

A paradox: Midwives' Experiences of Attending a Birth Resulting in Maternal Death in a Ghanaian Context

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ABSTRACT

Background & aim: In a lower-middle income country, such as Ghana, maternal death still occurs even in case of providing skilled perinatal care. The impact of maternal death on the family, community, and society has been largely studied. However, its implications for midwifery practice in Ghana has not been extensively investigated. The purpose of this study was to explore the experiences of midwives whose clients died during the peripartum period and unearth the influence of their experiences on their personal lives and practices as midwife.

Methods: The present study adopted a descriptive exploratory approach. Purposive and snowball sampling were employed to recruit six midwives attending the women who died during the peripartum period. The experiences of midwives were uncovered using in-depth interviews. Data analysis was conducted using Colaizzi's phenomenological method as a frame of reference. Rigor was maintained through member checking and prolonged engagement.

Results: Four main themes emerged from the data, including conceptualizing maternal death, midwives initial reaction to maternal death, perceived preparedness to manage maternal death, and building resilience (blurring the memory). There was minimal institutional support for the midwives when maternal death occurred. The participants used various coping strategies to rebuild their self-confidence and professional confidence.

Conclusion: Midwives attending women who die during the peripartum period suffer emotionally and psychologically. The implications of these experiences in the midwifery profession are enormous. Supportive strategies should be institutionalized to achieve the complete recovery of attending midwives and provide experiential training of the entire midwifery staff.

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Introduction

In Ghana, midwives are the largest indeterminate of health workforce providing peripartum care; attending 57% of all supervised deliveries in 2016 (1). Attending a woman in the peripartum period includes being emotionally and physically present for the expectant parents during the pregnancy, demanding labor process, and postpartum period (2). The attending midwife usually experiences the joy of safe delivery while caring for the mother and child; however, unexpected

adverse incidents, such as maternal deaths, sometimes occur during the peripartum period (3).

A peaceful death is an acceptable outcome of nursing care (4). Conversely, maternal mortality is an adverse incident still occurring in Ghana and many other third world countries in spite of all the efforts that have been made to end its occurrence (5). Therefore, the reduction of maternal mortality has been an important indicator of the success of both the Millennium

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Development Goals (MDG) (5) and Sustainable Development Goals (6).

Ghana as a country allocated many resources and efforts, including the improvement of access to skilled delivery, to meet the above-mentioned goals. Recent evidence indicates that both one and four antenatal visits for all expectant mothers recommended by the World Health Organization exceed 90%, and the estimated 73.7% of national deliveries are attended by skilled providers (7). Consequently, the maternal mortality ratio decreased from 580 mortalities per 100,000 live births recorded in 2007 (9) to 310 mortalities per 100,000 live births within 2010-2017 (8).

In spite of the decline in the rate of maternal mortality, Ghana was unable to achieve the MDG 5 indicating that some midwives experience the death of women they attend during the peripartum period. These experiences of client loss pose a professional risk to midwives that is described as secondary traumatic stress (10). Therefore, the midwifery profession has been described as stressful with psychological and emotional tensions (11,12).

Given that the role of midwives is indispensable, it is there is the need to take measures to perceive healthcare challenges from a midwifery perspective and ensure their wellbeing (13). With this background in mind, the present study aimed to investigate the experiences of midwives whose clients died during the peripartum period and unearth the effects of their experience on their personal lives and practice as midwives.

Materials and Methods

This qualitative study was carried out using the descriptive exploratory approach (14,15). The design was suitable as it allowed for an in-depth exploration of a sensitive subject that has not been widely studied in the Ghanaian setting. Furthermore, the identity of the midwives was protected as a strategy to shelter them from stigmatization and discrimination; as a result, the population size was not readily known. No pilot study was conducted prior to data collection.

The study population included registered midwives in Ghana attending women who died during the peripartum period. The inclusion criterion was registered midwives in active

service having experienced a maternal death in a health facility. Furthermore, midwives were excluded if they were retired.

