

# Reducing the Effects of Maternal Death: Midwives' Strategies

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## ABSTRACT

The ability to cope and adapt in a stressful work environment is a sign of good mental health. Some work environments are challenging and the individual employee is expected to take responsibility for his/her safety, whether physical or psychological. Coping and adaptation are functional roles for all humans, and are important for survival and well-being of every individual. Naturally, midwives working in challenging environment would employ some strategies to help them cope with the effects of maternal deaths. However, literature has little on the coping strategies adopted by midwives in the Ashanti Region of Ghana to deal with the effects of maternal deaths. Therefore, this article highlights the coping strategies adopted by midwives to mitigate the effects of maternal deaths and how they adapt to their work environment.

A qualitative research approach, with an exploratory descriptive design was employed in the study. Purposive sampling was utilized in selecting 18 ward supervisors and 39 ward-based midwives as they met the inclusion criteria. Data were collected through semi-structured individual interviews and focus group discussions. The Thematic Content Analysis was used to manage data through transcribing, organizing, development of categories and the coding of data. Final data management was assisted by qualitative computer data analysis package (Atlas ti version 7.1.7). Two main themes and six sub-themes emerged from the study. The major themes are: informal strategies and systemic support system using maternal death review/audit. It is recommended that, hospitals should provide counselling services through employee assistance programme to facilitate coping with maternal deaths.

**Key Words:** Coping strategies, wellbeing, adaptation, midwives and maternal deaths

## INTRODUCTION

Health professionals, especially midwives, come into contact with deaths of healthy but physiologically challenged clients every day, particularly in the Sub-Saharan Africa, where maternal death is highest. <sup>[1]</sup> According to World Health Organization (WHO) and its partners, 830 women die every day from preventable pregnancy and childbirth related deaths and 99% of these deaths occur in developing

countries. <sup>[1]</sup> Institutional maternal deaths in Ghana are equally not low. As demonstrated by GHS, <sup>[2]</sup> 195 maternal deaths were recorded in 2011, 152 in 2012, 153 in 2013 and 143 in 2014. These figures indicate that midwives are exposed to a number of maternal deaths such that some of these deaths are very quick and surprising. <sup>[3]</sup> This leads to ardent charged atmosphere and life-changing situations for both family members and the midwives as they are

confronted with grieving and suffering. Literature suggests that constant interaction with such sufferings increase the occurrence of stress, burnout and compassion fatigue. [4] Witnessing maternal deaths come with fear, emotional distress, and coping challenges, [3,5] which in turn does not only affect the quality of care offered to other patients, [6,7] but also the quality of wellbeing experienced by these midwives. In a study by Deffner and Bell, [8] it was established that health professionals have difficulty in relating to dying patients by expressing sadness, anxiety and helplessness. Similarly Cevick and Kav [9] found a significant association between negative attitudes with a greater fear of death and avoidance of such situations among nurses. Additionally, most negative attitudes towards the care of patients were common among nurses who reported a greater fear of death and who presented more avoidance behaviours. [10] Literature has established that continuous exposure to death influences nurses' perception towards death [11] and the response adapted to these devastating experiences is adaptation and coping. [12] Adaptation is seen as the readiness and willingness to make a change and negotiate the uncertainties associated with jobs. [13] It is believed that career adaptation is one major competency required from employees lately during recruitments [14] as it is needed for professional and organizational development. Coping on the other hand is the ability to face and manage challenges, difficulties and responsibilities, successfully in a calm manner. [15] Adopting and coping are the two very important mechanisms in life as they influence individual's behaviour; by not only dealing with basic survival, but also enhancing growth and development of the individual. [16] They therefore influence the quality of work life of the individual.

