UNIVERSITY of the WESTERN CAPE

FACULTY OF COMMUNITY AND HEALTH SCIENCES

SCHOOL OF NURSING

DEVELOPMENT OF AN EMPLOYEE ASSISTANCE PROGRAMME (EAP) FOR MIDWIVES DEALING WITH MATERNAL DEATH CASES IN THE ASHANTI REGION, GHANA

A thesis submitted in fulfillment of the requirements for the degree of PhD in Nursing in the School of Nursing, University of the Western Cape

Anita Fafa Dartey

Student Number: 3105163

Supervisor: Prof. D. R. Phetlhu (PhD)

August, 2016

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DECLARATION

I declare that the study entitled *"Development of an Employee Assistance Programme (EAP) for Midwives dealing with Maternal Death Cases in the Ashanti Region, Ghana",* is my own work, and that it has not been previously submitted for any degree or examination at any other university, and that all the sources that I have used or quoted, have been indicated and acknowledged by complete references.

Anita Fafa Dartey

August, 2016

DEDICATION

My love goes to my children, Isaac, Prince, Princess, and Falk for their patience, understanding and encouragement.

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To God be the glory! I am grateful to Him for taking me through the journey of this study. I had nothing to start the programme with and had no scholarship to support my studies but through all the difficulties, God provided at every stage of the study.

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LIST OF ABBREVIATIONS

ANC:	Antenatal Care
CHPS:	Community Based Health Planning and Services
GHS:	Ghana Health Service
ICD-10:	International Statistical Classification of Diseases and related Health Problems (10th Revision)
KATH:	Komfo Anokye Teaching Hospital
MDR:	Maternal Death Review
MMR:	Maternal Mortality Ratio
MMRate:	Maternal Mortality Rate
MOH:	Ministry of Health
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
WHO:	World Health Organization

ABSTRACT

Globally, Employee Assistance Programme (EAP) has become the most effective workplace programme used to assist employees in the identification and resolution of performance and behavioural related problems. Employees, irrespective of the sector of employment are seen as the most valuable assets of any organization and therefore their wellness is as important as the organization itself. Employees' personal or work related problems may adversely affect their health as well as their productivity, thereby impeding the growth of an organization. It is for this reason that the EAP has increasingly become an important tool in addressing employees' personal and work related challenges. Midwives as employees are prone to challenges such as maternal deaths at the workplace. They are more likely to undergo stressful situations for failing to meet the general goal of their profession, which, among others, include provision of adequate care for pregnant women until they safely deliver. These stressful conditions have negative effects on midwives' health, behaviour and productivity. However, there is no literature that has looked at how midwives in the Ashanti Region of Ghana are affected by maternal deaths and their coping mechanisms employed to address the effects of maternal deaths. Literature revealed that there is hardly any known work-related assistance programme designed to support Ghanaian midwives when faced with work-related challenges likely to affect their work-output. Hence, this study developed an appropriate EAP for midwives dealing with maternal deaths in Ghana based on the exploration and description of the effects of maternal death, coping mechanisms used and their experiences with the facility-based maternal death review (MDR).

In order to meet the general aim of the study, a qualitative research approach, with a combination of exploratory, descriptive and contextual designs was used. Purposive

sampling was employed to select participants; ward and unit managers (supervisors) (18) and midwives who met the inclusion criteria (39). A total of 57 participants were used in the study. Data were collected through semi-structured individual interviews and focus group discussions, as well as field notes. Thematic Content Analysis was used to manage data through transcribing, organizing, development of category and coding of data. Final data management was done with qualitative computer data analysis package (Atlas ti version 7.1.7). The full understanding of the effects of maternal deaths on midwives and the mechanisms of coping employed to address effects afforded the development of an EAP to support midwives dealing with maternal deaths.

Five main themes emerged from the analysis of collected data, namely effect of death as a unique experience, multi-dimensional effects of MD on Midwives' personal life, effects of MD on the midwives' associated environment, mechanisms of coping employed by Midwives and Perceived MDR process (Phase 1). Phase 2 considered the development of Employee Assistance Programme (EAP) for midwives dealing with maternal deaths in Ashanti Region of Ghana.

The steps of developing occupational health service at the workplace by Acutt Hattingh and Bergh (2011) were applied to develop the EAP. Ethical practices pertaining to the study of human subjects as specified by the Research Ethics Committee of the University of the Western Cape and research guidelines of Ministry of Health- Ghana Health Service were observed. It is recommended that, all hospitals in Ashanti Region institute the EAP programme to assist midwives cope with challenges associated with maternal death.

KEY WORDS: *Employee Assistance Programme, Occupational health and safety, Midwives, Maternal death and Facility-based maternal death review.*

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CHAPTER ONE

BACKGROUND TO THE RESEARCH STUDY

1.1 INTRODUCTION

This chapter provides an overview of the study. The chapter is organised into five sections. Firstly, it provides the background to the entire study and the rationale. Secondly, the chapter provides the problem statement which is followed by the purpose and objectives of the study. Thirdly, it highlights the significance of the study and the researcher's assumptions. Fourthly, an overview of the research design and research methods used in the study is provided. Finally, the chapter provides the definition of terms as used in the study and an outline of the thesis.

This study is focus on occupational health and safety as it relates to the safety of health workers and in particular, midwives in selected health facilities in Ghana. The challenges that workers face the world over and across fields are somewhat related in one way or another and yet some sectors seem to receive more attention than others. In recent times, every employer and worker alike, are concerned with the health and safety at workplaces. In this regard, midwives in Ghana's health sector are not left out in the quest to improving their work environment, especially in light of the difficult working conditions they find themselves in. Therefore, this study seeks to investigate occupational health and safety issues in the health sector with a view to promoting the

health of midwives. The study aims to achieve this through the development of an intervention programme that will help alleviate the challenges midwives face as a result of their exposure to maternal deaths (MDs) in their daily work. This intervention programme is an Employee Assistance Programme (EAP) which has been developed using the steps in Acutt et al., (2011) with some modifications to suit the context within which the study was conducted.

1.2 BACKGROUND AND RATIONALE TO THE STUDY

This section discusses the history of Employee Assistance Programme and its importance to workers in improving their quality of work life. The section further discusses the work of midwives and their encounter with maternal deaths.

1.2.1 Brief History of the Employee Assistance Programme

Employee assistance programmes started as far back as in the early 1940s in the United States of America (USA) as part of support programmes to assist employees with alcohol and drug problems (Dickman & Challenger, 2009; Center for Prevention & Health Service, 2008; Work-Life Services, 2008). As the years went by, the programme became more comprehensive with more services introduced to assist employees in areas such as work-related stress, legal problems, family problems, bereavement, and financial (Dickman & Challenger, 2009). Given its successes in addressing employee related problems, the programme was also extended to include other areas of concern at the workplace, such as job boredom, anxiety and other interpersonal problems that impact on health and wellness leading to stress and subsequent decreased work performance (Rajin, 2012). From the time EAP was

introduced, many organizations have employed it as a means to enhance the performance and well-being of their employees (Bhagat, Steverson & Segovis, 2007). The EAP is a programme that falls under Occupational Health and Safety. It is designed to identify and assist employees and their families with difficulties that impair their personal and occupational functioning (Canadian Centre for Occupational Health & Safety, 2009; Csiernik, 2006). In addition, the programme is intended to improve employer-employee communiqué and create a positive atmosphere within the work environment (Centre for Disease Control (CDC), 2011; World Health Organization (WHO), 2010a; Matlhape, 2003). Studies argue that the workplace is a crucial setting for health protection, promotion and disease prevention programmes, especially in cases where employees spend more time at work than at home (Acutt et al., 2011; CDC, 2011; WHO, 2010a; Canadian Centre for Occupational Health and Safety, 2009). Thus, the importance of a programme such as EAP, which provides an intervention in alleviating some challenges employees are faced with at workplaces is crucially important.

Furthermore, EAPs are designed to address occupational health and safety issues in the workplace and are also important for any profession or organization which seeks to comply with the standard requirements set by the International Labour Organization (ILO) and the World Health Organization (WHO). It is believed that EAPs can bring positive attitudinal change to individual employees within the organization they work for (WHO, 2010b) by establishing a wellness culture, thereby promoting a healthy behaviour for the entire workforce (Mattke et al., 2013). This is partly so because EAP lessens health risks and improves the quality of life for all employees (CDC, 2011;

WHO, 2010b). Owing to marked differences among workplaces, each may have different work-related problems which in effect necessitate the need to provide services that directly respond to the needs of employees in these work environments. Some of the services EAPs may provide are short-term counselling, referral treatment and other support services (McLord, 2010) and these may vary from one organisation to another. Prominent among organisations that employ such programmes include the police service, different business institutions and the health sector itself.

In the police service, EAP is employed to mitigate stress and strains experienced by police officers. Police believe that there are several risks associated with their job ranging from shift work, exposure to death, long standing posture, and family problems, to mention but a few (Rajin, 2012). These risks have to be managed in some way through the implementation of EAPs. In the business world, EAP has been used to enhance production and quality delivery of goods and services to clients in order to achieve their set business goals (De Frank & Cooper, 2007). In the health sector, EAP is employed in many ways, such as helping workers deal with patient and family issues, nurses' compassion fatigue, while in some hospitals EAPs is used as a means of dealing with human resources issues (Lombardo & Eyre, 2011).

1.2.2 Rationale to the Study

The healthcare sector is one of the workplaces highly associated with stress, sadness and grief; anxiety and depression due to the nature of hospital work. For this reason EAP as an instrument in the facilitation of occupational health care, offers employees psycho-socio counselling services in order to mitigate work-related challenges faced

by health workers (McLeod, 2010). In recognising the importance of addressing work-related challenges faced by health workers and in particular nurses and midwives, the International Labour Organisation (ILO) commissioned a manual on stress prevention in 1996 which could be used as a guide in addressing stress, grief, anxiety and depression experienced by nurses as they interact with their clients (Damit, 2007). The development of the manual by ILO on stress prevention is evident that nursing in general, by nature, and in terms of practice, is a very stressful profession (Bailey & Clarke, 2013; Kane, 2009; Duddle & Boughton, 2007; Oginska-Bulik, 2006).

Furthermore, Jan (2011) describes the nature of nursing practice as exposure to unpleasant, nauseating, frightful and traumatic scenery. One of the frightful and traumatic scenes which nurses and midwives are more likely to experience is the death of patients during the process of health care and more so sudden deaths. This kind of traumatic experience can impact negatively on the nurses and midwives' well-being, especially when there is lack of psychological support for them in the workstation where the trauma is actually experienced (Ní Chóinin et al., 2011; Wilson & Kirshburm, 2011; Jowett, 2003).

Due to the nature of nurses and midwives' profession which entails caring for their clients' well-being, relationships naturally develop between them. These relationships might also extend to family members of the clients who in turn may be a source of concern for health-workers (Wilson, & Kirshburm, 2011). Consequently, health worker-client relationships are a likely source of trauma for the health-workers if a client being cared for suddenly passes on. However, the degree of relationships would

depend on the length of stay that a patient spends at a hospital. It is understood that the longer the client stays at a hospital, the stronger the attachment. Moreover, research has shown that nurses and midwives are known to have more contact hours with clients at the hospital than any other health care professionals (Ní Chóinin et al., 2011; Costello, 2001). This in itself makes them a more vulnerable cadre of healthcare staffs with the high likelihood of experiencing trauma resulting from deaths of clients.

Generally, as part of their basic duties, nurses and midwives are supposed to welcome and receive clients for admission, provide beds, basic services of daily living such as bathing, feeding, cleaning up, serving of medication, providing emotional support, comfort and sometimes even providing spiritual support such as praying with them. These care givers listen and take action on clients' requests and complaints (Ghana Health Service, 2009). They further encourage and explain procedures to clients before they actually carry them out. This in itself, naturally, builds strong bonds between nursing staffs and their clients. It is this kind of relationship that arises from the interactions between nurses and their clients that sometimes nursing staffs are regarded as surrogate family members (Rickerson et al., 2005). The above mentioned duties are performed by all nurses, and additional care may depend on the area of specialisation, for example, midwifery.

The role of midwives is to care for pregnant women from the day of conception until six weeks after birth. The journey of the pregnant woman with the midwife starts on the day of the first visit of the client to the health facility. During the client's first visit the midwife gets the opportunity to collect data on the client: examine her from head

to toe; paying attention to general health, skin and scars, conducts some basic laboratory investigations, gives health education on a number of issues such as personal hygiene, diet, exercise, rest and sleep. The client is given information on what to expect as the pregnancy progresses and what to do in the event of an emergency. This kind relationship is built on and maintained for the nine months of pregnancy (Ghana Health Service, 2009). Clearly, midwives are likely to develop stronger relationships with their clients due to the length of the time that they spend with them.

The 'starring' role of a midwife during the labour process cannot be over-emphasized because it is a crucial moment for both the midwife and client. It is a moment when the client is expected to feel safe and to wholeheartedly trust the midwife. The midwife's knowledge and skills in the area of maternal health care, especially during the labour process, makes her take responsibility for the safety of the mother and the baby. A midwife is supposed to ensure the environment is conducive, the temperature of the delivery room is appropriate, monitor vital signs and intervenes when necessary (Ghana Health Service, 2009; Ghana Health Service, 2008). In most cases, during severe contractions, the client may become unaware of her environment and may not care who is around her until after birth (Reed, 2012; Lundgren, 2010). The midwife is expected to guide the restless client in labour, applying a cold compress to a client's forehead, clean sweat, monitor foetal heart beats and movements and check for the physiological changes of labour in general, while encouraging the client to bear down when it is time to do so (Reed, 2012; Thorstensson, Nissen, & Ekström, 2008). It is for this reason that when things go wrong and the patient's outcome is unfavourable,

the midwife is burdened with the responsibility of loss which is often emotionally, psychologically, physically and socially traumatic.

Midwives may develop personal problems arising from the death of a client (Ní Chóinin et al., 2011). Personal problems such as low self-esteem, difficulty in concentrating at work and the total workload involved, may all have a detrimental effect on their performance, productivity and attitude. This in turn may, result in the midwives experiencing stress (Centre for Prevention and Health Services, 2008). Stress is a major concern for employers and employees alike because it may lead to mental ill health and consequent loss of productivity. It is also evident that stress affects sleep and results in loss of concentration. It may lead to depression and a lack of motivation to work. Therefore, midwives who experience maternal deaths are not only stressed, but may also experience psychological pain (Caine & Ter-Bagdasarian, 2003). In this vein, Blood (2000) explains that maternal death (MD) is a difficult experience for midwives since in most cases a pregnant woman would have developed some kind of bond with midwives resulting from their interaction during pregnancy. A pregnant woman is a normal person who is simply under-going physiological processes and whose death may occur, mostly suddenly. Bryan (2007) is of the view that the occurrence of death causes anxiety and discomfort among midwives, especially at the hospital, a place with a mission to sustain life and prevent death. Besides, Rickerson et al., (2005) observe that, MD often times would make midwives emotionally affected to the extent of shedding tears when they lose a client. Shedding tears is a sign of grief, of the death of these clients.

Since by requirement of their profession, midwives are not expected to openly express their emotions to clients' death in their workplace, they may instead experience what Doka (2008) calls disenfranchised grief. One of the main roles of midwives is to support clients' relatives in their loss without expressly acknowledging that the loss is for all partners, including midwives themselves (Wilson & Kirshbaum, 2011). Due to this 'injunction', midwives may develop feelings of guilt, anxiety, incompetence, depression and perhaps low self-esteem. This experience is further worsened during Maternal Death Review (MDR).

Facility-based Maternal Death Review (MDR) is one of the health care strategies introduced in 2004 to reduce maternal mortality. WHO, United Nation Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and their development partners introduced this strategy as a result of many maternal deaths which occur mainly in developing countries (WHO, 2004a). MDR is a qualitative and in-depth investigation of the situations surrounding maternal deaths that occur at health care facilities, at home or anywhere else (Pearson, de Bernis & Shoo, 2009). The aim of the facility-based MDR is to follow the passageways of women who die, through the health care system and within the health facility, in order to establish preventable issues that could change and improve maternal care yet to come (Dartey, & Ganga-Limando, 2014). Therefore, the more maternal deaths a health facility records, the more the reviewing processes take place.

Ashanti Region of Ghana report maternal deaths on a regular basis. For example, Komfo Anokye Teaching Hospital (KATH) recorded 114 maternal deaths in 2009,

111 in 2010, 152 in 2011 and 152 in 2012 (KATH Annual Report, 2012: Ashanti Regional Health Directorate, 2012), while the whole region recorded a total of 235 maternal death cases in 2011 and 181 in 2012 (Komfo Anokye Teaching Hospital, 2012; Ashanti Regional Annual Report, 2012). Additionally, the region has been recording the highest maternal death cases in the country over a period of time (MOH/GHS, 2010). It is therefore obvious that midwives in the Ashanti region experience this phenomenon more frequently than those in other regions with potential negative impacts on their wellbeing. Figure 1.1 presents the map of Ghana in which Ashaniti region is found.

Figure 1.1: The map of Ghana (www.google.com.gh/search)

The researcher believes that the impact of maternal deaths on a midwife may be severe because of two main reasons; (1) midwives mostly care for women who are normally not seen as sick; and (2) pregnancy is not a disease but a normal physiological condition whose outcome is expected to bring joy to the client and her family. Hence the process involved during facility-based MDR, where the midwife is held accountable for maternal death despite other confounding factors, can increase stress levels among midwives. This category of health workers (midwives) have an important part to play in the achievement of the MDGs. Therefore, the quality of their work life is important as their key role is to work towards reducing maternal deaths. Consequently, midwives' wellbeing needs to be prioritized and supported in order to enhance their work. It is thus important that the health system they work for protect their welfare especially while at work. For this reason, this study seeks to develop an EAP whose main aim is to help midwives deal with effects of MD. Arising from an exploration and description of the effects of maternal deaths on the midwives, their coping mechanisms in addressing the situation and their experiences with facility-based MDR in the Ashanti region of Ghana, the programme seeks to improve midwives' physical and mental well-being. Figure 1.2 presents the map of Ashanti Region of Ghana.

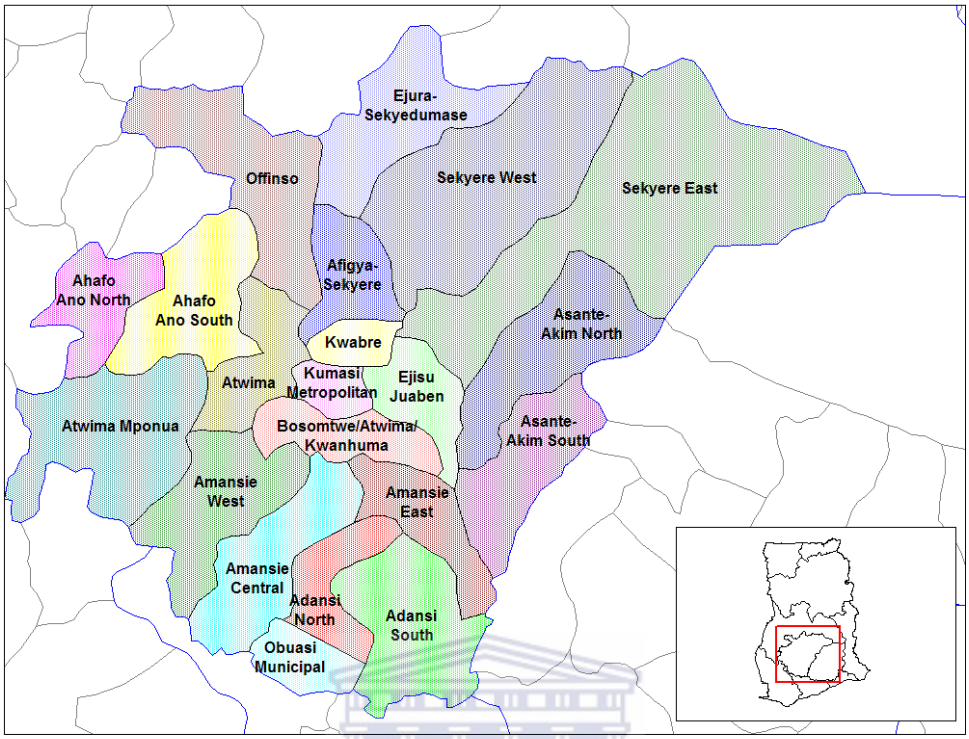


Figure 1.2: The map of Ashanti Region, Ghana (www.google.com.gh/search)

- **The role of Occupational health and safety in the workplace**

Occupational health and safety is part of the requirements of the International Labour Organization (ILO) and the World Health Organization member countries in relation to occupational health and safety. In 1950, ILO and WHO defined occupational health as "the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations" (Acutt et al., 2011, p. 16). Thus, occupational health has to do with the protection of workers in their occupations from risks resulting from elements adverse to health (Acutt et al., 2011). The main goal of occupational health is to maintain and promote a healthy, safe and satisfactory work environment as well as a healthy, active and productive employee. It is therefore the

right of every employee to stay free from both occupational and non-occupational ailments. Furthermore, every employee must be inspired to carry out his/her job by experiencing career satisfaction and developing both as a worker and as an individual (Acutt et al., 2011).

Given the importance of the health and safety of employees across sectors, it is absolutely vital for every organization to respect the standards set by ILO and WHO. In this vein, employers in WHO member countries are expected to ensure that all employees are safe and are protected from hazards associated with the workplace (WHO, 2010a). A hazard is said to be the risk to health or life that is inherent in or associated with, a particular occupation, production or work environment (Business Dictionary, 2014). Hazards can be categorised differently by different organisations. The following are some of the common categories of hazards as classified by different organisations: chemical, physical, biological, psycho-social and ergonomic hazards (Mitchell, 2011). These hazards are not isolated and as such it is possible that an employee could be exposed to more than one hazard at the same time depending on the kind of work and workplace involved (Center for Prevention and Health Services; Cotton, 2003).

The hazards in the midwives' work environment may include, among others, psychosocial, physical, chemical, biological and ergonomic. The common biological hazards for midwives are contact with blood and blood products, contaminated urine, vomitus, stool, to mention but a few. These are likely to cause direct infection to the midwife who comes in contact with these body fluids. The physical related hazards at

the hospital are noise and wet floors which may cause trips and falls. During emergencies, wet floors can cause harm to the midwife. Chemical related hazards include gas (oxygen and other anaesthetic gases); while and ergonomics related hazards has to do with lifting of patients and pulling and pushing trolleys leading to strain, springs and sometimes repetitive fatigues. The psychosocial hazards include death of a patient, loss of patients' body part among others. Among the above stated hazards, psychosocial is the most unassuming but the most challenging because it borders on the mental health and wellbeing of the midwife. Psychosocial hazards such as death of patients cause stress leading to low performance and absenteeism (ILO, 2016a). Therefore, an Employee Assistance Programme is one of the means through which work-related hazards and personal life problems of employees could be addressed.

1.2.3 Problem Statement

Employee Assisted Programme (EAP) is associated with wellness and increased productivity of employees and their families in countries like the United States of America, Europe and in some developing countries such as South Africa (Buon & Taylor, 2007). In these countries, a lot of attention has been devoted to the improvement of services provided by the programme in order to suit the changing global demands of jobs (Kirk & Brown, 2011). However, despite reported success of this programme in many countries, no special attention has been given to this important area of employees' health in Ghana. This lack of attention could be attributed to a lack of knowledge of the EAP in particular and occupational health in general.

Studies by Shelvington (2007) and Costello (2001) have established that a patient's death has traumatising effects on health workers who closely interact with patients and in particular nurses. These traumatising effects may even be more pronounced among midwives who in most cases provide care to normal women undergoing a normal physiological situation of pregnancy and labour. The deaths associated with pregnancy in women often time occur suddenly and the resulting effect is that midwives would suffer grief, distress and sadness upon the death of their clients. Since nursing a pregnant woman to the safe delivery of the baby is the ultimate goal of midwifery, maternal death is considered as some form of failure on the whole health system (Bickham, 2009). Given the importance attached to maternal deaths and the effects that they have on midwives and the entire health system, it is significant to explore and describe these effects of maternal deaths on the midwives, the coping mechanisms that midwives may employ to mitigate the effects and their experiences in relation to facility-based MDR. In addition, since little is known about the use of EAP in addressing workplace problems in Ghana, it is important to explore the use of this programme in addressing MDs related effects on midwives. Therefore, this study seeks to develop an EAP to assist midwives manage effects of maternal deaths. Consequently, the analysis of the impact of maternal deaths on midwives, their coping mechanisms employed to mitigate the situation and their experiences during facility-based maternal death reviews, would provide a premise for the development of an EAP.

1.2.4 Significance of the Study

Given the positive impact an EAP has on employees who experience different problems at work (Lamontagne, Keegel, Louie, Ostry, & Landsbergis, 2007), the motivation for this study is to develop an EAP that will help midwives deal effectively with the effects of maternal deaths experienced while at work in the Ashanti region of Ghana. The programme is intended to benefit midwives who could be having difficulties in coping with the effects of maternal deaths of their clients, thereby improving their general health, safety, wellness and job satisfaction (De Simone, 2014). Furthermore, the study may give rise to structured orientation and mentorship programmes for all ward and unit managers in the midwifery wards in order to provide immediate support to affected midwives thereby leading to general occupational health and safety improvement in the nursing profession.

In addition, the findings related to the effects of maternal deaths on midwives and the development of EAP may also lead to the adaptation of the programme in other sectors of the industry in the country. The adaption of the programme may require appropriate government strategies for the welfare of all workers in the country which in turn may lead to the establishment of comprehensive occupational health programmes (De Simone, 2014). Owing to the uniqueness of the study, the findings will also contribute to the general knowledge base for nursing practice because it will provide a programme that enhances the welfare of midwives and nurses alike. The findings may inform further research on work related stress that affects employee health behaviour and general work performance.

1.2.5 Research Questions

The research was guided by the following research questions:

(i) What are the effects of maternal deaths on midwives in the Ashanti Region of Ghana?

(ii) How do midwives cope with maternal death-related experiences in the Ashanti Region of Ghana?

(iii) What are the midwives' experiences with the facility-based MDR process in the Ashanti Region?

(iv) How can an Employee Assistance Programme be developed to support the midwives in managing maternal death-related effects in the Ashanti Region of Ghana?

1.2.6 Purpose of the Study

The purpose of the study is to develop an Employee Assistance Programme for midwives who experience maternal deaths in the Ashanti Region of Ghana. The development of the EAP is based on an exploration and description of effects of maternal deaths on midwives, the coping strategies employed in dealing with the situation. In addition, nurses' experiences with the facility-based maternal deaths review process, a process that exacerbates stress situations were used.

1.2.7 Objective of the Study

The study is guided by the following specific objectives:

(i) To explore and describe the effects of maternal deaths on midwives in the Ashanti Region of Ghana;

(ii) To explore and describe the coping mechanisms used by midwives when they experience maternal deaths in the Ashanti Region of Ghana;

(iii) To explore and describe midwives' experiences of the facility-based MDR process in the Ashanti Region of Ghana; and

(iv) To develop an Employee Assistance Programme (EAP) that supports midwives in managing maternal death-related effects in the Ashanti Region of Ghana.

1.2.8 Definition of Key Concepts

Client: An expectant mother for which professional services are rendered by midwives.

Employee Assistance Programme (EAP): Is a work-based confidential programme designed to assist employees in identifying and resolving generalized stress and problems with physical, emotional and mental health, family and marriage, finances, addictions to drugs/alcohol and any other personal issue that negatively affects the personal and professional life of employees (Canadian Centre for occupational health and safety, 2009). In the current study, EAP is designed to assist midwives in Ashanti Region of Ghana to deal with MD related effects in the cause of their work.

Environment: With reference to this study, environment means the health facilities where the midwives work.

Facility-based maternal death review: Facility-based Maternal Death Review is a strategy introduced by WHO in 2004 to help trace the passageways of women who died, through the health care system and within the health facility, in order to ascertain preventable issues that could change and improve maternal health care (WHO, 2004a).

Health: This study defines health as the ability of midwives to cope with grieving after their client's death and their ability to withstand maternal death review processes and still continue with their personal and professional life.

Human: In this study, human refers to midwives, ward and unit managers.

Maternal death: Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO ICD-10 volume 2:134).

Maternal Deaths Review (MDR): A qualitative, in-depth investigation of the circumstances surrounding maternal deaths. In this study, it will be limited to the investigation of maternal deaths that occurred at the health care facilities (WHO, 2004a).

Midwife: Refers to a person trained and recognized by the Nursing and Midwifery Council_of Ghana to practice using the title "midwife".

Midwifery: In this study, midwifery is a nursing science that seeks to improve the lives of all pregnant women and their infants and improves their well-being six weeks after a woman has given birth.

Occupational Health and Safety (OHS): The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations (Acutt et al., 2011). EAP is developed as a wellness programme to be used by midwives in order to promote their physical, mental and social health with their occupation.

Ward and Unit Managers: Refers to senior midwives who operate as midwives and supervisors in addition to administrative responsibilities of the wards and units of the hospital (GHS, 2008).

1.3 THEORETICAL FRAMEWORK

A conceptual framework is perceived to be an analytical structure that directs a research study. It gives a fleeting description of theory, or aspect of theory to be verified by a research project (MacDonald, 2012). Further, a conceptual framework describes the rudimentary structure of thoughts within which a research study is conducted and the results understood (MacDonald, 2012). In this regard, the current study had been informed by the Quality of Work Life Model by Lokanadha and Mohan (2010).

1.3.1 Quality of Work Life Model

The Quality of Work Life Model is a model with the philosophy that excellent work life is important because it maintains and promotes the health of workers in any organization. The model contends that workers become trustworthy, responsible and capable of making valuable contributions to the organization if their quality of work life is good and vice versa (Lokanadha & Mohan, 2010). The model examines the relationship between employees and the overall working environment and the extent to which work contribute to the wellness of an individual worker in terms of the physical and psychological factors. The model advances five dimensions to the Quality of work life as follows:

- Health and wellness being;
- Job security;
- Job satisfaction;
- Competence development; and
- Work and non-work life balance.

1.3.2 Health and Wellbeing

Health and wellbeing are the physical and psychological aspects of the individual in a working environment. It evaluates the direct and indirect impact of work on workers' health and wellbeing (Lokanadha & Mohan, 2010). It is believed that any work that causes stress to the worker is unsafe. In this study, the health and wellbeing of midwives are considered important for them to have a good quality of work life. Hence, maternal death is seen to be a stress inducing event which impacts their health and wellbeing negatively. For this reason, an EAP was developed after the researcher explored and described the impact of maternal deaths on midwives with the view to improving their quality of work life.

1.3.3 Job Security

Job security is when an organization provides permanent and steady employment to its employees. Thus, permanent and steady employment is believed to be one of the main strengths that employees may have in a contemporary work environment. However, job insecurity may occur as a result of change in an organisational policy, procedures or strategies leading to downsizing, rightsizing or outsourcing. Job security affects employees' morale, motivation and loyalty (Lokanadha & Mohan, 2010). In this

current study, midwives may suffer job insecurity depending on how the facility-based MDR is conducted. It is believed that, sometimes, facility-based MDR process causes stress to midwives who were attending to the pregnant mother before death occurred. It is in this vein that this study had developed an EAP to assist and prepare them for MDR whenever they experience maternal death in the course of their work.

1.3.4 Job Satisfaction

Job satisfaction is a situation where an employee finds his or her job interesting, stimulating, fascinating and motivating. Given the benefits of job satisfaction, the cognitive and social behaviour of an individual employee are positively affected. It follows then that, on one hand, if job satisfaction is positive, the employee's behaviour is equally satisfactory and this in effect entails positive mental health experiences by employees (Lokanadha & Mohan, 2010). On the other hand, if job satisfaction is negative, employees' mental health experiences will equally be negative and this in turn highly likely to cause stress. Job satisfaction may be as a direct result of promotion, supervision; support from superiors, adequate equipment and working space. It is for this reason that, ILO and WHO (1950) encourage that, all workplaces should mitigate factors that negatively affect mental and general health (Acutt et al., 2011). Therefore, occupational health services and programmes such as EAP are regarded as some of the main ways through which factors that are adverse to occupational health and safety at workplaces could be addressed in order to promote job satisfaction (WHO, 1980). There could be other factors that may promote job satisfaction, for example, an employee meeting objectives of a given task. Thus, for midwives in Ashanti Region of Ghana, safe delivery of mother and baby is satisfying.

Therefore, in order to maintain a risk free work environment and maintain positive job satisfaction for the midwives, there is the need to develop an EAP at the workplace that would in effect, address issues that have the potential of causing job dissatisfaction such as MD.

1.3.5 Competence Development

The quality of work life is related to adequate knowledge and skills acquisition by employees concerned. However, it is the provision of opportunities for knowledge and skills advancement that would enhance growth in a profession (Lokanadha & Mohan, 2010). In this study, like other professions, midwives require competence to manage pregnant mothers for safe delivery. They therefore need knowledge and skills in order to continually grow in their ability to execute their duties and in turn able to manage their stressful work environment. Midwives require the knowledge and skills to identify colleagues who may be having problems that may affect their job performance. Likewise, ward and unit managers require knowledge and skills to provide immediate counselling and refer the affected for further treatment, especially when there is maternal death or when midwives have problems preparing for facility-based MDR. Therefore, there is a need for the development of EAP so that midwives can easily access relevant information to address the challenges they may find themselves in while at the workplace.

1.3.6 Work And Non-Work Life Balance

Work and non-work life balance deals with the relationship between work and home life. It is believed that in a competitive environment, it is difficult for employees to

combine their work and home life (Lokanadha & Mohan, 2010). The working environment for the midwives is confronted with a number of stress situations which are encountered on a daily basis. Among the main conditions that may cause stress are maternal death and facility-based MDR. In this study, the need to develop EAP to help midwives balance work and home life has been established. The EAP would help midwives to live a healthy life.

1.4 RESEARCHER'S ASSUMPTIONS

A researcher's assumptions are generally considerations of a paradigm or worldview that informs a study (Healy & Perry, 2000). This worldview or simply standards are components of basic beliefs that guide all the ideas, logical proposition and the thoughts of the researcher by directing step by step actions of the research study (Fetterman, 2010). In this regard, the researcher's assumptions in this current study are based on the following dimensions: ontology, epistemology and research methodology which are discussed below:

1.4.1 Epistemology

Epistemology is the relationship between reality and the researcher (Sale & Brazil, 2004). With regard to this dimension, the researcher and the phenomenon of interest are related so that the results of the study can be jointly created within the context of the situation (Denzin & Lincoln, 1994). In this vein, Smith (1983) states that no reality exists before the investigation starts and reality is lost when the researcher's interest is lost. The researcher is therefore a crucial interpreter of the constructs of the phenomenon of interest and decides how data is collected in order to get the realities

of the situation (Mantzoukas, 2004). Epistemologically, the researcher considered midwives as professional colleagues who could help solve the identified problem. Therefore, the researcher approached and related to midwives as meaningful partners, not just as individuals, but also as a team. This in turn determined the type of data collected in order to answer the research questions. It also entailed a demonstration of how data were analysed to arrive at the expected goal of the study.

1.4.2 Axiology

Axiology refers the nature of value or worth of being. It deals with the concept of good and beauty of a logical value in a research study (Guba & Lincoln, (1994). From the constructivist point of view, research carries weight and is predisposed by personal, cultural and socio-political influences (Lott, 2009; Neuman, 2000). It is assumed from the axiological mind that, the researcher made every effort to have awareness of self; and valued or worth considered the important role played by the researcher in giving voice to the participants' words. The researcher had a subject position and went through reflection of self in order to impact on the participants' voices. The researcher in this case, was in the field of data collection and immersed herself in the process of data collection (established the necessary rapport, followed the process of interviewing and moderation of focus group, probed when necessary) and therefore her experiences could brought about deeper meaning to the results of the data collected. The adaptation of the constructivist view in this study is appropriate because it made it possible for the researcher to explore the issues surrounding the effects of MD on the midwives in their work environment while at the same time

giving the researcher the opportunity for her own subjectivity to be valued in the interpretation of such an important research process.

1.4.3 Methodology

Methodology is the mechanism used by the researcher to investigate the reality of the study (Gray, 2013; Chirkov, 2009; Blaikie, 2007). Depending on the nature and scope of a problem to be investigated, the methodological approach applied may differ from one study to another. In order to achieve the objectives of the study, the researcher employed a qualitative research approach to the study (O'reilly, 2012; Kalpan & Maxwell, 2005). The objective of the qualitative research approach is to bring to bear some understanding of the events and state of affairs for midwives in the health care facilities concerned, examining the viewpoints and behaviours of participants in a specific context as contained by a natural setting (Hollow & Wheeler, 2009; Kaplan & Maxwell, 2005). A full description of the research methodology is presented in Chapter Three.

1.5 RESEARCH DESIGN

A research design is a protocol of a research study that explains the means by which the aim of the study would be achieved. It addresses research questions and the integrity of the study (Polit and Beck, 2012). In the case of this study, a qualitative methodological approach with combination of explorative, descriptive and contextual designs were used to meet objective one, two and three as well as conceptualising objective four. In this vein, the researcher used focus group discussions and semi-

structured individual interviews as methods for data collection. A full description of the research design is presented in Chapter Three.

1.5.1 Outline of the Thesis

This thesis is divided into seven chapters as outlined below:

***Chapter One*:** This chapter presents an overview of the study in terms of the background of the study, the problem statement, the purpose and objectives of the study, the significance of the study, researcher's assumption, conceptual framework, the ethical statement, and the definition of key concepts.

***Chapter Two**:* The second chapter presents literature review on the study.

Chapter Three: The this chapter deals with the research methodology undertaken to reach the objectives of the study, discussing in detail the research design, study population, sampling, data collection instrument and technique and the method of data analysis.

***Chapter Four**:* The fourth chapter presents the results of the research findings.

***Chapter Five**:* This chapter presents the discussions of the research findings with literature control.

***Chapter Six**:* The sixth chapter presents the development of the programme (EAP)

***Chapter Seven*:** This chapter provides a summary of the main findings and the relevant recommendations as well as the limitations of this study.

1.6 SUMMARY

This chapter has provided the general background to the study, the purpose, objectives and the significance of the study. The chapter has also provided a brief background of

Employee Assistance Programme as it relates, generally to occupation health and safety; and in particular to midwifery. The chapter has argued that midwives face several challenges at their workplace and among them is stress associated with their strenuous work as well as maternal deaths they experience with their clients. In this vein, the chapter has revealed that the issue of maternal death as a source of stress and depression are a well-known and documented fact worldwide. The chapter has shown that maternal death is a cause of stress to midwives who attend to pregnant women before their death. It has also pointed out that EAP is an instrument which offers employees counselling services intended to reduce stress, sadness and grief, anxiety and depression due to the numerous challenges associated with midwives' work. In the following chapter, the review of literature relating to occupational health concepts: occupational health workplace policies.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one outlined the general background to the research study as well as the problem statement with its associated aim, objectives and research questions. The goal of this chapter is to review literature on concepts of occupational health and its objectives, occupational health policies, workplace policy intervention, and quality of work life. Thereafter, review of work and reasons why people work, midwives working conditions in the healthcare facilities leading to the reasons for EAP development for midwives in Ashanti Region, Ghana.

The WHO and International Labour Organization in 1950 devised an all-encompassing definition for occupational health as the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations (WHO, 2002). According to WHO (2001), occupational health is a multidisciplinary task with the protection and promotion of the health of workers: development, promotion of health and safe work environments, improvement of the physical, mental and social well-being of workers and empowering workers to conduct socially and economically productive lives to ensure sustainable development. Occupational Health Nursing is a branch of nursing that aims at securing the health, safety and well-being of the workforce in any job, (Acutt et al.,

2011). Moreover, WHO, 2002 contends that Occupational health was built on three primary objectives which include the following:

- the maintenance and promotion of workers physical, mental and social well-being;
- the prevention from occupational diseases and injuries; and
- the adaption of work place and work environment to the needs of the workers.

