International Journal of Health Sciences and Research
www.ijhsr.org ISSN: 2249-9571

Original Research Article

Effects of Death as a Unique Experience among Midwives in the Ashanti Region of Ghana

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ABSTRACT

Uniqueness among human beings is innate and it influences behaviour and way of life. Different people perceive things differently even under the same conditions. Midwives as employees and humanitarian workers are throwing down the gauntlet by the death of their patients at healthcare facilities. Thus, individual midwife uniquely grief the death of their respective patients. However, the uniqueness of grief among midwives in the Ashanti Region of Ghana has not been adequately explored. This paper, therefore, presents the uniqueness of grief among midwives as they experience maternal death at their workplaces.

Research methods: Qualitative exploratory and descriptive designs were used. The purposive sampling procedure was used to select 18 supervisors for semi-structured individual interviews and 39 ward-based midwives for eight (8) focus group discussions. Thematic Content Analysis was used to manage data with the assistance of computer data analysis package (Atlas ti version 7.1.7). Ethics were obtained from the Research Ethics Committee of the University of the Western Cape and the Ghana Health Service.

Results: Four main themes emerged from the analysis of the collected data. These are; grieving patterns, intensity and impact of grief experienced, helplessness and duration of grief.

Conclusion and Recommendation: This study has established the uniqueness of grief among midwives whenever they experienced maternal death. It is recommended that Employee Assistance Programme should be instituted in hospitals in order to help the midwives deal with grief.

Key words: Uniqueness, Experiences, Midwives, Maternal death and Grief.

INTRODUCTION

Globally, human beings are seen and described as unique for the simple reason that, no two people are the same even from the same womb at around same time. [1] This uniqueness in human beings makes each and every one of us special. [2] People have different skin colours, cultures, language, and are used to different food to mention but a few. [3] Our ways of thinking and perceiving things are absolutely different. [4] The uniqueness of the individual makes the individual different from all other people and this also comes to play when people grieve the loss of a dear one. Similarly, midwives in Ghana grief differently when they experience maternal death at their workplaces (hospitals, clinics and health centres). It is believed that different bereavement experiences in different units or areas of medicine exist. [5] But within the same unit, the different

bereavement by the health staff would be based on the variety of grief-related symptoms that are experienced individually. [6]

In the hospitals, patient caregivers such as nurses and midwives have different sensitivity and relationship attached to the patient. This leads to varied line of their grief reactions and adjustment towards the death of patient. [7] For this reason, the death of some patients in the hospital is traumatic to the staff mostly because of their unexpected nature. Specifically, most of those occurring in accidents, Emergency Department, Critical Care Units and Maternity Units [8] and midwives as human service workers are always confronted with grief and suffering. [9]

The pain that comes with a loss of someone close can cause shock to the people involved especially, those who simply witness the death of that person. [10,11] For example, the paediatric nurses in the children's ward exhibit a feeling of hurt as a reaction to the death of a child, and this feeling of hurt could be described as feelings of sadness and sorrow. [11] It is believed that, the main responses of nurses and midwives to their patients' death include physical, emotional, cognitive, social as well as professional reaction. The physical responses are numbness, sleep disturbances, nightmares, and eating disturbances while the emotional or psychological effects may include denial, depression, anger, anxiety and a sense of guilt. [12,13] On the other hand, cognitive reaction involves questioning oneself and reviewing treatment given to the deceased before death. [7] Socially, people become isolated and want to be on their own and the professional reaction include lack of control over the situation, feeling distracted as well as feeling irritated towards other patients.

Therefore, different healthcare providers would exhibit different grief reactions or death impact based on the nature of the relationship they have with the deceased. Some healthcare workers tend to become strongly attached to their patient due to the regular onus for the health of their patient [11] as well as culture and religion of the people. [14,15] Culture according to Shamaki and Buang [16] is seen as some values, beliefs and behaviours common to members of a particular society, which provide a direction for people as to what is acceptable or unacceptable in given situations. While religious belief is defined as anything that has affirmative connection with peoples' behaviours. [17] It was confirmed that cultural background and the religious beliefs significantly influence the individual nurses' perception about death and dying. [18] However, perceptions from the individual's ethnic culture, traditional norms and values may have a significant influence on the different sociocultural behaviours of individuals. [16] These explain the different levels of reactions to death, death anxiety and emotional stress experienced by the individual nurses. For instance, the comparison of death reaction among nurses in the USA, Middle Eastern or Asia, Israel, Japan, Turkey and Iran exhibit different levels of death impacts and this might probably be linked to variations in the socio-cultural background of the places where the studies took place. [18]

