. We did all we could..., but the patient could not survive.*

The study further reported that midwives who lived and worked in the same communities, were constantly reminded of the deaths of clients, as they met known family members of the deceased, especially, children delivered before death. This is what participants had to say:

M1: *Sometimes, if you see the child she left behind in the future, it reminds you of the loss.*

M9: *We are reminded of the death by family members, we meet in town and at church.*

M10: *I cannot forget totally. The family of the deceased must be visited and counselled on the care of the child left behind.*

Lack of concentration: The findings also demonstrate that most participants found it difficult to concentrate on the work at hand. This affected their output in many ways. This is captured in the following quotes:

FG2M2: *I try to get it off my mind so I will be able to concentrate on work, but I still become quiet throughout the day.*

FG5M3: *Sometimes, ...you are not able to concentrate on the work.*

Other participants reported the lack of concentration on their own selves, and family as mentioned by these participants:

FG4M1: *It affects me as an individual; I do not eat well, can't concentrate when chatting. I cannot do anything for myself.*

M2: *When I go home, instead of doing other things with my family (husband or children), I cannot do it so it affects me and my family at large.*

DISCUSSION

The study investigated coping challenges associated with maternal related deaths. Its findings suggest that midwives experienced various coping challenges at their workplaces as a result of these deaths. Typically, participants reported their inability to accept maternal deaths, exhibition of grief reactions, had difficulty forgetting the deceased and also lacked professional and social concentration. Difficulty accepting maternal deaths is where midwives live with disbelief that the client had died and cannot come to terms with the loss. The midwives admitted pregnancy was not a disease, and most clients presented healthy. Improvements in clients' physiological conditions were evident, yet the unfortunate happens, causing occupational trauma and pain for attending midwives. Bickham, (22) agrees by postulating that the death of the patients was a disappointing situation to midwives and

may create coping problems. Dartey and colleagues (4) identified with the study, adding that occupational trauma, such as death of patient interferes with the wellbeing and performance of midwives. WHO (2) advocates occupational wellness for all so as to enhance mental health at the workplace.

This study also found that participants exhibited denial, anger, bargaining and shock whenever maternal deaths occurred. This is consistent with findings of Kübler-Ross et al (21) where they brought meaning to grief through the five stages of loss. Although these are well documented, the stages vary from one person to another. The study also found that grief reactions exhibited by these participants were not in any order. Neither did participants go through all at the same time (23). These ascribe to the Stage Theory of Grief that says grief reactions do not necessarily occur in a specific order, and vary from person to person (24). Thus, while some midwives experienced anger, others bargained with the reality of loss (21). Midwives sift through these states of grief, at risks of substantial occupational trauma as each reacted differently to these established states of grief (25). These phases are likely to cause strain on satisfying exchange relationships between midwives and patients. The good harmony of network and communication for social wellbeing is threatened, weakening the intellectual health statuses of midwives (2,26,27,28).

Similarly, difficulty forgetting the deaths of pregnant women was identified as a coping challenge for midwives. Difficulty to forget means midwives still remember what happened to clients who died in their care and find it uneasy letting go of these memories. During the course of care, emotional relationships are established (29). Where they are non-existent, sheer affinity by femininity is sufficient to inspire empathy and grief among midwives when maternal deaths occurred. Some midwives still recount everything that happened with clients several years on. Dartey and colleagues (4,25) agree with this observation, and attest that indeed, midwives find it difficult to cope after experiencing bereavement. Wilson and Kirshbaum (30) also agree that people find it

difficult to forget the death of loved ones, and are likely to become more vulnerable to dangerous states of grief responses, which they sometimes are unable to recover from.

Further, lack of concentration on work, family and self was reported. This challenge stems because midwives get preoccupied with memoirs of patients they had cared for. They easily lose themselves in their own thoughts, or freeze intermittently, during care delivery and social adventures. Participation, intuitive, initiative drives are dampened, potentially creating enabling environments for mistakes and errors. Kubler-Ross and Kessler (21) affirm with the study saying that attending midwives had limited time to consume the grief process. Gerow, *et al.*, (31) admit that even in cases where nurses cared for the dying, their vulnerabilities regarding patient loss remains unknown to the world. Preoccupation, as a result, reduces time and attention given to other caregiving services.

The psychosocial environment of the worker directly commensurates to his/her mental health. Promotion of mental health at the workplace illustrates employers' contentment to employees since performance goes a long way to affect psychosocial wellbeing (2,27). All organizations depend on employees' wellbeing to achieve their long-term performance and productivity objectives (32). Midwives as pillars in maternal healthcare, calls for urgent needs of effective intervention programmes to mitigate the coping challenges they face in the workplace. Failure to address midwives' issues would mean a failure in maintaining or improving maternal healthcare in Ghana.

This study established that midwives face coping challenges with maternal related deaths. It must be well understood that continued lack of intervention for midwives may lead to poor maternal health outcomes. These challenges must be addressed in promoting the occupational health convention of the WHO (2).

The findings of this study enhance prevailing issues of coping challenges that midwives struggle with as they work hard to provide healthcare services to women and children within resource-limited hospitals in Ashanti Region of Ghana. The

study establishes the need to develop wellness-based intervention programmes such as Employee Assistance Programme to ensure a positive work environment.

The study cannot be generalized to a wider group of midwives since it was carried out qualitatively using a smaller population with subjective views.

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