The above means that, there should be the prevention of adverse health consequences for the workers as a result of circumstances in the workplace; protection of workers at risk because of existing conditions in their places of work and also placement and maintenance of workers in occupational environments that have been adapted to suit their physiological and psychological conditions (Chair in Occupational Health and Safety Management, 2005). Occupational health attained through assessing, monitoring and promoting the health status of employees, and developing strategies to improve the working conditions and complete environment that the employee functions in (Michell, 2011).

2.2 OCCUPATIONAL HEALTH POLICIES AT THE WORKPLACE

Occupational health policies are general rules and principles governing health and safety of workers at their work environment. These policies help establish boundaries for what is acceptable and what is not at the workplace. Workplace policies also regulate best practices leading healthy workplaces for all employees. A healthy workplace is required because it is the most basic of ethical principles to provide a harmless working environment for employees (WHO, 2010b). It is therefore the responsibility of the management of various health sectors to integrate into their

function[s] the health and safety of their employees. Managements should be committed to providing effective health and safety programmes within the institution (MOH, 2010b). The general definition of a healthy workplace is thus:

A healthy workplace is a place where everyone works together to achieve an agreed vision for the health and well-being of workers and the surrounding community. It provides all members of the workforce with physical, psychosocial, social and organizational conditions that protect and promote health and safety. It enables managers and workers to increase control over their own health and to improve it, and to become more energetic, positive and contented (WHO, 2010b:15).

A healthy EAP must have a comprehensive information system, policies and procedures that govern it. These issues are important because they would help in determining the effectiveness of the EAP, respond to employee and organisational changes' need and keeping of effective data on the trend of EAP within the organisation (Partnership for Workplace Mental Health 2006). The organisation should first be surveyed in order to quantify the various stresses specific to that organisation followed by a vigilant planning of the EAP provision and campaign before its introduction (Wieneke et al., 2016). In addition, the employees should be involved in the decision-making latitude when planning for the EAP implementation (Wieneke et al., 2016). However, in order to establish an effective and successful EAP within an organisation, the following factors need to be addressed: policy of the EAP describing its delivery with detailed procedures, confidentiality of issues, the location issue, subjecting of EAP professionals to consultation or supervision, staffing, promotion and education, evaluation of EAP, record keeping, and integrative and

preventive dimensions (Employee Assistance Professionals Association of South Africa, 2010). Furthermore, the thriving of EAP within an organisation depends on how active the administrative and management system monitors the changes in the ecological interaction between employees and the organisational conditions (Leonard, Lewis, Freedman & Passmore, (2013). Therefore, the EAP providers should be professionals and qualified counsellors forming a specialist in-house body and must remain as independent body within the organisation (Leonard et al., 2013).

2.2.1 Workplace Interventions and Policies

Workplace interventions take various forms based on the problems identified at the workplace. However, the target of these interventions is to mitigate stress at the workplace (Harvey et al., 2006). Organisations and individual based intervention programmes meant to deal with stress conditions at workplaces (Caulfield, Chang, Dollard, and Elshaug, 2004). Organization-wide health fairs and trauma intervention programmes at organizational level (Mattke, Schnyer, & Van Busum , 2012), while at individual-level, interventions programmes deal specifically with individual health risks. For example, the use of EAP to lessen the effects of MDs, training on the use of PPEs, educational campaigns on health, Workplace programmes could be individual or group based to reduce employee work stress (Center for Prevention and Health Services, 2008; Caulfield et al., 2004).

Therefore, organization's managers should utilize both interventions to achieve the targeted goals of the programmes. Indeed, both interventions aim to establish a wellness culture and promote a healthy behaviour for the entire workforce (Mattke et

al., 2012). The establishment of a wellness or workplace culture is seen as a means by which employees socialize at the workplace. The workplace culture includes self-management procedures, hierarchy, standard hours worked, and other informal aspects of workplace arena (Redmond, Valiulis, & Drew, 2006). Intervention programmes at the workplace may be technical, social or psychologically based, depending on the workplace environment in question (Harvey et al., 2006). Organizational commitment, positive quality of work life and employees well-being are very important when one is considering intervention programmes (Jain, Giga, and Cooper, 2008).

2.3 ORGANIZATIONAL COMMITMENT AND SUPPORT TO THE WELL-BEING OF EMPLOYEES

Organizational commitment is an ingredient of well-being at work (De Simone, 2014). The concept behind organizational commitment is to understand the dedication level of employees to the organization. Employees are willing to participate in activities when they are more committed to the goals of the organization (Lumley, Coetzee, Tladinyane & Ferreira, 2011). According to Islam and Siengthai (2009) and Kulkarni (2013), commitment to one's organization is indispensable and core to the organization's success. The organization's performance is directly proportional to job satisfaction, wages, company policies on conditions of service, and the trade union. In addition, training and development programmes are vital catalyst for improving quality of work life for the employees of an organization. In a study by Jain, Giga, and Cooper (2013), on the "mediating role of employee and organizational commitment" indicates that organizational commitment is perceived to have a direct impact on employees' health and well-being. For example, analysis of an organization's data in

the US companies proved that higher rates of employees attending the health care centres for treatment show employees' deterioration in performance, morale, and safety (Goetzel, Roemer, Levinson & Samoly, 2008).

Factors that do not ensure employees well-being should be reviewed and improved on in order to achieve appreciable employee retention and job satisfaction. Organizational commitment is one of the crucial dimensions pinpointed by researchers to tangibly have a positive impact on the quality of work life of employees (WHO, 2004b; Yadav & Khanna, 2014). According to Field and Buitendach (2011); Nanjundeswaraswamy and Swamy's (2012) perspectives, organizational commitment and job satisfaction are interrelated and directly commensurate. For example, organizational commitment has a strong relationship with turnover retentions and this link helps to further understand how committed nurses are to their various hospitals (Lumley, Coetzee, Tladinyne & Ferreira, 2011).

Organizational support such as EAP plays a major role in dealing and buffering nurses' stress-burnout relationship. This finding promotes the support and motivational force for intra-organizational support for nurses regardless of stress levels (Thanacoody, Bartram & Casimir (2009). Counselling was a model used in the past to solve stress outcomes, but with an associated stigma; the staffs member who received counselling were labelled as having failed to cope. This views, however, are changing gradually and the acceptance of counselling by staff members to enable them to better manage personal and professional stressors is increasing (Mackereth, White, Cawthorn, & Lynch, 2005). Alnems, Aboads, AL- Yousef, AL- Yateem and

Abotabar (2005), identify lack of staff support as a cause of stress. If that is the case, then EAP could help solve these stress-related problems. According to Rickerson et al., (2005) the individual staff responded in different ways towards the death of a patient. Therefore, there is the need for interventions that could help the health staff, especially nurses and midwives, manage the negative impact of patient death by developing coping strategies (Wilson & Kirshbaum, 2011). The aftermath of EAP is often associated with benefits to both the employer and the employee (ILO, 2013). Therefore the relationship between management and employees should be strengthened in order to enable EAP to provide psycho-social needs for its clients (ILO, 2016b; WHO, 2004b). In the section that follows, is a review of work and reasons why people work, the workers (midwives) of concern in the current study and the state of their working condition.

2.4 EMPLOYEES' WELL-BEING

According to Meyer and Maltin (2010), employee's well-being can be seen as a state of absence of physical illness and psychological strain. The psychosocial environment of the worker is directly commensurate to the mental health of the employee. Promotion of mental health at the workplace illustrates the way employees are content about their job since job performance is also used as part of employees' mental well-being as it goes a long way to greatly affect their psychosocial well-being (ILO, 2013; WHO, 2010a).

Social well-being is explained as having a good harmony of network and communication with peers as well as a healthy and satisfying exchange relationship

with the employer (De Simone, 2014). This is because workplace diversity has an influence on the employees' well-being, psychosocial and job satisfaction (Enchautegui-de-Jesus, Hughes, Johnston, & Oh, 2006). The quality of network and good communication with other co-employees at the workplace in an atmosphere of trust and deference is required to promote growth and development of the individual. Whenever the employer cares about the employees' problems, they reciprocate the desire to be more engaged at work. When psychological needs of employees are well attended to by the organization, on one hand, the negative impact of stress at the workplace is mitigated and employees desire for higher achievements and challenges (Jain et al., 2013). On the other hand, poor relationship with co-workers as well as the leaders would have a direct impact on employees' health and well-being at the workplace (De Simone, 2014). The concept of well-being at the workplace appears to be complicated since it includes integration of physical, emotional, and social factors, outside and inside the workplace.

However, different occupations and workplaces have their own definition of well-being at the workplace and this is usually based on their peculiar requirements and priorities. Employees' well-being is required, on one hand, because an organization depends on it to achieve the following: organization's long-term performance, higher productivity, commitment of employees, improved retention, higher resilience of employees, reduced sickness/absence levels, and it assists in a positive work environment (European Agency for Safety and Health at Work, 2013). Similarly, an effective and healthy workplace relationship promotes psychosocial well-being and enhances access to vital information, respect and decision making, resources that

benefit both the individual and the organization. Therefore, it is extremely essential for managers to create a working environment that increases retention of employees, provides a healthy psychosocial work environment and in the process improve productivity (Lumley et al., 2011).

2.5 QUALITY OF WORK LIFE

The word "quality" relates to evaluating dimensions such as reliability, performance and meeting the desires of clients. Indeed, evaluating "quality" means measuring freedom from wastage, freedom from trouble, and freedom from failure" (Srivastava & Kanpur 2014). "Quality of work" relates to effects of job/work on health and general well-being as well as means which positively influence the quality of a person's work experience at different levels of satisfaction (Indrani & Devi, 2014; Srivastava & Kanpur, 2014; Nowrouzi, 2013; Garg, Munjal, Bansal & Singhal, 2012). Thus, the notion of quality of work life describes the benefits and wellness of all workers across the globe. As pointed out above, employees' experience of a high quality of work life leads to organizational benefits such as a higher retention rate reduces/thwart sickness absence, and a drastic decrease in turnovers, more job involvement, more job satisfaction, and greater performance on job, and high productivity (Skinner & Chapman, 2013: Garg et al., 2012).

A study, conducted by Narehan, Hairunnisa, Norfadzillah, Freziamella (2014) demonstrated the relationship between quality of work life programmes such as EAP and quality of work life based on a qualitative research method. Indeed, the correlational data have confirmed that quality of work life improves employees'

quality of life. Pandey and Jha (2014); Yadav and Khanna (2014), conclude that, higher job satisfaction and efficient employee performance are directly commensurate to high degree of quality of work life since people spend more time at the workplace, it is advisable that organizations implement quality of work life programmes in order to establish a healthy work environment.

Research by Almalki, FitzGerald and Clark (2012) has shown that, nurses and midwives are mostly dissatisfied with their work and consequently exhibit dissatisfaction towards quality of work life. In addition, most of the nurses were not pleased with the health care work design, context, and world dimensions; obviously the nurses were dissatisfied with the quality of work life (Sheel Sindhwani, Goel, Pathak, 2012). According to Islam (2012), quality of work life is influenced by work load, family life, transportation, compensation policy and benefits, colleagues and supervisors (Islam, 2012). Quality of work life is associated with freely exercising one's talent and excelling in challenging situations, employee knowing his/her roles specific by the individual in organization activities to help achieve its goal, the individual is involved in rationale activities perceived worthwhile as well as pride of one's work and feelings of belongingness (Sheel, et al., 2012). It is therefore important to consider the quality of work life at all workplaces (Srivastava and Kanpur, 2014; Yadav, Khanna, 2014).

Therefore, quality of work life would be optimized if close attention is given to areas of work life such as working duration, nursing suffering, autonomy of practice, management and supervision, professional development opportunities, working

environment, attitudes of public towards nursing salary factors and family needs of employees, (Almalki et al., 2012). For example, one way suggested by researchers in providing high degree of quality of work life among nurses and allied health professionals is by increasing job autonomy and job control (Nowrouzi, 2013). However, other researchers also state that there are differences in the quality of life in organizations based on its size and group of people (Sheel et al., 2012). It was also suggested that quality of work life programme, such as EAP be implemented and it existence would improve the morale of nurses and a higher productivity of the organization (Almalki et al., 2012). In addition, retention of quality nurses in the workforce would increase drastically (Almalki et al., 2012; Sheel et al., 2012).

Owing to the importance of this approach to work life, several models have been proposed by researchers with an attempt to explain the primary purpose of quality of work life (Sheel et al., 2012). It is for these reasons why in the current study, quality of work life model by Lokanadha and Mohan (2010) was employed to help develop quality of work life programme EAP for midwives dealing with MD in the Ashanti Region of Ghana. The 5 areas of this model which were also taken into consideration in relation of the midwives are:

- Health and wellness being;
- Job security;
- Job satisfaction;
- Competence development; and
- Work and non-work life balance.

Health and wellbeing are the physical and psychological aspects of the individual in a working environment. Job security is when an organization provides permanent and steady employment to its employees. Job satisfaction is a situation where an employee finds his or her job interesting, stimulating, fascinating and motivating. Competence development is related to adequate knowledge and skills acquisition by employees concerned. Work and non-work life balance deals with the relationship between work and home life. A detailed description of this model is in Chapter One (1.3).

2.6 OCCUPATIONAL HEALTH SERVICES

Occupational health services are all services entrusted with essentially preventive functions (Alli, 2008). In addition, WHO (2002) defines occupational health services as services designed and delivered to institutions with higher degree of focus on the employees physical, mental and social well-being by occupational health professionals leading to mutual benefits of both the employer and employee. The aim of this service is to focus on establishing good physical and mental health of employees by providing and maintaining a safe and healthy working environment, as well as see that employees placed in suitable positions they identified with the adaptation and capabilities based on their physical and mental health state. The occupational health service provided must be specific to dealing with the stressors causing health risks in the organization (Alli, 2008).

Occupational health programmes should be transparent and tangent to the needs, relevance, scientific validity, reliability, effectiveness and efficiency, in order to be acceptable for management and workforce (WHO, 2002). Typical examples of

occupation health services applied at the workplace may include ‘a smoking cessation programme’, ‘weight management and fitness programme’ and so on (Morais & Shea, 2013; Mattke et al., 2013). However, the efficiency of occupational health services is analysed by the relationship between the immediate output of, and the input to the service activities. Evaluation of occupational health services would help answer the same questions asked by consumers of the services, and other stakeholders of occupational health services, thus the accountability of the services. Therefore, transparent and effective evaluation methods are required to help know the importance of the application of occupational health services at the workplace (WHO, 2002).

The professionals of occupational health service providers form an independent body within the health sector institutions. Due to confidentiality, they are required to protect the trust of their client, thus, the health workers (MOH, 2010). Occupational health professionals give advice in situations such as exposure to blood and bodily fluids, health surveillance, bullying and harassment, violence and aggression, sickness and absence assessment, workplace stress, drug and alcohol abuse. Since the occupational health professionals have a unique knowledge of the individual personal problems affecting their working ability and efficiency, it is important to have some of these people at the workplace (WHO, 2002). The strategies adopted for achieving an effective occupational health services among the staff of health workers include preventive activities, promotional activities, curative activities, rehabilitation activities, and research activities (MOH, 2010).

2.7 EMPLOYEE ASSISTANCE PROGRAMME

EAP is the work based resource, founded on core technologies or functions, to boost employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues (Bhagat, Steverson, & Segovis, 2007; Matlhape, 2003). EAP may be a work-based programme that is not limited to job related problems but also wide range of personal and emotional issues that affects the mental state of workers (Andrew & Arthur, 2010). Literature suggests that EAP is a programme that benefits both employee and the employer (Bennett et al., 2015). This is because it impacts positively on the users and reduces stress and increase job performance (Pahtak, 2012; Nakao, Nishikitani, Shima & Yano, 2007). EAP is one of the interventions that play a major role in the organisation's high productivity as recognised by managers (Vojnovic, Michelson, Jackson, & Bahn, 2014). Therefore, the relationship between the management of an organization and employees should be strengthened in order to enable EAP to provide psycho-social needs for its clients (Schemm, 2014).

Generally, EAP can solve problems ranging from finance, marital, legal, home management to mention but few (Nakao et al., 2007; Xaba, 2006). It is also able to prevent or mitigate absenteeism, accidents and time lost, and to boost morale of employees (Schemm, 2014; Feldman, 2012). Some EAPs cover a broad range of issues whilst some are functional specific, being limited to the organisation's interest, in order to augment work performance and efficiency. For instance, some EAPs may be restricted to mental or physical ill-health, inability to cope or an unacceptable behaviour at the workplace (Partnership for Workplace Mental Health 2006). EAPs at

most workplaces are short term counselling, identification, assessment, monitoring, referral and follow-up services (Muto, Fujimori & Suzuki, 2004). EAP provides information, help and support to persons suffering from a work-related mental health problem; it offers voluntary and confidential services that are available at all times; and it reduces the risk of relapse (Osilla et al., 2010; Chair in the Occupational Health and Safety Management, 2005; Mackereth et al., (2005). EAP presents an opportunity for many organisations to tackle and manage many employees' workplace-related problems that were often not understood previously and that have appeared to be difficult to manage and thus causing harm to the complement of employees' well-being as well as causing a decrease in the organisation's productivity. Some of the unacceptable behaviours exhibited by employees at the workplace include increasing absenteeism, presenteeism, selective nursing provision, increased rate of lateness, violence, alcoholism and substance abuse (Matlhape, 2003).

A study by Wilson and Kirshbaum (2011) also proved the profound motivational need to implement interventions that could help manage the distress/stress conditions of nurses and midwives. According to Bickham (2009), nurses and midwives are mostly looked up to by patients for providing care, comfort and reassurance. Organisational strategies to prevent occupational stress are described as the "creation of a suitable working environment in terms of employment characteristics, labour relation, organisation structure, and achievement of a healthy organisation culture" (Stoica & Buicu, 2010). This is because the implementation of a supportive system (intervention) based on knowledge, and conditions health care professionals face when confronted with death. As this may lead to improved service of patient care

(Mackereth *et al.*, 2005; Blood, 2000). Therefore, there is the need for interventions that could help the health staff (especially nurses and midwives) manage the negative impact of patient death by developing coping strategies (Wilson & Kirshbaum, 2011)

Matlhape (2003) concludes that EAP is under-utilised by many organisations as well as countries, particularly in developing nations such as Ghana because they have not been strategically introduced to form a vital component of the organisation's activities. Therefore, organisations should consider this position, to achieve the goal of EAP, thus employees' total well-being and maximising productivity. As such, the researcher intends to introduce EAP in Ghana's health sector for midwives dealing with MDs in the workplace.

2.8 WORK AND REASONS WHY PEOPLE WORK

According to Morin (2004), work is the inclination to apply one's mental and physical powers, skills and knowledge in order to achieve something, to reach a goal, to create and to express one's self. Work is seen as one important and most fascinating activity for human health as it helps enhancement of self-esteem and provides basic subsistence needs and comfortable living condition (Herzerg, Mausner & Snyderman, 2011). Work also helps develop the individual human's flair, skills and identity as well as provides a sense of belonging in society. According to Morin (2008) some people are of the view that work is a right and a necessity economically, while others perceive it as a social responsibility or moral self-punishment brought upon mankind. Work becomes meaningful only if it is beneficial to the development to members of the society or the society itself with its products, consequences (Morin, 2004). The

refusal to work is the same as refusing to feed one's body with food. In the context of this study, midwifery is one of the main occupations considered.

2.9 MIDWIFE AND MIDWIFERY

The word midwife generally means "with woman" or in France, it means "wise woman". With the passage of time, pregnant women in labour have depended on elderly skilled women in the process of giving birth, and according to some cultural values men are not permitted to practice or get involved (Fraser and Cooper, 2003). For many centuries ago, the practice of midwifery took place even without healthcare facilities. For example, there are Biblical verses such as Exodus 1: 15-22; Genesis 35:17; 38:28, where midwives are mentioned. As a profession, midwifery work started in the American continent between the 17th and 18th centuries. Midwifery was not regarded with much importance as midwives' jobs were assumed to be defined and executed by the physicians.

The definition for the word "midwife" was developed in 1972 by the International Conference of Midwives (ICM) and later adopted by International Federal Gynaecology and Obstetrics (FIGO) and WHO. However, ICM revised the definition in later years, which was ratified by FIGO and WHO. The ultimate internationally acknowledged definition developed by ICM in 1992, and was endorsed by FIGO and WHO. It states that a midwife is "a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and

has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery" (Fraser & Cooper, 2003:4).

The scope of work for a midwife revolves around the mother, infant, family and the community. The roles of a midwife to a mother consist of, but not limited to, prenatal period (during pregnancy/before birth), labour and delivery, as well as postnatal periods. However, in summary, the primary function of a midwife is maternity care and health of the young children. The definition of maternity care according to WHO (1966) begins much earlier and aims at promoting health and well-being of the young people who are potential parents. It also helps to develop the right approach to family life as well as help place of the family in the community. Additionally, maternity care provides activities such as preventive measures; immunization, health education and nutritional measures (WHO, 1966).

The roles of the midwife in the primary health care settings include advocacy and protection of rights of women, families, communities and defence of their right to self-determination. The roles of midwives also involve educating the women and their families in anticipation of pregnancy, birth, breastfeeding and parenting. The education provided also involves other aspects of reproductive health such as the wellness of the infant and family planning (Ashley, 2013; WHO, 1966). Refer to Chapter One for a detailed description of the roles of midwives as it is integrated in the background.

2.10 HEALTHCARE FACILITIES WHERE MIDWIVES WORK

Healthcare facilities are places where health care is offered. These could be hospitals, health centres, clinics, outpatient care centres and specialised care facilities such as psychiatric and maternities services are provided. The health care facility combines medical technology and the human touch to diagnose, treat, and administer care to the general populace in a form of inpatients and outpatient services. (Economic and Workforce Development, 2012). According to WHO (2016a) healthcare facilities could also be isolation camps and feeding centres where crisis situations are found needing special medical aid to the affected people. Healthcare facilities provide services to patients with both mental and physical challenges (Occupational Safety and Health Administration (OSHA), 2013). WHO (2016a) adds that healthcare facilities provide all kinds of services which include diagnostic and curatives to the acute, convalescent as well as the terminally ill patients. It is believed that, activities of the healthcare facilities produce information for education, management and research activities. There are several professionals working at the healthcare facilities and these include nurses and midwives, physicians, clinicians, laboratory technicians among many others.

2.11 WORK LIFE AT THE HOSPITAL

Working conditions in hospitals are considered, among others, the most hazardous compared to industries and companies. This is so due to the fact that health workers at different healthcare facilities are exposed to severe injuries or illnesses (OSHA), 2013). Subsequently, this leads to absenteeism of workers and at times some workers are assigned to restricted or modified duty. For example, in 2011, United States of

America statistical analysis saw hospital workers having a higher rate of "absenteeism" compared to private industries as a whole, taking into consideration construction and manufacturing companies. Out of this total number of workers, it was observed that registered nurses and nursing aides suffered more injuries compared to professionals in other occupations. The injury and illness rate in the hospitals are more than those of the two industries that are traditionally thought to be hazardous in the U. S which for twenty years earlier, were statistically considered the most hazardous workplaces (OSHA, 2013).

The risk associated with hospital jobs is unique and involve transferring patients who have circumscribed mobility in lifted reposition, challenges in handling larger patients, coming into contact with patients having potential contagious diseases or sharp devices, adulterated with blood-borne pathogens, and challenges in dealing with patients who have physical or mental health challenges where even in some cases there is likelihood of violent outbursts (Jackson, Sarac, & Flin, 2010; Singer, Lin, Falwell, Gaba, & Baker, 2009). However, "patient handling" causes strain, and this has accounted for the most prevalent causes of employees' compensation claims in the hospital (OSHA, 2011). The death of a patient on the ward comes with its own problems.

2.12 DEATH OF CLIENT AT THE HEALTHCARE FACILITIES AND EFFECTS ON MIDWIVES

The expectation of every midwife at the healthcare facility is provide ante-natal care, delivery pregnant women of the babies and provide post-natal care for both mother

and baby. The midwife is satisfied when pregnant women are happy and this good news leaves with them throughout the day till they return to their families. The least expectation of every worker is the death of a person at the workplace, irrespective of how it occurs (Dyer, 2002). The incidence of death of a client affects all midwives irrespective of whether the person is the attending midwife or not, from the labour ward or not. Indeed, the aftermath effect of death can be short or long lasting (Walter, 2008). According to Dyers (2002) death in the workplace can lead to "feelings of anger, guilt, unease, fears for personal safety, plus the pervasive need for someone or something to blame". Also, such unfortunate incidents make many workers exhibit self-doubts, guilt or moral distress, and these can go a long way to affect their performance (Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008). However, it may be difficult for some employees to return to work following the death of a client at the hospital. The death of a patient at the hospital may have emotional, psychological, physical and social impacts on the employees. The impacts of a patient death at the hospital comes with lack of focus resulting in making mistakes, thereby presenting safety hazard to both colleagues and patient alike.

Death, according to Moore and Williamson (2003: p. 3), is "separation from everything that gives life; it is the loss of everything that we hold dear". Death inevitably always brings the most painful adjustment challenges to families because it causes the most stressful life event for people (Murray, Toth & Clinkinbeard, 2005). The "grief" experienced by the bereaved according to Blood (2000) is defined as "all that represents the particular reactions people experience while in the state of bereavement, including anger, guilt, despair, and physical complaints". One could

actually recognize the pain and grief of individuals who did not personally know the dead person exhibit what is called “virtual grief”. Thus “not feeling the depth of pain and depression of actual grief” and their recovery is very quick as compared to when actual grief is experienced (Mizota, Ozawa, Yamazaki & Inoue, 2006 p. 77). Further, in situations when the death of the patient is anticipated by the relatives in advance due to disease, suicide, and accidents causing violent death, the bereaved family exhibit characteristics of actual grief, difficulty adapting, moral distress, traumatic responses, and posttraumatic stress disorder (Mizota et al., 2006).

According to Keene, Hutton, Rushton (2010); Bryan (2007), healthcare workers also experience grief when their patient's death occurs because, just like family members, they also have relationships with their patients. In most cases, such relationships are strongly established as a result of the extensive contacts with patients admitted in the hospital for a little longer period of time (Rickerson et al., 2005; Wilson & Kirshbaum, 2011). However, the initial reactions of nurses to their patient deaths include physical, emotional, professional and cognitive reactions. The physical reactions involve “shock and numbness, sleep disturbances, nightmares, and eating disturbances”, the emotional reaction is composed of “sadness, guilt, hurt for their patient, and positive feelings”, the professional reaction includes “having no control over the situation, being vulnerable, feeling distracted, feeling irritated towards other patients” and the cognitive reaction involves asking oneself questions and review of treatment (Blood, 2000). For example, the paediatric nurses in the children’s ward exhibit a feeling of “hurting” as a reaction to the death of a child, and this hurting feeling described as feelings of sadness and sorrow (Blood, 2000). It is very painful

emotional experiences to loss someone so dear to you and even the people who simply witness the death of that person(s) can easily evoke a natural horror and revulsion (Moore & Williamson, 2003).

In the hospitals, patient caregivers have different sensitivities and relationships attached to a patient and this results in varied lines of their reactions (grief) and adjustment towards the death of a patient, and also different bereavement experiences in different units or areas of medicine (Konietzny, 2016; Zambrano & Barton, 2011). But within the same unit, the different bereavement by the health staff would be based on the variety of grief-related symptoms experienced individually (Rickerson et al., 2005). The death of some patients in the hospital is traumatic for the staff, mostly because of their unexpected nature, most of those occurring in accidents, emergency department and critical care units (Wilson & Kirshbaum 2011; Costello, 2006) and nurses as human service workers are always confronted with grief, suffering and death (Wilson & Kirshbaum, 2011; Jowett, 2003), but little is known about the impact of grief experience on health professionals (Rickerson et al., 2005).

The research findings of Wilson and Kirshbaum (2011) show that people having secretive (non-traditional relationships) or close relationships unacknowledged by family and friends of the deceased may exhibit a feeling of grief more intensely. This is known as disenfranchised grief and is defined as "a grief experienced by an individual, but which is not openly acknowledged, socially validated or publicly observed". This is also applicable to the healthcare staff (especially nurses and midwives) who mostly would always experience disenfranchised grief and may try to

conceal their emotional response in the presence of the patient's death since it is not acceptable to express their emotions in the workplace. In such a situation, while others did not acknowledge that the death is a loss to them as well, they may be beckoned on to buttress other patients who need their help. This "disenfranchisement" can be argued as one major factor which brings about a different level of impact (reactions) on healthcare staff (especially nurses and midwives). However, the individuals' own attitudes in response to death are mostly influenced by, cultural, social and philosophical belief systems that shape their reactions in different ways.

Culture can also be argued to be responsible for the different level of impact or grief on healthcare staff towards a patient's death. Culture, according to Wilson and Kirshbaum (2011), was defined as "the pattern of behaviour, custom, beliefs and knowledge of a group of people". Cultural norms perceived by patient families can have a strong influence on healthcare staff behaviours, attitudes and beliefs. It has become a cultural norm and always perceived among members in the community who are not healthcare workers viewing healthcare staff as having a professional relationship with their patient without recognising that the death has an impact on them as well (Zambrano & Barton, 2011); Wilson and Kirshbaum, 2011). Again, according to Wilson and Kirshbaum (2011), some nurses and healthcare workers bring along with them their personal life experiences into their professional role. Respondents from some previous research revealed that it has become difficult for them to accept the death of someone (especially love one) in their personal life and are likely to become more vulnerable when simply becoming a witness to a patient death. However, when personal experiences of death outside work are well integrated by the

individuals in their lives would contribute positively to their work (Wilson & Kirshbaum, 2011).

In the research of Lange, Thom and Kline, (2008), it is stated that nurses with years of work experience are most able to exhibit a positive attitude towards death and dying patients. This also means that working experience influence the reaction of nurses when being exposed or witness the death of a patient. Therefore, in a nutshell, different health care providers would exhibit different reactions or death impact based on the nature of relationship 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 (Konietzny, 2016; Zambrano & Barton, 2011).

Grieving process theories with the aim of describing the bereavement of relatives and friends and there are also several studies on bereavement of family, friends, and spouses (Blood, 2000). Wilson and Kirshbaum (2011) identified some theories which support the validity of grieving following the loss of a love one. One of these theories is the attachment theory which states, the notion of separation anxiety is seen when a person dies. Thus, according to Blood (2000), the bonds that exist between parent and children, between spouses, between adults may exist between nurses and patients. All these theories and models aimed at achieving one thing; the way society acknowledged the grief expressed by the bereaved and also based on their cultural norms (Wilson & Kirshbaum, 2011).

The grieving action over the dead is normal, but survivors can experience physical, psychological, and social consequences (Murray et al., 2005). For example, the psychological characteristics exhibited following the death of a person by the bereaved family include resentment, anger, a sense of guilt and regret and anxiety over discrimination and the associated stigma (Mizota et al., 2006). However, the stress or distress accompanied the grieving is the issue of concern.

Stress, according to Bickham (2009) is any response to an event which overpowers one's coping skills. Similarly, stress is seen as the psychological strain resulting from experience in unusual or demanding situations, known as stressors (Finney, Stergiopoulos, Hensel, Bonato & Dewa, 2013). The overwhelming characteristics are manifested as "anger, frustration, guilt, loss of self-worth, depression, nightmares, suffering, resentment, sorrow, anxiety, helplessness, and powerlessness". But the distress leading to emotional burnout, frustration, and resignations can cause imbalance between work and home roles. Though, according to Tyson and Pongruengphant (2004) hospital nurses frequently rated dealing with 'death and dying' as one of the major stressful event and the impact on them which include burnout, health complaints and quality of patient care. However, if the stressful experience is not overcome, it may lead to symptoms such as depression, anxiety, depersonalization and dissociation (Bickham, 2009).

The initial reactions of healthcare professionals to a patient's death have an obvious impact on them which are grouped into emotional, physical and social. Emotional effects such as fear and distress, psychological effects with depression being a major

difficulty, with exhaustion exhibiting itself among physical effects and social isolation amongst others are issues midwives in the Ashanti Region of Ghana face. (Bickham, 2009; Caulfield, Chang, Dollard, Elshaug, 2004).

The idea of death alone raises a number of fears within an individual. The fear of death is innate and a natural response, thus all life fears death. Fear is one of the common natural reactions to be exhibited when confronted with death. But some researchers with a different school of thought have argued that the fear of death is not necessarily innate to the individual, but rather it is a learned reaction (Moore & Williamson, 2003). According to Lewis (2014) fear is toxic to both safety and improvement among humans. Death anxiety is seen as negative feelings midwives have about fear of their own death and death of others after experiencing maternal death at work (Muliira, Sendikadiwa, Lwasampijja, 2014; Peters et al., 2013).

Maternal death, as the word suggests, refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to, or aggravated by the pregnancy or its management but not from accidental or incidental causes" (Muliira et al., 2014). Witnessing death of expectant women, women with terminated pregnancy after 42 days his termed "experienced maternal death" (Muliira et al., 2014). Midwives who witness maternal death establish a sense of disbelief at the initial stage of the incident (Mander, 2009).

Furthermore, there are cognitive and behavioural problems related to distress. Behavioural characteristics such as substance abuse, aggressive behaviours, social withdrawal, and listlessness may occur. Cognitive related problems to distress such as the following may occur: confusion, difficulty concentrating, and memory lapses (AACN 2008). In a similar situation, AACN (2008) addresses moral distress as knowing the ethically appropriate action to take but unable to act upon it or you act in manner conflicting to your personal and expert values, and which undermines your integrity and authenticity. This is becoming a serious problem in nursing. However, people with serious moral distress carry the remnants of the experience for many years, if not for a lifetime. In the same way, when moral distress is repeated within the working environment of nurses, can lead to withdrawal and a flight response (De Villers, 2010; Austin, Kelecevic, Goble, & Mekechuk, (2009). Corley, Minick, Elswick, & Jacobs, 2005)

However, with regards to empathy, nurses are required to turn-off their empathy in order to be able to cope with stressful circumstances, such as patient deaths (Bickham, 2009) but this appears to be difficult to some. Nursing and midwifery are considered one of the known human service professionals which are more stressful and emotionally demanding. According to Lewis (2014) some of the expected core characteristics of midwives include respect, compassionate and empathy.

One characteristic typically associated with grief is a high rate of depression, which evoke a concern in this circumstance (Murray et al., 2005). The nurses regular attempt to deal with death and dying issues in their working environment causes stress, which

may evoke health concerns such as depression and burnout (McGrath, Reid, & Boore, 2003). Nurses always face caregiver distress or burden which leads to caregiver depression. Caregiver depression is seen as a mood commotion resulting from the stress of providing care, which may be demonstrated as feelings of loneliness, isolation, fearfulness, and being easily bothered (Given et al., 2005). Burnout is identified to be a display of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Mackereth et al., 2005). Burnout according to Royal College of Nursing (2013) observed that extreme experience of stress due to physical, emotional, and mental occurs with exhaustion.

The bereavement can result in negative consequences of the physical health of the survivor through physiological changes which heightened acute arousal (changes in the endocrine system, immune system competence, and sleep complaint). However, the inability to eat and sleep is typical characteristics associated with grief which evoke a physical health concern in this circumstance (Murray et al., 2005). Crying is perceived by Kukulu and Keser (2005) as a loss of control, the result of an emotional state of helplessness and inadequacy, or a sign if suffering. Basically, crying is universal, but its emotional expression can differ based on the social context. Health care providers in the hospital may cry for a number of reasons which include a sense of compassion for patients who are suffering or dying or patients' families, frustration, helplessness, being overworked. The act of crying by nurses was recognised as a coping mechanism for low job satisfaction (Golbasi, Kelleci & Dogan, 2008) and a clear signal of emotional distress, however, some of its benefits are considered as release of negative emotion, stress related biochemical, restoring homeostasis and

recover from prolonged sympathetic activation (Nowrouzi et al., 2015). Crying, according to the research result of Pongruegphant and Tyson (2000) was recognised palliative and ineffective in dealing with emotional distress, thus "crying was found not to have a cathartic, stress-reducing function in nurses when exposed to particular sources of stress, such as coping with dying patient" meaning as a coping strategy it did not have any stress-buffering effects (Kukulu & Keser, 2005).

The avoidance behaviour, according to McGrath et al., (2003) was observed as a coping mechanism for dealing with stress. For example, some bereaved of the AIDS deceased due to discrimination decided to avoid association with people at the school, workplace and neighbourhood (Mozota et al., 2006). Conversely, assumptions could be made from this by equating it to nurses or midwives who exhibit 'actual grief' and tend to isolate themselves from relatives, friends, and co-workers. For instance, the avoidance characteristics are exhibited as a coping strategy by nurses to help reduce occupational stress (Welbourne, Eggerth, Hartley, Andrew, Sanchez, 2007). Again, according to Mozita et al., (2006) the fear of being discriminated would result to self-restriction of their daily activities and hinder them from seeking the needed support. The affected victim (bereaved) experienced psychological well-being effects and refuse to go to places which remind him/her about the event.

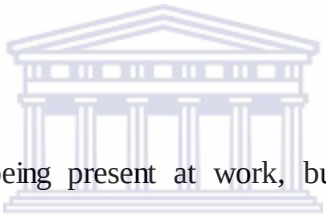
In the research, discussion, Wilson and Kirshbaum (2011) stated that, the death of a patient can have an impact on the nurses both inside and outside their work environment and can affect their relationship with others". According to Perinatal Society of Australia and New Zealand (2009), it is obvious some bereaved parents

find it difficult and distressing in the maternity ward since the crying of babies may intensify their distress. This, in the same way can also be applied to the nurses and midwives who had their patient dead. Despite the increasing recruitment and retention of nurses, occupational stress is leading to labour turnover, absenteeism, burnout, illness, poor morale and diminished efficiency and performance (ALnems et al., 2005).

The midwives become "second victim" whenever there is an adverse event. Second victim refers to "the feelings and experiences of healthcare professionals following an adverse event". The patient is the first victim and the second victim being the healthcare professional (Austin, Smythe, & Jull, 2014). The effects of patient deaths can also be felt on the nurses' working environment. In most cases, according to Glazer and Gyurak (2008) since death of a patient occurs in the working environment producing stress for nurses. The increased experience of stress, which leads to the occurrence of burnout and depression results to absenteeism, turnover of nurses and loss of nurses from the workforce (AACN, 2008).

Munro (2007) defines absenteeism as being absent from a workstation. However, absenteeism could take any of these forms; absenting from work for days without a leave, going out to shop during work hours, going out for lunch beyond the time frame, being indisposed and a deserter who does not intend returning to work. Similarly, absenteeism is also defined as an employee's time away from work due to illness or disability of any kind (Cancelliere, Cassidy, Ammendolia, Cote, 2011). Instances to be considered as potential cause of absenteeism are low job satisfaction,

boring repetitive work, unfair treatment and poor leadership due to poor morale existing within the health professionals and the work atmosphere (Munro, 2007). The measuring or estimation the cost of the extent of stress related problems of an organisation (especially health institution) is difficult, thus the cost of absenteeism is correspondingly higher (Brun & Lamarche, 2006). For instance, taking experienced nurses and midwives is a consideration. Another form of absenteeism such as "arriving late for duty on a regular basis, leaving work early, taking extended lunch break" (Munro, 2007) may occur which would have a heavy impact on the effective working environment of the employees (midwives) and the reputation of the organisation as well.