According to most cultures in Ghana, maternal death is believed to be a tragic omen and therefore rituals are performed. For example, after the burial of an expectant woman among the Ga-Adangbe, all the expectant women are expected to have a ritual bath in the sea. Similarly, in some Ewe communities, the dead expectant woman is buried at midnight. [16] Culture, in this case, always serves as the central core to every existing society and without culture there would be no expression of the self, language of expression, self-consciousness and ability to think or reason. [19] The different level of self-efficacy of every individual contributes to varied ways of thinking, feeling, and acting. For a case in point, low self-efficacy contributes significantly to depression, anxiety, pessimistic thoughts about oneself and performance, lack of confidence, and

helplessness. [17,20] These feelings are likely to impact on the wellness of the midwives' personal and professional lives. However, little is known about the uniqueness of grief by midwives in Ashanti Region of Ghana when maternal death occurs in the hospitals. This paper, therefore, explores and describes the uniqueness of grief among midwives in the Ashanti Region of Ghana.

RESEARCH METHODOLOGY

Research methodology is the mechanism used by the researcher to investigate the reality of a study. [21–23] Depending on the nature and scope of a problem to be investigated, the methodological approach applied may differ from one study to another. In this current study, qualitative research approaches, with exploratory descriptive designs were used. An exploratory design as applied in the study targeted the discovery of new ideas and clarification of existing concepts in relation to how midwives react to maternal death. In addition, Polit and Beck, [24] define descriptive research design as a study of the main objectives of describing an accurate representation of the characteristics of persons or situations.

Research Settings

The setting for this study was in the Ashanti Region of Ghana where the highest maternal death cases were recorded in the country between 2010 and 2014. [25] For instance, the region recorded 165 in 2010, 253 maternal deaths in 2011, 315 in 2012 and 200 in 2013. [25] These records in the Ashanti Region of a small country like Ghana are higher than world target of 185 per 100,000 live births. The research study was conducted in nine health facilities which include one teaching hospital, one regional referral hospital, four district referral hospitals and three health centres.

Data Collection Methods

Two methods were used for data collection in the current study; semi-structured individual interviews and focus group discussions. The participants were firstly briefed on the scope and nature of the study, the discussion process and ethical considerations. A pre interview meeting was organized with all the potential participants. In each hospital, the hospital matrons introduced the researcher to the supervisors. Then, the researcher explained the aim and objectives of the study to the supervisors. The researcher then proceeded to outline the inclusion criteria after which, all potential participants were provided with information sheet and the necessary clarifications were made to those that needed them. As per the inclusion criteria, all supervisors (unit and ward managers) were qualified to take part in the research study and therefore the interested unit and ward managers were individually contacted for a convenient meeting time. The researcher noted that each participant's time in a dairy and scheduled the interview at a time and place that was convenient to the participants. Participants were made to complete an informed consent form. In all, eighteen (18) participants volunteered for individual interviews. The supervisors facilitated the selection of the ward midwives. As a result, thirty nine (39) people volunteered to participate in the focus group discussions. These participants were put into eight (8) groups with each group constituting at least four to seven members. The participants were assured of the confidentiality of the information they gave and they were made to sign the Consent Forms. Alphabets and numbers were used in place of participants' names. They were also told that they have the right not to participate in the study or to withdraw from the study at any point in time. The duration of each interview was determined by saturation. All interviews were audio recorded with permission from the participants.

Scientific Rigor

In qualitative research, trustworthiness of the quality of data collected is measured in terms of conformability, dependability, credibility and transferability. [26] According to Guba and Lincoln, [27]) trustworthiness is ensuring scientific rigor in qualitative research

without sacrificing relevance. Polit and Beck [24] maintain that results in qualitative research must reflect the fact on the ground as experienced by human beings. In this vein, trustworthiness of the current research is based on Guba and Lincoln, [27] position. As a result, after each interview, the audiotapes were played back to the participants in order to have them confirm or make any necessary changes so that any new idea that could have emerged could be clarified.