It has been established that differences exist with individual ways of coping in challenging work environments. [15] Thus, no two individuals cope in the same manner, since individuals have

different resources such as motivation, self-esteem, and personal control. [17] It is believed that the capacity to cope with challenging work place depends mostly with trait, culture, resilience and the person's personality [18] and therefore, coping style is independent of the individual. The ability to work well and deliver appropriate nursing care services to pregnant women and young children equally depends on how well the affected midwife adapts to the stressful work environment. It has been acknowledged that stressful work situations affect physical, psychological and mental health and is related to the poor wellbeing of employees' as well as psychosomatic disorders. Inability to cope leads to absenteeism and poor work performance. [19]

Coping plays an important role in workers' lives since it improves wellbeing and health: "work stress strains relationships". In an ideal world, the use of coping strategies for dealing with stressful situations, by employees, solely depends on organizational arrangements, as some of these stresses are out of the control of the employees in many instances. [17] It is on these bases that Dolan and Ender [20] recommended the need to understand the type of stress the individual is battling with and the perception associated with it; contextual factors involved. Coping can be traditional and non-traditional. Traditional coping employs information sharing session consisting of a conversation between familiar people while non-traditional coping uses professionals or formal systems in dealing with the issues at hand. [21,22] Peiro [19] admits that coping with work stress has long been traditional for decades. A qualitative study by Dolan and Ender, [20] indicates that the use of traditional coping strategies helps, as workers seek social support from colleagues, family and elders of association. Khawaja, White and Schweizer [23] and Ano and Vasconcelles, [24] also acknowledged the importance of religion and social support system in coping with stressful situations. Apart from the social support, employees use other means

of coping such as music. It is believed that music helps people to cope by making them relax from their stress. Other research studies found that some people employ alcohol as a method of coping. [25] For midwives to deliver well at work, they must find a way to cope with maternal deaths that occur at their workplaces.

## **MATERIALS AND METHODS**

The study used a qualitative approach because it is an interpretative methodological approach that is supposed to create more subjective knowledge. [26, 27] It develops from the behavioural and social sciences as a process of understanding the exceptional, self-motivated and all-inclusive nature of human beings. [28] The exploratory design as applied in the study also targeted the discovery of new ideas and clarification of existing concepts. However, in doing this, the researcher had no intention in determining the cause-and-effect relationship of the phenomena under investigation. [29] Rather the idea was to portray coping strategies used by midwives to mitigate the effects of maternal deaths as they experienced them. [30] The descriptive design also enabled the researcher to highlight how the different coping strategies are used to reduce the effects of maternal death on midwives' personal and work life.

### **Research settings**

Nine health facilities that included one teaching hospital, one regional referral hospital, four district referral hospitals and three health centres in the Ashanti Region of Ghana, where maternal deaths have been high over three years were used.

### **Data Collection Method**

Data were collected through semi-structured individual interviews and focus group discussions. These two methods resulted in a conversation between participants [31] and also between individual participants and the researcher [29,32] which generate huge subjective data. Purposive sampling was used to select the sample. The sample size was determined by saturation of data. As a result, 39 participants constituted

eight (8) focus group discussions with four to seven participants. 18 semi-structured interviews were also conducted with ward and unit supervisors. Both methods used between 40 to 60 minutes for one interview or focus group discussion. Participants were educated on the type of the research study by the use of information sheets and participants were informed of their responsibilities if they agree to partake in the study. The inclusion criteria were discussed with the various hospital matrons who assisted the researchers to select qualified participants.

### **Data analysis**

Data were analysed concurrently with data collection with the aim of examining new information. Data analysis followed Holloway and Wheeler's [33] idea of Thematic Content Analysis. Data analysis started with validation of the recorded information. The researchers listened to the audio recording, in most cases two times before the transcription of data. Transcribed data were read repeatedly to make sure the audio recordings were fully transcribed and also to gain more understanding of the issues under investigation. Data were cleaned to identify unsound information in the data collected. Follow up was made in most cases for participants to confirm the information given. Data was coded to sort the different information. During the process of data analysis, similar codes that emerged were gathered to create families and similar families grouped together as themes. [34] The analysis was assisted by computer software, Atlas ti version 7.1.7 of qualitative data analysis.

### **Ethical Clearance**

The ethical clearance for the study was obtained from the Ministry of Health/Ghana Health Service and Senate Research Committee of the University of Western Cape, South Africa, where the lead researcher studied.