Presenteeism is seen as being present at work, but limited in some aspects of job performance as a result of health problems, and it is often a hidden cost for employers (Cancelliere et al., 2011). Similalry, according to Munro (2007), presenteeism is an illness related condition that negatively affects on-the-job productivity of an employee at post. This means that an employee would report for duty, but exhibit inability to work due to health problems, such as chronic back pain, allergies, rheumatoid arthritis and others just to mention a few. For instance, the nurses are aware of the pressure their colleagues and patients might face, so are always self-directed to go to work, whether unwell or unfit. Other reasons also include the fear of being denied a promotion if records of absence are found against the nurse (individual), and the guilty atmosphere created by colleagues and managers for the one who does not report for duty due to unfitness (Royal College of Nursing, 2013).

The fear of blame and punishment is still seen worldwide among health professionals, especially in the ex-Soviet states, cities and rural communities of Asia, Africa and Far East who still adhere to the draconian laws. Such laws are meant to punish the health caregiver (the midwives) in charge of the dead patient. In a nutshell, these midwives are used as scapegoats whenever a maternal death occurs. This would lead to most of them becoming demoralised and thereby neglecting their responsibilities (Lewis, 2014). Nurses and Midwives are expected to give an account of their actions and justify their decisions (Floyd, 2013), but failure to give a reasonable account shows incompetence (Savage & Moore, 2004). Competence according to Savage & Moore (2004) is the ability to perform a responsibility with appropriate knowledge and skill and to perform that responsibility in terms of appropriate scope and quality.

Therefore, it is obvious that any midwife who is unable to justify the cause of a maternal death would be stigmatised, as being responsible for the death. For example, there are instances when maternity death cases are reported to the police for criminal investigation, and a health staff put in custody until he or she proves innocence (Lewis, 2014). Since unexpected deaths of patients are stressful experiences for nurses or midwives, such experiences compound the already dire situation which may to 'job stress' (Alnems et al., 2005). Job stress is perceived as the unpleasant condition or position at the workplace which has a negative impact on an individual's overall well-being and performance (Khan, Aqeel & Riaz, 2014). This would lead to job satisfaction related problems and eventually to job dissatisfaction. Job satisfaction is understood as the degree to which employee enjoy their job (Alnems et al., 2005).

Similarly, Khan et al., (2014) stated that job satisfaction is "a stable and balanced arrangement of environmental, psychological and physiological situations at workplace". Job satisfaction is also "the positive orientation of an individual towards the work role which he/she is presently occupying" (Pathak, 2012). Job stress, however, is directly proportional to job performance (Khan et al., 2014). According to ALnems et al. (2005), job dissatisfaction of nurses may occur due to non-supportive work environment and stress. Job stress and job satisfaction were the most significant causes of job turnover among nurses and midwives (Zuzelo, 2007). The job dissatisfaction of employees can lead to the following: high turnover, less work commitment, physical withdrawal, and retreat emotionally or mentally from the organisation (Pahtak, 2012). In most instances, the victim's family seems not to appreciate the efforts of the midwives following an adverse event. For example, the bereaved father culpable the nurses put in charge of his dead son to be responsible for the adverse event. This may nurses and midwives culpable for being incompetence for the profession (Austin et al., 2014).

The study of Mander (2009) established that midwives accept maternal death as a situation which they are always unprepared for. The experience of patient death by health workers in America made them fear how they would die compared to death itself (Beckstrand, Callister, Kirchhoff, 2006). The physicians past personal experience about a loss of love one, the kind of relationship developed between the physician and the deceased patient and the extent of self-blamed influences their responses to patient deaths (Jackson et al., 2005).

An implementation of a supportive coping strategy is a profound motivational force because according to Bickham (2009) nurses are mostly looked up to by patients for providing care, comfort and reassurance. Organisational strategies to prevent occupational stress are described as "creation of a suitable working environment in terms of employment characteristics, labour relation, organisation structure, and achievement of a healthy organisation culture" (Stoica & Buicu, 2010). The organisation stress is defined as any perceived threat to the individual's safety or well-being that serve as a stressor in the workplace environment of the employee or the individual (Finney et al., 2013; WHO, 2016b).

2.13 SUMMARY

This chapter reviewed literature of concepts of occupational health and its objectives. It also looked at occupational health policies at the workplace, workplace policy intervention, and quality of work life, employee well-being. Thereafter, review of work and reasons why people work and midwives working conditions in the workplace leading to the reasons why EAP was developed for midwives in Ashanti Region, Ghana. The chapter that follows presents the research methods and design employed in the current study.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter two presented a review of literature on concepts of occupational health and its objectives and occupational health policies at the workplace. The aim of this chapter is to outline the research methodology used in the study. The chapter starts with a review of the research approach in order to show how qualitative approach was applied to the study and the justification for its choice. Subsequently, a discussion of the research design used in relation to phase 1 (data collection methods, sampling techniques and selection criteria) and phase 2 (the strategies used in the EAP development), of the research study is provided. Furthermore, the chapter outlines ethical considerations and the rigour applied to this research study. In addition, trustworthiness as it applies to the current study is discussed. Finally, the chapter outlines the processes used in analysing data.

3.2 RESEARCH APPROACH

As pointed out in chapter one, this study was conducted using a qualitative research approach. Qualitative research is an interpretative methodological approach that is supposed to create more subjective knowledge (Carter, & Little, 2007; MacDonald, 2012). It develops from the behavioural and social sciences as a process of understanding the exceptional, self-motivated and all-inclusive nature of human

beings (Lacey & Luff, 2009). The philosophical base of qualitative research is interpretative, humanistic, and naturalistic. Qualitative researchers trust that fact is both multifaceted and active and can be found only by studying persons as they intermingle with and within their socio-historical settings (Carter, & Little, 2007; Munhall, 2007). Qualitative research is conducted to generate knowledge concerned with subjective meaning and discovery (Brink, Van der Walt & Rensburg, 2012; Botma, Greeff, Mulaudzi & Wright, 2010).

The interest in subjective experiences of midwives in relation to maternal deaths makes the qualitative approach to the study suitable (Munhall, 2007) due to the fact that the objective of qualitative research approach is to bring to bear some understanding of the events and state of affairs of what is being studied. Therefore, the approach becomes useful to study circumstances that midwives in the health care facilities find themselves. This is best done through an examination of their' viewpoints in specific experiences in their context as contained in a natural setting (Hollow & Wheeler, 2009; Kaplan & Maxwell, 2005). According to Pope and Mays (2006), there are three main dimensions that one may follow when using the qualitative approach and these are: (1) understanding the context in relation to organizational factors that influence health (in the case of the current research, the impact of maternal death on the health of midwives who experience it on a daily base is examined); (2) understanding the people in that organizational context. This dimension seeks to explore how midwives make sense of their experiences in relation to the death of their clients; and (3) understanding the interactions between the various

factors, for example, their work environment and support systems available, in which midwives find themselves and how their health is affected by these factors.

The choice of the qualitative method in this research study, first and foremost, has to do with the research problem and the researcher's assumptions. The researcher's assumption is driven by an interpretative philosophy resulting in the belief that midwives experiencing maternal deaths and their lived experiences of these maternal deaths can only be evaluated under the qualitative method of data collection because of the nature of experiences which can only be documented qualitatively.

3.3 RESEARCH SETTING

The study was conducted in the Ashanti Region of the Republic of Ghana. The nation of Ghana covers an area of 238,537 square kilometres with a population estimated at 24, 233,431 (Ghana Statistical Service, National Population and Housing Census, 2010). In the year 2010, the population of the Ashanti region was estimated at 4,720,916, making it the largest region in the country (National Population Housing Census, Ghana Statistical Service, 2010). The region is divided into 30 administrative and health districts and therefore due to this, the region has the highest number of health facilities in the country (549 health facilities). These facilities include one teaching hospital, one regional referral hospital, twenty-seven district hospitals and the remaining 520 are sub-district and first level facilities (Dartey, 2012). The private sector owns 281 facilities, 197 are fully or partially owned by the Government, and 71 are owned by missionaries (GHS, 2009). All these health facilities provide maternal health care services. The type of service offered depends on the level of each of the health facilities (Dartey, 2012).

Thirty-eight percent (38%) of the health facilities in Ashanti are situated in the capital city of the region, Kumasi and by implication has a high number of health workers. According to the Ghana Health Service (2009) annual report, the Ashanti region had 7, 262 health care workers. The same report indicates that the region had the lowest number of supervised deliveries and the highest number of institutional maternal deaths in the country. Offei (2012) reports that between January to May in 2011, the Ashanti region recorded 125 maternal deaths and the teaching hospital alone had 85 cases. Therefore, the study took place in the Ashanti Region mainly due to the highest number of maternal deaths recorded in the country. However, the research study was conducted in nine health facilities that include the one teaching hospital, one regional referral hospital, four district referral hospitals and three health centres. The researcher was of the view that the nine healthcare facilities provided the needed data for the study because these seven out of the nine record high MD in the region for the year 2013.

3.4 RESEARCH DESIGN

A research design is a plan or a protocol of a research study. It explains how the aim of the research was addressed by clearly declaring the processes and procedures that followed each stage or level of research (Green & Thorogood, 2014). This study was conducted in two phases, that is, phase one and two. Phase one addresses objectives one, two and three while phase two addresses objective four of the study as illustrated in Figure 3.1 below:

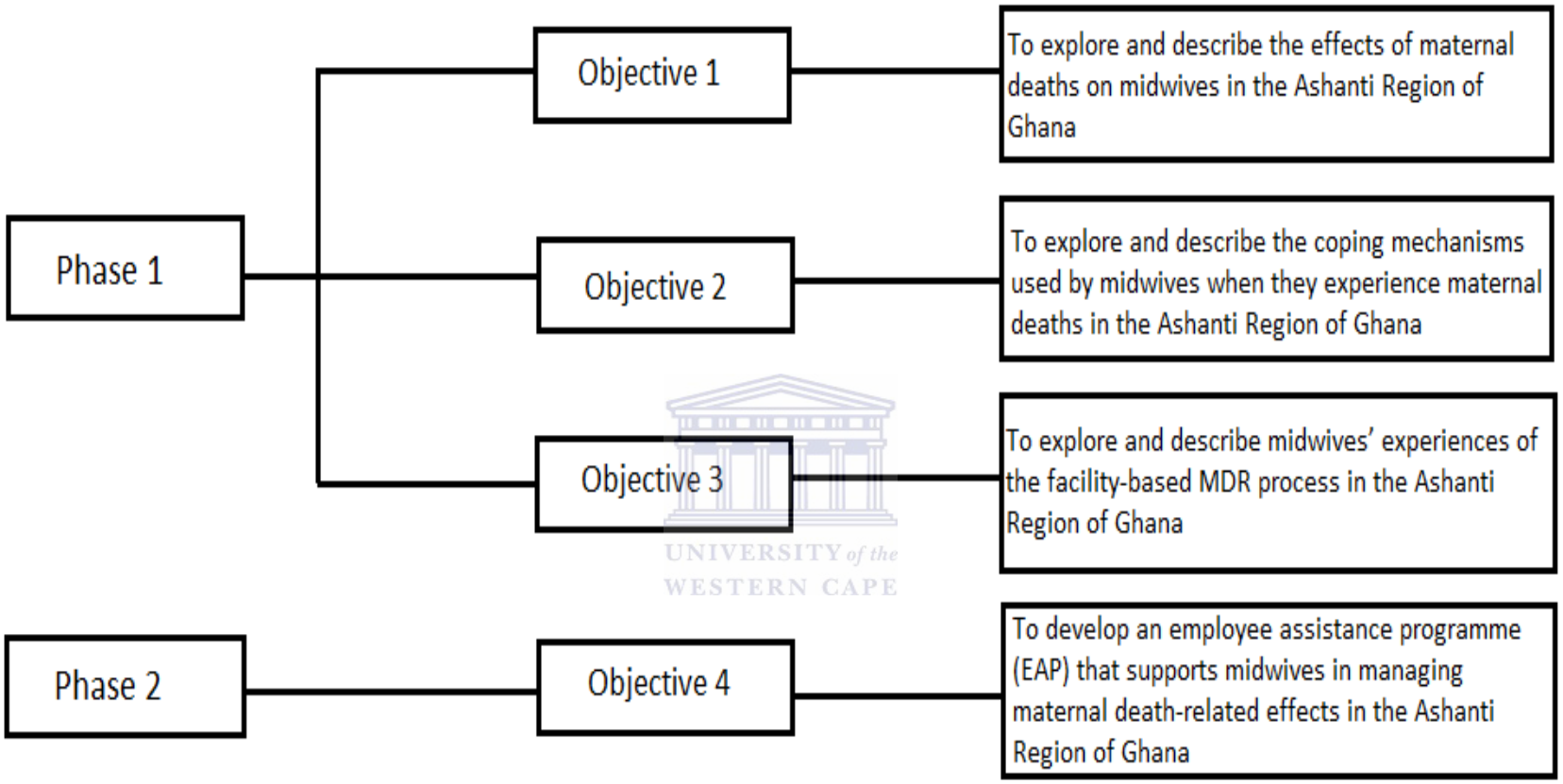


Figure 3.1: A graphic representation of Phase one and two of the study

3.4.1 Phase One

Phase one speaks to the following:

(i) objective one: to explore the effects of maternal deaths on the midwives;

(ii) objective two: to identify coping mechanisms midwives use when they experience maternal deaths and;

(iii) objective three: to describe midwives' experiences of facility-based MDR process.

In addressing the above objectives, the researcher followed the **exploratory, descriptive and contextual research designs**. These are explained in turn.

3.4.1.1 Exploratory Design

According to Polit and Beck, (2004), an exploratory research design is said to be a study that discovers the dimensions of a phenomenon, or that grows a relationship between phenomena. This design aims at examining the full nature of comparatively unfamiliar phenomenon (Polit & Beck, 2008; LoBiondo-Wood & Haber, 2006). In this study, exploratory research design was used to reveal the effects of maternal deaths on the midwives; the coping mechanisms used to deal with the situations and their experiences with MDR process. The exploratory design as applied in the study also targeted the discovery of new ideas and clarification of existing concepts. The use of exploratory research design helps the researcher to become familiarised with basic details and become grounded for the situation under investigation especially as it involves small groups of people. Therefore, an exploratory research design was employed to achieve insight into the context and comprehension of the experiences of the midwives in relation to MD (Polit & Beck, 2012; Babbie & Mouton, 2001).

3.4.1.2 Descriptive Research Design

A descriptive research is designed to provide a complete and truthful description of a particular situation, social setting or relationship in everyday life (Sandolowski, 2010). In addition, Polit and Beck (2012), define descriptive research design as a study of the main objectives of describing an accurate representation of the characteristics of persons or situations. From the perspective of Polit and Beck (2004), descriptive research design aims at driving observation, description and documentation of naturally occurring situations that help with vivid and detailed exploration. With regard to the current study, the descriptive research design brought out the meaning of the problem under investigation through a detailed description of the lived experiences of midwives at their workplaces. However, in doing this, the researcher had no intention in determining the cause-and effect relationship of the phenomena under investigation (Brink, van der Walt, & van Ransburg, 2012). Rather the idea was to portray the influence or impact of maternal death on midwives as they experienced them (Creswell, 2013). The descriptive design also enabled the researcher to highlight the effects of continuous experience of maternal deaths by midwives on their personal and work life. The design was also used to describe the coping mechanisms employed by midwives to mitigate the effect of maternal deaths on their health.

3.4.1.3 Contextual Research Design

The contextual research design examines behaviours, organizational culture and perception of the phenomenon under investigation (Wendy & McMillan, 2009). Furthermore, contextual design seeks to analyse and describe in detail the reality under investigation in a particular setting. Owing to the importance of context in both

contextual and exploratory designs, the two have been integrated. Context is indeed critical in research because they explored, understood and described events must be within the actual and natural perspective in which they transpire (Hollow & Wheeler, 2009). In research, context is understood as the situation in which the research is conducted; it may consist of human beings, the environment, the organization services and professionals (Polit & Beck, 2008). The aim of this study is not to generalize the findings to all midwives in Ghana but may be adopted in a similar context. For this reason, the context of this study is the midwives' work environment (Burns & Grove, 2009).

3.4.2 Research Procedures and Techniques

In the sections that follow, the research procedures and techniques used in the study are discussed. This is followed by a discussion on research techniques and procedures employed in phase one.

3.4.2.1 Population

The target population for the study was 300 midwives divided into two main category populations. The first part of the population (population one) consisted of ward based midwives (mainly junior midwives with few seniors who are not managers) and the second part of the population (population two) comprised ward and unit managers (supervisors) working in the research setting and who met the inclusion criteria (Polit & Beck, 2012; LoBiondo-Wood & Haber 2010). Population one was made up of 260 ward based midwives while population two was made up of 40 unit and ward managers (supervisors). This population was drawn from nine (9) health care facilities

of four level hospitals: level 1 (a teaching hospital), level 2 (a regional hospital), level 3 (district hospitals) and level 4 (health centres). The criteria for the selection of participants was based on them having been working in wards where maternal deaths occur and having experienced maternal deaths at the health care facilities of interest (Burns & Grove, 2009).

3.4.2.2 Sampling Technique

The researcher employed purposive sampling to select the participants from the target populations (Burns & Grove, 2009). Purposive sampling is used in research when the data needed for the study can only be provided by a particular population knowledgeable in the area of study or have experienced the phenomenon under investigation (Brink et al., 2012, Grove, Burns & Gray, 2012). The sampling was based on the inclusion criteria.

Inclusion criteria: Participants were eligible if they met the following conditions:

- have been working continuously as midwives for at least one year before the date of data collection;
- working in a ward where maternal deaths occur;
- experienced maternal deaths during the course of duty;
- have gone through the maternal death review process; and
- volunteer to participate

The researcher believes that the participants who met the above inclusion criteria were knowledgeable and provided rich information about the phenomenon of interest

(LoBiondo-Wood & Haber 2010; Polit & Beck, 2004). The above inclusive criteria also applied to population two (ward and unit managers) of their hospitals.

3.4.2.3 Sample Size

In a qualitative study, sample size is based on saturation of data. Consequently, for a population one, eight (8) focus group discussions with membership ranging between four to seven participants, a total number of thirty nine (39) people took part in the focus group discussion. By the 8th discussion, no new information was gained from the participants, therefore, saturation was reached. For population two, in which individual semi-structured interviews were conducted, researcher felt that data saturation had been reached at the point of interviewing the eighteenth (18th) participant. At that stage, no new information was coming from the participants.

3.4.2.4 Recruitment of Participants

Approval to conduct the study was obtained from the authorities of the selected nine hospitals (**Annexure 8**). In each hospital, the hospital matrons introduced the researcher to the ward and unit managers (population two). Then the researcher explained the aim and objectives of the study to the managers. The researcher outlined the inclusion criteria after which, all potential participants were provided with information sheet (**Annexure 3**) and the necessary clarifications were made to those that needed them. As per the inclusion criteria, all unit and ward managers were qualified to take part in the research study and therefore interested unit and ward managers were individually contacted for a convenient meeting time. The researcher noted each participant's time in a dairy and scheduled the interview at a time and

place convenient to the participant. Participants were made to complete an informed consent form (**Annexure 4**). In all, eighteen (18) participants volunteered for individual interviews.

In turn, each ward managers welcomed the researcher and introduced her to ward midwives (population one) in the various wards. The wards and unit managers facilitated the selection of the other participants. All discussions on the information sheet with regards to the study were done for each group (**Annexure 3**) and were given the opportunity to ask questions about the study. The participants were then requested to complete an informed consent form (**Annexure 4**). In this category, thirty nine (39) people volunteered for the Focus group discussions and these were divided into eight (8) groups which had at least four to seven members per group.

3.4.2.5 Pilot Study

A pilot research is a feasibility study of a small number of groups used to gather data in order to be familiarized with the process of data collection and procedures (LoBiondo-Wood & Haber, 2010). The main purpose of a pilot study is to improve the quality of data for the substantive study. Furthermore, a pilot study helps the researcher to deal with unforeseen challenges. In a qualitative research, pilot is used to ascertain the researcher's ability to conduct interviews. For example, it helps one determine the quality of questions and the type of probing questions that should be envisaged. Therefore, the purpose of this pilot study was to help the researcher identify the type of environment in which data would be collected and how it would proceed; identify any initial problems with data collection and to make the necessary amendments. The environment was assessed for suitability to hold discussions and/or

interviews in. The pilot study also helped the researcher to manage the time schedule for the midwives and how to negotiate with the participants without interfering with their duty time. The result of the pilot was that, participants understood the questions/ issues discussed.

There were no major changes after the pilot study. It however, helped the researcher to adjust focus group discussion participants' sitting arrangement with their codes. This was very helpful in easy identification of the participant's reactions with reference to observations made. In all, one focus group discussion and two individual interviews were conducted. Due to the nature of data collected in this pilot study, it was included in the data analysed. English language was used in data gathering. This is because English is the official language in Ghana, all institutions, including that nursing use it. In addition, all nurses can communicate in English.

3.4.2.6 Data Collection Methods

The study used two main methods of data collection, namely focus group discussions and semi-structured individual interviews. These were complimented by field notes.

- *Focus Group Discussions*

Focus group discussion is a data collection method that has an advantage of gathering in-depth dialogue that may be collected all together towards a hemmed in topic (Polit & Beck, 2008). This method of data collection permits participants to share more know-how information because comments from individual participants can generate further discussions in the group (Wilkinson, 2004). The researcher employed this

method of data collection and gathered information on the subject matter from midwives (ward based) who had experienced maternal deaths in the selected health care facilities. The researcher conducted eight (8) focus group discussions with each group consisting of at least four to seven midwives. At least one focus group discussion was conducted at each of the four district hospitals and at the regional hospital while three were conducted at the teaching hospitals. An interview schedule (**Annexure** 5) was used to facilitate the discussions. There were five main questions and probing questions followed depending on how the main questions were answered. Each focus group discussion took about 50-60 minutes. The length/duration of the focus group was determined by saturation.

- *Semi-structured individual interviews*

Semi-structured individual interviews were conducted among ward and unit managers (population two) of the maternity departments of the chosen hospitals. The researcher asked five (5) predetermined questions using an interview guide (**Annexure** 1) and made room for each participant to freely express themselves (Ip & Wagner, 2008). This guide directed the researcher in proper moderation of the interviews. This method of data collection was chosen for ward and unit managers because the researcher believed that these participants could provide rich and in-depth data of their own experiences as practicing midwives and supervisors. The researcher also believed that these participants also had delicate information on the topic that could form the basis for the development of the EAP.

Interviews were conducted on a face to face basis and an audio recorder was used to record the interviews (Polit & Beck, 2013). Each individual interview took approximately 40-50 minutes. The number of individual interviews was determined by saturation (Fain, 2004). In this regard, 18 out of 40 ward and unit managers were interviewed. Three participants declined participation in the study after there were made to understand that they had the right not to take part while others were left out due to saturation.

- *Field notes*

Field notes are notes gathered in the process of data collection. These notes tend to capture points or issues which may not have been catered for in the interview guides. Thus, field notes were gathered during data collection. The type of field notes gathered were observatory in nature (Polit & Beck, 2008). A diary was used as reflective journal for daily activities of the data collection process. In addition, a trained research assistant was employed to assist with the documentation and sorting of field notes. These field notes were gathered from almost all participants; the notes included aspects of facial expression of sadness, regrets, crying, pain in participants' voices and cutis anserine (goose bumps). Most importantly, the field notes ensured that reflective ideas that evolve during interviews and analysis of data were documented as a continuous process (Polit & Beck, 2008).

3.4.2.7 Data Collection Procedure

After the pilot study, the research instruments used were reviewed in line with the observations made during the process of piloting. These instruments were then

prepared for substantive data collection. The process of gathering data started gradually from the health centres, district, regional and teaching hospitals. For population one, a pre-focus group interview meeting was organized with all the potential participants. The participants were firstly briefed about the scope and nature of the study, the discussion process and ethical considerations. The researcher discussed the information sheet (**Annexure 3**) with the participants, including participants' right not to participate in the study and their right to withdraw from the study at any point in time. At the end of each meeting, the researcher sets up an appointment date and place for the focus group discussions.

Before the start of the discussion, the researcher ensured that the setting for interviews was conducive to free and uninterrupted discussions and had an appropriate room temperature (Kvale, 2007). All participants were welcomed by the researcher and were encouraged to speak freely as there were no right and wrong answers. The participants were assured of the confidentiality of the information they gave and made to sign the Consent Forms (**Annexure 4**) and focus group confidentiality binding forms (**Annexure 5**). In addition, participants were made aware of the need to respect each other's point of views. In conducting Focus Group Discussions, the researcher first introduced the topic to be discussed and then invited participants to begin the discussions. The discussions were audio recorded while the researcher and the research assistant took notes of narratives (non-verbal communications). At the end of each discussion, notes were compared. The Focus Group discussions took approximately 50 to 60 minutes duration.

Similarly, pre-interview meetings were held separately with the ward and unit managers. At these meetings, ethical issues regarding the study and the information sheet were explained to both teams, respectively. The researcher assured participants of anonymity and confidentiality and requested them to sign the Consent Forms following the explanation (**Annexure 4**) (Polit & Beck, 2013). The interviews commenced as a social conversation in a relaxed and trusting atmosphere and gradually moved to become highly interactive event. During the interviews, the participants were encouraged to express how they felt about MD, and to discuss their experiences and opinions regarding the support system available to them. The researcher, with the help of the research assistant, conducted the interviews.

The researcher employed facilitative communicative techniques such as the use of probing questions, interpreting silence, clarifying a point, observing and expressing non-verbal encouragement and minimal verbal response as well as surmising to facilitate interviews and discussions. All these techniques helped with the elicitation of more useful and detailed information from the participants. Saturation was reached when participants were no longer giving new information.

3.4.3 Data Analysis

Data analysis is the process of making sense of collected data in research. According to Richards (2014); Gibson and Brown (2009); Burnard, Gill, Stewart, Treasure and Chadwick, (2008) 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.

Furthermore, Elo, Kääriäinen, Kanste, Pölkki, Utriainen, and Kyngäs, (2014); Holloway and Wheeler (2013) argue that data analysis begins with management of data, which involves transcribing, organizing and the development of categories and coding of data. The intention of qualitative analysis is to produce a detailed and systematic recording of the themes and issues addressed in the interview and to link the themes and the interviews together under the reasonable exhaustive category system (Elo, Kääriäinen, Kanste, Pölkki, Utriainen, & Kyngäs, 2014; Chirema, 2007).

In this study, data analysis follows Holloway, and Wheeler (2010), idea of data analysis procedures which essentially involves a thematic content approach. Therefore, the study, adopted this approach in analysing data. The various themes that emerge during an interview are better managed under the mechanism of thematic content analysis. Thematic content analysis is a research method easy to use with a vibrant process because it brings a basic understanding of the research methodology when it comes to analysis based on the interview data. The process of data analysis used is outlined below:

3.4.3.1 Validation of Data

Validation of data is the means by which participants confirm information already provided, or change it to new information if they feel that what was initially provided previously was not accurate. In this vein, 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. In the case of any changes arising, a special note was made. This extra information was later

incorporated into the transcripts. In cases where the researcher wanted further clarification on any new topic, a return to the wards to see participants was made. In addition, listening to the audio recording by participants also served as member checking done together with the researcher. Above all, this was done to ensure that the recorded information was clear and of high quality.

3.4.3.2 Transcription Procedure

Data transcription is the process of transforming verbal and visual data into words (Sandelowski, 2010). According to Benard, Gill, Stewart, Treasure and Chadwick, (2008), the process of transcribing can only be possible after interviews have been recorded in full and should be done verbatim. In following this procedure, the researcher immediately transcribed all the interviews to avoid missing relevant data. According to Balls (2009), researchers should personally transcribe the interviews as in doing so they live with the data, familiarizing themselves with and immersing themselves within it. In addition, Green and Thorogood, (2014) argue that data management starts with the typing of notes into a standard format for easy use. The researcher followed these steps as it allowed for easy detection and recognition of recurrent ideas and patterns. The preliminary analytic procedure was used to make the quantity of data more manageable while at the same time maintaining the quality (Creswell, 2013; Graneheim & Lundman, 2004).

3.4.3.3 Data Cleaning

Cleaning of data is a means of denoting unsound information in the transcribed data. The denoted information is not related to the research topic under investigation

(Benard, Gill, Stewart, Treasure & Chadwick, 2008). Therefore, the researcher read through the transcripts several times in order to get rid of information that was unrelated to the topic under investigation. The researcher also compared the data with the field notes collected. The unnecessary information in the transcribed data was then filtered out to make the content more inclusive and easier for coding of data.

3.4.3.4 Coding

Coding is an interpretive technique of qualitative data analysis (Benard, Gill, Stewart, Treasure and Chadwick, 2008). Coding helps one to sort out different ways of saying the same thing as well as sorting different information given in the interviews conducted. In this study, the analysis was assisted by the use of computer software called *Atlas ti* version 7.1.7. The researcher inputted the transcribed word document into *Atlas ti* software. The researcher made use of a laptop to capture and save the transcribed group discussions and individual interviews accordingly (e.g. Focus Group 1 and Individual Interview number 1) in which the interviews were done. The vibrant process associated with thematic content data analysis is what the researcher went through by: (1) reading through the document line by line; (2) highlighting important phases and sentences; (3) coding them accordingly and then sorting information that relates to the objectives of the study; and (4) assigning codes to each sentence to represent a meaningful unit. Assigned codes were reasonably short: some were newly created while others were as per the original phrases from the data. Codes that had similar labels or colours were put together as families.

3.4.3.5 Creating of Families and Themes

As pointed out above, similar codes were merged together in order to create 'families' and similar families were in turn put together to form themes. Thereafter, the researcher used the inductive approach to thoroughly read the transcripts in an attempt to generate recurring patterns. Thus, the researcher employed an inductive reasoning process to identify themes and categorize so as to develop a rich description of the phenomenon (Polit & Beck, 2013). Alongside coding, memos were created to assist the researcher with initial discussions. Memos are notes made by the side of coding to help the researcher remember the reason or purpose of some coding. At this point of the research, themes and categories were organized with respect to the research objectives. This is what is presented as the results of the research study.

3.4.4 Scientific Rigour

In qualitative research, trustworthiness of the quality of data collected is measured in terms of confirmability, dependability, credibility and transferability (Patel, 2008). According to Lincoln and Guba, (1985), trustworthiness is ensuring scientific rigor in qualitative research without sacrificing relevance. Polit and Beck (2004) argue that findings in qualitative research must reflect the truth on the ground as experienced by human beings. In this vein, trustworthiness of the current research is based on Lincoln and Guba's (1985) position. Trustworthiness as applied in this study is discussed in the following section:

3.4.4.1 Credibility

Credibility of a study lies in the process of ensuring that the researcher establishes and presents the true picture of the phenomenon of the study (Shenton, 2004). Credibility may be ensured by member checking, peer debriefing, triangulating the different methods of data collected, prolonged engagement with participants and by using official methods of data analysis (Lincoln & Guba, 1999). Member checking credibility was attained by making the participants checking the transcribed data to ensure that their views were accurately represented. The two different data collected were triangulated to ensure trustworthiness with the current study. The researcher employed semi-structured individual interviews for ward and unit managers (supervisors) and focus group discussions for the ward based midwives in order to get different view and meaningful contributions that goes to answer the research questions. Further credibility with reference to official methods of data collection and analysis, was guaranteed through sticking to the correct procedures for interviews. as well as multiple reviews of the field notes were done, audiotapes were used for data collection, data transcribed verbatim , the neutrality of the researcher during the interviews, careful handling of the emotional expressions and the examination of the findings by an independent coder and supervisor (Babbie & Mouton, 2001).

In principle, participants in this study identified results of the study as their own experiences. There was prolonged engagement with the participants as well as the data collected. The purpose for this engagement was to create rapport, verify information provided by the participants and to be familiarised with the working culture of the midwives in the various work settings. The researcher also took the opportunity to

deal with personal opinions that might have an influence on the data collected. Persistent observation was carried out in this study to identify some essential factors that could influence the effects of MD on the midwife so attention can be given to them when developing EAP. While persistent observation was made, it gave way for the categorization of information which is equally important. For this reason, non-verbal communication played a vital role in bringing out the participants' behaviour during the interview and discussions.

3.4.4.2 Confirmability

Confirmability is the ability of findings in the current research to be confirmed by other researchers (Lincoln & Guba, 1999). It is also the situation where the researcher to make meaning of the phenomenon under investigation from the point of view of the participants and also to understand the meaning of participants' experiences in the context of the study (Jensen, 2008).

In this study, confirmability was attained when the research results represented the precise account of midwives' experiences as they lived and perceived them. In this regard, confirmability was achieved by going through the right processes of data collection. Research audit aims at illustrating clear thought processes as well as evidence that establish conclusion in a research evaluation process. In the current study, the researcher recorded events associated with the study over time and documented all the processes of the study, which can easily be followed by anyone interested and still obtain similar results. Self-reflexivity is an important part of any research just as it is with the current one. Self-reflexivity is the situation where the

researcher reflects and examines the assumptions made in the study. These assumptions may be with regard to data analysis, interpretation of data and immersing oneself in the data analysis process so the researcher can be knowledgeable about the midwives' situation.

3.4.4.3 Transferability

Transferability aims at the degree to which research findings can be applied to other people or setting with similar context (Graneheim & Lundman, 2004). Transferability has a goal of providing extensive information on the fieldwork which could help generalisation of the collected data to other groups of people and/or settings (Shenton, 2004). In this study, transferability was achieved through the provision of detailed descriptions of the participants' characteristics, participants' description of the phenomenon under study as well as the researcher's reports on findings so that anyone interested in making comparisons with any other group of people or needs to replicate the study elsewhere may do so. According to Polit and Beck (2004:41), dense description is the "rich and thorough description of research settings and of observed transactions and processes provided in the research". From the viewpoint of Lincoln and Guba (1985) dense description emphasizes the context of the study. In the current study, sufficient description has been made with regards to the processes of conducting research and also the actual context of the study.

3.4.4.4 Dependability

Dependability is the state of data consistency over time (Graneheim & Lundman, 2004). In qualitative research, dependability aims at ensuring consistent results of a

study which could easily be verified by another researcher in a different but similar context or setting. In this study, dependability was achieved through ensuring data consistency and usability. The researcher demonstrates the truthfulness of the data collected and analysed by presenting it as it is. Dependability puts emphasis on the need for the researcher to describe any changing context within which the research occurs. Dependability was also achieved through external audits. External audit is the process of examining data processes of the research study. The main purpose of external audit is to evaluate accuracy of the research findings and how it is applied in the study. In this study, external audit was achieved through frequent checks of every stage of the research process and the transcribed data by the supervisor. Furthermore, an independent coder was employed to code the transcribed data and thereafter, the findings presented to the academic supervisor.

3.5 PHASE TWO: PROGRAMME DEVELOPMENT

Phase two addresses objective four of the study which concerns itself with the development of EAP using five of the six steps involved in developing occupational health programmes and services (Acutt et al., 2011). For the purposes of this study, one step of the development process could not be used. This step involves the hiring of Occupational Health Nurse Practitioner (OHNP) to oversee the implementation of the programme. Since the researcher's objective was not to implement the programme at the various hospitals, this was left to the health care facilities to decide anytime they are ready to fully implement the programme after its presentation to them. The development of the EAP is based on the findings of phase one, which are outcomes of explorative-descriptive analysis.

3.5.1 Steps of Programme Development

3.5.1.1 Step 1- Situation Analysis/Need Assessment

Situation analysis/need assessment is the first step of the programme development and its aim is to ascertain the need for the EAP programme. Need assessment is a method for seeking information from sources to classify gaps with a problem. The needed information may come from employees, observation of work environment, evaluation of documents and other identified resources (Mai, 2016; O'Faircheallaigh, 2010). The assessment examined important issues regarding the impact of maternal death on the midwives at the selected healthcare facilities. It included individual worker demographics, the organization's environmental assessment, health needs, risks involve in midwives' work, support services available, resources available, services required to fill the needs and addressing risks (Vituri et al., 2013). A detailed assessment of the current situation for the need to produce an EAP was conducted. This process involved bringing together all the data explored and described in Phase one. The outcome details of the need assessment is presented in Chapter Three as the research findings of Phase one.

3.5.1.2 Step 2- Data Analysis

This type of data analysis is to help identify the need for the development of an EAP. It determines what the contents of the EAP should be and prioritizes the most important needs. Therefore, the researcher produced an integrated workplace needs assessment report after the analysis of the data in phase 1 was done. The findings were then presented to two groups of stakeholders: management of the teaching hospital, obstetric and the regional health directorate of the GHS (Population 3). The teaching

hospital presented members mainly from the department of Obstetrics and Gynaecology and included the directors and the professors, midwives, medical officers and other health professionals in that department. There were other staffs from other departs such as psychiatry, human resources and oncology to mention but a few. The Regional Health Directorate presented members from all the 30 district health directorates in the region. There were made up of district directors, hospital administrators, nurse managers and human resource persons. This was because I was asked to present on a day that the district health directorate have a meeting. The idea was to make them understand what the midwives go through with regards to MD, seek their views and contributions to help in the development of the EAP. Additionally, the researcher wanted to create awareness and support for the programme after its development. After the two discussions, it was evident that stakeholders in the health sectors saw the need for the programme development and thus pledged their support for its development. The discussions were fruitful after the presentations and questions were asked for verification, thus, their contributions were valuable. The research findings are very important because they speak to what the Ministry of Health (MOH), Ghana currently advocates. That is, a call for the availability of support in the form of occupational health services and programmes in the health sector (MOH, 2010).

During one of the two discussions, some medical professors in the Obstetrics and Gynaecological units of the teaching hospital acknowledged the need for occupational health services as some of them had experienced similar events when they witnessed MD while on duty. Others could recount memories of MD after 25 years of its experience and still strongly felt that the researcher should have included them in the

research instead of limiting it to the midwives. They, however, gave meaningful contributions and agreed to support the implementation of the programme when successfully developed. A report of the discussion was written and sent back to some key (management) participants (population 3) present at the discussion to append their signature for the support for the programme development (**Annexure 24** and **25**). After the discussions, some participants were selected to help review the draft of the EAP when ready. Some other experts from other areas such as clinical psychologist, social worker were also contacted to assist in the review process of the draft for Pilot implementation. These experts are referred to as population 4. The two discussions helped in the creation of the domain of EAP as discussions supported its establishment.

Step two forms the basis for the actual development of the programme: results of the study; contributions by the stakeholders in the health sector (the teaching hospital and the Regional Health Directorate). These are complimented by literature review of EAPs in other countries. Conclusion statements are put together as summaries of all the findings. These conclusion statements set the domain for the development of EAP for midwives dealing with MDs in the Ashanti Region of Ghana. Table 2 summarizes the step 1 & 2 of the developmental process.

3.5.1.3 Step 3-Planning

The actual development of the programme is done at this stage after setting up of the domain of the EAP. The domain of setting up an EAP was completed with the analysis of the data of the first phase of the study. The results indicated the need for

the development of an EAP for midwives dealing with MD cases in Ghanaian hospitals. The drafting of the EAP began after the development of conclusion statements from the findings together with the gathering and incorporation of views from stakeholders (population 3) from the MOH/GHS as well as staffs from the teaching hospital. In addition, ideas gathered from reviewing literature from other countries that are employing EAP complemented in drafting the programme. The drafting of the EAP involves formulating the objectives, vision and mission of the programme. It provides advice on hiring of professionals to the EAP and advertising the programme. Planning of the programme evaluation was instituted. After the draft, the researcher assembled a multi-disciplinary committee of experts (population 4). The committee to review the draft was made up of experts in the field of occupational health, public health, psychology, ward management, gynaecologist, health service administration and social work. The draft document once completed was revised accordingly. The document was then sent to two specialists in the field of EAP service providers outside Ghana (population 5) for their final inputs

Population 3 were recruited from two workshops organised to disseminate the results of the study and after the presentations, discussions were held and questions were asked for clarifications. Letters requesting date and time to disseminate research findings were sent to the two health institutions and adverts were made to gather the people for dissemination purposes.