DATA ANALYSIS

According to Richards, [28] and Gibson and Brown, [29] qualitative data analysis is a process of working with data collected, bringing it together from the various participants, breaking it into manageable working units, synthesizing it, and searching for recurring patterns of new discoveries. In this study, data analysis follows Holloway and Galvin, [30] idea of data analysis procedures. Holloway and Galvin, [30] argue that data analysis begins with management of data, which involves transcribing, organizing and the development of categories and coding of data. Therefore, the study adopted the Thematic Content Approach in analysing data. The various ideas that emerged during an interview were managed under the mechanism of thematic content analysis. Thematic content analysis is a vibrant research method easy to use because it brings a basic understanding of the research methodology when it comes to analysis based on the interview data. [30] The analysis was assisted by the use of computer software for qualitative data, *Atlas ti* version 7.1.7. The researcher inputted the transcribed word document into *Atlas ti* software.

Ethical Consideration

The lead researcher got ethical clearance from the Senate Research Committee of the University of Western Cape as required and the Ghana Health Service. Additional permission was obtained from the Ethical Clearance Committee of the Ghana Health Service, Accra and Ashanti Regional Health Directorate since the study took place in that region.

RESULTS

Four main themes emerged from the study. The participants in this study generally agreed that they grief over the death of their patients. The study found that there were significant differences in the way the participants expressed their grief in relation to maternal death. The emerged themes are; grieving patterns, intensity and impact of grief experienced, helplessness and duration of grief.

Grieving Patterns

With regards to grieving patterns, the behavior of midwives who experienced maternal death was unique in the sense that participants presented their grief differently. On one hand, some participants reacting in a subdued manner; expressed themselves only through non-verbal expression, mood change and self-questioning mood, making each grief subjective in nature. This is illustrated in the excerpts below:

> *"It [Maternal Death] does affect me. As human beings when you hear of maternal death you instantly react, sigh and ask yourself how did it happen?"* FG1M4

> *"...especially, when you get to the ward and you see that maternal death has occurred, your facial expression and your personality change.* M4

On the other hand, some participants expressed outright agony as told in the following quotes:

> *"...the doctor was like, how could that be possible, so they rushed in there and started resuscitation of client but the patient was gone. So for me, I just started crying."* FG7M2

> *"The midwives come out and say, 'aaah! aaah!' somebody died this*

morning or at this particularly time, in fact it is pathetic. Most of the time, their expressions show that they are emotionally affected" M14

Intensity and Impact of Grief experience

The second theme depicted uniqueness based on the intensity and impact of grief when participants experienced the effect of maternal death. One's previous experience with death in a personal capacity influenced the intensity and impact of grief as demonstrated by the quote that follows:

"*For me, I say maternal death affects me a lot because I lost a daughter when she was pregnant so I remember that every time such a death occurs. I even end up crying.* FG1M2

Additionally, similarities to the midwife's condition at that time influence the intensity and impact of grief as depicted by the statement below:

"….All of a sudden, we saw that the patient contracted so we started giving oxygen and all other procedures seen necessary in her case but the patient could not survive. So I was very sad, I wept the whole night, that time I was pregnant so you could see what I was going through. So it was very sad that day." M4

The length with which the midwife and the client had formed a relationship also contributes to the uniqueness of the grief experience. Participants reported that the more they got into contact with the client throughout pregnancy, the more they grieve. This is illustrated in the following quotes:

"So for me, I just started crying because the patient had become my friend but…" FG7M2

"As far as it's our client, we build a relationship, rapport, so you will be able to manage and communicate with the client well" M6

Helplessness

Participants observed that they become helpless and the grief is worse when the client is well managed and she is known to be well. The following quotes depict the phenomena:

"This maternal death that happened, we wished it has not happened but it has happened… women are suffering but what else can we do, we just have to support them" M14

You can't do anything about the death so you just have to control yourself and live. M8

"I feel pity for myself because I feel that I have wasted my time and worked in vain because I lost what I wanted to have (my patient)". FG3M4

"When a woman comes to labour and looking at the stress the woman goes through and at the end the woman loses the baby alive or the woman dies at the end of the delivery process, it kills me because looking at the effort I put in caring for her." FG4M3

"So sometimes your disbelief gets worse when the client is a regular attendant of Ante-Natal Care (ANC), has been on the ward for a while and was managed very well. One gets surprised when such a thing occurs to her. FG1M1