Two non-randomized sampling approaches were used in the recruitment of the participants. Purposive sampling was applied for the recruitment of the first participant. Subsequently, the other study subjects were recruited through snowballing. Six (6) midwives attending women who died during the peripartum period were identified as cases with each experience examined as a unit of study. No sample attrition occurred in the present study.

The study employed a face-to-face in-depth interviewing technique for the data collection using a semi-structured interview guide. The interviews lasted between 60-90 min. To ensure rigor, follow-up interviews were conducted for the clarification of participants' experience and member checking. Data saturation was achieved at the 12th interview. The interviews were carried out over a period of 6 months as a measure of prolonged engagement, and an audit trail was established as all decisions taken during the study were documented. The interviews were conducted in English and Fante (i.e., a local Ghanaian language) and audio-recorded. verbatim transcription of the interviews was performed. The interviews conducted in Fante were translated into English prior to analysis.

Back-translation was conducted to ensure that the meanings of the participants' experiences were not lost during the process of translation. Colaizzi's method of data analysis (16) was employed to analyze the data. This method involved seven steps of data analysis. It allowed for immersion in the dataset through repeated reading of the interview transcripts, extracting significant statements, and unearthing essential meanings that are present in the descriptions of the participants' experiences (16).

Ethical considerations were ensured by obtaining informed consent from all the participants and respecting their anonymity and privacy. The study also complied with all the ethical considerations stipulated in the Declaration of Helsinki.

Results

Characteristics of the participants

A total of six registered midwives participated in the current study. The mean age of the participants at the time of the study was 36.8 years. An equal number of the study subjects had worked in rural (n=3) and urban (n=3) health facilities at the time of the incident. The minimum qualification at the time of a maternal

death was a certificate in midwifery which was held by one participant; however, four participants had a diploma in Midwifery. The present study recorded 42 years of midwifery experience among the participants. Five of the maternal mortalities occurred in the postpartum period (Table 1).

Table 1. Biographic data and professional experiences of participants

Pseudonym of midwife	Age (year)	Educational level at time of incident	Location of practice at time of incident	Duration of experience at time of incident (year)	Incident ward
Adwoa	37	Diploma	Urban	4	Postnatal ward
Abena	41	Diploma	Rural	10	Postnatal ward
Akua	32	First degree	Urban	7	Labor ward
Yaa	28	Diploma	Rural	5	Postnatal ward
Afua	32	Diploma	Urban	3	Postnatal ward
Ama	51	Certificate	Rural	13	Postnatal ward

Characteristics of the clients

The mean age of the women who died while receiving peripartum care in the health facility was 31.5 years. Five cases were married among the participants. A total of seven surviving children were recorded among five women;

however, one mother did not leave a surviving child after her mortality. The major cause of maternal mortality as reported by the midwives following the audit was postpartum hemorrhage accounting for the death of four participants (Table 2).

Table 2. Characteristics of dead clients during the peripartum period

Pseudonym of client	Age (year)	Marital status	Gravidity	Parity	Established cause of maternal death
Joy	27	Married	2	1A	Postpartum hemorrhage
Peace	30	Married	3	2AA	Raptured uterus
Love	31	Married	3	2AA	Eclampsia
Hope	40	Married	1	0	Postpartum hemorrhage
Faith	36	Married	2	1A	Postpartum hemorrhage
Forgiveness	25	Single	2	1A	Postpartum hemorrhage

Four main themes emerged after analysis, including conceptualizing a maternal death,

attending midwives' initial reaction to a maternal death, perceived preparedness to manage a

maternal death, and building resilience (blurring the memory). Subthemes were generated under each major theme.

Theme one: Conceptualizing maternal death

The midwives conceptualized death as botched care, regrettable loss, adverse incident, and indelible scar.

Botched care

The death of a woman receiving supervised peripartum care was likened to botched care by the participants. This failure was ascribed to the attending midwife, midwifery unit, and health facility in which the care was accessed by the woman. It was due to the fact that maternal mortality is an altered outcome of the midwifery service delivery, which is to deliver a new life into the world. The attending midwife was the first person to experience the feeling of failure when the incident occurred.