Population 4 were recruited by contacts; after the presentation of the research findings to these stockholders, verbal invitations were given to selected experts, among them,

with the background expertise needed to contribute to the developed programme. Other experts such as clinical psychologist, psychiatric nurse were recruited by use of telephone and by direct contact (walking to their offices) for the draft programme to be reviewed. The total number of experts selected was 17, all with different educational backgrounds and levels of experience. All experts were health workers or those in a related field. The group comprised two occupational health nurses, two midwives, two public health nurses, one human resource manager, one health service administrator, one director of public health, one gynaecologist, one social worker, one clinical psychologist, one counsellor, one nurse manager, one medical superintendent, one psychiatric nurse and a researcher.

Population 5 were recruited through referrals by colleagues Occupational Health Nurses; these are providers of EAP services in South Africa. One had earlier seen the summary of findings of Phase 1 while the other was recruited after the development of the programme. They were particular concerns about the context of the EAP development. Report of specialist comments were sent via emails (**Annexure 27**).

3.5.1.4 Step 4-Implementation

For the purposes of this study, a pilot intervention was carried out on a small scale at one hospital for two months. All strategies and protocols were put in place for observations and the feedback was incorporated into the main programme. The strategies used included, the involvement of the hospital management in the implementation of the intended programme, needed protocol was followed to gain the necessary support from management. A meeting was held between the management of

Obstetric and Gynaecological Department and the researcher about the pilot implementation. An agreement was reached as to the number and the background of EAP counsellors to be involved, the duration of the programme and how to organise the target population for the programme.

A formal letter for the pilot implementation was sent to the Director of Nursing through the Head of Department for the Obstetrics and Gynaecology asking for permission to conduct the pilot programme at the teaching hospital. Thereafter, several meetings were held between the counsellor and the researcher with reference to the services to the provided, time and place of service provision, duration of the programme. The letter took three weeks to be processed for approval. The programme was then advertised for all midwives in that hospital, (those who have previously experienced MD and have not properly dealt with the situation and those who had experienced MD during the time of the pilot). Counsellors were trained and made to prepare themselves to receive any midwife who needed their services. Airtime for communication purposes was provided to the counsellors in order to call and follow up on any client who might have needed their services. In addition, some money was given to the counsellors for refreshments for the clients during EAP counselling sessions.

3.5.1.5 Step 5-Evaluation

This refers to the assessing of the final outcome of the programme. With reference to the current study, a pilot evaluation was made. The evaluation forms were designed and made available to midwives who benefited from the pilot programme. In all, 10

midwives participated in the EAP for the two months of the pilot stage. Participants were asked to complete the evaluation form. The following were considered for evaluation: the developed programme was measured; the advertisement of the EAP; confidentiality, the services provided; the counseling section; and how the programme could be improved. At the end of the pilot evaluation, remedial actions were taken to address any established gaps. A report was written at the end of the pilot implementation programme (**Annexures 26**).

3.6 ETHICAL CONSIDERATIONS

Ethical considerations embrace those of general scientific research and those that are appropriate for qualitative research. Qualitative research stresses that the researcher respects the participants and that the methodology reveals this respect (Creswell, 2013). Thus, efforts were made to grant respect to all the participants, valuing their expressions and the researcher as the recipient. The researcher took ethical measures, approaches and customs in order to demonstrate the value that the researcher placed on the participants and their views. Therefore, as part of ascertaining that ethics were followed in the study, the researcher got ethical clearance from the Senate Research Committee of the University of the Western Cape as required (**Annexures 2**), and the Ministry of Health/Ghana Health Service (**Annexures 8**). Additional permission was obtained from the Ethical Clearance Committee of the Ghana Health Service, Ashanti Region where the study was to take place (**Annexures 6**). The clearance letters from the Ministry of Health and Ghana Health Service- Ashanti were sent to four district hospitals, one regional hospital and one teaching hospital.

3.6.1 Consent

Informed consent forms were given and signed by those participants willing to take part in the study. The researcher preserved an attitude of transparency, as well as being open on what it was that the researcher endeavoured to achieve. Therefore, the researcher provided the participants with an information sheet that included the purpose of the study, the right to privacy, the benefits and risk associated with the study and the data collection methods and process. Participants were asked to indicate their willingness to participate in the study by signing the consent form. They were informed that they had the right to withdraw from participating in the study at any time.

3.6.2 Confidentiality

Confidentiality entails not disclosing any information about participants to the public (Green & Thorogood, 2014). In this regard, every precaution is taken to avoid linking the participants' identity. To ensure confidentiality, the researcher made sure that participants remained unidentified through the use of pseudo names and/or identifying participants by the use of codes. Recorded audiotapes and other study materials were kept under lock and key where only the researcher had access and would be kept for three years.

3.6.3 The Right to Withdraw from Research

The researcher accorded all participants equal opportunities to withdraw their consent at any point during the research in accordance with qualitative research principles. Owing to this, participants were further assured that there was no implication against

them with regards to their work or personal life should they decide to withdraw from the study.

3.6.4 Professional Honesty with Colleagues

The researcher assured research participants that the research results would always be presented honestly and in an accurate manner. Besides, the researcher ensured that falsifications, misrepresentation or data omission that distorts the viewpoint of any participant was avoided at all times. In the current study, the results were precisely presented as words and ideas of participants' duly preserve.

3.6.5 Rights To Privacy

According to Babbie (2007), participants in a study have the right to expect that any information given to the researcher would be kept as private data. Thus, the researcher ensured that no other person would be able to link the names of the participants with their interviews. Therefore, the audio records are to be kept in a separate locked filing cabinet and will be destroyed three years of completion of the study. Thus, in order to ensure total confidentiality of participants, their names were substituted with numbers in the interview transcripts, and in the final report. For example, manager one was to read as (M1) and focus group one- midwife one was to read as (F1M1)

3.6.6 Principle of Justice

All participants in a study have the right to fair and equal treatment before, during and after taking part in a research study (Brink, 2006). Therefore, the researcher did not collect any other data outside of the scope of the study and treated all the participants

equally. The researcher used fair and non-discriminatory selection process in selecting participants. Other midwives who refused to be part of the study were not prejudiced for doing so. All appointment times were met and all participants made comfortable during interview time.

3.6.7 Risk/Benefit

There may be potential psychological risks associated with this study. Participants who felt sad or emotionally distressed due to reliving a bad experience were referred for a counselling session by one of the research team members with a psychology background. The participants were encouraged to speak out in order to let go of the pain they might have had all the years past. The researcher also ensured that interview questions were carefully phrased and participants are offered an opportunity to ask questions at the end of the interview. The benefit of the study was that, at the end of the study, the employee assistance programme was developed in order to assist them in times of MD. The participants also had the chance to voice out their experiences with MD that they might have been harbouring for years.

3.7 SUMMARY

This chapter outlined the methodology used for conducting the research. It concentrated on the qualitative research designs and clarified why qualitative research design, methods and techniques of data collection were used. The chapter also examined how data were analyzed and theme of interest assembled to bring meaning to data collected, which at the end provided answers to the research questions. The furthermore, chapter defined EAP and the five steps adopted in developing the

occupational health programme for midwives. The next chapter looks at the results of the findings of the study.

CHAPTER FOUR

RESULTS OF THE STUDY

4.1 INTRODUCTION

Chapter three outlined the research methodology used in the study. This chapter presents the results of the study and the focus relates to the findings for objectives 1, 2 and 3. The chapter is organised into two parts: section one, presents an overview of participants' characteristics and section two, presents the themes that emerged from the study.

4.2 REVIEW OF PARTICIPANTS CHARACTERISTICS

A total of 18 unit and ward managers (supervisors) were individually interviewed using semi-structured interview guides and 39 midwives (ward based) were involved in focus group discussions. There were 8 focus groups in total and each was made up of between four and seven members. The number of participants in each focus group was determined by the staff strength in the ward and availability of staff at the hospital at the time of making the appointment with the participants. As indicated in Chapter two, data saturation was reached after collecting data from these participants.

4.2.1 Demographic Information of Participants

In the sub-section that follows, participants are described according to their gender, age, current position/rank; and number of years they had been working since their

qualification as midwives. All though this study did not use a quantitative approach, it was however imperative to note and quantify the representation of the participants in order to bring more clarity and understanding of the dynamics that was to unfold during data collection, thus solidifying the exploratory nature of the study from an etic perspective given by the researcher.

4.2.1.1 Gender Distribution

All the participants in this study were females. No males were included in the study because there were no males practicing midwifery in Ghana at the time of the study. Males found in the maternity units in Ghanaian hospitals were either medical officers or other paramedics who were not considered to be part of the study.

4.2.1.2 Position/Rank of Participants

Participants ranked from the lowest rank (Staff midwife) to the highest rank (Director of Nursing) in midwifery. Table 3.1 below shows that there were more junior ranked officers (52.6 %) than there were senior ranked (47.4 %) ones mainly because of the nature and scope of data that was collected.

Table 4.1: Position/rank of Participants

Rank/Position	Frequency	
	Number (n)	Percentage %
Deputy Director of Nursing	1	1.8
Principal Nursing Officer	1	1.8
Senior Nursing Officer	10	17.5
Midwifery Officer	15	26.3
Senior Staff Midwife	14	24.6
Staff Midwife	16	28
Total	57	100

4.2.1.3 Age Distribution of Participants

Participants' ages ranged between 22 to 61 years with the majority (56.1%) under the age of 46 years, implying that there are younger midwives who are likely to be exposed to maternal death in their work life without proper support in the form of EAP. One participant was older than 60 years of age and as such had passed the retirement age of 60 years. Table 3.2 below provides the age distribution of the participants.

Table 4.2: Age Distribution of participants

Age of Participants	Frequency	
	Number *(n)*	Percentage (%)
20-25	6	10.5
26-30	14	24.5
31-35	4	7.0
36-40	5	8.8
41-45	3	5.3
46-50	5	8.8
51-55	6	10.5
56-60	13	22.8
60 and above	1	1.8
Total	57	100

4.2.1.4 Number of Years Worked as a Midwife since Qualification

Participants in the current study had work experiences ranging from 3 to more than 25 years since their qualification and first appointment. Only 24.6% of the participants had up to 5 years of experience as midwives which mean that the majority of participants have good working experiences. There is also the probability that most of the participants might have had repeated exposure to maternal death and the process that follows. Table 4.3 below defines the number of years midwives had worked since attaining qualification:

Table 4.3: Number of years worked as a midwife since qualification

Number of years worked	Frequency	
	Number (n)	Percentage (%)
0-5	14	24.6
6-10	10	17.5
11-15	8	14
16-20	15	26.3
21-25	5	8.8
25 and above	5	8.8
Total	57	100

4.3 PRESENTATION OF THE MAIN FINDINGS

Five main themes emerged from the analysis of the collected data. In all, three (3) themes emerged under objective one; one (1) under objective two and another one (1) under objective three. Each theme was further divided into categories and sub-categories. Table 4.4 below presents a summary of the results according to the themes, categories and sub-categories.

Table 4.4: Summary of the themes and their respective categories and sub-categories

Objectives	Themes	Categories	Sub-categories
Objective One: effects of MD on the midwives	**Theme One**: Effect of death as a unique experience	1. Grieving patterns	• Open agony • Subdued reaction
		2. Different intensity of grief and impact	• Personal experiences • Similarity of situations
		3. Different duration of grief	• Exposure leading to midwife-client relationship
	Theme Two: Multi-dimensional effects of MD	1. Emotional effects of MD on Midwives' personal life	• Fear • Difficult to accept/inability to forget • Emotional confusion and distress • Sense of guilt; Sense of failure and Sense of incompetence • Empathy • Disenfranchised grief

		2. Psychological effects of MD on Midwives' personal life	• Depression: insomnia and Crying
		3. Physical effects of MD on Midwives' personal life	• Exhaustion • Inability to eat
		4. Social effects of MD on Midwives' personal life	• Self-isolation
	Theme Three: Effects of MD on the midwife's associated environment	1. Effects of MD on Midwives' work environment	• Positive effects • Negative effects
		2. Effects of MD on Midwives' family environment	• Neglect of responsibility • Associated stigma
		3. Effect of MD on the hospital	• Hospital stigmatized

		4. Effect of MD on the Community	• Waste of Community resources
Objective Two: coping strategies employed by midwives	**Theme Four**: mechanisms of coping employed by Midwives deal with effects of MD.	1. Informal mechanisms of coping	• Individual support • Self-support • Family support • Spiritual support
		2. MDR as a support structure	
Objective Three: midwives' experiences with MDR	**Theme Five**: Perceive MDR process	1. MDR as an effective tool 2. Spiritual/Cultural beliefs as part of MDR	

4.3.1 Theme One: Effect of Death as a Unique Experience

The participants in this study generally agreed that MD has an effect on them in one way or the other often resulting in different manifestations which are unique to each individual. The study found that, there were significant differences in the way the participants expressed their experience in relation to MD. These were expressed through the different grieving patterns, the intensity and impact which the participant experienced the effect as well as the duration of grief as a result of midwife-client relationship in the ward.

4.3.1.1 Grieving Patterns

With regards to grieving patterns, the effect was unique in a sense that participants presented their grief differently with some, on one hand, reacting in a subdued manner expressed only through non-verbal expression, mood change and self-questioning as illustrated in the following excerpts:

> *"It [MD] 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 MD has occurred, your facial expression and your personality change. "aaah!!! Why this?" M14*

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

4.3.1.2 Different Intensity and Impact of Grief

This second category which depicted uniqueness was based on the intensity of grief when participants experienced the effect of MD. One's previous experience with death in a personal capacity influenced the intensity as demonstrated by the quote that follows:

> "*For me, I say MD 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 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*

4.3.1.3 Different Duration of Grief

The duration which the midwife and the client had formed a relationship also contributes to the uniqueness of the death experience. Participants reported that, the more they got into contact with the client throughout pregnancy the more the effect, and it becomes worse with sudden passing of an individual who was known to be well. This can cause denial, shock and dismay for the midwife. The following quotes depict the phenomena:

"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 has managed very well. One gets surprised when such a thing occurs to her." FG1M1

"Why is it that the patient died, because she was talking to you, I was talking to her, so why all of a sudden I don't know what happened!" FG6M3

4.3.2 Theme Two: Multi-Dimensional Effects of MD on Midwives' Personal Life

The multi-dimensional effects of MD on the midwives' personal life emerged as a second theme under objective one. The personal life of the midwife has to do with the 'self', and how MD affected wellbeing as such. This theme was divided into categories and sub-categories depicting the emotional, physical and social effects that the midwives personally experienced when they recorded MD in the health facilities where they work. This theme provided most of the answers to the research question one: 'what are the effects of MD on the midwives in Ashanti Region of Ghana?' These are presented below:

4.3.2.1 Emotional Effects of MD on Midwives' Personal Life

The participants in this study experienced different emotions that had a significant impact on their lives when they were confronted by MD. These are presented as sub-categories that follow:

- **Fear**

Fear is an emotional reaction to a situation that has the possibility of recurring. As a result of MD, most participants reported having been afraid of death and its related issues. In addition, participants reported that fear made it difficult for them to attend to other clients in the wards who needed their services. The participants' fears were related to the following: a) death itself; b) Recurrence of death; c) fear of the MDR process; d) fear of family members' reactions; fear of stigma by community people; f) fear of family being attacked, among other. These different fears were reported to have been experienced by most participants.

Fear of own death was expressed by participants anytime MD occurs. This is confirmed in the following quotes by the participants:

> "*As humans, the mention of death will always bring fear" M16*
>
> *Death is inevitable; you can do nothing to stop it so putting that information in my mind at times…..but someone still dies under your care, you would be affected [and] there will be fear". FG4M3*

Participants in this study were afraid death may reoccur as they care for other clients. This can be seen in the following quotes from the participants:

> "*It affects the midwife very much because sometimes when a pregnant mother dies while you are on duty, and then you have a different pregnant woman with that same condition, you would think that if you help that person or you try to care for that person, that person might die in your care as in the case of the*

deceased client. And then you don't have a sound mind to work; because you are always thinking and afraid of the consequences". FG6M4

"Yes, you would be scared if the person has a bad obstetric history and will panic with thoughts of it happening all over again". M1

Often fear causes some midwives to refuse to care or render healthcare services to some others as depicted in the statement that follows:

"*The fear within me does not allow me to give injections, especially MgSO4 because as soon as I gave the drug [to a patient], the patient died, so I do not administer Mgs04 anymore to any client." FG8M1*

In addition, one of the consequences of fear is to flee and avoid the situation, and that is exactly what some participants reported to have done in the following quotes:

"So you flee from the new patient because of fear, especially if this new patient has the same condition that killed the other patient. So you may be running away from such a patient". FG6M1

"Hmm, when the next patient comes, you will be hurting inside, so you flee from her". FG6M3

The deceased family members' reaction to the death of the beloved one brought fear to these midwives as presented from the following quotes:

"*When you come to work and you deliver someone and at the end of the delivery process, say mother dies, the client family will not [say] ... that you*

have killed their relative, but the way they will behave [react]; cry and roll on the floor …, it [would] affect(s) you" FG4M3

"Sometime when relatives come and we have to inform them, it is not easy at all as the [manner] they accept it is a burden on us. You are afraid of their reactions" M7.

Fear of reactions from members of the community who relate the death of the pregnant woman to the attending midwife was evident in the data collected:

"If somebody comes to deliver and dies. The community members, who saw you attending to the client before her death, will point accusing fingers at you whenever they see you. M5

In this community, sometimes you go to town, some of them who identify you will be pointing accusing fingers at you that this is the nurse who delivered my relation and I lost her or the baby" M4

The midwives who live and work in the same community where the healthcare facilities are located were found worrying about their families especially children:

"I am afraid for my family, my children attend the school in the community so the other school children say things about me to my children. For example, "as for your mother, anytime people go to the hospital to deliver they die." M17

Fear of being accused by colleagues and management for not giving proper care was exhibited in the data collected. This is established in the following quotes:

"*The way your other colleagues will talk to you when there is MD, its' like you killed the client and this makes you feel like hitting your head on the wall and killing yourself". FG5M6*

There was an instance where a client came and I was calling the Doctor for help but by the time the Doctor came, the patient had died. The Doctor [then] shouted at me as if I [had] caused the death. That day I nearly collapsed because I was thinking [that] the Doctor would have said something or supported me in a way. To me, it looked as if the fault [was] from the midwife on duty at that time. FG5M6

The participants in the current study were scared of going through the MDR process. This is demonstrated in the quotes that follow:

"The death will be audited and I have to travel to Accra [Ministry of Health Headquarters] to answer questions about what happened and the woman died" M13

"We also have to answer so many questions about the death of a client. So we always want to prevent it". M8

Fear of a lawsuit against the individual midwife of the hospital for negligence was evident in the data and presented as such:

"*The hospital or the ministry [of health] will suspend you, ask you to go home for investigations to be done and you may not return. M14*

The Nursing Council will withdraw your license to practice". M8

- **Emotional confusion and distress**

Confusion is the state of not being able to think properly or orderly. Confusion brings about lack of concentration on self, work and family duties. It was evident from the analysed data that some midwives expressed a state of confusion when MD occurred in their wards. This confusion is demonstrated in the following quotes:

> *"When you go to the theatre and you are told that the client you (midwife) brought from the ward to the theatre has died, you become so confused. For a while you don't even recover; just thinking about the client who was left under your care. M12*
>
> *"When I experience MD, I become confused, not knowing what to do. My mind is stress up". FG5M4*

Emotional confusion is likely to cause participants to be disorganized; not knowing what to do or say and such an experience was reported by some participants as follows:

> "*I feel very sad and disorganized when I experience or hear of MD. It is not a good thing. It feels very sad and am disorganized anytime it happens" M3*
>
> *"When I hear or experience of maternal death, I feel disorganized for some time…." FG1M3*

According to *Oxford English Dictionary*, distress, (2009) distress is "an extreme anxiety, sorry, or pain". Emotional distress is a situation where an individual responds to a sudden and painful experience. Owing to the nature of their work, midwives are emotionally distressed and this affects their ability to function efficiently in

performing their roles. Emotional distress experienced by midwives included: feeling bad, sad, traumatized, a feeling of failure to endure, a feeling that experiencing MD is an unpleasant thing that could occur to anybody. Emotional distress was expressed verbally and also through observable non-verbal communication.

Additionally, midwives expressed emotional distress both as a group and well as individuals. Midwives as a group were all of the view that the occurrence of MD in the wards distressed them emotionally. Although the group felt the same way, the issue of individuality still stood out. Expression of emotional distress as a group is a situation where the midwives feel helpless because they collectively could not save a woman's life. This is demonstrated in the participants' quotes that below:

> *"...MD is something I think we all need to address because emotionally we (midwives) all don't seem fit when we lose a client" M8*
>
> *"Death is something nobody wishes to happen, not even to the enemy because it's an emotional thing. So when it happens to a pregnant woman it is very sad ..... It is something you, At the mention of death everybody becomes emotionally distressed. This is the same thing that happens to us all in the ward. We also feel about it very much. So why the pregnant woman should die as a result of delivery is very sad and it is not something we wish for". FG4M3*

Besides expressing their emotional distress as a group, most participants expressed their distress as individuals too. As an independent midwife, one has her own aspirations to follow in improving on skills and competences. Thus, death of a client

during the course of duty makes one feel distressed and pain. Some participants expressed individual emotional distress in the following ways:

> *"The fact that the person is not my relative does not mean I don't feel the pain that the relatives go through or I don't care about how the relatives feel. It affects me emotionally". FG1M4*
>
> *"Hmm, when we (midwives) record MD, emotionally I am disturbed. Although I am able to do some work, I am emotionally unstable". M5*

Furthermore, emotional distress was observed in some participants by their managers and peers who were not present during the occurrence of MD. Thus, according to these participants, their colleagues who experience MD directly whilst on duty are mostly seen to be in deep distress. The distressed midwives are mostly seen to be blaming themselves and asking themselves what actually happened for the woman to perish. This is demonstrated in the following quotes:

> *"Yes the midwives are normally affected emotionally: particularly when we are marking their reports. Most of the time, their expressions show that they are emotionally affected but they have to work by bringing the emotions down" M14*
>
> *"It actually affects us emotionally because I do remember a colleague had gone through that situation where a mother died while she was on duty and it was tough for her. She was repeatedly and sadly questioning herself why such an incident (MD) happened to her and I had to support her psychologically". FG1M*

While some participants used the phrase "emotional distress" to describe their experience with MD, other participants simply put it as "feeling bad" or "feeling sad". Feeling sad or feeling bad is an emotional feeling of loss and helplessness. The expression "feeling sad" and "feeling bad" were used by the majority of the participants in expressing their experience with MD. This is illustrated in the following quotes:

> *"I always feel very sad when I hear that a patient died in the ward. I feel so sad. You know one cannot revive a dead person. It is so sad when we record maternal death because we are all trying to support maternal health, not to encourage maternal death". FG1M3*
>
> *"It is so bad to hear that someone expecting a baby is dead. I think I have experienced it three times. It is very sad because nobody expects it but, it happens, and when it happens like that, one feels bad as a care giver". FG1M4*

Some participants expressed being traumatized when they experience MD in the hospitals. To be traumatized means one has experienced a disturbing event that has the potential of causing shock. This is illustrated in the following quotes:

> *"When there is MD the midwife herself is in shock /traumatized so …."FG1M3*
>
> *"… If the patient expires, you the midwife you are traumatized….". FG1M2*

Similarly, some participants expressed their experience with MD as unpleasant, painful, and 'inhuman' in nature. Some participants reported their feeling of the experience of MD:

> *"It's very sad, unpleasant and is very painful to experience MD. Why? Because a woman is pregnant, expecting to deliver in a healthy and beautiful way and all of a sudden something will come out concerning the situation then she dies, so it's not something good". M5*
>
> *"Some time is very inhumane to experience MD. Ooh, we are human being and a human being's life taken away is not good, who is going to look after the baby, and all these things go into consideration so is sad when you experience MD." FG6M5*

- **Sense of guilt**

Guilt is an emotional experience that happens once the person feels he/she has not done his/her best in a particular situation. The use of the word "guilty" was found to be prominent in the data analysed. Participants expressed the views of carrying guilt around wherever they went after the death of their clients. This in itself does not make them comfortable since they turn to blame themselves for not doing enough to save the life of the pregnant women. The sense of guilt among midwives was openly demonstrated through the following sentiments:

> *"We feel guilty when someone dies because you will feel there was something you should have done which you did not do. In my case, for instance, it did not occur to me to do a speculum examination. I felt very bad when the Doctor told me it was a vagina tire." M13*

"It's not comfortable to experience MD, sometimes when a person comes and dies, you go home with the guilt; is it my fault that the person died? Did I care for this person well? You always think about the patient even though you don't know the patient." FG5M2

The guilt felt by some participants made them regret taking up midwifery as a profession. To regret being a midwife may be indicative of the frustration that these participants undergo as they practice their profession. The expression of frustration is illustrated in the following quotes:

"*Though the cause of death can be connected to anything one can feel bad and even regret taking midwifery as a profession"M1*

'Failure' did not stand on its own, it is thus depicted by "Sense of guilt". Failure elicited an emotional problem for midwives who experienced MD in line of work. Failure is a situation of inability to meet one's set objectives. The Thesaurus online Dictionary defines failure as a fact of not being able to achieve the desired goal. The participants expressed sense of failure as seen in the following quotes:

"Sometimes, both the mother and the baby are gone. You don't even get one of them and that means in a way your goal or mission as a midwife has not been reached. Midwives are to save lives and if life passes on like that, it feels bad." FG1M4

"I am a midwife, I am to see the woman for antenatal care, safe delivery and post-natal care, but why did she die? I'll think about that. I feel embarrassed because I was attending to the woman when she died and though I am a

professional midwife, I feel embarrassed because somebody has lost a member of the family and one of my clients is gone". M11

Incompetence is the inability to do something successfully. Some participants felt that they have not done their work well in providing care to the client and that may be the reason for the client's death In this regard, 'sense of guilt' was another emotion that seemed to depict a "Sense of incompetence". Despite the professional skills received by the midwives while in training, sense of incompetence preoccupied their minds whenever they experienced MD. This fact is demonstrated in the following quotes by the participants:

"Oh, if the mother dies, I feel bad because it is you the midwife who delivered and the mother died, it looks as if you did not do your work well." FG4M3

"It affected me badly and it made me think that maybe I didn't do my work well. A human being dying in our hands is not easy, not good." M13

As participants feel the sense of incompetent, they are discouraged in caring for other clients. Participants in this study reported a loss of courage and confidence needed to nurse other clients when they experienced MD in the wards. This is demonstrated in the following quotes:

"*Well, personally my confidence level, sometimes goes down, yeah it goes down". M10*

"You don't even have the courage to approach other clients because of what has happened [the death of the other client]". M6

The study also revealed that guilt also brought out moral distress among the participants as the majority of the midwives' experience moral distress over the death of a client (Zuzelo, 2007). Moral distress is defined by Corley Elswick, Gorman, Clor, (2001: 250) as: "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time and institutional policy". Moral distress experienced by the midwives results from the fact that they are not sure whether they provided the required services to the client or it was a case of negligence. Moral distress is exemplified in the following quotes:

> *"The one that happened recently, when I felt the woman's condition was beyond my control, I called the medical officer on duty to come and see her, when the Doctor was seeing her, I saw that the woman had soiled herself. When I brought things to clean her up, she had died. I felt very, very sad". FG3M3*

Moral distress leaves the midwives to question themselves regarding the services provided as well as the general health system and/or competence as in the following excerpt:

> *When MD occurs, the questions follow; why should this happen? What was the cause? What could we have done? Or what could the woman have done to prevent the death or what could the facility have done to prevent it? Or maybe to the broader public, what could the Ministry of Health have done to prevent it?" M14*

I mostly ask if there was something we could have done to prevent the death of the woman." FG1M2

- **Sense of Empathy**

Empathy in this study was a common phenomenon and was expressed by the majority of the participants. The question that came to mind of these participants was "what if I was the one who died?" The participants in this study confirmed their sense of empathy in the quotes that follow:

"I feel so sad because I put myself in the shoes of the client and picture the scene as a mother, dying and leaving the child behind." M2

"It affects you; it could be your sister,…Sometimes you think about it and it reminds with you that you are also a woman and one day you will like to have a child. You could be in that state! It could be you! Hmm, ask yourself if it were you, what will have happened. "FG4M2

- **Disenfranchised grief**

To be disenfranchised means to be deprived of your right. Midwives feel that seeing someone die in front of you is in itself is painful despite the fact that they may not be related to the deceased person. 'Disenfranchised grief', therefore, means that midwives are denied the right to grief over their patients' death. Participants in this study find it worrying that people do not recognise that they grieve whenever they experience MD at the workplace. This is demonstrated in the quotes that follow:

"The fact that the person is not my relative does not mean I don't feel the pain that the relatives go through or I don't care about how they feel". FG1M4

"We are hurt like the relatives; we do not want MD to happen". FG1M3

Some participants complained that they are not allowed to cry at the hospital even if they are empathetic of the client's situation following the bond developed them over time. The following were their sentiments:

"*So for me, I just started crying because the patient had become my friend, but I was advised not to cry"*

"I even end up crying just that I don't cry in front of the patient's relatives, but mostly do so when I go home" FG1M2

- **Difficult to accept/inability to forget death of client**

'Difficult to accept/inability to forget death of client' was the third sub-category that emerged under "Emotional effects of MD on midwives' personal life". According to study participants, it was difficult to forget about MD when one experienced it, probably because there is no official assistance for the midwives who experience it in the course of their duty. While some midwives take a shorter time to cope with the situation others take a longer time. This fact is illustrated below:

"When we record MD it affects us and we discuss it for some time and move on but sometimes you try so hard, but you can hardly forget [it] especially when you have been emotionally attached to the client." FG1M4

"There was this particular client I was close with and had become friends with. The next day I came to work, she had died. For that woman's death, the coping was not easy, coping was very difficult because, every day I would reflect on how she could have died but with time, I became ok." FG3M2

Some participants are not able to tell or mention how much time it takes for them to cope or forget the MD experience, especially when there is an emotional attachment between a midwife concerned and a client. The participants were of the view that time heals whatever experience one might have gone through and this is demonstrated in the following extracts:

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

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

As midwives try to manage the situation in which they find themselves after experiencing MD, they are expected to put aside their own feelings and support deceased relatives as evidenced below:

"But as a caregiver, you are to support the deceased family; you are not supposed to show your feelings for the relatives to know. You try as much as possible to console them, but [in the process] it affects you". FG1M3

"I am the one to comfort the relatives when the news is broken to them". M7

4.3.2.2 Psychological Effect of MD on the Midwives' Personal Life.

Psychological effects were exhibited as a result of mental stress while participants think about how the death occurred, what they did for the client and what they could not do. The participants in this study depicted depression by many signs and symptoms that they experienced after experiencing MD.

- **Depression**

According to WHO (2012) depression is a condition of general emotional dejection and withdrawal from people, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, and poor concentration. Thus, depression is a situation where people lose interest in normal and familiar activities. In this state, the individual feels helpless about a situation. There following were some of the excerpts which illustrate a form of depression:

> *"For me, when I experience MD and I got home; I don't even bath, I do not eat, I do not want to talk to anyone. I go straight to bed. When my children ask me what was wrong, I say nothing. When I am able to get some sleep in the night, I manage and come to work the following day". FG5M4*
>
> *"MD affects me in every way; I do not feel like eating my food, chatting with people. I do not want to do anything or interested in anything. Want to be by myself." FG4M1*

A depressed person can suffer from either excessive sleeping or insomnia (WHO, 2012). Insomnia presented itself as a prominent symptom of depression in the current study. Most participants in the study intimated that they had difficulties with sleep each time they experienced MD in the hospital. Sleep is a natural way of resting where the individual loses consciousness for some time and in the process allows the body to re-energise for another day's work. Sleep is therefore an important part of human health as it ensures renewed energy. A lack of sleep among participants who experienced MD is illustrated in the following quotes;

"I was so disturbed psychologically that night because I was still thinking about MD that I could not sleep. A client dying in your hands is not easy." M13

"Personally, my sleeping habits change in such a way that I am not able to sleep. I am preoccupied by the thought of the death of the client" FG3M2

'Crying' as a sign of depression was also depicted as some participants found themselves crying continuously each time they experienced MD. Crying is the act of shedding of tears as a response to an emotional state in humans and animals (Pongruengphant and Tyson, 2000). Participants' crying after the experience of MD is demonstrated by the quotes as below:

"I sometimes cry because the woman came in walking, talking and relating to other clients." FG5M1

"I also cry, because I become sad. As the client comes to us (in the hospital wards), you create rapport with her, you relate to her well suddenly the person dies, hmm!" FG5M2

4.3.2.3 Physical Effects of MD on Midwives' Personal

Physical effects of MD are the signs exhibited out of grief and examples include loss of appetite and exhaustion.

- **Loss of appetite**

Participants observed that each time they experienced MD while on duty, they usually lost appetite and this in turn obviously impacts their well-being negatively. The

association between experience MD and loss of appetite is revealed in the following participants' quotes:

"*Sometimes, when you go home, you can't even eat because you feel like, what if it was you who had died, what would you do? Will you be eating?"M17*

"When a client I take care of dies in the ward, sometimes if I go home, I cannot even eat to my satisfaction." FG1M1

- **Exhaustion**

Exhaustion comes in when normal daily and simple activities become daunting because there is a lack of energy and interest in performing those activities as a result of the experience of MD. Participants in the study revealed that they often got exhausted when they experienced MD in the wards. This is revealed in the following quotes:

"From the moment that I experience MD I cannot even do anything, even simple activities because it affects my emotions and I feel exhausted." FG1M4

"Personally, the enthusiasm you use to work with goes away, exhaustion set in."FG5M3

4.3.2.4 Social Effects of MD on Midwives' Personal Life

Social effects have to do with the fact that midwives are unable to socially relate to people around them after experiencing MD. The people in question are colleagues at work, spouses, children and other family members. This social distance with relatives often leads to social isolation for a certain period of time. Consequently, affecting one's well-being.

- **Social isolation**

Social isolation is a situation where the individual is likely to be by him/herself without contact with other people around him/her. Participants in this study stated that whenever they experienced MD in the wards, they did not want to associate with anyone else but to be left alone because they were preoccupied with what had actually happened. This social isolation affects their relationships with significant others at home and their colleagues at work. The effect of social isolation on the wellbeing of a health worker is clearly seen in the following:

> "*When I experience MD, I go home thinking about what went wrong, what didn't I do right, why did this happen to me, I always think about it and am preoccupied with your thoughts. So it affects the relationship I have with other people because I am bored, so I isolate myself from people." FG6M2*
>
> *"When you experience MD and you go home, you do not want to speak to anybody, neither do you feel like doing anything with anyone." FG4M3*

4.3.3 Theme Three: The Effects of MD on The Midwives' Associated Environment

The theme "Effects of MD on midwives' associated environment" was the third theme that emerged in the study. It has to be pointed out that this theme has no direct relationship with the midwives' "self" but rather their work, family, the hospital and the communities where these deaths occur. The theme has been categorised into the following: (1) effect of MD on midwives' work; (2) effects of MD on the midwives' family; (3) effects of MD on the hospitals; and (4) the effect of MD on the community.

4.3.3.1 Effects of MD on the Midwives' Work

From the data analysed, all the participants in the study agreed that that MD has some effect on their job. However, it was noted that in the work environment, the effect can either be positive or negative on midwives. These effects are presented in turn:

- **Positive work output**

The positive effect of MD on the midwives' work has to do with resultant positive work output depicted by their positive attitude towards work in attending to their clients especially in their attempts to avoid a recurrence of MD. A positive effect of MD on the midwives' work was thus exhibited by some participants as in the following statements:

> "*…On the other hand, sometimes when you hear of maternal death and there is a client with a similar diagnosis, you end up giving the other client extra care because you know if care is not taken, she may end up like the previous one so it's a mixed feeling sometimes you will hold on for some time before you [attend] see to clients and sometimes too you go straight to clients who have similar conditions to help them after hearing of the maternal death". FG1M4*
>
> *"You try to control yourself and work effectively [work harder]. Even sometimes you put in more efforts to ensure that an event such as maternal deaths hardly occurs." FG2M3*

- **Negative work output**

The negative effect of MD on midwives' work relates to the fact that they are unable to effectively perform their duties after recording MD. From the data analyzed, it is evident that participants felt inhibited to perform well and experience a sense of paralysis after an encounter with MD at work as demonstrated in the following excerpts;

> "*MD does affect your work because immediately after the death, one cannot work, but has to take a break, reflect on the death and continue work later." FG2M1*
>
> *"Sometimes when MD happens, it affects you. You even forget that there are other clients who need your care and you will have to sit quietly for a while." FG1M2*

The negative work output is also seen by different behaviours that are shown by participants such as absenteeism, which has an impact on health care. Absenteeism is the absence from duty or from a given obligation. It was evident from the study that each time a participant experienced MD, he/she felt like not reporting for work the following day. This is illustrated in the following quotes:

> *"The other day, when it happened, one of my colleagues had to go and reported sick [in order] for another one to come and do the work." FG5M3*
>
> *Sometimes you do not want to go to work because you are not able to concentrate on the work. Why go to work? FG6M4*

In contrast, presenteeism as a resultant behavior was reported. Presenteeism is a situation where an employee works while sick or not in the right frame of mind to work thus do not perform to their utmost ability (Johns, 2010). Most participants in this study were reported for work, although they felt 'sick' within as a result of having experienced MD. This is seen in the following quotes:

> "*We go to work, but most times, you are not able to perform. Sometimes not only the nurses or the midwives, but also the Doctors. Personally, the enthusiasm you use to work goes away." FG5M3*
>
> *"At times it affects my performance at work, even though you go to work. You have to become yourself so you don't do what you are not supposed to do." M16*

While some participants just come to work because the presence is needed and therefore will not do any meaningful work, other participants felt that it was not good for the other client to be waiting in order to be cared for. Thus, to these participants, other clients waiting should be care for rather than taking a rest because of MD. The participants feel that, there is shortage of midwives in the wards and if the other clients are not cared for, they may develop complications or even deaths. They get more energy to deliver services to the other clients as mentioned in the quotes that follow:

> "*That moment, it affects me, but I have to overcome it because it is part of the work. If it affects me too much, the work will also be affected so I have to overcome it and not think about it so much since I will be down. "It will take a*

longer time for you to forget it but you have to come to work because we are short of midwives. M4

You try to control yourself and work effectively. Even sometimes you put in more efforts to ensure that such events MD hardly occurs. FG2M3

4.3.3.2 Effects of MD on the Midwives' Families

From the data, midwives observed that MD at work equally affects their families at home. The effects on family include neglect of family responsibilities, and associated stigma.