Participants maintained that the relationship between midwives and clients are not limited to the hospital environment as found in the following quotes:

"The clients to the wards are people we worship with at church, people we meet in town. They are the people we meet in shops where we buy all the things we need so if I am caring for them and then I end up losing them, it means when I go to church, one church member will be gone, when I go to the market to buy something, the person wouldn't be there…." M9

Duration of grief

The duration of grief experienced is also affected by the age and the condition of the client. This is demonstrated in the quotes that follow:

> *"Maternal death, when it occurs is very sad especially when the patient is very young, so sometimes it is very sad in cases like abortion, the patient is very young, it is very sad"* FG7M1

> *"I feel very sad; ...I consider it like the client was my relative, and when it happens to the young woman?" FG2M3*

> *"It is very sad because the patient is very young and she is not matured to die. I feel sad because, maybe she took something to abort the pregnancy and it caused her life".* FG7M2

DISCUSSION

The word 'unique' means something special while 'experience', according to Moore, [31] relates to "an event or activity that leaves a lasting impression". Thus, a "unique experience" of maternal death in the context of caring for pregnant women in healthcare facilities each midwife experiences and expresses grief in a special and different way, as each death occurred uniquely and differently. Consequently, each participant in the study articulated herself uniquely and differently with each experience of maternal death as an outcome of grief related to the death.

A common uniqueness exhibited in this study is grieving patterns. The expressions of the participants in this study evidently revealed that midwives showed different grieving patterns whenever there is an occurrence of maternal death in the wards. While some participants showed a subdued reaction to grief others demonstrated open agony. Blood [32] defines grief as "all that represents the particular reactions people experience while in the state of bereavement, including anger, guilt, despair, and physical complaints. The participants' experiences of maternal death are subjective in nature, and this contributes to the uniqueness of the individual participants in this study. Thus, within the same unit, a different bereavement experienced by health staff would be based on a variety of grief-related symptoms experienced individually. [6]

The differences in participants' grieving patterns may be first and foremost be related to their different personalities as some participants communicated their grief through non-verbal communication. For example, sighing, change of mood, with a heavier heart while others used self-questioning, and many more not knowing what to do. Other participants expressed their grief through crying and trying to find answers to the questions that came to mind. It is a belief that different people with different personalities have different capabilities in expressing their grief. Doughty, [33] agrees with the current study that people's grieving patterns are influenced by their personality. Similarly, in a study done by Doka and Martin, [34] it was reported that the personality of the individual influences the person's reaction to loss.

The pattern of grief may also be as a result of the individual culture and religious beliefs of the person. It is believed that when peoples' culture and religion prescribe certain behaviours to certain deaths, the people become used to what is acceptable in their societies. This opinion is shared by McCance*et al.*, [9] who argue that the individual's own attitudes in response to death are mostly influenced by, cultural, social and philosophical belief systems that shape their reactions in different ways. This argument shows that culture can also be responsible for the different level of impact or grief on healthcare staff towards a patient's death since the pattern of behaviour forms part of the culture of people. Also, Peters *et al.*, [18] observe that people who become familiar with death due

to recent wars and natural disasters with a cultural environment and religiosity have a greater influence on their attitudes to death.

Individual grief was also considered as unique in relation to intensity and impact. Some participants expressed intense grief due to personal experiences and similarity of the situation. Personal experiences resulting from previous experiences from the death of a loved one that might not have been properly resolved. For instance, a participant who had lost a daughter through childbirth reported to experience emotional trauma each time maternal death occurs at work. To this participant, the occurrence of maternal death brings fresh memories of what happened when she lost her daughter. The unique experience which arises from every maternal death may be a mental image of peoples previous exposure to death or more so their perception of death at the particular moment. Therefore, unresolved 'mental picture' of death is likely to direct the behaviour of a person concerned which in turn would give a reflection of the emotional state of the person. [35]

In relation to a similar situation, pregnant midwives nursing pregnant women who died do experience a huge impact of grief. Some participants were seriously traumatised and this made their grief more intense because these midwives are unable to tell how their own pregnancy would end up. A participant, who experienced maternal death while pregnant, disclosed she was unable to do anything but cry throughout the night on duty. This situation did not only affect the midwife emotionally but also affected productivity and therefore the quality of healthcare received by other clients on admission at the said time.