"...this [the death of a mother] is every midwife's greatest fear... if it happens, it is like you are incompetent... ahaaaaa... like, you were tested, and you failed... like, I don't know how to say it, but, like you failed...so do you understand?" (Ama)

The failure is further imputed to the midwifery unit and health facility by family members, community, and in some instances other members of the health team. This concept of failure reportedly fueled the perception and rhetoric of the client's family and community members about the competence of the unit and health facility in providing peripartum care.

"I remember when the news of the death was broken to the client's mother, she started wailing and insinuated that she told her daughter to deliver at a private hospital and she had always known that the midwives in our hospital were not experienced... it was painful... like one person died, and every midwife and even the facility were blamed..." (Abena)

Regrettable loss

All the participants described a maternal death as a loss. The death creates a vacuum in the family that is mostly felt by the immediate family, especially the partner and (unborn) child.

"My main concern as a midwife at the time is the newborn. If a mother dies, the child will lose

maternal love, colostrum, and warmth... they are precious things. No one can replace a mother..." (Afua)

The midwives expressed a sense of loss when a maternal incident occurred. The participants' narratives revealed the establishment of a relationship between the midwife and client beginning when the women referred for admission at the onset of labor. The relationship reportedly evolved when the midwife performs various assessments, providing emotional and physical support as the labor progressed until mortality occurs. Consequently, the midwife's feeling of loss is based on the abrupt severing of the relationship with the client.

"Hmm, it is not easy; we get to know the women... ooh... Me, for instance, in my case, I like to chat with the women when they come on admission. Especially, the primips; they come as soon as they experience a little pain... they usually stay for a while before they deliver. So, we chat and comfort them, and reassure... so if such a person dies, you also feel it..." (Akua)

Adverse incident

Most of the midwives described a maternal death as an adverse incident. The midwives revealed that the processes which are triggered when maternal mortality occurs project an aura of urgency and negativity.

"When a maternal death occurs, you have to write a detailed report. In my ward, we quickly organize a ward meeting, then metro health [department] is informed, then they set a date for maternal audit, meetings upon meetings with everybody who matters in the facility occur... even this is a sign that all is not well... Heh! It is not easy... ooh... even outsiders will know, the news spreads so fast eeh... hmmm! (Akua)

Indelible scar

From the narratives, a maternal death was similar to an indelible ink that permanently left a mark on the attending midwife's professional life. Its implications on the subsequent practice of the midwife are enormous. The experience unconsciously cultivates and nurtures the feeling of incompetence, self-doubt, and fear in the midwives.

"It is unconscious. I don't know if it is because mine happened a few years after I started

midwifery, but sometimes, I feel inadequate, like I doubt myself... I don't know if you understand but I sometimes fear that it [maternal death] can happen again..." (Ama)

The incident is also sculpted in their memory and is easily recalled although the emotions associated with the death wane over time.

"The pain associated with the incident [death] disappears over time but the fact is that you never forget that patient, face, family... it remains in your memory forever." (Akua)

Theme two: Attending midwives' initial reaction to maternal death

The attending midwives' reactions to a maternal death were categorized as psychological, emotional, and spiritual. These reactions sometimes occurred concurrently, and most midwives were oblivious of their reactions at the time of the incident.

Psychological reaction

An initial feeling of denial, characterized by a refusal to accept the death, and rapid performance of nursing and midwifery resuscitation emerged from the narratives. Several respondents mentioned neurological assessment techniques, such as calling the mother's name and hitting or shaking the patient to wake them up (response to pain) as their immediate actions following the death.

"I kept calling her name and shaking her to ensure that she remained with me. I knew I was losing her; she was slipping away... Then, I opened the infusion to run it faster (exclaims), it was unbelievable, her death... (Exclaims)... I don't understand it even today." (Adwoa)

When these techniques failed to elicit any response from the mothers, the midwives were frequently catapulted from their state of denial to shock. The utter confusion that greets the midwife immediately when the death occurs was evident in all the narratives.