- **Neglect of family responsibilities**

Neglect of family responsibilities was the first sub-category that arose from the category. Participants confirmed that they are at often times unable to perform their domestic chores at home when they experience MD at the workplace. This can be seen in the quotes that follow:

"At times when MD happens, I feel sad throughout the day and even when I go home, am ever sad. Instead of doing other things for my family like cleaning and taking care of the house, I cannot do it so it affects me and my family at large." M2

"And even at home, you will be thinking about the MD. So you won't have a free mind to attend to your children nor your husband or do anything. So it affects everything and every part of your life". FG6M1

- **Associated stigma**

Associated stigma is the means of relating midwives to the family members. Midwives observed that their family members are often stigmatized for being related to a person who had attended to a pregnant mother who died at the health care facility. This is even more of a problem when the family members of the midwives share a common social environment with those who are affected by MD. This problem is illustrated in the participants' quotes that follow:

> "*MD affects my family too. My family leaves with me in the same community as the deceased family and friends. My children attend the same community school, so the other school children say things about me to my children. [Such as]…'your mother, anytime people go to the hospital to deliver they die'." M17*

4.3.3.3 Effects of MD on Hospitals

'Effects of MD on hospitals' was the third category that arose from the theme. MD does not only affect the midwives who work at the health facilities, but also the health facilities where these midwives work. Depending on the number of MD cases taking place at a facility, the hospital is likely to be stigmatized, thus the number of clients seeking antenatal services drastically reduces at these facilities. This challenge is evident in the following;

> *"It affects the hospital. Last year, when we had lots of MD cases, pregnant women refused to come to the hospital. Everyone is concerned with his/ her life and nobody will like his or her relative to attend hospital where pregnant*

women die continuously. The women were going to other hospitals and this affected the hospital negatively." M16

"When there is MD the name of the health facility is stigmatised. Some people will label the health facility by telling others not to go to that hospital because when they go there to deliver, they will die because pregnant women who go there to deliver end up dying." M13

In addition, since the number of MD cases is a measure of hospital performance and is captured in quarterly and annual reports of the hospital, a high record of MD would in effect indicate poor performance at regional review meetings and thus a poor reputation of the regional health sector as seen in the quote below:

"The hospital will be recorded as having a higher mortality rate, people get afraid to use the hospital so it does affect my work." M5 (referral hospitals).

"The more the number of cases we provide services for, the better for us as a health facility. We need this data for expansion work and to improve on the equipment in the hospital. M16

4.3.3.4 Effects of MD on the Community

Effects of MD on the community' was the fourth category that emerged under the theme. The participants observed that the communities in which these hospitals are situated are affected by MD. Participants mention that, finances and time is loss when community members die because they then have to travel far to avoid using the nearby clinic.

"It affects the community because the hospital is for the community people, so if the women in this community have to use extra money and time to travel and visit other hospitals in other communities for the simple reason that women are dying in their community hospital, then the people are affected." M16

4.3.4 Theme Four: Mechanisms of Coping Employed by Midwives in Dealing with the Effects of MD

The coping mechanisms' employed by midwives in dealing with MD was the fourth theme that emerged from the study and the only theme that emerged under objective two. This theme emerged from the researcher's desire to explore the coping mechanisms adopted by participants when they experience MD. Two main categories with four sub-themes emerged. The categories are informal mechanisms and systemic support system (MDR).

4.3.4.1 Informal Coping Mechanisms

The category comprises individualised non-professional support, self-support and family support. These support mechanisms are not official means of support for the midwives by the health facilities they work for. The midwives devolve their own means of dealing with the MD situation as there is no formal support system available for them when they experience the effects of MD. For this reason, different participants employ varying means of coping. This is demonstrated in the quotes that follow:

- **Individualised non-professional support**

According to the participants, talking to someone they trust after experiencing MD is regarded as a coping mechanism after experiencing MD therefore most of them spoke to someone they trusted who is not a professional nor a family member to debrief. This sub-category is supported by the quotes that follow:

> "*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*

- **Family support**

Support from family is an important part of one's life. People expect family members to support them in times of difficulties. Thus, this category emerged as another coping mechanism as reflected in the excerpts below:

> "*When my mum gave me the psychological support, I became ok. 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*

- **Self-support**

Self-support is a means of encouraging yourself in the midst of difficulties, where you put assure yourself. The data reveals that some participants' support dependent on their own will power and inner strength to survive each time they experience MD. This is illustrated in 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 do nothing 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*

In contrast, few of the participants on duty at the time of the incident where a pregnant woman passes on, console one another. This is seen in the participants' quotes that follow:

> "*Nobody counsels or supports the midwife psychologically, we counsel ourselves, especially those of us on duty." FG2M1*
>
> *"Weeping, holding on to it wouldn't bring anything. Because it will make you sad, it will prevent you from attending to other patients, but 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, the data reveals that some participants cope well only after taking time off duty 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 client and go home, but you can take a rest, like a few minutes rest and continue later to see the other patients." FG1M2

Participants believe that coping sometimes comes naturally depending on how much care the midwife is able to provide the client on admission and also client's diagnosis/prognosis on admission. This is affirmed in the following quotes from the participants:

"*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*

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

- **Spiritual support**

'Spiritual support: Praying to God' was the fourth sub-category under "Coping strategies employed by midwives". From the data analysed, most participants tend to find relief in prayer to their God who is regarded as a source of comfort. Thus, spirituality was seen as another form of coping strategies 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 before I forget about the death, but I pray over it that God should take away the unhappiness from me." M15

4.3.4.2 MDR as Supportive Structure

Indirect systemic support received through undergoing MDR was the second category that gave rise to the theme "Coping strategies employed by midwives". Although participants felt supported, mostly by intentional human actions, the system was also seen to have an unintended effect that assisted the midwives to cope after MD has occurred. MDR is an official process that midwives go through after recording MD 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. Due to the nature of the process, midwives regard this as a coping strategy as can be seen in the extract 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*

"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 them the cause of that death. If they did well, we encourage them to keep it up, if there was something that

was supported to be done properly, we also talk to them to tighten their belt and then sit up and do the work." M14

4.3.5 Theme Five: Perceived MDR Process

Perceived MDR process is the fifth theme of the study and the only theme that emerged from objective three: "the experience of midwives with MDR". This theme has three categories, namely "effectiveness of MDR; spiritual/cultural beliefs and observations by midwives.

4.3.5.1 MDR as an Effective Tool

Majority of midwives were of the view that, the MDR process is now more effective than initially introduced, where the review process was seen more of a blame game between doctors and midwives. This is demonstrated in the following quotes:

"Now it's better, we make recommendations which we follow. An example is the management of eclampsia protocol; now the nurse must start before Dr comes. The MDR is good, it's good. There is no blame game. The recommendations that come out of the review are carried out. MDR helps us to correct our mistakes and where we needed some form of training or equipment for the work to go on well in order to prevent MD - it is done. Most maternal deaths are preventable though there are a few that are not preventable." M6

"Oh, MDR is not fault finding, not. We gather to know, maybe the things we didn't do well, not mentioning names, but when a finger is pointed, by all means you know you didn't do your work. For example, we had one maternal mortality auditing here, the Magnesium Sulphate protocol we didn't follow it

well maybe that would have caused the death, so the auditors may recommend that the protocol should be learnt. So later we had a meeting and taught everybody how it is done. So not fault finding but to correct mistakes, correct mistakes, and to be extra careful." M11

4.3.5.2 Spiritual/Cultural Beliefs as Part of MDR

The data reveals that some participants were of the view that, spiritual aspects should be integrated into the MDR process as culture and religion plays an important role in midwives and communities' belief system as indicated below:

"*In Ghana some MD is not fully physical but spiritual. For example, if a woman snatches someone's husband and the person is cursed, no matter how experienced or skillful the midwife is, MD can occur because it is spiritual and not physical. But during the MDR, spiritual issues are never given the platform". M1*

It will be good to include spiritual aspects. Sometimes because they don't consider the spiritual aspects in the MDR, it becomes difficult to know the actual cause of death. .... There was a scenario like that when the client came to the hospital directly from a prayer camp because she was only allowed to leave the camp after they realized that her condition was deteriorating and she eventually came to die at the health facility. M1

4.4 SUMMARY

This chapter has presented the research finding for Phase 1 of the study. The research findings were generated through individual semi-structured interviews and the focus groups discussions with reference to the first three objectives of the study. The study highlighted the lived experiences of the participants in line with their work. The chapter has revealed that MD affects all midwives in many respects. However, these effects vary from person to person and from context to context. The chapter has further revealed that the effects of MD can influence many spheres of the midwives' lives, such as their personal lives leading to emotional and psychological problems. The effects of MD further influence the participants' work, family, the workplaces, and the communities in which the hospitals (workplaces) are found. The next chapter presents the discussion of the findings

CHAPTER FIVE

DISCUSSION OF RESULTS WITH LITERATURE CONTROL

5.1 INTRODUCTION

Chapter four presented the findings of the study. This particular chapter presents the discussion in line with the objectives of the study, the theoretical framework used as well as the available literature. The discussion is organized in three parts; the first part deals with a description of the general characteristics of participants; the second, discusses the main findings; and the third part concludes the chapter.

Although studies have been done on MD but few (or limited information) focussed on the subjective experiences of the midwives to this life changing event and the impact of MDR on their quality of work-life and well-being. Hence, most of the literatures used to support the findings of this study are from studies that are not amongst midwives, but those that explored the "concepts" that emerged in the findings either from a humanistic view or other health cadres who had similar experiences in their health discipline.

5.2 A DISCUSSION ON THE BIOGRAPHICAL CHARACTERSTICS OF PARTICIPANTS AND THE HEALTH FACILITIES

The biographical data will be discussed in relation to types of healthcare facilities, gender, position/rank, age of participants and the number of years worked since qualified as a midwife:

5.2.1 Types of Healthcare Facilities

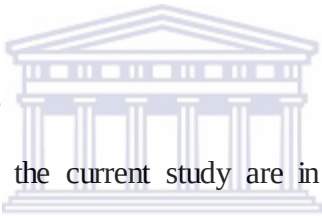
The healthcare facilities used in this study provided the needed information on the study as it traced the issue under investigation from the health centres, the district, regional and to the teaching hospitals. The different level hospitals have similar and unique experiences when it comes to MD. Ronsmans, Graham, and Lancet Maternal Survival Series steering group (2006) agree with this study that, the experiences of MD vary from hospital to hospital, region to region as well as from country to country.

5.2.2 Gender Distribution

In the current study, there were only female participants as there are no males practicing midwifery in Ghana at the time of this study. The lack of males practicing midwifery in Ghana is attributed to the long held belief that nursing, in particular midwifery, is a female discipline. Ozdemir, Akansel and Tunk (2008) agree with the current study that, nursing remains a female dominated profession despite males having entered the profession in recent years. According to Fraser and Cooper (2003), some cultural values discourage men from practicing or getting involved in midwifery as a discipline.

5.2.3 Rank/Position of Participants

The participants in this study held eight (8) different positions with the majority being staff midwives, representing 28%. This is due to the fact that currently, there is no Post Basic Midwifery Programme for professional nurses. The midwifery programme available now is Direct 3 year Diploma in Basic Midwifery for students from High School and two year Post-basic Midwifery for Enrolled and Community Health Nurses (non-professionals). The 3 year training is not unique in Ghana as a study by Phuma (2015) showed that in Malawi, there is 3 year training for midwives to qualify as nurse-midwifery technicians.



5.2.4 Age of Participants

Most of the participants in the current study are in the reproductive age group as the majority (50.8%) between 23 and 40 years. Some of these participants are likely to be affected by the death of their clients as clients are in the in the same reproductive age groups. This is consistent with a study by Kübler-Ross (2009) who states that, nurses and midwives find it difficult nursing patients with of the same age groups or younger.

5.2.5 Number of Years Worked since Qualification as a Midwife

The participants in this study have good working experiences as majority (57.9%) of them have worked for more than 10 years as midwives since qualification. It is known that, the more the experience, the better the quality of care provided to the clients who come into contact with these midwives (Gulliford, Naithani, & Morgan, 2006).

5.3 DISCUSSION OF THE MAIN FINDINGS

As pointed out in Chapter Three, five main themes emerged from the analysis of the data collected in this research study. In this vein, the discussion of the findings of the research concern the following: Effect of death as a unique experience, Multi-dimensional effects of MD, Effects of MD on the midwife's associated environment, Mechanisms of coping and Perceived MDR process The five main themes that emerged from the study with their corresponding objectives are summarized in Table 5.1 together with the categories and sub-categories that emerged under each theme. Thereafter, a discussion in relation to the objectives of the study follows:

Table 5.1: Summary of the themes and their respective categories and sub-categories

Objectives	Themes	Categories	Sub-categories
Objective One: effects of MD on the midwives	**Theme One**: Effect of death as a unique experience	1. Grieving patterns	• Open agony • Subdued reaction
		2. Different intensity of grief and impact	• Personal experiences • Similarity of situations
		3. Different duration of grief	• Exposure leading to midwife-client relationship
	Theme Two: Multi-dimensional effects of MD	1. Emotional effects of MD on Midwives' personal life	• Fear • Difficult to accept/inability to forget • Emotional confusion and distress • Sense of guilt; Sense of failure and Sense of incompetence • Empathy • Disenfranchised grief

		2. Psychological effects of MD on Midwives' personal life	• Depression: insomnia and Crying
		3. Physical effects of MD on Midwives' personal life	• Exhaustion • Inability to eat
		4. Social effects of MD on Midwives' personal life	• Self-isolation
	Theme Three: Effects of MD on the midwife's associated environment	1. Effects of MD on Midwives' work environment	• Positive effects • Negative effects
		2. Effects of MD on Midwives' family environment	• Neglect of responsibility • Associated stigma

		3. Effect of MD on the hospital	• Hospital stigmatized
		4. Effect of MD on the Community	• Waste of Community resources
Objective Two: coping strategies employed by midwives	**Theme Four**: mechanisms of coping employed by Midwives deal with effects of MD.	1. Informal mechanisms of coping	• Individual support • Self-support • Family support • Spiritual support
		2. MDR as a support structure	
Objective Three: midwives' experiences with MDR	**Theme Five**: Perceive MDR process	1. MDR as an effective tool 2. Spiritual/Cultural beliefs as part of MDR	

As pointed out in Table 5.1 above, the discussion of the findings is done in light of the objectives of the study.

5.3.1 Theme One: Effect of Death as a Unique Experience

All participants in the study, irrespective of the age, position/rank, type of health facility, or years of job experience, agreed that they are affected by the death of their clients. Participants are of the view that the mere mention of MD causes each and every one of them in the ward to be troubled in one way or the other. The word 'unique' means something special while 'experience', according to the *Concise Oxford Dictionary*, (2009) relates to "an event or activity that leaves a lasting impression". Thus, a "unique experience" of MD in the context of healthcare facilities in relation to midwives entails that each participant experiences and expresses the effects of death 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 MD as a result of grief related to the death.

5.3.1.1 Grieving Patterns

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 MD in the wards. While some participants showed subdued reaction to grief others demonstrated open agony. Blood (2000:77) 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 about MD are subjective in nature, and this contributes to the uniqueness of the individual participants in this

study. The differences in participants' grieving patterns may be, first and foremost, relate to their different personalities. As participants communicated their grief through non-verbal communication through signing, for example, with a heavier heart used self-questioning and change of mood, not knowing what to do. Others 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 (2009), agrees with the current study that peoples grief patterns are influenced by their personality. In a study done by Doka and Martin, (2011) it was reported that the personality of the individual influences the person's reaction to loss.

5.3.1.2 Intensity and Impact of Grief

Individual grief was also considered unique in relation to intensity and impact. Some participants expressed intense grief due to personal experiences and similarity of situation. Personal experiences resulted from a previous experience of death that might not have been properly resolved. For instance, a participant who had lost a daughter through childbirth, is reported to express emotional trauma each time she experienced MD at work. To this participant, the occurrence of MD brings fresh memories of what happened when she lost her daughter. In relation to similar situations, pregnant midwives nursing pregnant women who dead and these midwives cannot tell how their own pregnancy ends up. 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 (2009) who argue that different people grieve with different intensity. In essence, people have different ways and attitude of dealing with stress situations and

circumstances. In supporting this, Bozarth, (2013), compared death to love and further explained that each death is unique as love is and thus a loss of life is experienced differently. Therefore, it is most likely that previous exposure to MD will highly influence the intensity of the effect of death in later years. According to the National Center for Victims of Crime (2012) 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.

5.3.1.3 Different Duration of Grief

Furthermore, duration of grief was not only dependent on exposure, but on the relationship that exists between midwife and client. Besides, other factors associated with clients such as how long a client has been on admission at a given healthcare facility; the age of the deceased; the diagnosis and condition of the client on admission; the services rendered by the midwives on duty and the suddenness of death. This is reinforced by (Meyers, et al., 2009), who are of the view that these factors may greatly influence the duration and intensity of grief that health workers experience. The duration of grief may also be as a result of the individual culture and gender of the person.

It is obvious that, the longer the client stays on admission the greater the attachment between them. Likewise, on one hand, the type of nursing services provided and time spent on the client makes a difference in the relationship they build. On the other hand, if clients condition on admission is such that, the midwife has no control over, the duration may also differ. To this effect, Zambrano and Barton (2011), adds that in hospital contexts, nurses and midwives have different sensitivities and relationships

attached to their patient, which may give rise to varied line of their reactions (grief) and adjustment towards the death of 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 (2010), agrees with this study that relationship between a health caregiver and client affects the duration of grief caused by feelings of 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.

5.3.2 Theme Two: Multi-Dimensional Effects of MD

The responses of the participants indicate that they are emotionally, psychologically, physically and socially affected by MD. These responses are consistent with all participants notwithstanding the age, years of practice as midwife, nature of the hospital or rank of the participants. The theme "psychosocial effects of MD" has to do with all the psychological (emotional), physical and social effect of MD on human beings who are in this case midwives. Blood (2000) confirms that the reactions of nurses to their patients' deaths include physical, emotional, professional and cognitive reactions. Psychosocial effects originate from the workplace (health facilities) of the midwives and are regarded as stressors in occupational health. Due to the nature of their work, midwives are often times stressed as a result of exposure to MD at workplaces. The next section discusses all the psychosocial effects of MD which include emotional, physical and social effects on midwives' personal life.

5.3.2.1 Emotional Effects of MD on the Midwives' Personal Life

Emotion is believed to be a person's state of mind at a particular time. Emotion could either be negative (bad mood) or positive (good mood) Cyders & Smith, (2007). In the current study, emotions are regarded as being negative. Therefore, this means that the midwives are affected negatively whenever they experience MD at their workplaces. In all, eight emotional situations which impact on the wellbeing of the midwives were identified in the study. Emotional situations are known to be stressful. These may cause a lack of self-confidence and make people feel helpless under any circumstances and as such impact negatively on the participants' quality of work-life. Fear, difficulty to accept/difficult to forget, emotional confusion, sense of guilt, empathy and disenfranchised grief are the sub-themes the emerged under theme two and are discussed in turns.

- **Fear**

'Fear' is the second sub-category under the category "Emotional effects on midwives' personal life". Fear is one of the emotional effects of MD on midwives' personal life identified in this study. This is demonstrated to a greater extent as fear that engulfs the participants after the death of clients left under their care. All participants expressed some form of fear whenever they experience MD regardless of age, type of health facility working in, rank of participants or number of years work experience. Fear is an emotion caused by believing that someone or something is likely to cause harm, pain or is a threat. Fear of death, according to Peter, Cant, Payne, O'Connor, McDermott, Hood, Morphet and Shimoinaba (2013), is a universal life process that exists among humans and the reason why health professionals preserve life. Penson Partridge, Shah, Giansiracusa, Chabner, & Lynch, (2005) add that fear is a defense

behaviour basic to individual survival. Midwives expressed fear of death in relation to: (a) fear of own death, (b) recurrence of death, (c) fear of the MDR process, (d) fear of decease family members' reactions (e) fear of stigma by community people (f) fear of family being attacked, (g) fear leading to selective nursing care, (h) fear and flee (i) fear of colleagues and hospital management and (j) fear of law suit or malpractice to hospital, individual or both. The types of fear exhibited by these participants, is discussed as follows:

Fear of own death was highly prominent in this current study. This may be because death terminates dreams, ambitions and goals of individuals. As stated by one of the participants, "*as humans, the mention of death will always bring fear*". Kübler-Ross, (2009), agrees with this study by saying that, death is always distasteful to man and will continue to and thus, causes fear. The fear of own death in the finding was not surprising as all participants are females and the majority at reproductive ages, and feel it could be any of them. It could also be that elderly participants (out of reproductive age group) still have children to take care of and also their own life to enjoy. This perception is congruent with literature where Lehto and Stein (2009) observe that health care workers often feel unprepared for their personal death and therefore its occurrence brings deep fear to the people involved. A study conducted by Kübler-Ross (2009), still relevant in the current study as it described the difficulties nurse and midwives go through in nursing patient with same gender as themselves and also same age groups or younger.

Another dimension of fear that emerged was fear of recurrence of other clients' death, especially, those with the same diagnosis or similar conditions on admission. Fear of

recurrence of death was also prominent among midwives in the health centres, where resources were limited. These participants prefer to refer clients to other healthcare facilities, even if they can manage such cases because of fear. This may be because some of these clients on admission may have some signs and symptoms that reminded midwives of the death that they experienced previously. This stand is supported by Papadatou, Martinson, & Chung (2011), who observed that, nurses who experienced the death of close relations have problems nursing patients with some features that remind them of the death of such people. Besides, referring patients that can be cared for to other hospitals, fear can cause some midwives to leave their job if it is not well managed and becomes unbearable, leading depression and thus, job insecurity, Boya, Demiral, ERGÖR, AKVARDAR, & De Witte, (2008).

Fear of bereaved family members' reaction upon disclosure of death was a major concern to participants in this study. The findings show that all midwives agree that the clients' they deal with are not sick people; they are physiologically normal but merely going through temporal changes. It is for this reason that fear is likely to set in when it is time to disclose to family members about the demise of the client. In such circumstances, the fear has to do with the reaction of relatives present at the time of death. It was evident in the study that, disclosure was particularly difficult for the young midwives; they admitted the ward managers must help in such situations. The fear of disclosure and family reaction to death ties with the view of Liu, Su, Chen, Chiang, Wang, & Tzeng, (2011) who observes that care takers worry over the response of the death of clients. This worry and fear may be because midwives are often not ready to face clients' family since some of these reactions are very painful to deal with and do not know how to handle their own emotions when family members

react. This study agrees with Rassin, Levy, Schwartz and Silner (2006) study in which they contend that health care professionals experience helplessness when disclosing bad news to patients' family

Participants in the district and sub-district health facilities are afraid of being labelled or stigmatised on the street by members of the community. Markets, churches or the street are places where midwives are introduced and/or pointed fingers at as those responsible for the death of family members. This situation may be frustrating to midwives since it reminds them of the sad event and also make them feel like they caused the death of another person. This can affect their health and well-being as well as their quality of work life. The current situation can equally prevent them from socializing since one would not know where she will meet any of those people. The effects of this situation can eventually affect all relationships with these people. On the contrary, some participants are very happy when are introduced for safe delivery of family members. They are happy for being the first to see and cared for the newly born. These are positive things that enhance the quality of work life of the individuals and are encouraged to do more (Herzberg, Mausner & Snyderman, 2011).

Fear for midwives' family members being attacked because of associated stigma was revealed in the study. This situation was in reference to midwives at the health centres and some district hospitals where the participants live and work in the same community with the people they serve at their health facilities. Here, participants fear for their children being labelled by other school children in the community. Fear of children being labelled for mothers' perceived incompetence makes the participants extra anxious about the whole incident of MD. Peters et al, (2013), argues that

individuals have their own understanding and attitudes to death, which is subjective in nature and influenced by personal beliefs, social convictions as well as the culture of the person. It is obvious that, experiencing MD on regular bases exposes their families to dangerous situations such as verbally or physically abuses by community members. This situation may disturb the peace of mind of these participants' and their children' as well as socialization in the community.

Selective nursing care emerged strongly as an effect of MD among midwives. It was evident that, some midwives avoided some clients totally. At times, part services may be provided while leaving the other services for other midwives. This results from the fact that, participants did not render certain nursing services to pregnant women on admission because those services resulted in the death of client earlier. For example, in a case where a midwife says: "*I gave this injection and the client died, I will never give that injection for...fear*". They do this by intentionally avoiding clients who need same services as the previous ones that resulted in death. The above finding is in agreement with Keene et al., (2010), who found out that nurses sidestepped other patients and families because of the impact of an earlier death of a patient. This may be because avoidance of the pain associated with MD.

This behaviour is seen as a means of coping for some midwives either for total avoidance of clients or selecting some nursing activities and avoiding others is an acceptable in the nursing profession (McGrath et al., 2003). Since this behaviour is likely to cause serious problems for clients who come into contact with such midwives, ear and flee was evident among midwives who were overwhelmed with fear of patients' death at the hospitals. Unintentionally, some participant, out of fear

complicated with confusion, 'flee away' from other clients who needed their care and the ward environment entirely. Majority of these participants painfully expressed their fears with strong emotions and therefore find it difficult to stay in their work environment at that moment, touch and nurse the other clients on admission. This may be as a result of 'fight and flight response'. 'Fight and flight response' is a nervous system response to unbearable fear. It is a biological response that occurs as a response to an event that is perceived as harmful or trait to the individual survival. The physiology energizes the individual by the increase in adrenaline production, which also causes the production of epinephrine and norepinephrine to either fight or flee the environment of trait. To support this study, research has documented that when fear becomes unbearable, the individual experiencing it may flee in order to take him/her from the situation (Parikh, Taukari, & Bhattachaya, 2004). Furthermore, Baumgardner and Crothers (2009) argue for the need for physical survival using the lens of biological and evolutionary experts in times of fear. Welbourne, Eggerth, Hartley, Andrew and Sanchez (2007), added that dodging mechanisms are means of reducing occupational stress among midwives.

The dimension of fear of colleagues' and hospital management's reaction was one of the major worries the attending midwives had to deal with each time there was MD at the hospital. Fear of being judged by colleagues and management as a result of MD may be due to the fact that these people are equally affected. Probably because collectively, death at the healthcare facilities affects everyone working there irrespective of the person's connection with the deceased person. Therefore, fear of criticism, shame and guilt for an omission or action by colleagues and hospital management was an issue. The attending midwives mostly wished to be supported

with calm words and questioned in a conducive environment and thus, if their expectation is met with hash posture, this caused fear. For example, in a situation where a participant expresses a bad feeling about the reaction of hospital management and she felt '*like hitting her head against the wall and killing herself'.* This is likely to cause low self-esteem among these workers and can bring interpersonal conflict among colleague and hospital management causing stress and affecting work output. According to Duddle and Boughton (2007), this kind of conflict in the hospitals may cause work-related stress issues such as burnout, psychological and somatic health challenges, rise in staff turnovers and heightened level of job dissatisfaction.

Fear of MDR process and the possibility of being blamed for the death of a client was one of the concerns of the participants. As pointed out earlier, MDR is a process for auditing the death of each pregnant mother who dies as a result of MD (WHO, 2004a). The process of MDR looks simple, but it takes time and thus some form of tolerance and patience is required. It is at the review process that the individual is seen to be "guilt or otherwise" for the death of a client. The fear of the outcome of the reviews increases participants' anxiety. Consequently, according to WHO (2004a), MDR is not to be conducted as a blame game review, but to learn from the lessons that might have caused the death of the client, especially the preventable deaths in order to put in place measures to mitigate the causes of such deaths. However, from the study findings, it appears that the process is sometimes regarded as a 'faulty finding' exercise which in effect puts pressure on midwives. This finding is supported by Kongnyuy and van den Brock (2008) who observe that MDR is under no circumstances conducted without health workers blaming each other. It may also lead to major health problems and at the same cause job dissatisfaction.

Fear in relation to malpractice or lawsuit either for the hospital or personnel, even both, also emerged as disquiet in the study. Participants in this study experienced fear because MD can cause their jobs: lose their license to practice or even be suspended from the hospital. Malpractice is the situation where the midwife competently misses the mark to perform her medical responsibilities which resulted in harming a patient under her care. Withdrawal of practicing license by the Nursing Council of Ghana does occur when a nurse or midwife on duty is found guilty of malpractice. Gündoğmuş, Özkara and Mete (2004) admitted that malpractice cases among nurses and midwives can be tried as civil or by the court of law involving the regulatory bodies and other stakeholders. The mere thought of this happening could make workers uncomfortable and thereby affecting their quality of work life.

The study has established that due to fear, participants have narrow thoughts in terms of innovations in attending to their clients and therefore, reducing their ability to plan and provide care needed to clients. This is so because fear reduces the ability for ingenuity and restricts the individual's focus in putting in extra effort. According to Lachman (2009), fear can cause nurses and midwives to compromise on ethical issues. Quality of work life does not only relate to enumeration workers get as a reward but also the satisfaction that they are able to provide needed care to clients. The quality of work life of these midwives is indeed compromised and so is the quality of health care services required by pregnant women who visit the health care facilities.

- **Emotional confusion and distress**

Emotional confusion was observed to be one of the effects of MD on the midwives. Participants revealed some form of emotional confusion whenever they experience

MD notwithstanding the age, type of health facility working in, rank of participants or number of years work experience. This was illustrated, to a large extent, as participants' inability to concentrate on the job at hand immediately after the passing away of a client. The work of nurses and midwives are critical and therefore, lack of focus on the job of caring for others could cause malpractice. In midwifery and for that matter health care setting, confusion of any kind can affect the quality of health care given to clients. A confused midwife may, for example, give wrong medication. This observation is consistent with Center for Prevention and Health Services (2008) which suggests that confusion brings about difficulty in concentrating on the work and consequently may affect productivity and behaviour. This view ties in with Bozarth (2013) who observes that confusion is one of the symptoms an individual faces when one experiences death.

The participants in this study, to a large extent, share the view that they are distressed whenever they experience MD at their work places. According to Bickham (2009) distress, is a response to any incident that overwhelms a person's ability to handle. Distress leads to emotional burnout, frustration and resignations which can cause imbalance between work and home roles. Schulz and Sherwood (2009) add that nurses and midwives distress over the death of their patients they cared for, and this impact negatively on their physical health, consequently affecting individuals' well-being. The study findings show that participants suffered emotional distress. It has been established that health professionals who experience emotional distress due to their inability to cope with the impact of patient death can lead to negative effects on their work performance (Keene et al., 2010). These negative effects may be because midwives become helpless in situations of death. Emotional distress may also be that

death brings to an end the story chapter of people, unfortunately, where nothing can be done to bring back the person. Tice, Bratslavsky and Baumeister, (2001), agree that there is always emotional distress whenever people experience the death of others in any form of friendship. If midwives could go to work without the needed concentration, the possibility of making mistakes is very high, hence, putting herself, colleagues as well as clients at risk. Making mistakes that affects clients and colleagues on regular basis can bring about job insecurity.

- **Sense of guilt**

The findings in this study indicate that midwives who experience death of clients feel guilty of that particular death. Guilt is an emotional state of the mind where an individual goes through conflict of a sort, for not having something done or done properly. The feeling of guilt does not easily go away since it is driven by one's conscience. All participants in this study evaluated the healthcare provided to their clients after the client's death; by interrogating their mind in most cases, if they have provided all the services they were obligated to provide to the clients and whether the correct procedures were employed. This, according to Blood (2000), is called cognitive reaction to death and it involves asking oneself questions and reviewing treatment given to patients. Guilt feeling is an indication that an employee might have compromised on standard, that is, a conduct has been violated. Bozarth (2013) acknowledges that people who experience any form of death feel guilty. This is likely to cause psychological problems to these midwives. On the other hand, guilt caused some midwives to work better in saving the lives of other clients in the ward since they do not want to experience similar feelings. Berger (2005) sees guilt as something good sometimes because it may lead to motivation for improving efficiency, this he

concludes, may act as a voice to health personnel and therefore can assist in behaviour change. The finding also indicates that a sense of guilt was linked to sense of failure and sense of incompetence.

Consequently, a sense of failure' was linked to a sense of guilt. It appeared that midwives fault the 'sense of failure' when they were unable to save pregnant women from dying. Failure is said to be the state of mind where the individual fails to meet a desired objective. The perceived failure is associated with 'Self' as individual attending midwives. As part of their responsibility, every midwife is to safely deliver pregnant and therefore failure to do that is a breach of contract. Some participants appeared embarrassed with the issue of MD probably because they did not work up to expectation. This was seen as a worry to many who thought that as professional midwives, they have the aim to see pregnant women through antenatal, delivery and post-natal successfully and that if something went wrong and the client dies, they have failed themselves. Bozarth (2013) agrees with the current study by stating that people who experienced the death of others feel embarrassed and despair with the situation.

Midwives in this study seemed to have failed family and friends of the deceased, who left their relation under their care. This may be difficult for midwives because society, trust their abilities, judgement, skills as well as knowledge and therefore would bring their love pregnant women to be cared for hence the death of one pregnant woman means, the society has lost. This is, however, a break in trust between them and the relations of the clients. In a study conducted by Muliira et al., (2014), established that, midwives experience a sense of failure when there is MD at the workplace; the sense of failure is related to the decease person and family.

‘Sense of incompetence’ is linked with a sense of guilt. Incompetence is seen as lack of both theoretical and practical knowledge that guide an individual behaviour to doing good job. Combination of competence on the other hand is not limited to theoretical and practical domain, but also to cognitive, value as well as behaviour that help an individual in improving on performance in a particular field or a specific role. It is believed that competence comes with thinking and emotional intelligence. This feeling of incompetence affects their next duties. A sense of incompetence among midwives ties with studies done by Caulfield, Chang, Dollard, Elshaug, 2004; Bickham, 2009), who observe that sense of incompetence are primary reactions among nurses and midwives whenever death of a patient occurs at the healthcare facility which consequently impact, not only on their emotional, but also social life. In addition, Brun & Lamarche, (2006) acknowledge that these types of work stresses may overwhelm an individual midwife negatively and would further make her the victim.

‘Moral distress’ was reported to be experienced by most midwives in the current study. Moral distress is usually experienced by midwives when a client dies under their care. According to De Villers (2010), moral distress is a mental imbalance that affects a person due to the fact that, ethically correct action was not taken in a particular situation though knowing what to do. This situation arises as a result of an inhibiting institutional policy or powerful medical structure. Similarly, AACN (2008:1) views moral distress as “not following the appropriate ethical decision despite having knowledge of it which contradict personal and professional values, and undermines your integrity and authenticity”. In analysing the issue of moral distress, one examines her involvement with the situation, an awareness of alternatives, the

need to make a decision, and uncertainty about the best solution. The impression of moral distress is the conflict associated with the choice and conflict between values, principles and duties. Moral distress in the hospital set up occurs during emergencies where time to take decisions as to what is the best under the circumstances healthcare workers find themselves. This study agrees with Bruce, Miller and Zimmerman (2014); Pauly, Varcoe, Storch, & Newton, (2009); Austin, Kelecevic, Goble, & Mekechuk, (2009), that moral distress is mostly manifest in critical care situations where nurses question themselves as to what they could have done and did not do.

- **Sense of Empathy**

The findings of this study suggest that participants empathized with the deceased and family. Empathy is believed to be a way of putting oneself into another person's situation. Empathy agrees with self-cognitive questions on what exactly you think the person will be going through or feeling. Trying to share the pains and feeling with the person, or putting yourself in the person's shoes (Penson et al., 2005). Lombardo and Eyre (2011), observed that, the situation where nurses and midwives show empathy, support to clients and family lives that experiencing the pain which eventually results in empathy fatigue. All participants indicated some degree of empathy each time MD occurred in the ward notwithstanding the age, type of health facility working in, rank of participants or number of years work experience. The participants' empathy originates from the fact that all of them are mothers as well as potential mothers. Lewis (2014) identified empathy as one of the core characteristics of nurses and midwives. Therefore, empathizing the death of a patient may cause more stress to the care giver. In Ghana currently, only females practice midwifery and therefore seeing the death of a mother as a result of pregnancy is a worry to most midwives.

- **Disenfranchised grief**

The study established participants' disenfranchised grief in the face of MD notwithstanding the age, type of health facility working in, rank of participants or number of years work experience. Disenfranchised grief is defined by Wilson and Kirshbaum, (2011) as grief experienced by a person, but which is not openly acknowledged, socially validated or publicly observed, and showed that people having secretive (non-traditional relationship) or close relationship unacknowledged by family and friends of the deceased may exhibit a feeling of grief more intensely. This is applicable to the healthcare staff (especially nurses and midwives) who mostly would always experience disenfranchised grief and may try to conceal their emotional response in the presence of the patient's death since it is not acceptable to express their emotions in the workplace. In such a situation, while others did not acknowledge that the death is a loss to them as well, they may be beckoned on to buttress other patients who need their help. Not been sympathised with these midwives is likely to restrain them overcoming the grieving pain, (Doka, 2002). However, a little sympathy to comfort them would go a long way to calm them down and help them organised better for work. This shows the agreement in a study conducted by Fessick, (2007) that, grief support extended to nurses after the death of a patient is very useful as it helps them in the grieving process and work management.

- **Difficult to accept/ difficult to forget**

The participants in this study cited that they are unable to accept and/or forget MD regardless of age, type of health facility working in, rank of participants or number of years work experience. Difficult to accept MD is a situation where the midwives lives in disbelieve that the patient is dead. This finding is not surprising, probably because

these clients are 'not sick'; they mostly walk into the wards on their own. They communicate with midwives and other clients, and in some cases, they see improvement in their conditions but suddenly something happens. Difficult to forget means that the midwives still remember all that happened to each of the clients who die under their care and find it difficult to let go of the memories of these clients. For example, one participant experienced three MDs and could recount everything about those clients several years after their death. Mizota et al., (2006), agree with the current research that people find it difficult adapting to their environment after experiencing death. Wilson and Kirshbaum, (2011) add that because people find it difficult to accept the death of someone (especially love one) in their personal life, they are likely to become more vulnerable when they witness a patient death.

5.3.2.2 Psychological Effects of MD on Midwives' Personal Life

Humans are psychological being and thus an individual needs to be of sound mind in order to survive the stresses of life. The participants in this study exhibited psychological effects when they experienced MD at the work places. This was as a result of them being depressed, with crying and unable to sleep.

- **Depression**

The majority of participants in this study established that they are depressed when faced when MD regardless of age, type of health facility working in, rank of participants or number of years work experience. The results of the study indicate that, participants' suffer some form of depression whenever they experience MD in the wards. Depression is an emotional feeling that is exhibited by someone who physically experiences the death of someone. However, the level of depression varies

with individual participant probably because of their understanding of death and also because clients who come to die are young in their reproductive. The depression experienced by the participants in the current study made them lose interest in their environment and the people around them, therefore, wish to be by themselves, lack of interest in self-care, neglect personal hygiene, neglect of family responsibilities and inability to work. It is believed that, when people neglect their own personal hygiene, and want to isolate themselves from family and friends, then; this becomes a great source of concern. Furthermore, depression does not motivate anybody to work, especially when clients are waiting to be cared for. Therefore, this leads to low productivity among midwives at the workplace. Tennant (2001), acknowledges that depression is the most adverse emotional related problems faced by nurses and midwives at their workplaces. According to literature, depression among nurses is well known, but the needed support services are not standardized. This is in line with Hargrave, Hiatt, Alexander, & Shaffer, (2008); Hargrave and Hiatt, (2005) who point out that depression causes poor mental health and thus leading to low productivity. Furthermore, Caine & Ter-Bagdasarian, (2003) concluded that depression leads to lack of drive to work.

A strong link emerged in the findings between the crying of nursing staffs at the hospital and death of patients/clients. Some participants in this study indicated that they cry when there is MD irrespective of age, type of health facility working in, rank of participants or number of years work experience. Crying is seen by Kukulu and Keser (2005) as loss of control as a consequence of feelings of powerlessness and inadequacy, or a sign of suffering. Some participants observe that they would normally cry anytime they experience MD. These participants emphasized that clients

became their friends. Some of the midwives mentioned that they become the surrogate family members to their clients. To the midwives, they spend more time at work than at home and therefore, clients are the people they relate with on a daily bases. It is therefore not surprising that some participants cry when a client dies. Basically, crying is universal, emotional expression and can differ based on the social context. Kukulu and Keser (2005), observe that healthcare providers, for example, midwives in the hospital may cry for a number of reasons which include a sense of compassion for patients who are suffering or dying, frustration, and helplessness and for being overworked. Besides, as healthcare givers, it is painful to see patients come to the hospital and die in the process of seeking health care. The act of crying by nurses as noted by Golbasi et al., (2008) is a coping mechanism for low job satisfaction and a clear signal of emotional distress.