### **Trustworthiness**

The study achieved trustworthiness by the use of member checking, the use of multiple participants (unit manager, ward supervisors

and ward midwives) with different work experiences to examine the topic under investigation. Further, peer checking and prolonged engagement with data was employed to verify credibility. Triangulation of different methods of data collected, peer debriefing, and prolonged engagement with participants as well as using official data analysis methods was ensured.

## RESULTS

### Demographic Characteristics of Respondents

Only females took part in the study, ranging from the Staff midwife to the Director of midwifery. Approximately 53% of the participants were from the junior ranked officers. Midwives were between the ages of 22 and 61 years with 56.1% of them less than 46 years. This means that more young midwives suffer maternal death in their work life with coping challenges. The midwives had at least 3 years of work experience and at most 25 years working experience since their first appointment. More than half of the participants have been in service for more than 10 years, giving a clue that the midwives have good working experiences and possibly multiple exposures to maternal death and the process that follows.

The study findings highlight the adaptive strategies employed by midwives to mitigate the effects of maternal death on them. An official support system from the participants' workplace was non-existent, leaving them to adopt different strategies to reduce these effects. All participants agreed that they adopt one or more of these strategies to help them cope with the effects of maternal deaths. Two main themes with six sub-themes emerged from the study and these are Informal strategies and systemic support system using the maternal death review/audit.

#### Theme one: Informal Coping Strategies

This theme comprises six sub-themes: individualized non-professional support, support from colleagues, family

support, self-support and spiritual support. These support strategies are employed individually or combined. Sometimes, participants change from one strategy to another if one fails to work for them. The midwives devolve their own means of dealing with the maternal death situation as there is no formal support system available for them when they experience the effects of maternal death.

#### Individualized non-professional support

*Most participants, irrespective of years of work experience, reported that talking to someone after experiencing maternal death helps them to cope. For this reason, they spoke to someone they trust irrespective of the person's professional background. The participants expect to be consoled by the one they talk to. This is evident in the statements by participants:*

*When you talk to someone, when you get someone to talk to, then, you will be a little bit relieved, 'that person will console you, that person will tell you it's not your fault, you tried to do everything for the patient but then the patient died, it's not your fault, there is nothing you can do about it. (FG6M1)*

*Also, like talking to someone, it helps a lot. So if you have someone who talks to you like that, I think it calms you down for the next shift so that you can come to work. (FG7M2)*

#### Support from Colleagues

The findings revealed that colleagues assist with coping. Attending midwives reported having been comforted by colleagues at work when one experienced maternal death. This they believe helps a lot, even though they are not consistent with consoling each other, as noted by these participants:

*Colleagues sometimes when it happens [maternal death] and you are there and you are discussing it, then you might say something to console your colleague but it's not something we normally do. (FG6M3)*

*Nobody counsels or supports the midwife psychologically, we counsel ourselves, especially those of us on duty. (FG2M1)*

*Hmm! I just talk with my colleagues... we talk about certain things that should have been done in order for the woman to be saved, so when talking about all these things, then may be will bring out a joke or something like that then all of a sudden everything will go off. (M5)*

Some participants reported that some colleagues think that only family members of the deceased should be consoled and not colleague midwives who are not related to the deceased. This therefore makes support from colleagues not consistent, as some get consoled and others do not. This is what one participant has to say:

*Even among your colleagues, all they can do is to ask "ooh..., what happened?" and sympathize, but because the patient is not your relative they don't support you so much. (FG1M4)*

*More so, it was observed that colleagues comfort each other based on the performance of the attending midwives. If the attending midwife performed well during the care of the deceased woman, she is consoled. Otherwise, forget it. This is demonstrated in the quotes that follow:*

*I point it out to those who do well and those who do not do well, will let you know that you have neglected your duty as a midwife so that next time you sit up. I even remove them to another area of the unit. (M16)*

Some supervisors, however, acknowledged that the support they offer to the attending midwives at the time of maternal death is not good enough because they are not professional counsellors:

*The support I give as the ward manager is not enough, but the hospital doesn't have a way of motivating or helping in this way. (M8)*

#### **Family support**

Family is important for every individual and for this reason, people expect family members to support them in times of difficulties. Family support was acknowledged by some participants:

*When my mum gave me the psychological support, I became okay. If she was not there, I would have called my husband*

*(currently in school) for the psychological support on the phone because I really needed that support. (M13)*

*I had to narrate the incident to my mum who consoled me before I could calm down. My mum said God will not allow that to happen to you. (M17)*

*Sometimes you tell your husband by explaining what actually happened 'a pregnant woman came to die today' and it's so pathetic (FG6M5)*

#### **Self-support**

The findings reveal that some participants supported themselves in the midst of difficulties. They depended on their own will power and inner strength to survive each time they experienced maternal death. For instance, the following quotes:

*You the midwife will be sorry for yourself without knowing what to do. Nobody cares for the midwife - you have to reassure yourself in order to overcome the pain. (FG7M6)*

*Death is inevitable: you can't do anything to stop it so putting that information in my mind at times I tried to overcome it. And that I did my best under the circumstances. (FG4M3)*

*When you put the sadness behind you, you will enjoy what you do, you try to do what you do to help other clients'. That's what I think. (FG6M1)*

Furthermore, participants perceived that coping only occurs for them after taking time off duty. Thus, they needed to be by themselves without anyone interacting with them, as illustrated below:

*Immediately after the death, one cannot work, but has to take a break, reflect on it and continue work later... (FG2M1)*

*You cannot leave the [other] clients and go home, but you can take a rest, like few minutes rest and continue later to see the other patients. (FG1M2)*

*I will let her [other client] wait for a while to reorganize myself from the shock. (M2)*

*I just take about 30 minutes rest... then, take care of the rest of the clients. (FG1M3)*

#### **Self-reflection**

Participants believe that coping sometimes comes naturally depending on how much care the midwife is able to provide to the client on admission and also client's diagnosis or prognosis on admission. The participants come to terms with this information after a sober reflection of all what happened. This is affirmed in the following quotes:

*When I sit and reflect on what I did (care provided) for the mother, say I did my best, maybe I tried all I could, but could not save her life I will overcome it, but if I did not do my best it is difficult to overcome it. (FG4M1)*

*You will be asking yourself what you did wrong, but most of the time, it will not be your fault because you gave the accurate care, but along the line, something comes up and the patient expires. (FG1M4)*

*Sometimes when maternal death occurs, you sit down and reflect on what could have been done or what went wrong or what didn't you do? (FG1M2)*

*It depends on the condition that the patient died with. If it is very preventable, it takes longer. (FG2M4)*

### **Spiritual support**

Another adaptive strategy reportedly used by midwives to cope with the effects of maternal deaths is spiritual support. Thus, some participants tend to find relief in praying to God, the comforter as indicated in the excerpts below:

*I wonder where the dead people are and say a word of prayer for them; at least, it makes me feel good that God has accepted them into his bosom. (FG1M4)*

*It takes time, but I pray over it that God should take away the unhappiness from me. (M15)*

*Just the grace of God and life must continue. (FG4M4)*

*It is just by the grace of God, we are able to move on. (FG4M3)*

### **Theme two: Systemic support system using maternal death review/audit**

Systemic support received through undergoing Maternal Death Review was

captured as a coping strategy useful to midwives in addressing the effects of maternal death. The maternal death review is a system of checking how maternal death occurred to assess if there were any lessons to help prevent future occurrences of such nature. It has an unintended effect that assisted the midwives to cope after maternal death occurred [3] Thus, participants felt supported and the system was also seen to be an official process that midwives go through after recording maternal death in their health facilities. Although it was reported as a process that can instil fear, the participants also perceived it as a form of support that brings closure to each maternal death case. The ward first does the review/audit to hear from all the attending midwives as seen in the extracts below:

*The ward review helps to calm the nerves of the midwives down. I think that if the ward review is not done, the staff cannot give their all when caring for [other] patients for fear of reproach from the authorities" ... It is a way of supporting the staff instead of blaming them, even if we want to say something to them "you could have done this another way so next time try that way" one can put it nicely and tell the staff. (FG1M3)*