It is known that no two people are the same and therefore no two people would grieve with the same intensity or impact even under the same circumstances. This is clearly supported by Meyers, Golden and Peterson [36] who argues that different people grieve with different intensity. In essence, people have different ways and attitude of dealing with stressful situations and circumstances. In supporting this, Bozarth [37] compared death to love and further explained that each death is as unique as love and thus loss is experienced differently. Therefore, it is most likely that previous exposure to maternal death is highly likely to influence the intensity of death in later years. Furthermore, the similarity of the situation (pregnant midwife nursing pregnant woman to death) for some participants made the grieving unique. According to the National Center for Victims of Crime [38] the fact that people are unique, it is expected that these individuals are assisted differently according to how intense they feel and respond to death.

Duration of grief experienced is dependent on attachment and relationship that exists between midwife and client. The relationship is as a result of the length of stay of the client on admission or number of visits made to a given healthcare facility. Besides, attachment and relationship, other factors associated with the duration of grief are; the age of the deceased, the diagnosis and condition of the client on admission and suddenness of death. This finding is reinforced by Rickerson *et al.*, [6] who are of the view that these factors may greatly influence the duration of grief that health workers experience.

It is obvious that the longer the client stays on admission, the greater the attachment developed between her and the midwives. Therefore, relationship, friendship and bonding influence the duration of grief; the more the attachment to the pregnant woman, the more the grief and vice versa. Participants declared that the attachment and relationship with clients do not only occur at the hospitals but extend beyond the boundaries of the healthcare facilities as they worship and fellowship at churches, meet at the shops, markets and other social gatherings. Additionally, if clients condition on admission is such that, there is little time for the midwife to build a strong relationship but to concentrate and provide the necessary services to the patient, the duration of grief may also differ. Also,

the age of clients who die affects the duration of grief. The younger the client who dies, the more time it takes to grief over the person and the other way round. This is because, according to the midwives, the younger client is not mature to die and therefore such deaths affect the duration of grief. The suddenness of deaths of clients in the healthcare facilities also influences the duration of grief experienced by midwives. Participants express shock when clients pass on suddenly, especially when the client is recovering well due to proper management. To this effect, McCance*et al.*, [9] adds that in hospital contexts, nurses and midwives have different sensitivities and relationships attached to a patient who may give rise to a varied line of their reactions (grief) and adjustment towards the death of the patient. The main concern is that if the duration of grief takes too much time, the person becomes pre-occupied with sorrow.

Grief takes over the mental capability of the individual midwife and therefore lack of concentration leading to reduced quality of nursing care provided to clients. In this regard, De Villers and DeVon, [39] agrees with this study that relationship between a health caregiver and client affects the duration of grief caused by anger, frustration and anxiety and may bring a sense of being unable to take ethically appropriate actions to rescue the life of the dying patient. The different duration of grief experienced by the participants is not surprising, because of the attachment midwives developed for their clients. It may also be because as humans as midwives are, would exhibit unique reactions to the death of people who come into contact with them whether related or not. Generally, grief is linked with severe emotional trauma and in this vein Costello, [8] and McCance *et al.*, [9] observe that deaths of some patients in the healthcare facilities are often traumatic to staff mostly because of their unexpected nature.

The grieving patterns, intensity and duration of grief are likely to affect the work of the midwives as their services are needed by other clients. The more the intensity of grief, the more likely the midwife will have low output. The duration of grief equally affects total work output as productivity becomes low. In addition, it is believed that most people are less attentive to planned activities when they are either traumatised or grieving. [37] This may result in loss of creativity where the individual becomes dismal and shows no interest in her environment or what must be done while others get wound up easily with little things. This may inadvertently lead to compromised quality of work and subsequently, compromised quality of work-life.

CONCLUSION AND RECOMMENDATION

This study has established how unique midwives grief over the deaths of the patients' as they experienced maternal death. This implies that even when strength is purported in the midst of the bereaved families and colleagues by this population, grief is still being experienced. It is recommended that irrespective of the uniqueness of grief experienced by midwives' as a result of maternal death, Employee Assistance Programme should be instituted in hospitals so as to help midwives deal with their grieves.

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How to cite this article: Dartey AF, Ngaiyaye EP, Phetlhu D. Effects of death as a unique experience among midwives in the Ashanti region of Ghana. Int J Health Sci Res. 2017; 7(12):158-167.

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