The participants in this study noted that they are unable to sleep well when MD occurs at the hospital, irrespective of age, type of health facility working in, rank of participants or number of years work experience. Participants in this study, associated sleeplessness with the mind thinking about the incidence of death starting from when the client came into contact with them. Sleeplessness is a disorder where the individual cannot fall asleep even though in bed. It is a well-known fact that sleep plays an important role in the life of human beings as it refreshes the individual and gives energy for the next day's activity. Thus, continuous lack of sleep can lead to poor quality of life and eventually poor quality of work life. Poor quality of work life may result from poor memory, lack of self-esteem and irritability. It is for this reason that clients' care is highly likely to be compromised. In this vein, Caine and Ter-Bagdasarian (2003), adds that stressful situations such as death of a patient affects

sleep and results in loss of concentration, leads to depression and lack of motivation to work.

5.3.2.3 Physical Effects of MD on Midwives' Personal Life

Physical effects of MD were to affect all participants in this study. From the perspective of the participants, they physically, are affected by the death of their clients. Aspects of the physical effects identified from the participants interviewed were: exhaustion, and inability to eat

- **Exhaustion**

The participants in this study noted that they are often exhausted whenever MD happens in the wards regardless of age, type of health facility working in, rank of participants or number of years work experience. It is evident from the participants' experience that they usually get exhausted after the death of a client; mainly because of the emergency situation they find themselves before the client dies and the loss of the client as they would feel that they wasted their time and energy without good results. Some express it as doing all they could to save life, but not successful at the end. The experience of exhaustion felt by participants in the current study is as a result of grief of client and this has a negative impact on their ability to work efficiently. It may also be, probably because there is sudden loss of energy as a result of mental fatigue. This is in agreement with the findings of Sanders (2015), who acknowledged that total exhaustion is one most common physical features of someone who has experienced death of another person.

- **Inability to eat**

The participants in this study allude to the fact that they are unable to eat well after the experience of MD notwithstanding of age, type of health facility working in, rank of participants or number of years work experience. Eating is a normal as it supports everyday activity and enables one to live a healthy life. In this study, a loss of appetite as a result of experiencing of MD was eminent among most study participants. It is obvious that loss of appetite arising from the midwives' experiences with MD has the potential to 'weaken' someone's ability at work and thereby failed to perform according to expectations. People cannot concentrate when they are hungry. Furthermore, lack of appetite may lead to loss of interest in people or the environment and therefore the role of a midwife may not be achieved. Although Bozarth (2013) agrees with the findings of this study, he also points out that other people who experience death of someone or others may also over eat, which equally causes health challenges in the long run and further jeopardizing their performance at work.

5.3.2.4 Social Effects of MD on Midwives' Personal Life

Social life of an individual has to do with time that an individual spends with other people who may include family or friends. Social effects of MD on the midwives' personal life relate to the inability to share her space with other people. According to *Psychology Today* (2016), human beings are social beings and need to interact in order to have a good influence on the mental health of others. It is believed that humans are dependent on each other for survival. The aspect of social effect identified in the current study is self-isolation.

- **Social-isolation**

Social isolation is lack of social interaction or contact with the social world. This may probably be because the individual want to be by themselves in order to think and reorganize their thoughts. Social-isolation occurs when an individual is depressed, discouraged, feels worthless and has no hope for the future. It can also be said that the person is in darkness. According to literature, without positive and durable associations, both the mind and the body cannot work together, Fredrickson (2003). The results of the study brought to bear that some of the participants isolated themselves both at home and at work after experiencing MD in the wards. It has been established that short-lived social isolation has huge negative impact on all types of animals, including human beings (Narvaez, 2013). Such impact may affect one's productivity at work thereby endangering the well-fare of the institution he/she works for as well as the general service offered to clients. In the case for midwives, their ability to work efficiently and effectively is compromised thereby putting the lives of clients at further risk.

5.3.3 Theme Three: Effects of MD on the Midwife's Associated Environment

The effects of MD were not only seen on the midwives' personal lives but also on the midwives' family, job, the hospitals where these midwives' work as well as the communities where these health care facilities are located. These have been classified as midwives' environment. All participants, regardless of the age, position/rank, type of health facility, or years of job experience pointed out that MD affects other things related to them in the environment in which they work and live in. The theme "Additional effects of MD on the midwife's environment" is discussed as follows:

5.3.3.1 Effects of MD on Midwives' Work

The participants are consistent with the fact that MD affects their jobs. The study has established that there are positive and negative outcomes of MD on the midwives' job. These are discussed below:

- **Positive outcome of MD on the midwives' job**

Some participants described how the use the unfortunate situation of MD to improve on their attitude to work (as they tend to become more vigilant, and caring in order to avoid MD in the future). The participants with positive outcomes ideology put in the necessary efforts to overcome the effects of MD regardless of age, years of practice as a midwife, the nature of the hospital they work or rank of the participants. For this reason, they would work harder to avoid MD in the future. This is consistent with literature in which Stroebe et al., (2007); Blood (2000) observes that the positive consequences of bereavement include resolution of distress, acquired knowledge, willingness to get involved, and feelings of having made a difference and this bring job satisfaction to most people. Lundstrom, Pugliese, Bartley, Cox, Guither (2002) added that, a higher job satisfaction among health workers correlates to the positive patient outcomes.

- **Negative outcomes of MD on midwives' job**

These responses are consistent with most participants notwithstanding their demographic differences. These negative outcomes brought about low productivity and are discussed below:

Some participants exhibit absenteeism and refuse to report to work after having experienced MD. Absenteeism is the affinity to stay away from work without any good reason. Munro (2007) defines absenteeism as "being absent from a workstation". In this study, absenteeism by midwives who experience MD may be attributed to participants' fear of the environment which is assumed to have caused them pain. In this study, different forms of absenteeism were established and these include: absenting from work for days without a leave; going out to shop during work hours; going out for lunch beyond the time frame; and being indisposed and a deserter who does not intend returning to work. Similarly, absenteeism has also been perceived as an employee's time out of work due to illness or disability (Cancelliere et al., 2011). These forms of absenteeism arising from experiences of MD by midwives have serious effects on service delivery in health care facilities and in particular, maternal related care.

Presenteeism is a situation where an employee goes to work despite the fact that he/she is sick or lacks interest and energy to work. Presenteeism is defined as "being present at work, but limited in some aspects of job performance by a health problem, and it is often a hidden cost for employers" (Cancelliere et al., 2011). Munro (2007) also defines presenteeism as "an illness related condition that negatively affects on-the-job productivity of an employee". This means that the employee would report for duty, but exhibit inability to work due to health problems such as emotional trauma associated with the death of a patient, chronic back pain, allergies, rheumatoid arthritis and others just to mention a few. The findings revealed that several participants go through presenteeism whenever they experience MD at the healthcare facilities. This may be as a result of the fact, their presence is needed at work to give an account of

the incident, complete the necessary protocol for reporting MD and also answer questions that may need clarification to the ward manager so a full report can be written about the client while on admission. It may also be because of fear of being denied a promotion if absenteeism is recorded against them. Presenteeism leads to productivity loss because the employee's presence does not guarantee that work would be effectively done.

5.3.3.2 Effects of MD on the Midwives' Families

All participants in the study established that MD affects their families. It is a well-known fact that MD experienced by midwives at the healthcare facilities affects their homes. Midwives' homes/families suffer the consequences of maternal related deaths. The suffering ranges from associated stigma to neglect of household responsibilities. The section that follows, discusses these aspects in turn.

- **Neglect of household responsibilities**

Participants affirm that they are not able to do anything at home each time they experienced MD at the workplace. They are unable to carry out their daily domestic chores which affect the well-being of the family. This obviously would result in compromising the general relationships with other family members which in turn could affect the worker. This also puts unnecessary pressure on the families who may offer little or no help at all. This may be because having no interest in doing anything at all and do not have the energy to endure these activities. Therefore, the affected midwives are left to heal on their own while their work and family life deteriorates. According to Peters et al., (2013) it is normal for people who witness death and developed negative emotions. They further added that it is as a result of 'losing the

self' in the mist of the trauma. Not paying attention to children, even husbands at home because of MD at work may be a major concern to the family.

5.3.3.3 Effects of MD on the Midwives' Hospital

Participants came out clearly that the effects of MD are not limited to the midwives on duty or the families but also the hospitals where these deaths occur. It appears that the hospitals loss clients utilising the services. Once clients to the hospitals are reduced, so is revenue for development of the facility. The description participants gave is that, the hospitals are stigmatised. Reduction in clients to the hospital means reduction of financial resources needed for use in improving equipment and other services for the hospitals. For a hospital to request for resources for use there is the need for adequate data showing the number of clients who visited the hospital.

5.3.3.4 Effects of MD on the Community

Some participants feel that the communities where clients come from to the healthcare facilities and die are equally affected. It affects the finances and time pregnant women in the community take to travel to other healthcare services because they are afraid to die in the healthcare facilities in their communities. Participants in the current study, observe that, as humans, we live in communities where social amenities or resources are shared by all and therefore becomes a problem where some people are indirectly excluded from enjoying the facilities. Thus, pregnant women in the communities are prevented from utilizing the resources such as healthcare facility in their own community, but seek help from elsewhere is a disservice to the community. Participants question what happens to those pregnant mothers who cannot afford the cost of travel to other health care. The social amenities are to help serve the people

and make them comfortable. This implies that, the right to accessible and affordable health care is taken away. This may also lead to waste of accessible and affordable care. Globally, affordable healthcare is the goal. This research study is supported by Berwick, and Hackbarth (2012), who argued for the need for sustainable health for all.

5.3.4 Theme Four: Mechanisms of Coping Employed by Midwives Deal with the Effects of MD.

All participants, regardless of the age, position/rank, type of health facility, or years of job experience employed different means of coping when MD occurs in the hospitals. It was revealed that there was no formal support system (counselling, EAP services or debriefing services) available for midwives to deal with effects of MD.

Coping is a process of curbing the effects of occupational stress; mental and physical health to inhibit suffering, burnout and psychological maladjustment. Coping according to Tyson, Pongruengphant and Aggarwal (2002:455) "is intervening variable that may moderate the effects of stress on an outcome variable such as job satisfaction". Coping mechanisms are depended on the source of stress, individual's appraisal and situation in the workplace. According to Parikh et al., (2004), mostly used coping strategies are avoidance of the situation, problem solving and social support. Welbourne et al., (2007) add that the ability to cope effectively with stressful work situations depends on the individual understanding of the event. Positive coping helps the individual to settle quickly and this brings internal stability while negative coping does not help the individual. Muliira et al., (2014), contends that coping strategies should be varied since some coping strategies may not help some midwives in averting death anxiety. Thus, death of patients is seen as a stress situation for nurses

and midwives and therefore needed attention should be provided. In the sections that follow, the different forms of coping strategies arising from the findings of the study are discussed.

5.3.4.1 Informal Coping Mechanisms

The category of "Informal coping mechanisms" established that all midwives regardless of years of experience, age or type of hospital working for, use at least one of these strategies in dealing with MD when it happens. Informal strategies present with individual support, self-support, family support as well as spiritual support. These support strategies are unofficial means of dealing with MD in the healthcare facilities since there are no formal support systems available for midwives when they experience MD. Informal mechanisms are presented as follows:

- **Individual non-professional support**

The participants in this current study, appreciate and like to talk someone, a non-professional, who they trust to talk about what happened before the pregnant mother died. From the perspective of these participants, talking to someone about the incident and how they feel brings relief. People the participants talk to anyone immediately found. Some nurse managers in this study attest to the fact that they help call the midwives on duty during the incident for a talk, but also acknowledge that since they are not trained, they may not fully meet the needs of the anguished midwives. A good performance in term of the services provided to the client before her demise is however important in getting the needed support from colleagues when there is MD at the hospitals. Some participants are only relieved after discussing the whole incident with colleagues at 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 with (Austin et al., 2014).

- **Family support**

Some of these participants depend mostly on family members: the young midwives were found talking to the parents, especially mothers, those who are married were talking to their husband either by phone or physical. Bickham (2009); Hanna and Romana, (2007) admit that information sharing is important in coping and sees stress debriefing as an information sharing event or processing session consisting of a conversation between peers. However, this is good in managing work-stress, but may not always be the answer to remedy work-stress related problems (Hanna & Romana, 2007).

- **Self-support**

Some participants say they support themselves for seasons been that, colleagues think they are not related to the decease; they do not deserve to be supported. Others think that, colleagues would judge them instead of supporting them. They therefore take themselves out of the uncomfortable situation in which they find themselves. Self-support strategies employed are taking a break and reflecting on the events that lead to the death of the client, comforting yourself that, you have done your best under the circumstances. Blood (2000:31) pin point out some self-support coping strategies adopted by nurses to help them manage their grief, and these include self-expression, self-nurturance, and termination of relationship activities; engage in control taking activities, and self-reflection. Self-expression involves the nurses' intention to disclose the event with colleagues, family members and friends. Self-nurturance involves

"activities the nurses engaged in to care for themselves during this stressful time such as long walks, massages, and meditations".

- **Spiritual support**

Spiritual support is the fourth sub-category under Theme Four "Coping strategies employed by midwives in dealing with the effects of MD". 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 and ask their pastor to pray for them and the deceased soul. The employee utilizes personal mechanism such as prayers that would enable her to withstand or cope with the existing trauma (stress) experienced through access to social support (Chair in the Occupational Health and Safety Management, 2005). Another way that helps the individual to cope and overwhelm the negative effects of stress is having a strong positive perception or perceived self-efficacy. Perceived self-efficacy is defined as "beliefs in one's own capacity to organise and execute the courses of action required to manage prospective situations (Grau, Salanova, & Peiro, 2001).

It is obvious that, those who experience MD become worried and would want to be comforted by anybody. They expect to hear positive things from the people they talk to, in order to make them feel better. So therefore, would like to explain what actually happened when the client under their care; they talk about the services provided to these clients before the client expired. In this context, the person could be anybody, a friend, a church member or even a pastor.

5.3.4.2 MDR as Supportive Structure

MDR is an official auditing process use 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 MD and improve quality of maternal healthcare so therefore, MDR is done anytime there is MD in Ghana (Dartey & Ganga Limando, 2014). MDR is not an official counselling or debriefing section, nor is it a workplace intervention programme. Participants consider MDR as a means for coping for midwives in this study because until they go through the MDR and their case is heard and the case is closed, they are not free. They cannot tell if they would be blamed for the death of the client or even be punished for the death. Participant 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 patients' death related problems. Austin et al., (2014) health institutions have refused to recognise 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, nurses must identify and confront their own feelings towards patient death (Bickham, 2009).

It was obvious that little attention and buttress was based on providing nurses with the needed strategies to help them cope with the stress involved when confronted with a patient death (Bickham, 2009). For example, Ní Chroinin et al., (2011) confirmed from their result that the hospital used for their research setting lack bereavement management services and/or counselling skills required to help the nurses cope with stress, thus patient deaths. Coping or adjusting to stress (stress management and self-mobilisation) is seen as the ability to organize and successfully or unsuccessfully deal with stress and its' factors (Stoica & Buicu, 2010). Therefore, it is important that the

potential stressors specific to an organisation be acknowledged to aid implement define interventions aimed at reducing and preventing the negative impact of stress (Finney et al., 2013). This also helps them to cope after identifying what they did rightly or wrongly.

5.3.5 Theme Five: Perceive MDR Process

'Perceive MDR process' is the fifth theme of the study and the only theme that emerged under objective three of the research study, "To explore and describe midwives' experiences of facility-based MDR process in Ashanti Region of Ghana" Majority of the participants in the study agreed that MDR has improved since its introduction in 2005. MDR was instituted to look beyond the number of pregnant women who died, but why and where they died. MDR is one of the best interventions implemented at low cost to promote and protect as well as fulfil the highest attainable right to health and the right to life among pregnant women, Dartey and Ganga Limando (2014). The categories that emerged under theme 5, Perceived MDR is discussed as followed:

5.3.5.1 MDR as an Effective Tool

'MDR as an effective tool' is the first category that emerged under Theme Five: "Perceive MDR process" majority of participants in the current study admits MDR is an effective process of identifying the cause of death of pregnant women regardless of age, type of hospital working for, ranks or number of years working experience. They further explain that, the MDR process is helping midwives improve their work in so many areas of midwifery. The areas of improvement include equipment, training, workshops. Through MDR, the health care facilities benefit from some equipment

needed to deliver better nursing care. This, according to the participants, recommendations are given after every MDR is carried out. For example, if during an emergency there were no monitors to work with; MDR recommends that management should provide them to improve health care delivery. MDR according to midwives has helped to correct mistakes they have done in the past.

5.3.5.2 Spiritual/Culture Beliefs as Part of MDR

'Spiritual/Cultural beliefs are not considered is the third category that emerged under Theme Three: "Perceive MDR process". This assertion is conceived by few participants. They ask that spiritual and cultural lenses should also be considered during the process of MDR (Hill & Pargament, 2008). There are some health facilities which understand that human errors are normal in nature and to be unintentional and therefore should always provide confidence and courageous atmosphere for the health staff (Lewis, 2014). According to most cultures in Ghana, maternal mortality 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 (Senah, 2003). Culture from the perspective of Shamaki and Buang (2014) is values, beliefs, customs and conducts that are shared by members of a society and which provide a direction for people as to what is acceptable or unacceptable in given situations. Culture in this case always serves as the central core to every existing society and without culture there would be no "language of expression, self-consciousness and ability to think or reason". However, organisational cultures in the same way should be established for the benefit of employees and the organisation as a whole. Therefore, knowing and understanding

the culture of the organisation is significant (Floyd, 2013). The cases reported by health professionals should be given attention and review, which can then be integrated into the organisation's culture (Lewis, 2014). There are beliefs established by an individual from social exchange perspective which becomes a culture in an organisation, thus, according to Pathak (2012:154) the individual intended to "form global beliefs concerning the extent to which the organisation value their contributions and cares about their well-being".

The Royal College of Nursing (2013) emphasize based on their result that an open culture which provides an enabling atmosphere for the nurses (midwives) to do away with fear and be able to express and disclose freely their concerns and room for questions and answers, must be established. For example, the research of Royal College of Nursing (2013) confirmed that most nurses claimed the need for emotional support to help them recover from their traumatic situations such as MD. Nurses and midwives are human service professionals for which reason they are always exposed to stress-related problems at workplace (especially death of patients), and therefore they are susceptible to become negatively impacted with burnout, turnover, and absenteeism (Royal College of Nursing, 2013). According to retrospective studies, it was confirmed that cultural background and the religious beliefs significantly influence the individual nurses' perception about death and dying (Peters et al., 2013). However, perceptions from the individual's ethnic culture, traditional norms and values may have a significant influence on the different sociocultural behaviours of individuals (Shamaki & Buang, 2014). These explain the different levels of reactions to death, death anxiety, emotional stress experienced to mention but few, on the individual nurses. For instance, the comparison for fear of death among nurses in the

USA, Middle East or Asia, Israel, Japan, Turkey and Iran, all with varied cultural background, exhibit different level of results of death impacts (Peters et al., 2013).

5.4 CONCLUSION STATEMENTS

a) The effect of death is uniquely experienced by all midwives despite the similarities in the situation preceding the events, indicating that midwives are individuals who react differently to situations as other humans would.

b) The experience of MD was subjective in nature and is influenced by the intensity of impact and duration of the midwife-client relationship; personal experiences relating to death, similarity of situation; and grief patterns demonstrated through a display of open agony and subdue reactions.

c) The multi-dimensional effects of MD affects all midwives' in all aspects of their personal lives and consist of emotional, psychological, physical as well as social effects likely to cause low quality of work life and reduced quality of health care received by their clients.

d) Maternal death impacts midwives' personal life due to its emotional effects which is often exhibited by distress, fear, guilt feeling and confusion resulting in lack of concentration on work which affects the competence level of the midwife.

e) Maternal death has severe psychological effects on midwives that often result in depression, as portrayed by the continued crying and sadness from the

affected midwives ultimately affecting their health and wellbeing; role performance at home and their quality of work life.

f) Physical effects of MD cause job dissatisfaction among midwives as they present with physical exhaustion and inability to eat after their experience; and this impact negatively on their health.

g) Social isolation experienced by midwives impact on both family and work relationships, compromising their health and wellbeing further.

h) Maternal death affects the midwives' environment as a whole because their families, work environment, hospital and communities within which they function are affected.

i) 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 MD and the health care facilities.

j) Although the Maternal Death Review was seen on one hand to be a good auditing process that helps midwives find the cause of death of pregnant mothers and improve healthcare delivery to pregnant women in Ghana, it was also experienced as a punitive process due to the blame that is placed on the midwives thus result in job insecurity among these workers and therefore poor quality of work life.

5.5 SUMMARY

The chapter presented discussion of results with literature control. The discussion was conducted in a narrative format in line with the objectives of the study and the theoretical framework used. The discussion was organized in three parts; the first part deals with a description of the general characteristics of participants; the second, discusses the main findings; and the third one, provides conclusion statements from the entire discussion in the chapter.

CHAPTER SIX

THE DEVELOPMENT AND DESCRIPTION OF EMPLOYEE ASSISTANCE PROGRAMME FOR MIDWIVES DEALING WITH MD CASES IN ASHANTI REGION OF GHANA

6.1 INTRODUCTION

Chapter Five discussed the results of the study with literature control. The purpose of this particular chapter is to develop an Employee Assistance Programme for midwives dealing with MD cases in the Ashanti Region of Ghana based on the findings of the study as presented in Chapter Four. The developed programme is expected to improve the quality of work life of the midwives concerned and to generally improve maternal health in Ghana. The programme development in the current study followed the processes stated in Chapter 2.5.1 under Phase Two according to Acutt et al., (2011).

The review processes take into account the vision, mission, principles and objectives of the programme and further discusses what the programme is and what it is not. The services to be provided, referral procedures and follow-ups on clients are deliberated upon. The chapter concludes with a discussion on the implementation and evaluation of the pilot programme.

6.2 PHASE TWO

As stated in previous chapters, Phase Two is the actual development phase of the study. This section, presents the structure of the EAP. It gives a brief description of what EAP is and the steps followed in developing it. This section also presents diagrams accompanying the various stages of the development. Figure 6.1 shows the orientation of the objectives of the study and the phases.

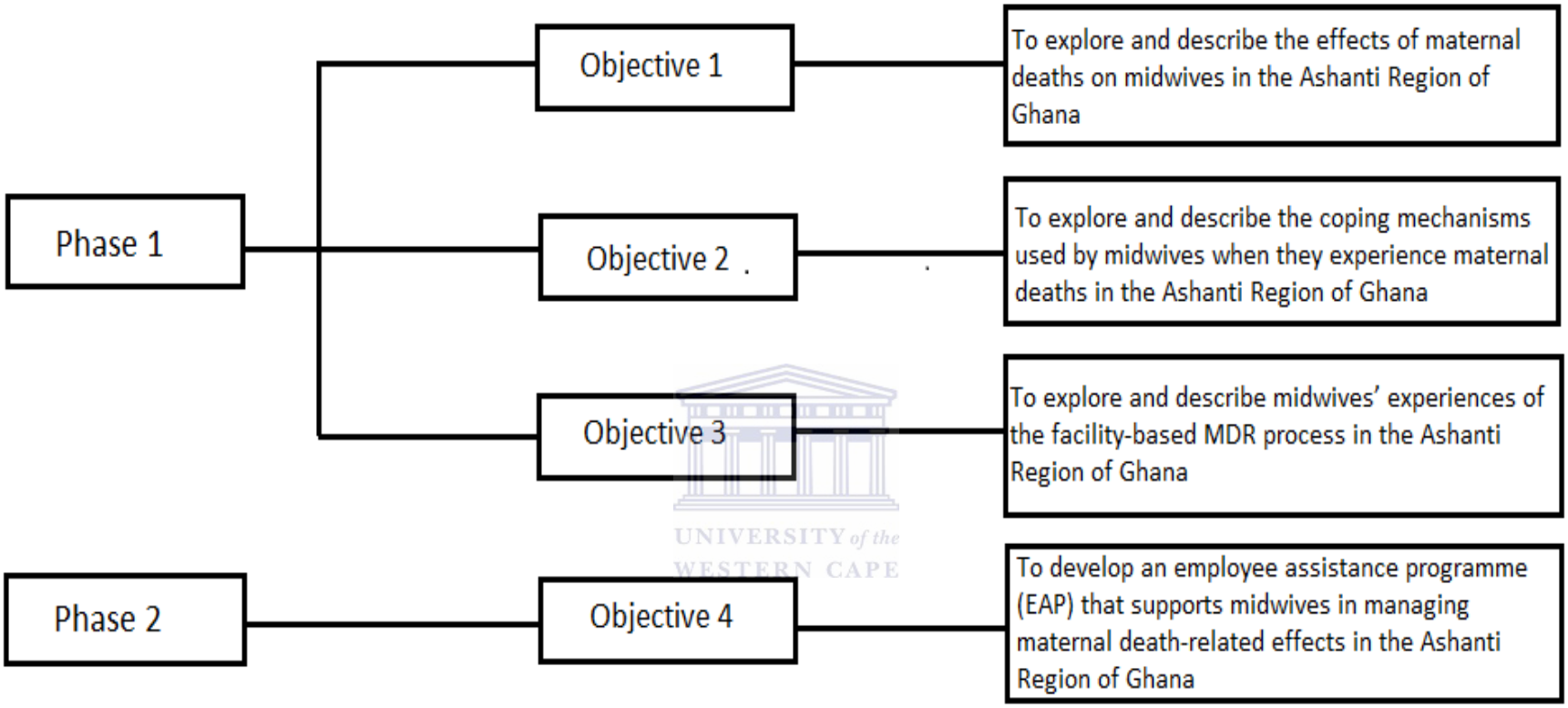


Figure 6.1: Orientation of objectives and the phases instituting the study

6.2.1 The Development of EAP

This phase (2) aims at achieving objective four of the study; developing an Employee Assistance Programme in the context of occupational health to assist in supporting midwives whenever they experience MD. The development of an occupational health programme does not happen in isolation, but rather follows a process. Therefore, the researcher sought to adopt Acutt, Hattingh and Bergh's (2011): *steps of providing occupational health programmes and services at the workplace*. The following are the steps: situation analysis/data collection, data analysis, planning, implementation and evaluation. A review of the processes in developing employee assistance programmes and how they are managed in other countries was examined (Center for Prevention and Health Services, 2008) and a more contextual one developed to suit the health system in Ghana. Acutt et al., (2001) contend that, the establishment of occupational health programmes and services should be done in relation to organizational philosophy, vision and mission as well as the legal requirements of the country in which the programme will be based. Since workplace hazards vary greatly from one organization to another, Acutt et al., (2001) argue for the need for the content of the programme to meet the needs of the workers. The findings in phase one indicate the need for EAP development in phase two. The methods of development are presented in the figure 6.1 as follows:

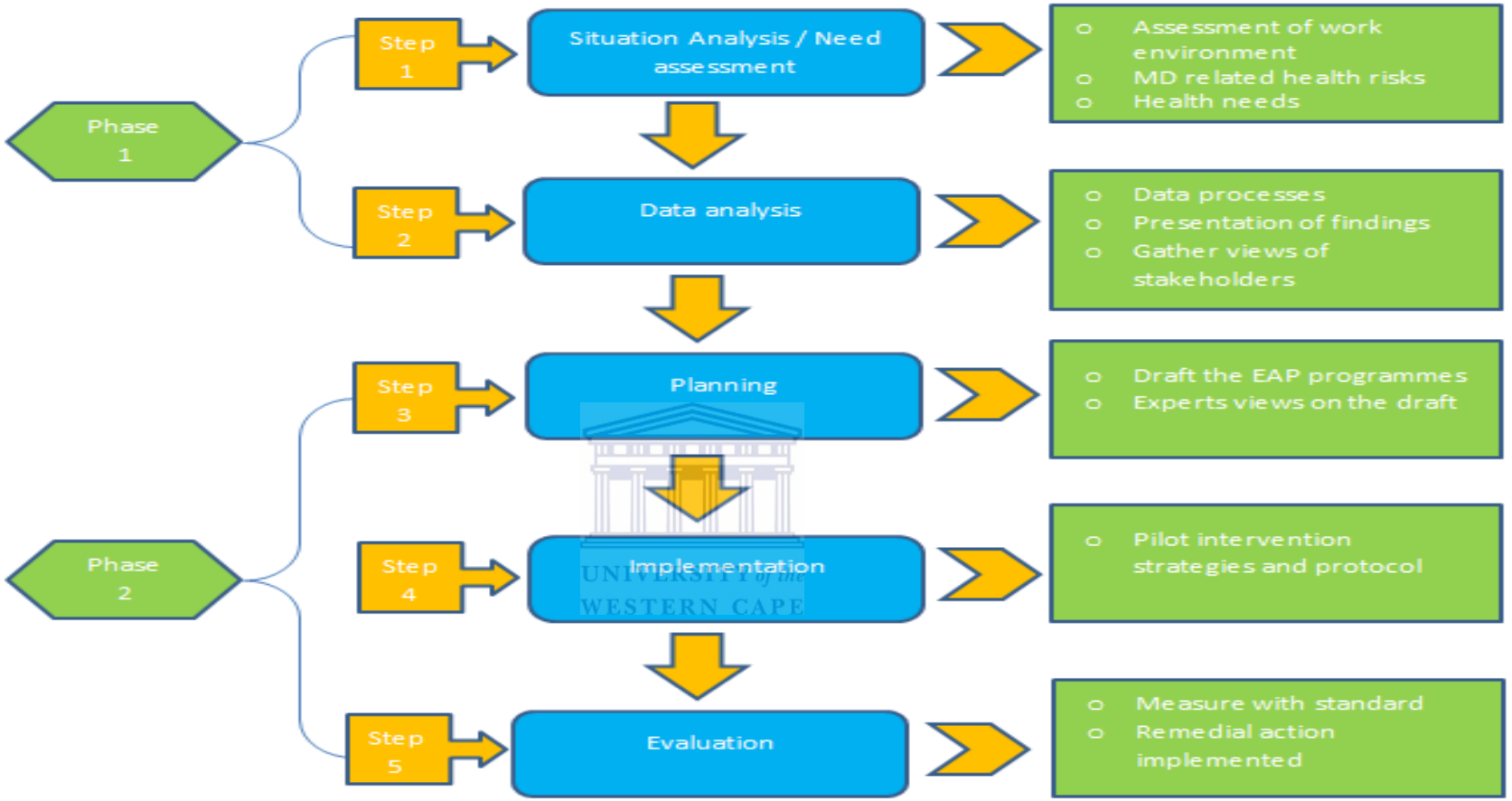


Figure 6.2: Summary of steps in developing EAP

6.2.2 Step 1: Situation Analysis/ Need Assessment

A comprehensive situation analysis was conducted. In the situation analysis, data were collected from midwives dealing with MD in selected health care facilities in Ashanti Region of Ghana (as presented in Chapter Three). The data collected, provided a rich source of information as the participants gave their experience dealing with MD, how they coped with the situation of MD and their personal experiences with MDR process. This brought to bear the considerate content of the programme to be developed. Data were collected by means of focus group discussions and individual semi-structured interviews as described in Chapter Two.

6.2.3 Step 2: Data Analysis/Report of Assessment

Data were analysed to ascertain the lived experiences of midwives in dealing with MD cases and establish the need for EAP for midwives in Ashanti Region of Ghana. The data were analysed using thematic content analysis and the report was presented to experts in the health sector as well as policy makers of the regional office of the GHS and Teaching. Experts' views were gathered and incorporated into conclusion statements of the research findings, proposing the need for the establishment of EAP for the midwives. The details are discussed in Chapter Two.

6.2.4 Step 3: Planning

This step involves the setting up of the domain of the EAP. It involved formulating the objectives of the programme and assembling of a multi-disciplinary committee. The drafting of the EAP began with gathering and incorporation of views from experts in

the field of health, occupational health, psychology and social work. The draft document was revised accordingly. It provided advice on hiring of professionals to the EAP and advertising the programme. Planning of the programme evaluation will also be instituted. The details of step three (planning) follow five stages:

6.2.4.1 Stage 1: Components of EAP

- **The domain of EAP**

The domain of EAP states and defines what it is and establishes boundaries of operation. EAP per the current study is "A wellness programme" developed for midwives dealing with MD cases in Ashanti Region of Ghana. The programme is meant for early identification and diffusion of MD related problems at their workplaces (healthcare facilities) (Caine & Ter-Bagdasarian, 2003; Dietz, 2009). From the perspective of this study, EAP is **NOT**:

(a) a social welfare programme;

(b) a prescriptive programme;

(c) a long term programme; or

(d) the only programme that can solve all problems workers face in the health sector.

Therefore an Employee Assistance Programme (EAP) is work-based, voluntary programme for midwives dealing with MD cases that provide free and short-term counselling, confidential assessments, referrals, and follow-up services to employees who have personal and/or work-related problems. EAP speaks to a number of issues

affecting psychological, physical and social well-being of employees such as stress, grief, finance and family problems (Dickman, & Challenger, 2009; Center for Prevention and Health Service, 2008; Work-Life Services, 2008; CDC, 2011; WHO, 2010a).

In the following sections the characteristics of EAP: vision, mission, core values, purpose of the programme and the objective.

- **Vision statement of EAP**

Since a vision is the first requirements in the development of a programme, it is essential to consider it before programme is established. The vision of EAP is to provide a programme of choice that aims at organization of self-worth even after experiencing MD and to develop the culture of well-being takes away the all the emotional, physical and social effects MD among midwives.

- **Mission statement of EAP**

According to Wright (2007), every organization has a mission for its existence and this mission must be unique to differentiate that organization from all others or otherwise. In this study, the mission of EAP is to provide counselling, debriefing services and training related services to individual midwives as well as group therapy.

- **Core Values**

The core values of EAP are:

Compassion

Excellence

Veracity

- **Purpose of the programme**

The purpose of the Employee Assistance Programme is to improve the quality of work life among midwives in the Ashanti Region of Ghana. The objectives of the programme include the following:

(i) To promote health and wellbeing of midwives in the Ashanti Region of Ghana;

(ii) To ensure job security among midwives in Ashanti Region of Ghana;

(iii) To enrich job satisfaction and job performance through improved well-being; and

(iv) To promote balance between work and non-work life of the midwives in the Ashanti Region of Ghana.

- **Principles of EAP**

Principles are important for the success of any programme, and therefore EAP would operate without compromising on the principles. The EAP would function under the following four principles:

(i) Confidentiality

(ii) Voluntary participation

(iii) Equal treatment

(iv) Proper record keeping

- **Models and Drive of EAP**

The models of EAP are as follows:

(i) On-site or internal model

On-site or internal model: this is the model that is based at the workplace and run by the organization. All workers of EAP are part of the organization and work within the organizational policy. These models are short time and no fee is paid by users of the programme.

(ii) Off-site or external model

Off-site or external models: These are models that provide services from outside the organization. The company of the employees is responsible for the payment of the service employees receive.

(iii) Combine model (on-site and off-site)

Combine model: (on-site and off-site): this is the combination of on-site and off-site models. In this case, the employees enjoy some services on-site and are referred for other services off-site.

For EAP to function well in any organization, it is important to identify what can drive and keep it running. In the current study, EAP is driven by **midwives wellness** or **wellbeing** as well as **management involvement** or **support** for the programme. It focuses on midwives' wellness because the EAP is designed to help them deal with effects of MDs at their workplaces and therefore improves quality of work life. Management involvement or support for EAP is important for the reason that the programme would need to be supported financially, workers referred for treatment or counselling may need to take some time out and some workers may need training Figure 6.3 below presents the EAP 'drives';

Figure 6.3: EAP drives

Figure 6.4 shows the Characteristics of EAP. The figure demonstrates how the characteristics come together to present what EAP is all about.

Figure 6.4: Characteristics of EAP

- **Services to be offered under EAP**

There are two main types of services to the offered under the EAP. These are direct and indirect services. Figure **6.5** presents the services to be offered under the EAP.

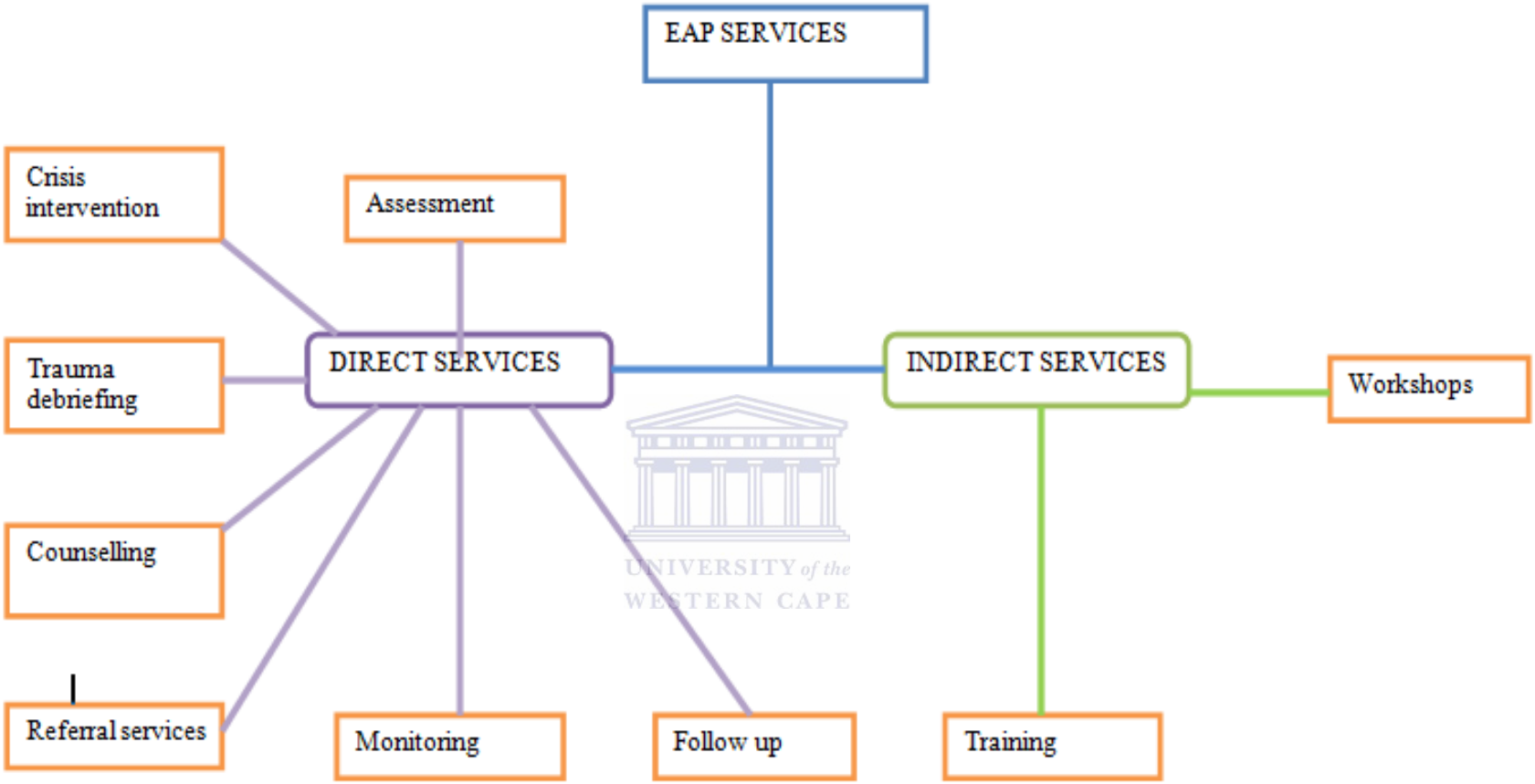


Figure 6.5: Services to be offered under EAP

- **Direct services:**

Direct services are services that deal with the individual workers either identified and referred or self-referred. These services are provided to the workers who need them. The type of services to be provided under direct services may include, but not restricted to, the following;

(a) Assessment

(b) Trauma debriefing

(c) Crisis intervention

(d) Counselling services

(e) Referral services

(f) Monitoring

(g) Follow-up

- **Assessment**

Assessment:

- Assessment is conducted to identify employees' problems and develop plan to resolve them. Assessment helps to identify and evaluate midwives' strengths, difficulties and needs so as to plan solution for action to be taken on them.
- Thorough situation analysis is essential to arrive at a good intervention.