*We come so that all of us will sit down, and then we probe our work: what we have done so far, what went wrong, where there is a need to congratulate, we also congratulate, but where there is a need to also change certain things for the better we do and we talk to ourselves and we allow some perfections. (M10)*

The hospital does its review/audit after the ward has. This is demonstrated in the following quotes:

*When there is maternal death, we have maternal death audit, we go through auditing, look at the cause of the death, what could have been done well, and what was done well, and if we need to put something in its proper order. So after the audit, we also meet and then explain to other midwives the cause of that death. If they did well, we encourage them to keep it*

*up, if there was something that was supposed to be done properly, we also talk to them to tighten their belt and then sit up and do the work. (M14)*

*I don't think...aside the maternal audit, there is nothing official to address it and support midwives. (FG3M2)*

## DISCUSSION

The study indicated various adoptive strategies employed by midwives to cope with the effects of maternal deaths at the workplaces. Distinctively among these are Informal Coping Strategies: individualized non-professional support, support from colleagues, family support, self-support, spiritual support and systemic support system using maternal death review. It was reported that coping strategies employed by midwives were unique as each and every one employed a different one. It was observed that few participants changed or added other coping mechanisms if what employed earlier was not useful to their needs. This position is not different from the stands of Muliira et al. [35] who contended that coping strategies should be varied since some coping strategies may not help some midwives in averting death anxiety. A previous study by Krasner, et al. [36] also support this stand as coping at workplace is seen as a process of curbing the effects of occupational stress; mental and physical health to inhibit suffering, burnout and psychological maladjustment. Welbourne et al. [37] added that the ability to cope effectively with challenging work situations depends on the individual understanding of that event. Coping mechanisms depend on the source of the problem, individual's appraisal and situation in the workplace. Positive coping helps the individual to settle quickly and this brings internal stability while negative coping does not help the individual. Thus, maternal death is seen as a difficult situation for midwives and therefore needed attention should be provided. The participants in this current study, appreciate and like to talk to someone; non-professional, someone they

trust; explain what happened before the pregnant mother died.

Further, some participants also discussed the incidents with colleagues. According to these participants, talking to someone about the incident brings relief. This looks like an important intervention to midwives to keep their heads above reproach and cope with the work ahead. Tyson, Pongruengphant and Aggarwal [38] agreed with the current study as they defined coping as "intervening variable that may moderate the effects of stress on an outcome variable such as job satisfaction" (pp. 455). More so, getting relief after talking to someone demonstrates the important role communication plays in coping with occupational challenges as affirmed in a research conducted by Hansmann, Hug and Seeland, [39] where they indicated that talking to a friend help with coping. Talking to a friend could be colleagues at work or even outside work and gaining their approval for doing their best. However, the barrier to self-expression is the unresolved previous experience of a peer with whom the newly affected midwife can disclose her feeling to. [40]

A good performance in terms of the services provided to the client before her demise is, however, important in getting the needed support from colleagues when there is maternal death at the hospital. Some ward managers (supervisors) in this study attested to the fact that they call the midwives on duty after the incident for a talk, but also acknowledged that since they are not trained counsellors, they are unable to fully meet the needs of the anguished midwives. Other participants complained about some colleagues who do not care about how the attending midwives feel because they think the attending midwives are not related to the deceased in any way, and therefore, do not deserve to be supported. Few participants complained that they are judged by colleagues for not giving the best of care to the dead and therefore do not need to be supported. This is in line with a study conducted by Mc Kenry, [41] where a death

is identified to pose painful challenges to people who experience loss and become vulnerable to adapt. They therefore take themselves out (leave) of the uncomfortable situation in which they find themselves. This is a form of avoidance coping strategy in line with a study by Parikh et al., [42] that revealed that the most used coping strategies are avoidance of the situation.