"I kept asking myself, what just happened? It wasn't that I didn't know she [mother] had died, but like what happened?" (Abena)

"I stood by the women, helplessly... My colleague covered her and pushed her to sideward. I was confused. I asked myself, what just happened? Did she just die? Just like that?" (Ama)

For some participants, they needed time to process what had occurred and required their colleagues to initiate the processes of notifying the superiors and other team members of the death. Reflection on the circumstances leading to the death of the women was a disturbing process for some of the midwives as they sought to recall all the activities they had performed for the client during the shift.

To most of the participants, there were no debriefing sessions geared to their coping with the situation. Attempts at debriefing were usually underscored by fact-finding on the cause of the death.

Emotional reaction

The midwives narrated various emotional experiences during the period after death. The emotions fluctuated from a fear of blame to hope of exoneration as the midwives prepared and participated in maternal audits. All the participants, except Ama and Adwoa, reported feeling abject, especially when they had to write their reports. The midwives reported a heightened sense of worry and anxiety when they thought about an impending maternal mortality audit. Sorrow expressed by crying was also reported by some participants.

"I cried myself to sleep on many nights after the woman died..." (Afua)

The participants reported a lack of emotional support they needed to overcome the emotional hurdle created by the maternal death.

"When the others [colleagues] came to you, they were just interested in 'what happened' but not to comfort you. As for support, I can't say that it was institutionalized. You gained it from a few friends and maybe the ward-in-charge" (Yaa)

Theme three: Perceived preparedness to manage maternal death

According to the narratives, the majority of the participants felt that they were ill-prepared for a maternal death. The theme was further categorized as formal training and experiential knowledge acquisition.

Formal training

The main source of education about death was during their first-year training in nursing college, and most of the participants had not undertaken

any refresher courses on the management of a maternal death.

"We were taught about death and last offices in the midwifery training college, I think in the first year, when we were studying basic nursing... but it [death] is not really something that happens in midwifery so I quickly forgot about it." (Adwoa)

Experiential knowledge acquisition

The main source of knowledge about the management of an incident was experiential, and it started with the person's own experience of a maternal death. Although some midwives conceded that they had received on the job training from their senior colleagues, the unconscious desire to repel the situation from occurring during their shifts clouded the knowledge transition process.

"As for me, I had seen it [a maternal death] happened on my ward once, but hey, I was praying it never happens to me, so although I learnt about the reporting process and everything, I quickly forgot about it." (Abena)

Their focal knowledge of coping was the grieving process which was directed at assisting the family of the deceased to manage following the death. Not much information was directed to the care of the midwife following the incident.

Theme four: Building resilience (blurring the memory)

All the participants at the time of the study were still practicing as midwives in public health facilities and shared how they coped with the adverse incident. Three subthemes emerged from the analysis.

Drawing strength from the supreme power

All the participants reported turning to their religious core for sustenance and hope during the period following the death. The initial activities included prayers questioning God about why the death had to happen during their shift. Some midwives also reported fasting and requesting for prayers from friends, family, and even their religious leaders during the period prior to the maternal audit. The words of encouragement about the deliverance of God were recurring themes in all the narratives.

"I knew that God will deliver me" (Yaa)
Bargaining with God to be exonerated from any

blame was also identified in the narratives as a strategy for handling the repercussions of a maternal death.

"I prayed that God will show himself strong, and he did..." (Afua)

The belief in a superior being who supposedly has the power to orchestrate measures for the good of those who believed was identified as an important coping strategy.

Audit: Submitting to queries

For most of the participants, the process of notification of a maternal death and participation in a maternal audit was a time of personal reflection, which was sometimes interrupted by colleagues who showed up to support the attending midwives. Some identified related factors that were attributed to the midwives included delayed intervention or referral. A feeling of relief was achieved when the cause of mortality was identified and not linked to the midwife.

"When the cause of death was linked to delayed referral from the... [Primary health center], I was relieved. At least, I had been cleared..." (Adwoa)

However, some participants shared the feeling of guilt, even when they had been cleared. The guilt was self-inflicted as most of the participants reported something they would have done differently. Nevertheless, the audit was the beginning of healing and recovery for most of the participants.