NB: *Assessment may include clients' statement of the problem, how MD occurred, past experience of death, mental state of the client, relation with the family when she experienced MD, effects on job performance and sources of support. EAP workers must ensure that assessment is conducted in a competent manner. When this is well done, they would be able to assist midwives balance work and non-work life.*

- **Trauma debriefing**

Trauma debriefing:

- The aim of this service is to respond timely to MDs that are traumatic to attending midwives on duty at the time of the incident.
- It will provide trauma-defusing services to attending midwives immediately after MD at the hospital.
- This will help reduce the initial confusion and stress that come with the loss of clients at the hospital.
- It also prepares midwives for MDR and prevents long-term difficulty and dysfunction with work and family life.

NB: *The EAP workers should ensure that all midwives who attend to clients before their deaths are timely defused and debriefed immediately after confirmation of death and all protocols related to MD are observed. They should ensure that midwives are*

well prepared for the MDR process without any fears and that they are confident to present the report of happenings to MD to the auditing team. This goes a long way in promoting the health and wellness of the midwives.

- **Crisis intervention**

Crisis intervention:

- This service will be provided to midwives who find MD as a source of crisis. It aims at containing and normalizing crisis among midwives after MD.
- When intervention is available at the time of crisis during work, it helps with settling of emotions and timely proper adaptation to situations at work and home.

NB*: EAP workers should identify midwives with crisis after the experience of MD and intervene appropriately. Clients should be referred when necessary. Appropriate techniques should be employed to ensure that crisis does not interfere with the health and wellness of the midwives in question*.

- **Counselling services**

Counselling services:

- Aims at ensuring that all psychological, physical and social effects of MDs that impact on your wellness and capacity to perform at work are reduced.
- Counselling would help the midwives gain insight into the difficulty they may experience with MD and develop the needed resilience to deal with the situation in order to attain wellness.

N.B: *Counselling should be individual-problem-based. Group counselling may be done if all attending midwives want to be counselled together. During group counselling, participants should be encouraged to support each other. EAP workers should ensure that during group counselling, every participant is treated with fairness, everyone is given an equal chance to talk. Equal opportunity and fairness in workplace programme enforces job satisfaction.*

- **Referral services**

Referral services:

- The services aim at ensuring that all midwives get access to the right resources and care.
- Midwives could also be sent to access services outside the internal counselling and debriefing services through referrals.
- When midwives are referred, it is expected to increase wellness of the individual midwife and job performance. When referral is performed well, it ensures credibility of the EAP programme and also timely intervention of problems associated with MD.

NB: *There are two types of referrals; one is referral from the ward mostly by ward and unit managers or colleagues for EAP services while the other is referral from the EAP consultants for further treatment outside the EAP. Cases that are beyond short-term counselling and debriefing and beyond the scope of EAP should be referred EAP by counsellors and follow-up be made. Employees who enjoy this type of service feel secure in their job as the workplace takes responsibility of their health.*

- **Monitoring**

Monitoring:

- This helps to maintain steady contact with the client to ensure that goals of the interventions are achieved.
- It is very important that monitoring is done during EAP services provision so as to track deviation from normal intended outcomes. Good monitoring will help improve the EAP programme. Confidentiality should not be compromised.

N.B: *EAP counsellors should give appropriate feedback to referring nurse manager or colleague about the progress. All monitoring should be documented. Monitoring can help trace the progress of the individual midwife's case. This can help any imbalance that might be affecting the midwife either at home or at work.*

- **Follow-up**

Follow-up:

Follow-up should start immediately after assessment and referral as well as after completion of intervention. EAP workers could call a client on phone to find out progress made with the intervention. Confidentiality must be affirmed.

N.B: Midwives referred for other services should be followed up and a demand for a written progress report on referral. Follow-ups and progress report are important to trace any imbalance between work and non-work life among midwives.

- **Indirect services:**

Indirect services are services that are provided to supervisors and all midwives to help them identify colleagues with problems; behaviour change, low outputs and so on for early referral and treatment. The services are as follows:

- Training

Assertiveness training;

Induction training; and

In-service training of unit, ward managers and all ward midwives.

- Workshops

The indirect services of EAP are the training (assertive, induction and in-service) of unit, ward managers as well as all ward midwives to identify any colleague who have

problems after experiencing MD for behaviour change and refer and workshops for all. These also serve as a means of preparing midwives on what to do when they experience MD on the wards. Figure 6.6 shows direct and indirect EAP Services.

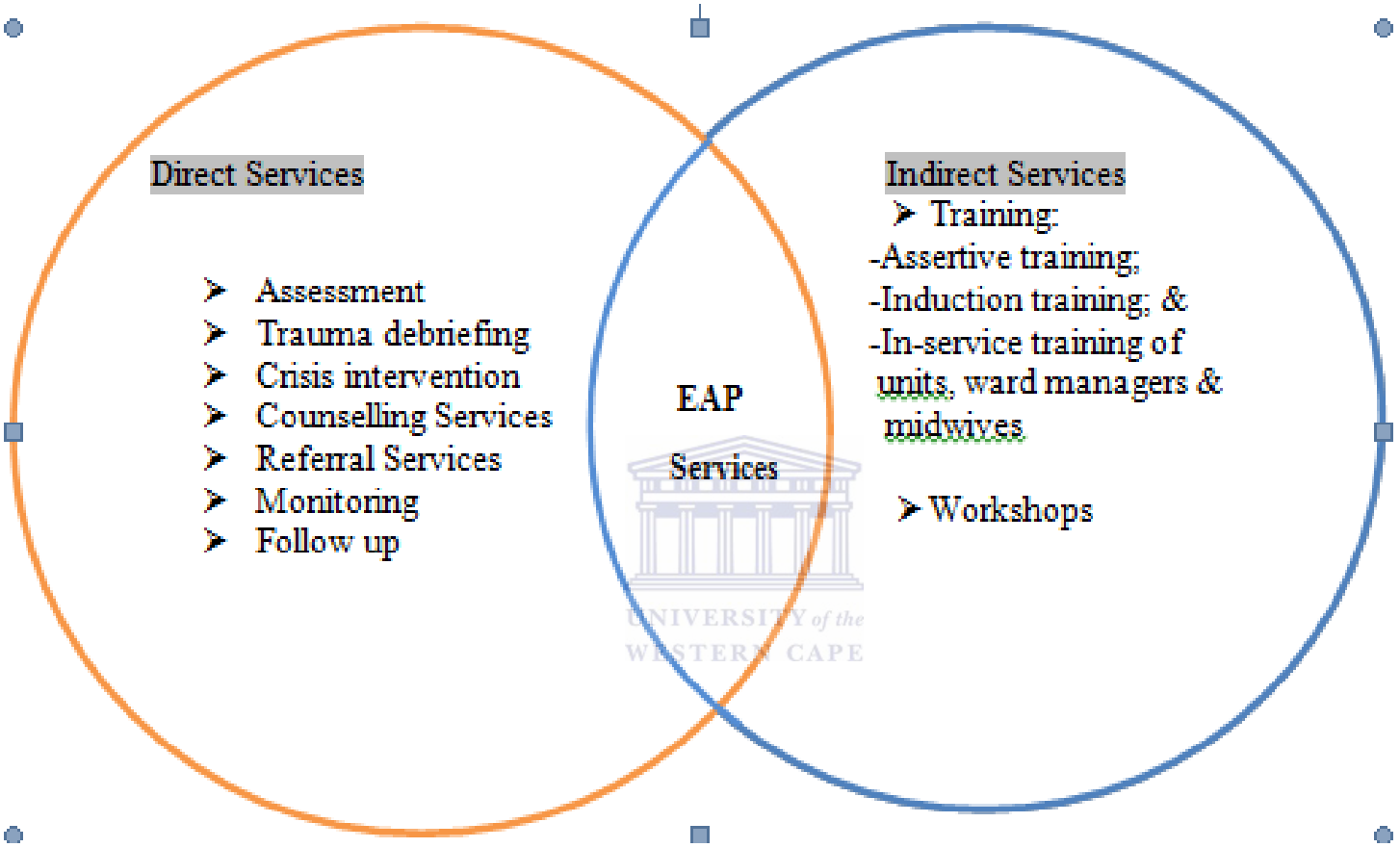


Figure 6.6: EAP Services

Type of services to be provided under indirect services may include, but not restricted to, the following:

- **Training of unit, ward managers and all midwives**

EAP Training of unit, ward managers and all midwives:

- Ward and unit managers will be trained to identify troubled midwives and refer them to EAP consultants for counselling and debriefing.
- Managers will be trained to identify midwives behaviours that may impact on work and family. Confidentiality should be maintained at all times.

N.B: EAP workers should train unit, ward managers and all midwives to be observant and identify behaviour change in any midwives' document these behaviours. Any midwife with behaviour change should be called and interviewed for problem identification. The ward managers refer these midwives for EAP counselling. Managers are expected to follow up on the referrals for feedback. Further training should be in the area of assertiveness, induction training and in-service training.

- **Assertiveness Training**

Assertiveness training:

- For the midwife to manage the effects of MD on a daily bases, there is need to be assertive.
- Assertiveness is an effective technique in health promotion and helps the individual to attain the needed health and self-esteem.

NB: EAP workers must ensure that, all midwives go through assertive training in order to develop interpersonal skills and build techniques that helps in decision making in self-management in times of work related problems. Assertiveness leads to the right decision making and taking bold decision results in health and wellness of the individual midwife.

➢ **Induction Training**

Induction Training:

- It is an orientation of an employee in a new working environment.
- It prepares an employee to understand the nature of work and how to deal with certain situations when they occur. Therefore reduces fear and uncertainty.
- The culture of MDR audit should be explained to midwives.

NB: The areas to be covered in induction training are physical and geographical lay out of the wards where the midwife will be working. Details information on where to find working tools, for example, emergency trolley, drugs, oxygen. Induction should also cover life saving techniques so midwives can perform their duty to the best of their abilities so as to enjoy job satisfaction.

- **In-service Training**

In-service Training:

- It is an update training of employees already on the job. It is designed to fill in the gap in skills and knowledge of employees.
- It will also help the midwives to learn new diagnosis and treatment relating to pregnancy and its complications.

NB: *EAP workers must help develop competency level among midwives to enhance the building of confidence. Knowing the new requirement of the job will guarantee job security for the midwives because they have what it takes to perform their job to the fullest.*

- **Workshops**

Workshops:

EAP workers should organize workshop on regular bases depending on the need of midwives. These workshops could be conducted to improve on midwives' delivery skills, preparing them for self-management in case of MD, how to report MD at the review and how to document services provided even after the death of client among others.

NB: All midwives are expected to attend these workshops to improve on skills delivery and develop competencies that go a long way to enhance quality of work life as these midwives build their skills, knowledge, confidence levels and prepare themselves for any eventualities.

EAP services should help all midwives become more positive even after experiencing MD at the hospitals and be more productive, giving the best nursing care needed by their clients. When these can be achieved, the midwives have attained the needed quality of work life.

- **How to access the EAP**

Accessibility of EAP services will be based on the following conditions:

(a) There will be 24 hour service available either by face to face or by telephone;

(b) Seven (7) days a week service for all who need it throughout the three month pilot study.

(c) The services will be in any language of clients' choice, especially the major languages spoken in Ghana, for example, in English, Twi, Ewe, Ga, Hausa, and Dagbani.

(d) The services could be provided at different locations as per the agreement between the EAP service providers and the client midwives. This location, however, will be within Ashanti Region.

- **Participation in programme:**

Participation in the EAP may follow:

(a) Voluntary participation/Self-referred by individual who seek the services on their own;

(b) Informal referral where ward managers or colleagues recommend the programme; and

(c) A formal referral based on job performance and a supervisor sends an employee with a referral note.

6.2.4.2 Stage 2: EAP Description

The draft of the EAP, describes what the programme is about, what it intends to achieve in relation to employees' job, it provides step by step explanations on how employees could access the services. It also contained an assurance to employees on

how privacy and confidentiality would be maintained. Detailed descriptions of events leading to a draft development of EAP are discussed in turn:

As mentioned in Chapter Three, the actual development of an EAP started with a draft after:

(a) Two workshop presentations of the research findings of the empirical data collection and analysis to stakeholders in the MOH/GHS at the Regional Health Directorate and the teaching hospital in the Ashanti Region of Ghana;

(b) The researcher gathered suggestions, comments and recommendations from the said stakeholders. An example suggestion is, services should be individual based;

(c) Conclusion statements were drown from the discussions of the results; and

(d) The review of EAP from other countries and companies through literature.

A contextual draft of EAP for midwives in Ashanti Region of Ghana was thus developed.

6.2.4.3 Stage 3: Development Processes

A multidisciplinary committee of members was assembled to consider the initial draft and to decide on the operational model of EAP and how the programme would be implemented internally on a pilot base. The researcher informed the committee about the responsibilities of the chosen health care facilities and the selected facilitator of the pilot study. The total number of experts is 18, with different educational backgrounds and levels of experience were recruited, to review the programme. All experts are

health workers or its related field. The group comprises of one occupational health nurse, two EAP workers, two midwives, one public health nurses, one human resource manager, and one health service administrator, one director of public health, one gynaecologist, one social worker, one clinical psychologist, one counsellor, one nurse manager, one medical superintendent, one psychiatric nurse and profession of research. After the experts have gone through the draft, they made the necessary inputs and the draft was revised. The document was then sent to the experts in the field of EAP service providers outside Ghana for their final inputs. Majority of these experts were part of the stakeholders group. Gathered information on views from the experts in the field of health care were incorporated and document revised accordingly.

6.2.4.4 Stage 4: Hiring of Professionals

Advice was given as to the type of professionals to hire for the provision EAP to the health facilities, according to the chosen model and provide the necessary resources to be used. Figure 6.7 presents the EAP Diagram.

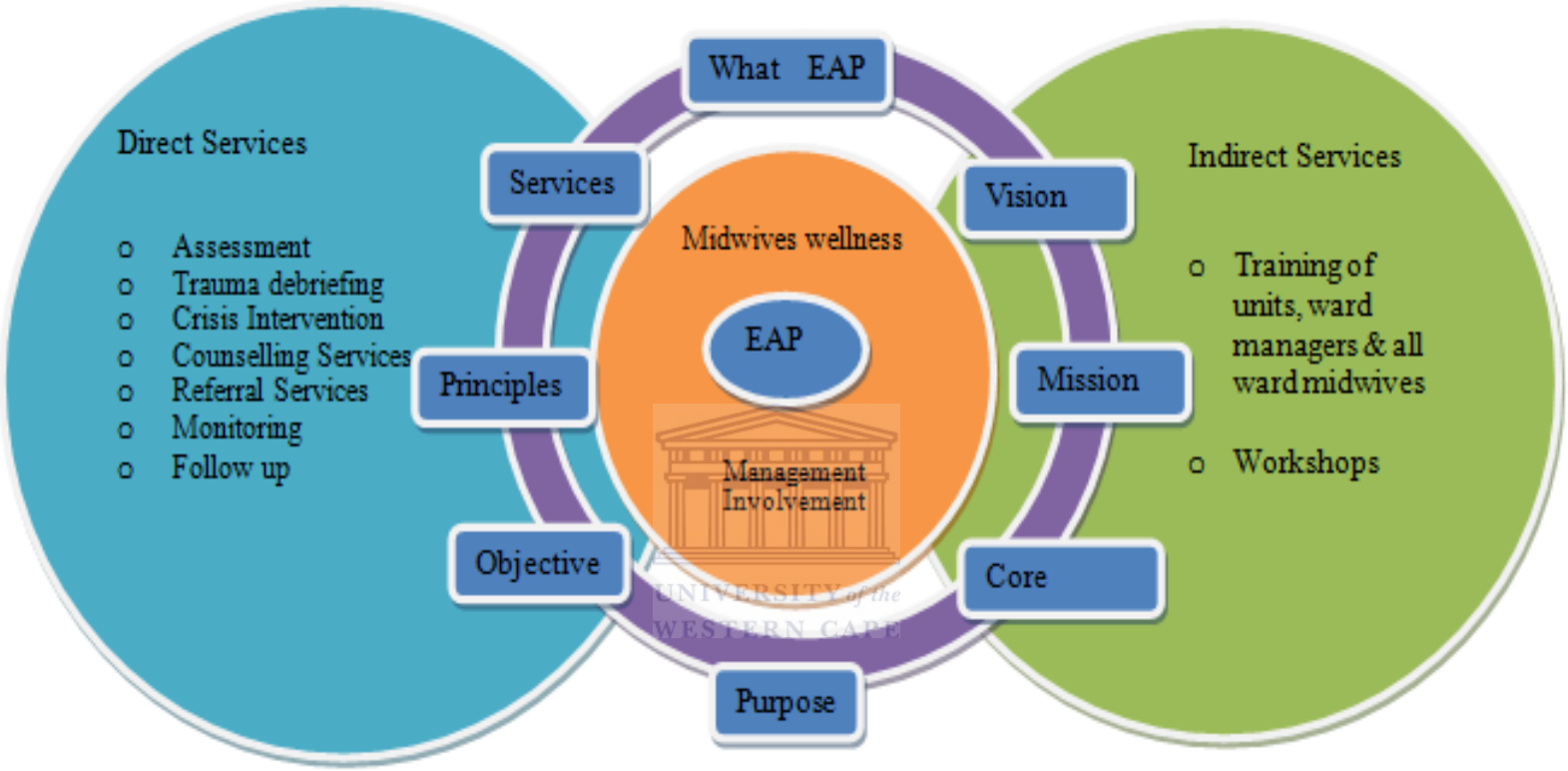


Figure 6.7: EAP Diagram

6.2.5 Step 4: Implementation*:*

For the purposes of this study, a pilot intervention was carried out on a small scale at one hospital for two months. All strategies and protocols were put into place for observations and the feedback incorporated into the main programme.

6.2.5.1 Stage 1: Advertisement

The programme was advertised through the various mediums of communication in the health facility such as meeting in-charges, posters on notice boards and hospital intercom. Names and contact numbers of midwives who had experienced MD before in that hospital were provided to the EAP councillors. Calls were made to these individuals to voluntarily seek for the EAP counselling. Advertisement could also follow orientation programmes at the hospitals and introductory letters could be given to staff while brochures could also be used.

6.2.5.2 Stage 2: Operation Time

Details of appointment times were given.

6.2.5.3 Stage 3: Services Available

List of available services was provided and confidentiality was assured.

6.2.6 Step 5: Evaluation

Evaluation refers to the assessing of the final outcome of the plan. It is defined as the attributing value to an intervention by gathering reliable and valid information about it

in a systematic way, and by making comparisons, for the purposes of making more informed decisions or understanding causal mechanism or general principle" (WHO, 2002). With reference to the current study, pilot evaluation was done. The following would be considered for evaluation in the actual EAP: what would be measured and how; what standards would be used for comparison; how often the plan would be measured and how remedial action would be implemented. At the end of the pilot evaluation there no major changes, however, remedial actions were taken into account to address any gaps that were found. The researcher, incorporated the findings of the pilot, edited and put the finished document together. An example of gap incorporated was that, place of service provision should be the midwives' choice. The final document will be made available to the various hospitals where data were collected and copies given to MOH and GHS to be implemented. Quarterly and annual reports must be submitted to the hospital management. The names and staff identity should not be part of the report. The report should be based on how many clients used the services of the EAP and how these clients felt afterwards.

At the end of the study, the researcher summarized all actions into figure 6.8. The figure presents the problems identified during phase 1, inputs made in terms of direct and indirect services in phase 2 and the output (outcomes).

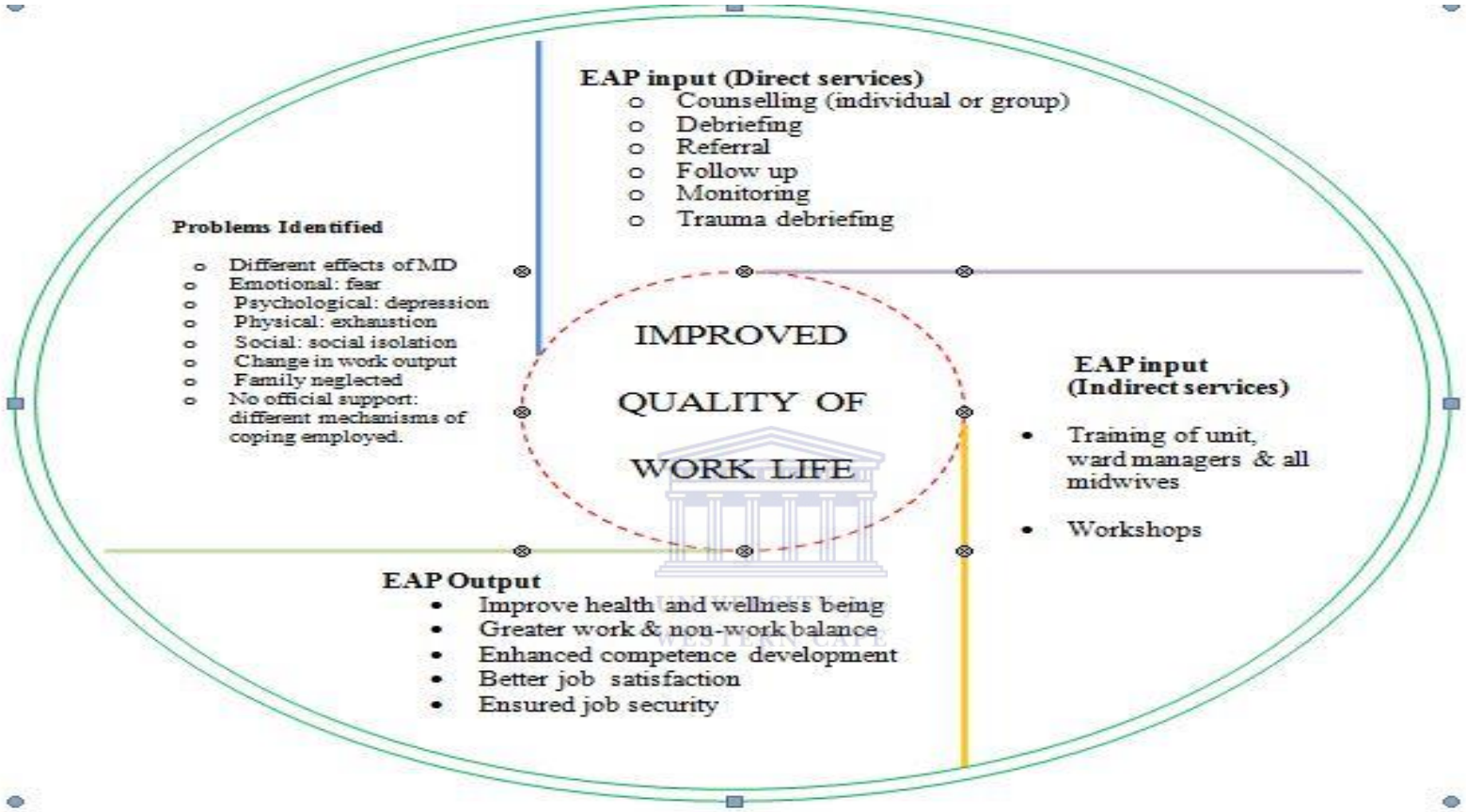


Figure 6.8: EAP input and output

6.3 EAP FOR MIDWIVES DEALING WITH MD IN ASHANTI REGION OF GHANA

Definition and domain of EAP: EAP is "A wellness programme" developed for midwives dealing with MD cases Ashanti Region of Ghana. The programme is meant for early identification and diffusion of MD related problems at their workplaces (healthcare facilities). EAP is a short term work-based voluntary programme meant to provide free counselling, confidential assessments, referrals, and follow-up services to midwives with difficulty dealing with MD at the hospital.

Vision: The vision of EAP is to maintain midwives' self-worth and well-being even after experiencing MD.

Mission: The mission of EAP is to provide counselling and debriefing services to individual midwives as well as group therapy.

Core Values: The core values of EAP are; Compassion, excellence and veracity

Purpose of programme: The purpose of the Employee Assistance Programme is to improve the quality of work life among midwives in the Ashanti Region of Ghana.

Objectives of the programme: The objectives of the programme are as follows;

- To promote health and wellbeing of midwives in the Ashanti Region of Ghana;
- To ensure job security among midwives in Ashanti Region of Ghana;
- To enrich job satisfaction and job performance through improved well-being; and
- To promote balance between work and non-work life of all midwives in the Ashanti Region of Ghana.

Principles of EAP: The principles of confidentiality, voluntary participation, equal treatment and proper record keeping must be adhered to.

Models of EAP: Each hospital decides on the model appropriate according to their budget and situation. The models of EAP are; On-site or internal model, Off-site or external model or Combine model (on-site and off-site).

EAP services: EAP is structured to provide two types of services; direct and indirect. Direct services are; Assessment, trauma debriefing, crisis intervention, counselling services, referral services, monitoring and follow-up services. Indirect services are training of supervisors (ward and unit managers) to identify and refer midwives for EAP services.

(a) Accessibility of EAP: There will be 24 hour service, either by face to face or by telephone;

(b) Seven (7) days a week service for all who need it;

(c) The services will be in any language of clients' choice. Especially the major languages spoken in Ghana; example, in English, Twi, Ewe, Ga, Hausa, and Dagbani. Hospitals are therefore encouraged to employ EAP consultants with different language backgrounds; and

(d) Services could be provided at different locations as per the agreement between the EAP service providers and the client midwives. This location, however, will be within Ashanti Region.

Participation in the programme: Voluntary participation/Self-referred by individual who seek the services on their own, Informal referral where ward managers or

colleagues recommend the programme or a formal referral based on job performance and a supervisor sends an employee with a referral note.

6.4 SUMMARY

This chapter sought to provide definitions, development and implementation of the EAP for midwives in the Ashanti region, Ghana. Thus, the chapter defines key concepts used in the programme, that is, the concept of work, work life at the hospital, quality of work life, workplace intervention programmes. The chapter also explained what EAP is and what it stands for in relation to the current study, and discussed the processes involved in the development of the programme. The chapter further reviewed the processes of developing a programme by stating the vision, mission, principles and objectives of the programme. The services to be provided and how client would be referred were elaborated upon. The chapter concluded by discussing the pilot implementation of the programme and its' evaluation.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

Chapter Six provided concept of work and related issues in quality of work life of midwives. A description of the development of EAP for midwives dealing with maternal death cases in Ashanti Region of Ghana was done. The current chapter presents summary, conclusions, limitations and recommendations of the study. This information should be utilized by policy makers and stakeholders in the health sector of Ghana and elsewhere in the improvement of occupational health and safety of employees.

7.2 SUMMARY

The primary purpose of this study was to develop an EAP for midwives dealing with MD in Ashanti Region of Ghana based on the results of objectives one, two and three (Phase one). These three objectives provided information on the need for the programme and content established. Phase one of the study was accomplished through the use exploratory, descriptive and contextual designs. In the interior of the context of the study, the findings of the empirical study, from the objectives 1-3 were presented in chapters 4 and result discussed with review of related literature presented in chapter

5. The findings of phase one were written in conclusion statements, stakeholders' contributions reported, expert reviewers' comments inserted and review of literature guided EAP development process for midwives in Ashanti Region of Ghana. Considering the processes followed in conducting the current study, this chapter presents the summary of procedures in relations to the objectives, and how it lead to the development of EAP. The programme would help midwives in the maternity wards to better adjust when they experience MD at the hospitals by providing support appropriate to the effects of MDs.

7.2.1 Summary of Objectives of the Study

Objective one sets off to explore and describe the effects of MD on the midwives in Ghana's Ashanti Region. Results of the study indicate that, the effects of death are uniquely experienced by participants as grieving patterns differ from person to person. Some participants grieved openly while other subdued grief with non-verbal reactions. The intensity and duration of grief experienced by midwives were also captured in the findings as these equally exhibited differences with respect to similarity of situation, personal previous experiences as well as relationships that existed between midwives and clients. This aspect of the results did not actually answer any of the research question but described how the participants experienced and expressed the effects of MD.

Objective one also resulted in multi-dimensional effects of MD. The multi-dimensional effects of MD comprise of emotional, psychological, physical and social

effects and were personalised to the midwives. The multi-dimensional effects of MD provided most answers to research question one. Midwives expressed different emotions as MD impact of their lives on daily basis when they confront MD. Notably among these emotions is fear which seems to reign the lives of these participants after their experience of MD. Psychological effects were resulted from mental stress associated with MD. Depression was at the centre of these effects as other body functions were influenced by it. Physically, participants in this study exhibited signs of exhaustion and loss of appetite as effects of MD. Social isolation was the main effect of social effects of MD and resulted in the neglect of family responsibilities.

Effects of MD on the midwife's associated environment were seen on the midwives' job, midwives' family, the hospitals where MDs occurs and also the communities where these clients came from. These effects indirectly affected the midwives. The effects were mostly negative and provided answers to research question one.

Objective two explored and described the coping strategies employed by midwives in dealing with the effects of MDs at their workplaces. Findings suggest that, all midwives irrespective types of healthcare facilities, gender, position/rank, age of participants and number of years worked since qualification as a midwife use one means or another, though there were no established or institutionalised programmes or systems provided by the hospital management to help midwives cope with the death of their clients. Midwives employed different means of coping depending on what was available to them. The coping mechanisms employed include informal support

(individual non-professional support, self-support, family supports or spiritual support) and systemic support (MDR). The findings related to this objective answered the research question two.

Objective three set forth to explore and describe midwives' experiences in relation to facility-based MDR process in Ashanti region Ghana. The outcome of this brings to light that, the process of MDR as an effective and efficient system that improves the service delivery at the healthcare centres. The results also indicate that spiritual/cultural beliefs of Ghanaian society have not been considered during the processes of MDR.

Objective four is the main aim of the study: to develop an EAP for midwives dealing with MD in Ashanti Region. This objective was depended on the first three which helped in the contextualization and interpretation of the EAP developed: to help midwives in Ashanti Region of Ghana cope well when they experience MD at the workplaces and to improve the quality of their work life. The development of EAP used the steps described in Acutt et al., (2011). These are proposed steps for setting up any occupational health programme at the workplace. In all, five steps were involved in the development and are described as follows:

Step one was situation analysis/need assessment; description of work environment, workers' demographics support services available to help midwives cope with MD when they experience them on regular bases.

Step two addressed data analysis of the study, it identifies the need for programme development. Five themes emerged after data analysis, conclusion statements and directed the content of the programme. In addition, results of the research were presented to stockholders in the health sector.

Step three was planning of the development; it involves formulation of objectives, vision and mission of the programme. It outlined the characteristics of the programme and how it should be evaluated when developed. A draft of EAP was developed and sent to experts in the field for their inputs.

Step four was implementation of EAP; pilot implementation was done at the teaching hospital for two months. EAP counsellors (one clinical psychologist and one psychiatric nurse) were recruited and trained to carry out the programme. In total, 10 midwives benefited from the programme. Report was written and recommendations made with reference to evaluation of the programme. Recommendations were implemented.

Step five was evaluation; pilot evaluation was done. Evaluation forms were designed and made available to participants in the programme. Evaluation considered advertisements, counselling sections, confidentiality as well as other services provided.

7.3 CONCLUSION

In conclusion, the aim of the current research study has been accomplished for the one main reason that the EAP for midwives dealing with MD in Ashanti Region has been developed. The programme is simple to understand, easy to use in mitigating the effects of MD on the midwives and also help in improving their quality of work life. The researcher believes that this will go a long way in not only improving maternal health in Ashanti Region, Ghana and beyond, but also improving the work life of midwives. At this point, all objectives of the current study have been achieved.

7.4 LIMITATIONS OF THE STUDY

The limitations experienced in the current study were as follows:

All participants in this study were females since males are not allowed to practice midwifery in Ghana at the time of the study. There was no opportunity to determine the emotions of the male nurses with regard to the death of pregnant women. Therefore the results cannot be generalised in countries where males practice midwifery.

Equally, time for the pilot was too short and therefore few participants utilized the programme. The evaluation may therefore not present the full representation of all midwives.

7.5 RECOMMENDATIONS

Recommendations are based on further research, education and nursing practice:

7.5.1 Recommendations for Further Research

- Further research may be needed among male midwives in other countries where they are allowed to practice midwifery to find out the effects of MDs particularly in relation to their spouses.
- In addition, research is needed to establish how EAP can be implemented to benefit other nursing groups and other health care professional in the health sector of Ghana.
- Research is also needed to determine how the hospital environment can be made safer and conducive for midwives who find their work environment destructive whenever they experience MD on the wards.
- Additionally, research is needed to find out how midwives can be trained to better handle disclosure of death of clients to relatives.
- It is recommended that research be conducted to identify other issues that may lead to selective nursing practices among midwives in the health sector and how it can be resolved.
- Further research to identify how spiritual/cultural causes of MD can be included in the MDR processes.
- It is proposed that, additional research be needed to establish how other aspects of midwives, personal problems, for example, family and financial that impact of work and well-being can be included into the EAP programme in future.

7.5.2 Recommendations for Nursing Practice

- It must be noted that people are different and therefore consideration must be given for individual counselling as well as group counselling.

- Occupational health programmes should be instituted in Ghana health sector where workers at high risk of injury and ailments.
- It is suggested that, all hospitals should have established and functioning EAP to help reduce the effects of patients' death on health care providers.
- Nurse Managers should be trained to support their nurses and midwives from abuse from hospital management.
- Nurse Managers and hospital management should be trained to exercise retrain when dealing with attending midwives after their experience with MD since this may cause more harm if not properly handled.
- Hospital management should show interest in the wellbeing of its work force in order to make EAP function and improve workers' quality of work life.
- Efforts should be made to protect the family members of midwives, especially children from abuse from other children.

7.5.3 Recommendations for Nursing Education and Policy

- Nursing and midwifery schools in Ghana should include into its curriculum coping mechanism during the death of patients in the wards.
- Nursing and midwifery training schools should include into its curriculum disclosure of patients' death.
- WHO and its partners should continuously organise workshops for the auditors as to how MDR can be done in member countries.

- WHO and partners should continuously monitor and evaluate the MDR processes to completely do away with the blame game.
- There should be a policy on implementation of EAP all health care institutions, including private health institutions to help solve workers problems.
- It is recommended that, occupational health workers together with the EAP Counsellors at the various hospitals introduce hospital stress manage exercise group, where all workers are encouraged to join and exercise on regular bases.

7.6 SUMMARY

This chapter gave an overview of the purpose of the research. It enumerated how the objectives of the study were achieved. It also outlined the limitation of the study. Recommendations with reference to research, nursing practice and education were not left out in this chapter.

In conclusion, the researcher believes that the EAP would help midwives in mitigating the effects of MD on their work and social life and improve their quality of work life, even as they continue to give EAP benefits both employees and employers in the improvement of quality of work as well as improving the work put of all workers.

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ANNEXURES

ANNEXURE 1: INTERVIEW SCHEDULE

Section 1: General Information

Date of interview: ----------

Time of interview: Start---------- End----------

Interviewee number----------

Place of interview----------

Age of interviewee----------

Rank/Position of interviewee----------

Name of facility- ----------

How many years have you being practicing as a midwife? ----------

Section 2: Main Questions

1. What is your experience with maternal death?
2. How does it affect you (personal and professional life)?
3. What do you do (coping mechanisms use) when you experience maternal death effects?
4. What is your experience with maternal death review (MDR)?
5. What forms of support structures are available for you in times of maternal death related stress?

Examples of probing questions:

- Tell me more!
- Please elaborate on this!
- And what happened after that?
- What did you do?
- What was the outcome?
- How did you feel afterwards?
- What does that mean to you?
- What were your expectations?

ANNEXURE 2: UWC ETHICAL CLERANCE

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

17 December 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms AF Dartey (School of Nursing)

Research Project:	The development of the employee assistance programme (EAP) for midwives dealing with maternal deaths in Ashanti region, Ghana.
Registration no:	13/10/27

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

ANNEXURE 3: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: + 233 20 021 37 69, E-mail: aniadfafa@ yahoo.co.uk

INFORMATION SHEET

Project Title: Development of the Employee Assistance Programme (EAP) for midwives dealing with maternal death in the Ashanti region, Ghana

What is the research about?

This is a research being conducted by ANITA FAFA DARTEY at the University of the Western Cape. You are invited to participate in this research because you are a midwife who experiences maternal death in the Ashanti Region. The purpose of this study is to develop employee assistance programme based on the exploration and description of the effects of maternal deaths on the midwife in the Ashanti Region of Ghana.

What will I be asked to do if I agree to participate?

You will be asked to discuss in a group or answer questions, which will be asked by the researcher. The discussion will seek information on how effects of maternal deaths, what coping mechanisms available to support you when you experienced maternal death. It will also cover how you feel going through maternal death review.

Would my participation in this study be kept confidential?

The information you provide on the tape will be kept confidential as much as possible. Your name or address is not required. The tape will be locked away by the researcher for a period of three. No individual names or identity will be used in the report.

Should an article be written about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There may be risk associated with participating in this research.

What are the benefits of this research?

This research will not have any monetary benefit to you as a participant. However, after the research is completed, employee assistance programme will be developed as a support system you.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide to participate in the research and you will not be penalized or lose any benefits which you otherwise qualify for.

What if I have questions?

The research is being conducted by ANITA FAFA DARTEY SCHOOL OF NURSING at The University of the Western Cape, South Africa. If you have any

questions about the study itself, please contact Anita Fafa Dartey on +233 20 021 3769 or aniadfafa@yahoo.co.uk, Nurses Training College, Kwadaso Kumasi, Ghana

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: Head of Department: Professor K. Jooste- +27-(21)-9593003.

Dean of the Faculty Community Health Sciences: Professor J Frantz– +27-(21)-9592632

University if the Western Cape

Private Bag X 17

Bellville 7535.

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics committee.

ANNEXURE 4: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: + 233 20 021 37 69

E-mail: aniadfafa@ yahoo.co.uk

Nurses Training College

Kwadaso, Kumasi-Ghana

CONSENT FORM

Project Title: Development of the Employee Assistance Programme for midwives dealing with maternal deaths in Ashanti Region, Ghana

Dear Participant,

I am a PhD Student at the University of the Western Cape. I am conducting a research project to development of employee assistance programme for midwives dealing with maternal death cases in Ashanti Region of Ghana. You are kindly requested to participate in the focus group discussion or individual interview at the time which is more convenient to you. Both focus group discussion and interview will be tape recorded and no one else will have access to the tapes except the researcher. The tapes will be stored in a safe by the researcher and will be destroyed after three years. The information is confidential and your name will not appear on the report. The

participation is voluntary and there will be no consequences should you refuse to participate. If you so wish, you may withdraw from the interview at any time.