Results further revealed that some of these participants depend mostly on family members for support. This was prominent among young midwives, who resorted to talking to their parents, especially their mothers, those who are married talking to their husband either by phone or face-to-face. Bickham [21] and Hanna and Romana [22] admit that information sharing is important in coping and sees stress debriefing as information sharing event or processing session consisting of a conversation between peers. Twoy, Connolly and Novak, [43] approve the current study, that active coping strategies are vital positive ways of solving stressful problems such as death of patients at work. In as much as talking to someone is good in managing the effects of maternal deaths; it may not always be the answer to remedy work-stress related problems. [22] Lim, Bogossian and Ahern, [44] also agree with the current study, acknowledging the role of family support in times of work challenges.

It was evident in the results that some participants supported themselves by consciously motivating themselves from the effects of a patient's death. Self-support strategies employed are comforting themselves that they have done their best under the circumstances, taking a break and reflecting on the events that led to the death of the client. Tugade and Fredrickson, [45] admit that coping strategies bring out positive emotion in the individual and this helps in modifying negative emotional circumstances that affect the individual. Taking a break gives people the opportunity to leave the tense environment for some time. This is seen as avoiding "coping" as confirmed by Tugade and Fredrickson. [45]

In which case, patients had to wait for midwives till they are okay psychologically before they attend to them. This is seen as a form of emotional repair to the individual. This finding is similar to other research findings that help professionals make sense of services they provide to their clients. Montes-Berges, and Augusto, [46] concurred with the current study and posit that emotional repairs improve mental health for better delivery. Furthermore, self-reflection on the care provided to the deceased patient before her death was a means of coping to the attending midwives who experienced maternal death. This position was also accepted by MacDermott and Keenan, [47] who highlights some self-support coping strategies adopted by nurses to help them manage their grief, and these included self-expression, self-nurturance, and termination of relationship activities; engage in control taking activities, and self-reflection.

Additionally, the results of the study show that some participants in this study cope with the death of clients after praying for 'the souls to be received by God in heaven'. They pray to God for the deceased soul. The employees utilize personal mechanisms such as prayers that would enable her to withstand or cope with the existing trauma experienced through access to social support. [48] It is obvious that, those who experience maternal death become worried and would want to be comforted by somebody. They expect to hear positive things from the people they talk to, in order to make them feel better.

#### **Systemic support system using the maternal death review (MDR) /audit.**

MDR is an official auditing process used to ascertain the cause of death of any pregnant woman at the healthcare facilities. MDR is a WHO requirement for all member countries to help reduce maternal death and improve quality of maternal health care, therefore; MDR is done anytime there is a maternal death in Ghana. [49] MDR is not an official counselling or debriefing section, nor is it a workplace intervention programme. Participants consider MDR as a



means of coping for midwives in this study because until they go through the MDR and their case is heard and closed, they are not free. They cannot tell if they would be blamed for the death of the client or even be punished. Participants in this study see MDR as an important part of coping and depend on it as such since there are no workplace intervention programmes to help them cope with patients' death related problems. Austin et al. [40] posit that health institutions have refused to recognize the effect of adverse event on its staff and provide the support needed to help such victims cope with stress. The need to improve services towards clients is really paramount and therefore, midwives must identify and confront their own feelings towards patient death. [21]

It was obvious that little attention and buttress was provided to midwives as well as the needed strategies to help them cope with the stress involved when confronted with a patient death. [21] For example, Ní Chroinin et al. [50] confirmed from their study that the hospital lacked bereavement management services or counselling skills required in helping the nurses cope with stress resulting from patients' deaths. Coping or adjusting to the effects of maternal death (stress management and self-mobilisation) is seen as the ability to organize and successfully or unsuccessfully deal with stress and its factors. [51] Therefore, it is important that the potential stresses specific to an organisation be acknowledged and interventions aimed at reducing and preventing the negative impact of stress should be put in place [52] This also helps them to cope after reflection on what they did rightly or wrongly.

## CONCLUSION

Despite the maternal death experience, all midwives still find a way to cope often using informal coping mechanisms such as engaging with family and close trusted people not associated with maternal death and the health care facilities.

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