Time away: Renewing strength

Most of the participants were given time off from work and encouraged to stay away from the work environment to emotionally and psychologically rebuild themselves. Time away was often followed by the maternal death audit. For some of the midwives, the period away from work, coupled with the feeling of self-blame and self-stigmatization resulted in an emotional distancing from friends and loved ones.

"I needed the time alone to think, and I also felt that others were talking about me behind my back. Although now I feel that it may not have been so. But this made me keep to myself. I needed to work through it on my own." (Yaa)

The period allowed for reflection and rejuvenation of the midwives' self-esteem and confidence to return to work. This subtheme

emerged as an important concept underscoring the midwives' return to work.

Discussion

The causes of maternal death recorded in the present study were all direct maternal causes, which is in line with the findings of other empirical studies in this regard (17,18) as well as the national trends in Ghana (1). The midwives participating in the current study had served the requisite years of internship and had the skills to provide peripartum care in Ghana with the aggregated years of experience amounting to 42 years. Consequently, it is important to note that studies have shown that the duration of midwifery experience of a practitioner is not associated with the risk of perinatal mortalities of women accessing midwifery care when known risk factors are adjusted for (19).

Similar to the participants' concept of maternal death, the Center for Disease Control and Prevention describes it as an adverse outcome (20), and its implications for the family, society, and country have been largely studied (21, 22). However, most empirical studies do not explore the concept of a maternal death from the perspectives of midwives attending women who died in the peripartum period. Conceptualizing a maternal death as a failure of the midwife, health facility, and profession can be attributed to the altered outcome of midwifery care which is to assist in delivering a new life instead of ending another (23).

The midwives in the present study were psychologically and emotionally traumatized following the experience, and this finding corroborates the experiences of other midwives reported in other studies (19, 20). The sense of loss expressed by the participants is consistent with the notion of loss proposed by Kubler-Ross and Kessler (21, 22). This sense of loss is attributed to their close engagement with the women while providing care (12). Similarly, their reactions are consistent with the grieving process in which denial, bargaining, and acceptance are stated as normal milestones.

Although they continue to practice as midwives, some of them had not attained acceptance even when the audit indicated that they were not liable for the death. The effect of the midwives' experience of a maternal death under their supervision on their professional

practice unearthed in this study is consistent with the findings of a similar study (24) as the innocence of their successful practice is traumatically striped and the possibility of being sued in a law court looms.

The present study highlighted ineffective coping with maternal death by the midwives. The emotional and psychological impacts of a maternal death were enormous; however, midwifery training did not adequately prepare the midwives for the management of maternal mortalities (24). There was obviously a lack of support by the midwifery leadership and hospital management for coping, and opportunities for debriefing were sparsely available in this study. Contrary to this, the availability of debriefing and support following similar incidents was recorded in Inner-City, UK (25). The findings of the two studies showed a consensus on the midwives' need to be prepared to effectively respond to the incidence of maternal death through training.

The negative implications of a death on the image of the professional midwife (26) and health facility unearthed in this study are supported by Cauldwell et al. (25). A maternal death during supervised delivery affects expectant mothers' perception of safer peripartum care (27). This could be contributed to low uptake of supervised delivery and delay in accessing care, thereby leading to maternal and even neonatal mortalities (28). Therefore, the need for the improvement of midwifery care is nonnegotiable.

The strength of the present study includes the originality and design allowing for an in-depth exploration of the cases under study. It also provided a comprehensive description of the experiences of midwives attending women who died in the peripartum period. However, the current study has limitations, including the small sample size decreasing the generalizability. This limitation was addressed as the cases were investigated as individual units, thereby generating a depth of knowledge. Furthermore, recall bias could have happened as the participants were expected to share experiences that may have occurred more than 6 months; nevertheless, the researchers tried to minimize this limitation using clarifications, feedback interviews, and member check to allow for the

participants to report their experiences as close to the actual ones as possible.