If you have any questions you can contact the Department directly at this number +27-(**21)-9593003.**

I ..... voluntarily consent to participate in the above mentioned research project.

The background, purpose, risks and benefits of the study have been explained to me. I have received an information sheet and understand the contents thereof. I also understand that I may withdraw from the study at any time without prejudice. I understand that my participation in the study will be acknowledged, although my identity and the identity of health facility will be withheld.

I agree to be audiotaped during my participation in this study.

I understand that my participation in the study is voluntary.

…….. ……..

Participants' signature Date

..... ….....

Witness Date

Declaration by investigator

I *(name)* Anita Fafa Dartey…….…… Declare that:

- I explained the information in this document.
- I encouraged her to talk freely or ask questions and took adequate time to answer them.
- I am satisfied that she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.

……

Signature of investigator

ANNEXURE 5: FOCUS GROUP CONFIDENTIALITY BINDING FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel:+ 233 20 021 37 69 , E-mail: aniadfafa@ yahoo.co.uk

Nurses Training College

Kwadaso– Kumasi, Ghana

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Project Title: Development of the Employee Assistance Programme for midwives dealing with maternal deaths in Ashanti Region, Ghana

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

- Participant's name: …….....
- Participant's signature: ……
- Witness's name: …….
- Witness's signature: ……..
- Date of participation: ……...

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

Researcher: Anita F. Dartey

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: 020 021 3769

Email: aniadfafa@yahoo.co.uk

ANNEXURE 6: INTRODUCTORY LETTER FROM SUPERVISOR

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

09/12/2013

TO WHOM IT MAY CONCERN

This letter serves to introduce Miss Anita Fafa Dartey, a PhD student of the University of the Western Cape, South Africa to you.

Miss Dartey is conducting a research titled "The development of the Employee Assistance Programme for midwives dealing with maternal deaths in Ashanti Region, Ghana" and I am her supervisor. She is about to collect data in Ghana and will need your assistance to do so. Kindly give her the necessary assistance.

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study supervisor:

Study Supervisor's Name: Prof. D. R. Phetlhu

University of the Western Cape

Private Bag X17, Bellville 7535

Tel: +27 021 959 9532

Fax: +27 86 5108808

E-mail: dphetlhu@uwc.ac.za

Yours faithfully,

Prof. D.R. Phetlhu

ANNEXURE 7: PERMISSION LETTER TO GHANE HEALTH SERVICE FOR ETHICAL CLERANCE

University of the Western Cape

Private Bag X 17, Bellville 7535

South Africa

10 December, 2013.

The Health Service Research Unit,

Ghana Health Service

Accra.

Dear Sir,

PERMISSION TO USE SOME HEALTH FACILITIES FOR RESEARCH PURPOSES

I am a nursing Tutor at SDA Nurses' Training College, Kwadaso-Kumasi, currently pursuing PhD in Nursing at the University of the Western Cape, South Africa. I am conducting a research in Ashanti Region entitled " Development of the Employee Assistance Programme (EAP) for midwives dealing with maternal death in the Ashanti region, Ghana". The data collection will take place in six hospitals in the region: KATH, Atonso Agogo, two district hospitals with high maternal deaths and two district hospitals with the least maternal deaths for the year 2013.

The purpose of this letter is to introduce myself and seek your permission to proceed with the data collection in the health facilities. Please find attached the ethical clearance letter from the university research committee.

Hope my letter will be given the necessary attention.

Yours faithfully,

Anita F. Dartey

ANNEXURE 8: GHANA HEALTH SERVICE ETHICAL CLERANCE

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

My Ref: GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah.Frimpong@ghsmail.org

28th March, 2014

Anita F. Dartey
School of Nursing

ETHICAL APPROVAL - ID NO: GHS-ERC: 15/01/14

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"The development of the Employee Assistance Programme (EAP) for midwives dealing with maternal death in the Ashanti Region, Ghana"

This approval requires that you inform the Ethical Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethical Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

DR. CYNTHIA BANNERMAN
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

ANNEXURE 9: PERMISSION LETTER TO KATH

University of the Western Cape
Private Bag X 17, Bellville 7535
South Africa
10 December, 2013.

The Director,
Office of the Dean Department of Research Development
KATH

Dear Sir,

PERMISSION TO USE SOME HEALTH FACILITIES FOR RESEARCH PURPOSES

I am a nursing Tutor at SDA Nurses' Training College, Kwadaso-Kumasi, currently pursuing a PhD in Nursing at the University of the Western Cape, South Africa. I am conducting a research in Ashanti Region entitled "The development of the Employee Assistance Programme (EAP) for midwives dealing with maternal death in the Ashanti region, Ghana". The data collection will take place in six hospitals in the region including Komfo Anokye Teaching Hospital (KATH).

The purpose of this letter is to introduce myself and seek your permission to proceed with the data collection in the health facilities. Please find attached the ethical clearance letter from the university research committee.

Hope my letter will be given the necessary attention.

Yours faithfully,

Anita F. Dartey

ANNEXURE 10: KATH ETHICAL CLEARANCE

KOMFO ANOKYE TEACHING HOSPITAL

RESEARCH AND DEVELOPMENT UNIT (R & D)

CERTIFICATE OF REGISTRATION

REG. NO* RD/CR14/100

This is to certify that

Prof/Dr/Mrs/Ms/Mr *Anita Darko*

has registered his/her proposed study titled *The development of an Employee Assistance Programme (EAP) for midwives dealing with maternal death in Ashanti Region*

with the Research and Development Unit.

Date *17th April, 2014*

Name of issuing officer *Dr. Daniel Antwi (Dep. Director, R&D)*

Signature

1132170

Receipt No

***This certificate does not constitute ethical clearance for the conduct of the study but proof of registration of study with KATH. Ethical clearance from the Committee of Human Research Publications and Ethics (CHRPE) is required to conduct the study*

ANNEXURE 11: PERMISSION TO GHS ASHANTI

University of the Western Cape

Private Bag X 17, Bellville 7535

South Africa

01 December, 2013.

The Regional Director,

Ashanti Regional Health Directorate

Ashanti Region

Dear Sir,

PERMISSION TO USE SOME HEALTH FACILITIES FOR RESEARCH PURPOSES

I am a nursing Tutor at SDA Nurses' Training College, Kwadaso-Kumasi. Currently pursuing a PhD in Nursing at the University of the Western Cape, South Africa. I am conducting a research in the region entitled "The development of the Employee Assistance Programme (EAP) for midwives dealing with maternal death in the Ashanti region, Ghana". The data collection will take place in six hospitals in the region: KATH, Atonso Agogo, two district hospitals with high maternal deaths and two district hospitals with the least maternal deaths for the year 2013.

The purpose of this letter is to introduce myself and seek your permission to proceed with the data collection in the health facilities. Please find attached the ethical clearance letter from the university research committee.

Hope my letter will be given the necessary attention.

Yours faithfully,

Anita F. Dartey

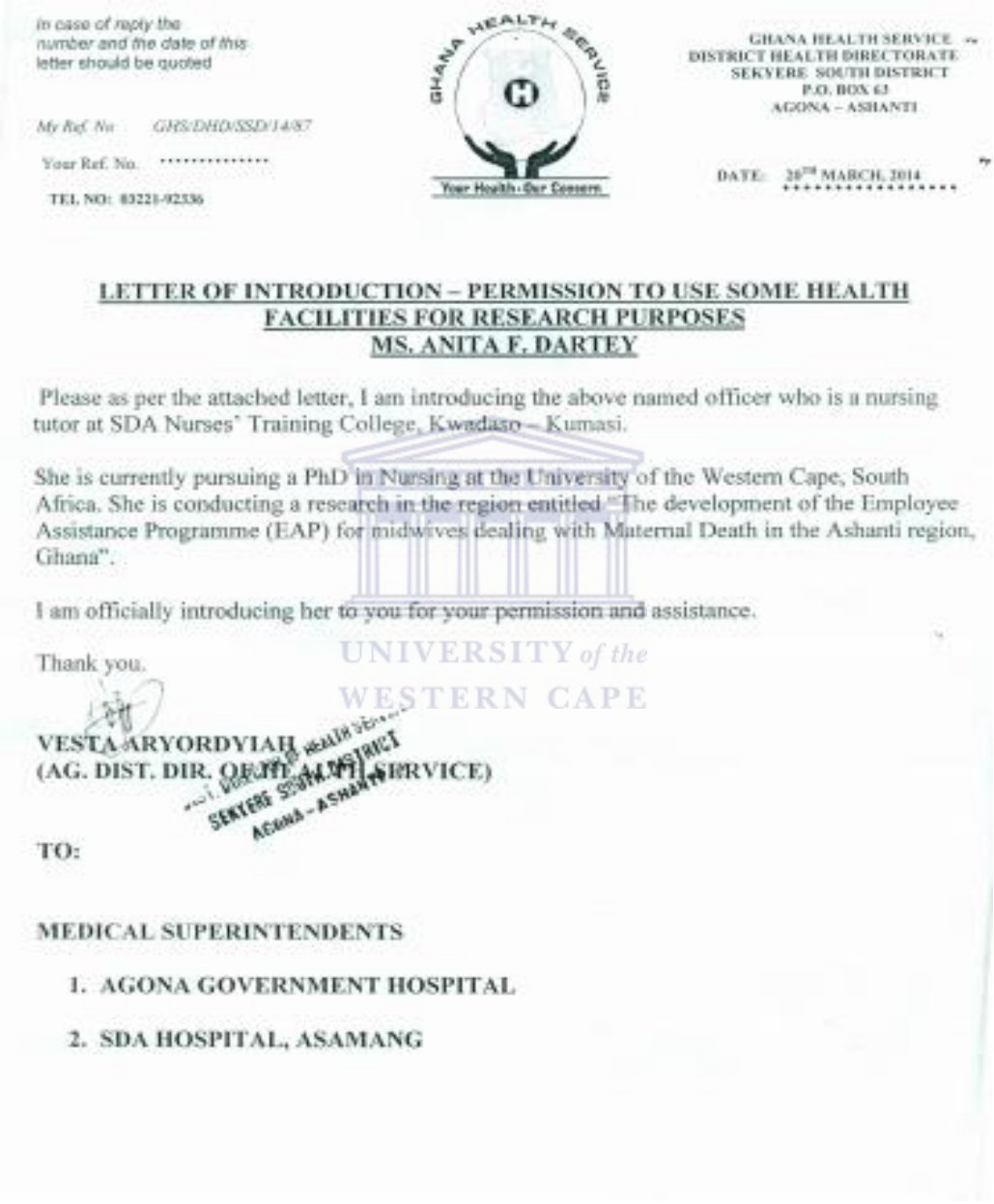
DDHS / Med Supt's / Medical Director
please assist the bearer to collect data from your facilities
- Offinso municipal
- Bosomtwe
- Sekyere East
- Sekyere South
- KSH

34

01/01/14

17/12/13 Sela

ANNEXURE 12: INTRODUCTORY LETTER- SEKYERE SOUTH DISTRICT



In case of reply the number and the date of this letter should be quoted

My Ref. No GHS/DHD/SSD/14/87

Your Ref. No. .....

TEL NO: 03221-92336

GHANA HEALTH SERVICE
Your Health Our Concern

GHANA HEALTH SERVICE
DISTRICT HEALTH DIRECTORATE
SEKYERE SOUTH DISTRICT
P.O. BOX 63
AGONA – ASHANTI

DATE: 28TH MARCH, 2014

LETTER OF INTRODUCTION – PERMISSION TO USE SOME HEALTH FACILITIES FOR RESEARCH PURPOSES
MS. ANITA F. DARTEY

Please as per the attached letter, I am introducing the above named officer who is a nursing tutor at SDA Nurses' Training College, Kwadaso – Kumasi.

She is currently pursuing a PhD in Nursing at the University of the Western Cape, South Africa. She is conducting a research in the region entitled "The development of the Employee Assistance Programme (EAP) for midwives dealing with Maternal Death in the Ashanti region, Ghana".

I am officially introducing her to you for your permission and assistance.

Thank you.

VESTA ARYORDYIAH
(AG. DIST. DIR. OF HEALTH SERVICE)

SEKYERE SOUTH DISTRICT
AGONA – ASHANTI

TO:

MEDICAL SUPERINTENDENTS

1. **AGONA GOVERNMENT HOSPITAL**
2. **SDA HOSPITAL, ASAMANG**

ANNEXURE 13: INTRODUCTORY LETTER -GHS BOSOMTWE DISTRICT

In case of reply the number and the date of this letter should be quoted

My Ref. No: BOS/DHD/55
Your Ref. No.

Tel. No. 0289 106493

DISTRICT HEALTH DIRECTORATE
GHANA HEALTH SERVICE
P. O. BOX 40
KUNTANASE

13TH JANUARY, 2014

INTRODUCTORY LETTER

The bearer of this letter, Ms. Anita F. Dartey is a nursing Tutor at SDA Training College - Kwadaso, Kumasi. She is currrently pursing a Phd in nursing at the University of the Western Cape, South Africa.

Ms. Dartey wishes to indertake a research in the Bosomtwe District among other District titled 'The Development of the Employee Assistance Programme (EAP) for Midwives dealing with maternal death in the Ashanti Region'.

The District Health Directorate would be grateful if you could introduce Ms. Dartey to the midwives at your facility for a brief meeting with them.

Kindly find attached a copy of the permission letter for the research.

Thank you for your co-operation.

JOSEPH ADOMAKO
DISTRICT DIRECTOR OF HEALTH SERVICES

Distribution

The Medical Superintendent
St. Michael's Hospital
Pramso

The Deputy Chief Physician Assistant (Medical)
Jachie Health Centre
Jachie

File

ANNEXURE 14: INTRODUCTORY LETTER - GHS OFFINSO

In case of the reply the number
And the date of this letter
Should be quoted

GHANA HEALTH SERVICE
Your Health - Our Concern

GHANA HEALTH SERVICE
MUNICIPAL HEALTH DIRECTORATE
P. O. BOX 237
OFFINSO

My Ref. No.:

You're Ref. No.

21st January, 2014

The Physician Assistant
Abofour Health Centre
Abofour - Offinso

INTRODUCTORY LETTER
MRS. ANITA F. DARTEY (NURSING TUTOR)

This is to introduce to you the above-named nursing tutor at SDA Nurses Training College, Kwadaso-Kumasi who seeks for permission to use your facility in conducting a research entitled "The development of the Employee Assistance Programme (EAP) for midwives dealing with maternal deaths in Ashanti Region of which our municipality has been selected.

I implore you to give her the uppermost assistance she will need to make her research very effective and successful as maternal health is an issue of concern to the municipality.

Many thanks in anticipation to your usual co-operation.

Mrs. Martha Somuah
Ag: Municipal Dir. of H/Service
Offinso

ANNEXURE 15: PERMISSION TO COLLECT DATA FROM O & G DEPARTMENT

SDA-NTC, Kwadaso- Kumasi

16/04/2014.

The Head,

Obstetrics and Gynecological Directorate,

KATH

Dear SIR,

PERMISSION TO CONDUCT RESEARCH

I am ANITA DARTEY, am conducting a research entitle 'The development of an Employee Assistance Programme for midwives dealing with maternal deaths in Ashanti Region, Ghana'.

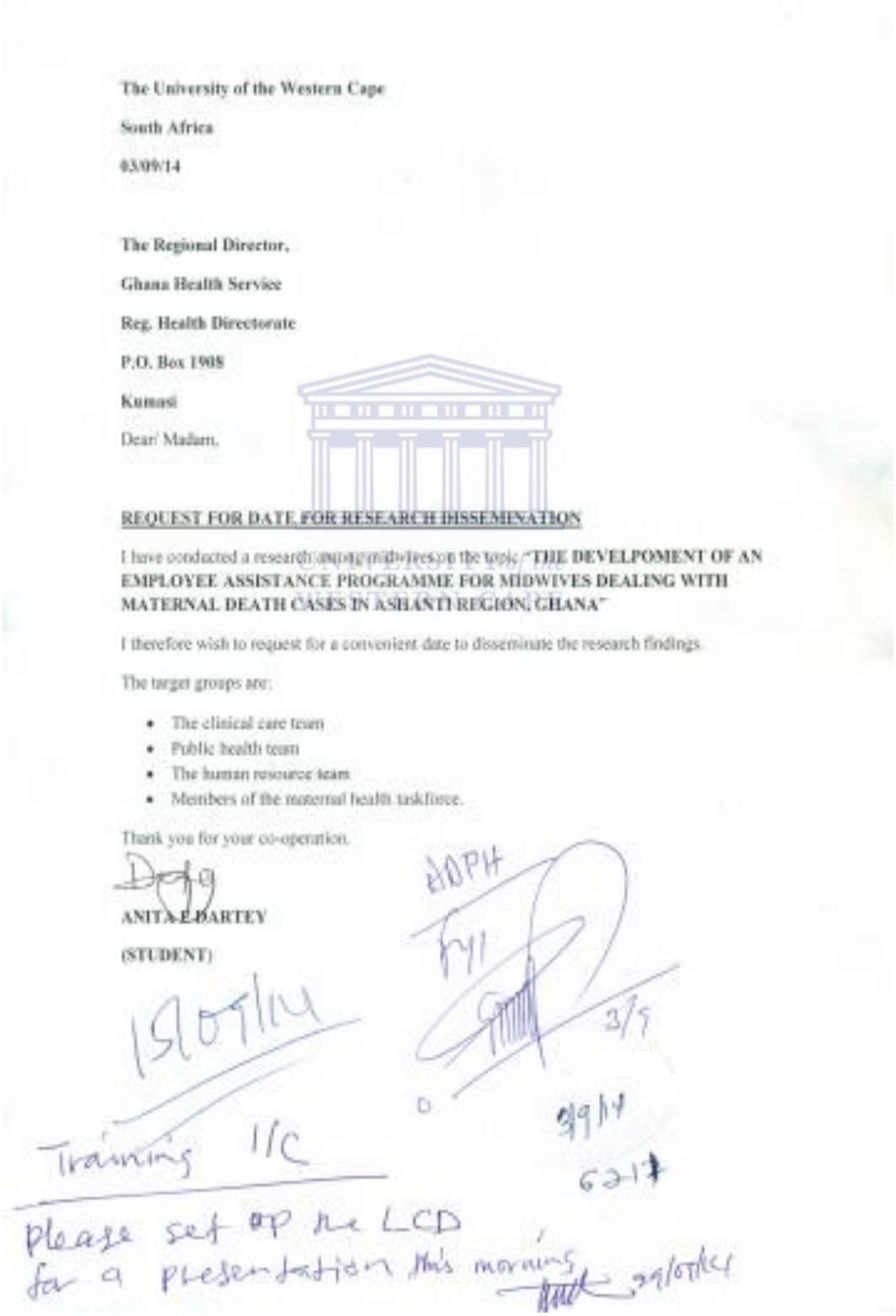
I am hereby asking for your permission to collect data from the midwives.

Thank you for the assistance.

Yours faithfully,

Anita Dartey

ANNEXURE 16: REQUEST FOR DISSEMINATION OF RESEARCH



The University of the Western Cape

South Africa

03/09/14

The Regional Director,

Ghana Health Service

Reg. Health Directorate

P.O. Box 1908

Kumasi

Dear/ Madam,

REQUEST FOR DATE FOR RESEARCH DISSEMINATION

I have conducted a research among midwives on the topic "**THE DEVELPOMENT OF AN EMPLOYEE ASSISTANCE PROGRAMME FOR MIDWIVES DEALING WITH MATERNAL DEATH CASES IN ASHANTI REGION, GHANA**"

I therefore wish to request for a convenient date to disseminate the research findings.

The target groups are:

- The clinical care team
- Public health team
- The human resource team
- Members of the maternal health taskforce.

Thank you for your co-operation.

ANITA E DARTEY

(STUDENT)

15/09/14

ADPH

FYI

3/9

9/9/14

Training I/C

6-17

Please set up the LCD for a presentation this morning 9/9/2014

ANNEXURE 17: REQUEST FOR DISSEMINATION OF RESEARCH FINDINGS

The University of the Western Cape

South Africa

03/09/14

The Regional Director,

Ghana Health Service Reg. Health Directorate

P.O. Box 1908 Kumasi

Dear Sir/ Madam,

REQUEST FOR DATE FOR RESEARCH DISSEMINATION

1 have conducted a research among midwives on the topic "THE DEVELPOMENT OF AN EMPLOYEE ASSISTANCE PROGRAMME FOR MID WIVES DEALING WITH MATERNAL DEATH CASES IN ASHANTI REGION, GHANA"

1 therefore wish to request for a convenient date to disseminate the research findings.

The target groups are:

- The clinical care team
- Public health team
- The human resource team
- Members of the maternal health taskforce.

Thank you for your co-operation.

ANITA E DARTEY

(STUDENT)

15/09/14

Training I/C

ADPH

FYI

3/9

3/9/14

6217

Please set up the LCD for a presentation this morning 29/09/14

ANNEXURE 18: REQUEST FOR DATE FOR RESEARCH DISSEMINATION (KATH)

The University of the Western Cape

South Africa

29/09/2014

The Head of Department,

O & G Department,

KATH,

Kumasi.

Dear Sir/Madam,

REQUEST FOR DATE FOR RESEARCH DISSEMINATION

I have conducted a research among midwives on topic "THE DEVELOPMENT OF AN EMPLOYEE ASSISTANCE PROGRAMME FOR MIDWIVES DEALING WITH MATERNAL DEATH CASES IN ASHANTI REGION, GHANA".

I therefore wish to request for a convenient date to disseminate the research findings. The target groups are:

- The clinical care team
- Public health team
- The human resource team
- Members of the maternal health taskforce

Thank you for your co-operation.

Anita F Dartey

(Student)

ANNEXURE 19: INVITATION TO PRESENTATION OF RESEARCH FINDINGS

The University of the Western Cape

South Africa

03/09/14

The Regional Director,

Ghana Health Service

Reg. Health Directorate

P.O. Box 1908

Kumasi

Dear Sir/ Madam,

INVITATION TO PRESENTATION OF RESEARCH FINDINGS

You are kindly invited to attend one day research dissemination as stake holders in the region on a research title "THE DEVELPOMENT OF AN EMPLOYEE ASSISTANCE PROGRAMME FOR MIDWIVES DEALING WITH MATERNAL DEATH CASES IN ASHANTI REGION, GHANA"

Details are as follows:

Date: 11 September, 2014

Time: 10am prompt

Venue: RHD conference Hall

All are invited especially, the clinical care team, public health team, the human resource team, members of the maternal health taskforce.

Thank you for your co-operation.

Anita F. Dartey

ANNEXURES 20: EAP ADVERT 1 FOR PILOT IMPLEMENTION

EMPLOYEE ASSISTANCE PROGRAMME (EAP) FOR MIDWIVES!!!

1. ALL MIDWIVES WHO EXPERIENCED MATERNAL DEATH AND HAVE NOT DEALT WITH THE EFFECT PROPERLY SHOULD GO FOR COUNSELLING.
2. MIDWIVES WHO WILL EXPERIENCE MATERNAL DEATH FROM NOVEMBER, 1ST TO 31ST DECEMBER, 2015 CAN ALSO GO FOR COUNSELLING AND DEBRIEFING.
3. THE PURPOSE OF THE EMPLOYEE ASSISTANCE PROGRAMME IS TO IMPROVE THE QUALITY OF WORK LIFE AMONG MIDWIVES IN THE ASHANTI REGION OF GHANA.
4. SERVICES TO BE PROVIDED ARE:

- ASSESSMENT
- TRAUMA DEBRIEFING
- CRISIS INTERVENTION
- COUNSELLING SERVICES
- REFERRAL SERVICES
- MONITORING
- FOLLOW-UP

5. EAP PRINCIPLES:

- CONFIDENTIALITY
- VOLUNTARY PARTICIPATION
- EQUAL TREATMENT
- PROPER REPORT KEEPING

6. TIME OF SERVICE: 24 HOURS A DAY, 7 DAYS A WEEK FOR 2MONTHS

CALL NOW: 050 918 0015 OR **050 056 8674**. **EAP COUNSELLORS ARE WAITING!!!**

ANNEXURES 21: EAP ADVERT 2: FOR PILOT IMPLEMENTATION

EMPLOYEE ASSISTANCE PROGRAMME (EAP) FOR MIDWIVES!!!

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CALL NOW: 050 918 0015 OR 050 056 8674. EAP COUNSELLORS ARE WAITING!!!

ANNEXURES 22: PERMISSION FOR PILOT IMPLEMENTATION

The University of the Western Cape
Private Bag X 17
Bellville 7535- South Africa

23rd October, 2015.

The Director of Nursing Services
KATH

Thro'

The Head of Department,

Obstetrics & Gynaecology Directorate,

KATH- Kumasi.

Dear Sir/Madam,

PILOT IMPLEMENTTION

I am a PhD student from the University of the Western Cape, South Africa and conducting a research titled **"*The Development of an Employee Assistance Programme for Midwives Dealing with Maternal Death Cases in Ashanti Region of Ghana*".** I collected data from this hospital and came back to disseminate the findings of the research last year. I wish to inform you that, it is time for the developed programme to be piloted for "Two Months".

Since it is a pilot study, I intend to use the services of one Psychiatric Nurse and one Psychologist in the capacity of EAP counsellors for debriefing and counselling of midwives after they have experienced maternal death. All midwives who previously experienced

maternal deaths and have not properly dealt with the effects of those deaths can also see the EAP counsellors for counselling.

The details of EAP counsellors, services to be rendered and service hours of EAP would be made available to all midwives in the Obstetrics and Gynaecology department. The counsellors and the midwives decide where to meet for counselling.

Thank you for your co-operation.

Yours faithfully,

Anita F. Dartey

ANNEXURE 23: PILOT EVALUATION FORM

Evaluation of EAP

We appreciate your help to evaluate this programme. Please complete the questions below;

Date: time:

1. How do you find the counselling/ debriefing programme?

   Ans……

2. What contributions has the pragramme made to your life?

   Ans…….

3. How will this program help in your work?

   Ans…….

4. Does the service meet your expectation?

   Ans……..

5. Should the programme be instituted in the hospital for the midwives?

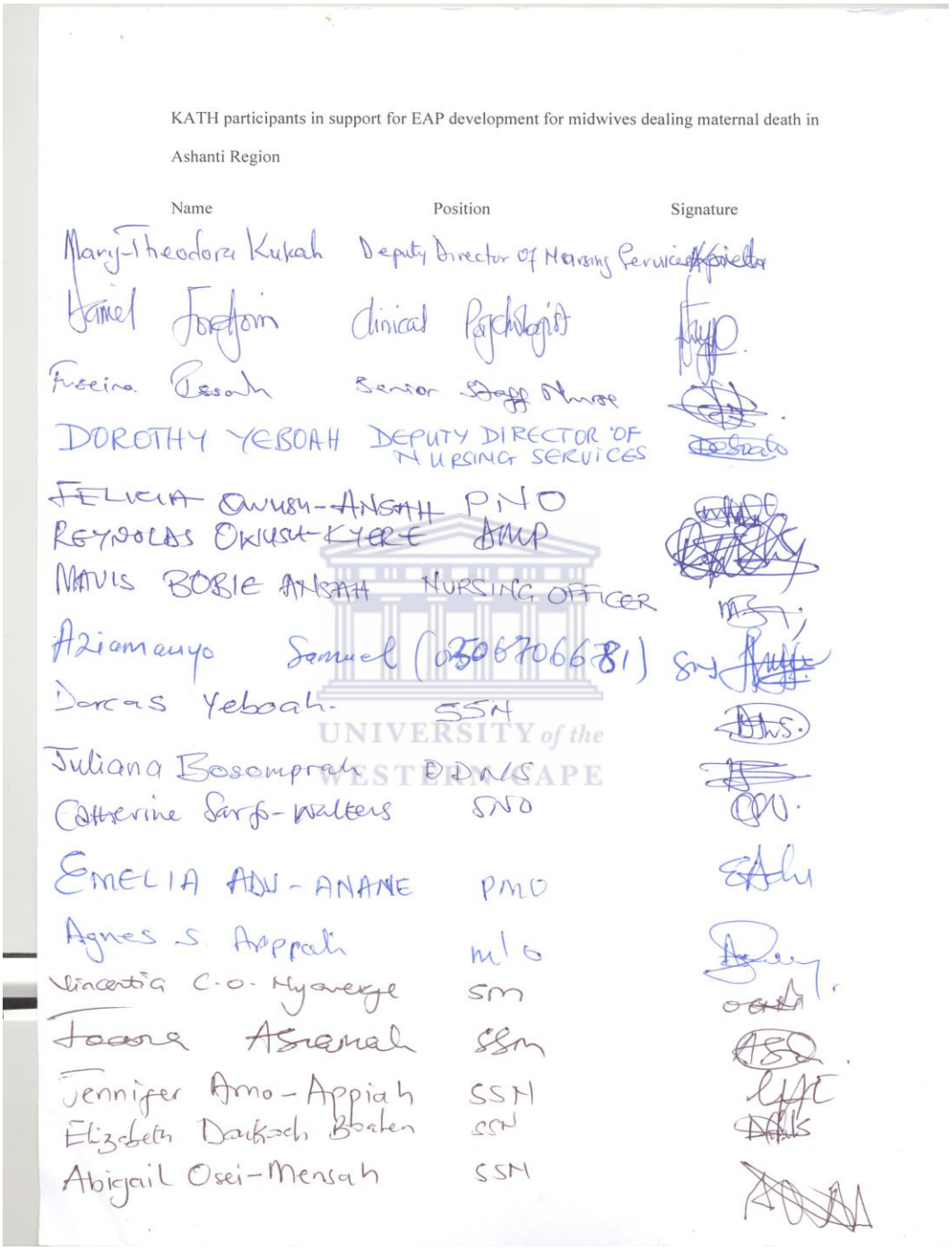
   Ans…….

6. How do you think the programme can be improved?

   Ans……..

7. Any other comment?

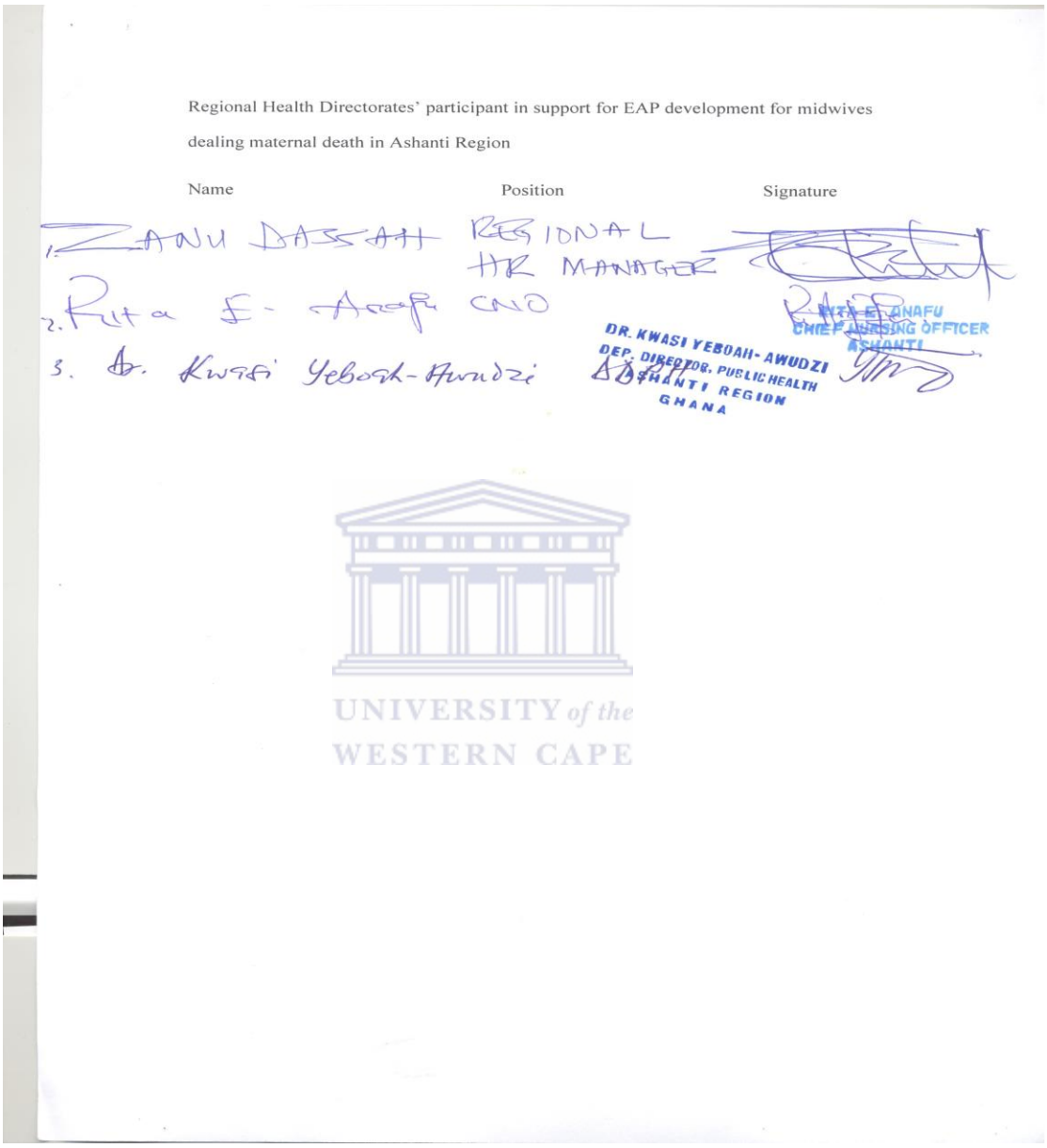
ANNEXURES 24: PARTICIPANTS IN SUPPORT OF EAP AT KATH



KATH participants in support for EAP development for midwives dealing maternal death in Ashanti Region

Name	Position	Signature
Mary-Theodora Kukah	Deputy Director of Nursing Services	
Daniel Forfom	Clinical Psychologist	
Fuseina Issah	Senior Staff Nurse	
DOROTHY YEBOAH	DEPUTY DIRECTOR OF NURSING SERVICES	
FELICIA OWUSU-ANSAH	PNO	
REYNOLDS OWUSU-KYERE	AMP	
MAVIS BOBIE ANSAH	NURSING OFFICER	
Aziamanyo Samuel (0506706681)	SN	
Dorcas Yeboah.	SSN	
Juliana Bosompra	DDNS	
Catherine Sarfo-Walters	SNO	
EMELIA ADU-ANANE	PMO	
Agnes S Appiah	m/o	
Vincentia C.O. Nyarkoye	SM	
Joana Asamoah	SSM	
Jennifer Amo-Appiah	SSM	
Elizabeth Dankoh Boaten	SSM	
Abigail Osei-Mensah	SSM	

ANNUXURES 25: PARTICIPANTS IN SUPPORT OF EAP AT ASHANTI REGIONAL HEALTH DIRECTORATE



Regional Health Directorates' participant in support for EAP development for midwives dealing maternal death in Ashanti Region

Name	Position	Signature
1. ZANU DASAH	REGIONAL HR MANAGER	
2. Rita E- Arafi	CNO	
3. Dr. Kwasi Yeboah-Awudzi		

DR. KWASI YEBOAH- AWUDZI
DEP. DIRECTOR, PUBLIC HEALTH
ASHANTI REGION
GHANA

ANNESURES 26: REPORT FROM PILOT IMPLEMENTATION OF EAP

The EAP is a work-based voluntary programme that seeks to provide free short-term counselling, confidential assessment, referrals, and follow-up services to employees who have personal and/or work-related problems. Employees, who work in a hospital environment encounter a number of stressful situations which in one way or the other, affect their output in general. For midwives, one of such stressful work-related issue is dealing with maternal death, which is experienced most often at a Teaching Hospital environment such as Komfo Anokye Teaching Hospital (KATH).

The trial of EAP was conducted at the O & G directorate of KATH, specifically the labour wards. Initially, 10 midwives who had experience maternal death at some point in the performance of their duties agreed to participate in the programme. Specifically, they responded to open-ended questions that assessed their experience with maternal death, how these experiences affected different aspects of their lives, and how they coped with it.

The questions used in the assessment of these experiences are listed below:

1. Have you experienced maternal death in your work recently?

2. How long ago was the maternal death experience?

3. What are the psychological challenges that you have had after experiencing maternal death as a midwife?

4. Have you had any physical effect of the maternal death on your life?

5. Do you have interpersonal difficulties because of your experience with maternal death as a midwife?

6. Has any of these problems affected your capacity to work as a midwife?

7. Has it affected your relationship with your family in any way?

8. Would you want to see a psychologist in the event of experiencing maternal death / would you recommend a psychologist for a colleague who experiences maternal death?

In using these questions, some themes emerged from the responses given by the participants. These themes included empathy, guilt, sympathy, sadness, anguish, anxiety, apprehension, and cautiousness.

In expressing empathy, most participants reported that they tend to see themselves in the position of the deceased and thought of how their families are going to deal with it. The inability to give motherly love to the neonate at that point filled their thought. One participant report, "I placed myself in the shoes of the deceased, and that made me cry uncontrollably." One also recalled by saying, "I could feel the pain of the husband and the rest of the family even before I could meet them. How was he going to deal with the neonate?" Another reported expressing apprehension that "I am always nervous now when I hear we have a patient with similar condition as the mother that passed on." Another reported that, "I felt that it happened because of a mistake we made, and that made me feel awful."

It is obvious that the thoughts reported by these midwives are mostly negative. It is these negative thoughts that contribute immensely to their psychological as well as their physical health. Two

participants reported having elevated BP levels after experiencing maternal deaths. They go on to explain that they believed it had contributed to their hypertension diagnosis by their physicians. Others also reported having flashbacks of the experience, sleep difficulties, and problems with their relationships with others. The psychological symptoms reported by participants at the time of their experience with the maternal death was that in line with depression, acute stress illness, and post-traumatic stress disorder as per the classification of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (2013).

All participants accepted that experiencing maternal death is stressful and that it will be helpful to see a psychologist to help in dealing with the different dimensions of its effect on their professional as well as their personal lives. They all reported that their family support has been their protective factor for their survival. However, they were enthusiastic of EAP being a necessary addition in helping them through such an experience.

As a recommendation, midwives who experience maternal death would need support at the time of the experience. As some of them may have formed a bond with the mothers, they will have to go through the process of grieving. This helps in the catharsis necessary for their wellbeing both psychologically and physically. The right debriefing and easy access to psychotherapy services will help in this direction. This is what EAP seeks to offer employees and employers alike.

Mr. Daniel Fordjour

Clinical Psychologist

Psychiatric Unit - KATH

ANNEXURE 27: COMMENTS FROM AN EAP SPECIALIST OUTSIDE GHANA

From: Samukelisiwe Mzele <MZELES@cput.ac.za>
To: DARTEY ANITA <aniadfafa@yahoo.co.uk>
Sent: Friday, 17 June 2016, 9:09
Subject: RE: EAP program doc

Good Morning ANITA

The programme is clear, concise and feasible. It matches the current EAP Programme which is very much functional within the Department of Health in the South African Context. Just a few comments that you may consider to revise:

1. Objective 2: 'ensuring of job security'

   - When drafting EAP policy and procedure, it may be difficult to account for this objective. It might be wise to relook at this objective and research if it forms part of the direct functions of EAP.

2. Models of EAP:

   - Clarity is advised, and you might look into including a diagram of the model you are referring to.

3. EAP services:

   - You might consider 'in-service training' as part of the *indirect services* for employees. This might be a preventative measure to curb the adverse effects of MD.

Kindest regards :
Lifestlye & Wellness Specialist
Ms Samukelisiwe (Sam) Mzele
Office 6.12 Human Capital Department, 6th floor,
Cape Town campus

: mzeles@cput.ac.za

: 021 460 9070