It is recommended that further research is conducted on training to prepare midwives for the incidence of maternal mortalities as well as institutional policies supporting and offering debriefing opportunities for midwives experiencing a maternal death while providing peripartum care.

Conclusion

Midwives attending women who die during the peripartum period experience emotional and psychological distress. The death of a woman receiving supervised peripartum care from a midwife affects the midwifery profession and uptake of care from the health facility. The current study also reflected the need for curriculum development and establishment of support pathways for midwives following a maternal death.

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Conflicts of interest

Authors declared no conflicts of interest.

References

1. Ghana Statistical Service, Ghana Health Service, ICF. 2017 Ghana Maternal Health Survey Key Findings. Rockville, Maryland, USA; 2018. Available from: <https://dhsprogram.com/pubs/pdf/SR251/SR251.pdf>
2. International Confederation of Midwives. International definition of the midwife. Toronto; 2017. (Revised and adopted at Toronto Council meeting, 2017). Available from: https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf
3. Kerkman T, Dijkman LM, Baas MAM, Evers R, van Pampus MG, Stramrood CAI. Traumatic Experiences and the Midwifery Profession: A Cross-Sectional Study Among Dutch Midwives. *Journal of Midwifery & Women's Health*. 2019; 64(4): 435–42.
4. Henderson V. *The Nature of Nursing A Definition and Its Implications for Practice, Research, and Education*. New York: Macmillan; 1966. Available from: <https://philpapers.org/rec/HENTNO-7>
5. Reinke E, Supriyatiningih JH. Maternal mortality as a Millennium Development Goal of the United Nations: a systematic assessment and analysis of available data in threshold countries using Indonesia as example. *Journal of global health*. 2017;7(1): 010406.
6. World Bank Group. *World development indicators 2014*. World Bank Publications; 2014. Available from: <http://hdl.handle.net/10986/18237>
7. Ghana Statistical Service. 2010 Population & Housing Census District Analytical Report: Sekondi-Takoradi Metropolitan. Accra: GSS; 2014. Available from: http://www.statsghana.gov.gh/docfiles/2010_Districts_Report/Western/STMA.pdf
8. Ghana Statistical Service, Ghana Health Service I. *Ghana Maternal Health Survey 2017: Key Indicators Report*. Accra, Ghana; 2018. Available from <http://www.statsghana.gov.gh/docfiles/PR95>
9. Ghana Statistical Service (GSS), Ghana Health Service (GHS) and MI. *Ghana Maternal Health Survey 2007*. Ghana Statistical Service, 2007. Calverton, Maryland, USA; 2009. Available from <http://www.dhsprogram.com/pubs/pdf/FR340/FR340.pdf>
10. Beck CT, Anderson BA. Being With Woman": Is There a Cost for Midwives and Students Attending Traumatic Births? *International Journal of Childbirth*. 2018; 7(4): 181-191.
11. Mollart L, Skinner VM, Newing C, Foureur M. Factors that may influence midwives work-related stress and burnout. *Women and Birth [Internet]*. 2013; 26(1): 26–32. Available from: <http://dx.doi.org/10.1016/j.wombi.2011.08.002>
12. Coldridge L, Davies S. "Am I too emotional for this job?" An exploration of student midwives' experiences of coping with traumatic events in the labour ward. *Midwifery*. 2017;45(2017):1–6. Available from: <http://dx.doi.org/10.1016/j.midw.2016.11.008>
13. Creedy DK, Sidebotham M, Gamble J, Pallant J, Fenwick J. Prevalence of burnout, depression, anxiety and stress in Australian midwives: A cross-sectional survey. *BMC Pregnancy Childbirth [Internet]*. 2017;17(1):1–8. Available from:

- <http://dx.doi.org/10.1186/s12884-016-1212-5>
14. Mishra SB, Alok S. Handbook of Research Methodology: A Compendium for Scholars & Research. Delhi: Educreation Publishing; 2019. 1–398 p. Available from: https://www.researchgate.net/publication/319207471_HANDBOOK_OF_RESEARCH_METHODODOLOGY/link/5c3c2a5792851c22a373630a/download
 15. Given LM. The Sage encyclopedia of qualitative research methods. Sage Publications; 2008. Available from http://www.scholar.google.com/citations?User=_xYpg9MAAAj8hl=en
 16. Colaizzi PF. Psychological Research as the Phenomenologist Views It. In: Valle K, Eds. RS and M, editor. Existential Phenomenological Alternatives for Psychology. New York: Oxford University Press; 1978. Available from: [http://www.scirp.org/\(s\(lz5mqp453edsnp55rrgict55\)\)/reference/ReferencesPapers.aspx?ReferencelD=1477787](http://www.scirp.org/(s(lz5mqp453edsnp55rrgict55))/reference/ReferencesPapers.aspx?ReferencelD=1477787)
 17. Der EM, Moyer C, Gyasi RK, Akosa AB, Tettey Y, Akakpo PK, et al. Pregnancy related causes of deaths in Ghana: a 5-year retrospective study. Ghana Medical Journal. 2013;47(4):158–63.
 18. Lee QY, Odoi AT, Opere-Addo H, Dassah ET. Maternal mortality in Ghana: A hospital-based review. Acta Obstetrica et Gynecologica Scandinavica. 2012;91(1):87–92.
 19. Sadler LC, McAra-Couper J, Pittam D, Wise MR, Thompson JMD. Risk of perinatal mortality in the first year of midwifery practice in New Zealand: Analysis of a retrospective national cohort. Obstetrics and gynaecology. 2018;8(4): e019026.
 20. Center For Disease Control and Prevention (CDC). No Title. Pregnancy Complications. 2018 [cited 2020 Mar 17]. p. 1–3. Available from: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html>
 21. Miller S, Belizán JM. The true cost of maternal death: Individual tragedy impacts family, community and nations. Miller and Belizán Reproductive Health. 2015;12(1):10–3. Available from: <http://dx.doi.org/10.1186/s12978-015-0046-3>
 22. Molla M, Mitiku I, Worku A, Yamin AE. Impacts of maternal mortality on living children and families: A qualitative study from Butajira, Ethiopia. Miller and Belizán Reproductive Health. 2015;12(1):S6.
 23. Buddingwood L. Midwifery is about the celebration of new life, but it is also about loss. Nursing Times. 2020 [cited 2020 Mar 16]. p. 1–3. Available from: <https://www.nursingtimes.net/students/midwifery-is-about-the-celebration-of-new-life-but-it-is-also-about-loss-10-03-2020/>
 24. Dartey AF, Phetlhu DR, Phuma-Ngaiyaye E. Coping with Maternal Deaths: The Experiences of Midwives. Ethiopian Journal of Health Sciences. 2019; 29(4): 495–502.
 25. Cauldwell M, Chappell LC, Murtagh G, Bewley S. Learning about maternal death and grief in the profession: A pilot qualitative study. Acta obstetrica et gynecologica Scandinavica. 2015; 94(12): 1346–53.
 26. Kubler-Ross E, Kessler D. On grief and grieving: Finding the meaning of grief through the five stages of loss. New York City: Simon and Schuster; 2014. Available from <http://www.grife.com/the-five-stages-of-grief/>
 27. Adjei CA. Factors Influencing Uptake of Institutional Delivery Service By Skilled Birth Attendant ' S in Ghana : Review of Literature. KIT (Royal Tropical Institute); 2015. Available from: https://www.researchgate.net/publication/278036629_FACTORS_INFLUENCING_UPTAKE_OF_INSTITUTIONAL_DELIVERY_SERVICE_BY_SKILLED_BIRTH_ATTENDANT'S_IN_GHANA_REVIEW_OF_LITERATURE/Link/557b0a4908ae26eada8afc50/Download
 28. Calvello EJ, Skog AP, Tenner AG, Wallis LA. Applying the lessons of maternal mortality reduction to global emergency health. Bulletin of the World Health Organization. 2015; 93(6): 417–23.