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ORIGINAL ARTICLE

"Everywhere in the community you are seen as a bad luck midwife": experiences of midwives upon conducting stillbirth deliveries in Northern Ghana

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Midwives have a huge responsibility when it comes to conducting deliveries. They expect to save the life of both the mother and child. The purpose of the study was to explore the experiences of midwives and their coping strategies when they conduct a stillbirth delivery. The study used an exploratory qualitative approach to understand the experiences of midwives upon conducting a stillbirth delivery. The study was conducted among 15 midwives in one district in northern Ghana. Participants were purposively selected and data collected through individual face-to-face in-depth interviews. The interviews were audio-recorded, transcribed, and analysed using content analysis. The study findings indicate that midwives who conduct stillbirth delivery suffer psychological effects such as sadness, guilt, sleeplessness and loss of appetite. They also suffer social effects such as social stigma, social withdrawal, altered relationships, and difficulty communicating the news to the affected mother. The midwives coped with the psychosocial effects upon conducting stillbirth deliveries through spirituality, diversional therapy, support from peers, and support from family. There is a need for a systematic structure in the hospital to provide psychological assistance to midwives who perform stillbirth deliveries and are emotionally affected.
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INTRODUCTION

A stillbirth is said to have occurred when a baby is born at or after 28 weeks of gestation with no signs of life (World Health Organisation, (WHO), 2016). Stillbirths continue to be a major public health and developmental challenge globally over the years (Hoope-bender et al., 2016; Osman, 2017). In the year 2015, about 2.6 million stillbirths (SBs) occurred globally, meaning more than 7000 stillbirths occurred in a day (WHO, 2016). Ninety-eight percent of all these stillbirths were recorded in low and middle-income countries (LMICs) (WHO, 2016).

The occurrence of stillbirths though predominant in Lower Middle-Income Countries (LMICs) does not uniformly affect countries. The rates per annum vary from about 10% in high-income countries to 59% in lower and middle-income countries with the majority of the deaths occurring in sub-Saharan Africa and South Asia (WHO, 2016). Between 2010 to 2016, the average stillbirth rate in Africa was 21.3 per 1000 births, India was 25.3 per 1000 births, Pakistan was 56.9 per 1000 births for and Guatemala was 19.9 per 1000 births

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(Saleem et al., 2018). The rates of SBs in Ghana range from 14 to 22 per 1000 live births (Ghana Statistical Service and Ghana Health Service and Macro International, 2017). In Ghana, the occurrence of stillbirths differs from one region to the other (Engmann et al., 2012; Ha et al., 2012; Dassah et al., 2014).

Midwives are involved in maternal health services from preconception to childbirth. Events surrounding midwifery practice are said to provoke strong emotions because delivery could bring happiness and stillbirth delivery will normally bring sadness. Caring therefore for bereaved families in times of stillbirth is stressful to the midwife who has to deal with her emotional state and that of the bereaved family (Wallbank & Robertson, 2013). Helping the bereaved family to deal with the loss is very important and the health professional must be psychologically stable to do this. The health care system in most situations does not have provisions for psychological management after SB and even bereavement support services (De Bernis et al., 2016). Many care providers are not adequately prepared to manage mothers after stillbirth as they are most often used to dealing with positive events (Kelley & Trinidad, 2012).

Health professionals are filled with disappointment, sadness and grief when children die and this results in stress. This impairs their ability to provide adequate care for grieving families and makes it difficult to manage their personal feelings and care for themselves (Gold et al., 2008; Nuzum & Meaney, 2014). A study in Japan on providing perinatal loss care revealed that midwives after SB delivery became distressed, helpless and frustrated as to why the babies should die (Fenwick, 2007).

Stillbirth impacts on parents, care providers, and society at large yet related studies, policy direction, and practice remain low globally (Alderdice, 2017). The experience of stillbirth may come with a burden on health professionals, especially on their health and wellbeing. There is therefore the need to also provide psychological care to health professionals caring for women after stillbirth delivery (Alderdice, 2017).

With an annual live birth of 64,148 in the year 2016 in Ghana, the Northern Region of Ghana recorded 1239 stillbirths for the same period. Out of this, East Mamprusi Municipality (EMM) recorded 90 stillbirths placing it third out of 28 districts in the Northern Region with the highest numbers of stillbirths (Ghana Health Service, 2016). In the year 2018, the East Mamprusi Municipality recorded 102 stillbirths (Ghana Health Service, 2018). Though stillbirth is seen as a loss to the mother, attending midwives could suffer psychosocial effects requiring support to cope. However, there is a dearth of studies on the experiences of midwives following stillbirth delivery and the accompanying trauma on them. The purpose of the study was therefore to explore the experiences of midwives upon conducting a stillbirth and how they cope with such situations.

MATERIALS AND METHODS

Research Design

This is a qualitative study with a descriptive exploratory design. This design enables the researchers to explore subjective realities about a phenomenon under investigation (Mayan, 2009). The design allowed the researchers to explore the experiences of midwives following stillbirth delivery.

Study Setting

The study was conducted in the East Mamprusi Municipality (EMM) of Ghana. Gambaga is the capital town of the Municipality and one of the 26 Districts in the Northern Region. However, Gambaga became the regional capital of the North -East region which was carved out of the Northern region in 2018. The EMM covers a landmass of 1,706.8 square kilometers, representing about 2.2 percent of the total landmass of the Region (Ghana Statistical Service, 2014). The EMM is located in the North-Eastern part of the Northern Region. The population of EMM according to the 2010 opulation and Housing Census was 121,009 representing 4.9 percent of the Region's total population (Ghana Statistical Service, 2014). The municipality has one hospital, five health centers and three clinics.

Population, Sample and Sampling

In this study, all practicing midwives living in the EMM who have conducted labour which was a stillbirth delivery were the target population. In qualitative studies, unique experiences or views of the participants on the particular subject under

investigation is a key determinant in participant selection (Munhall, 2012). A purposive sampling method was applied to recruit midwives with stillbirth delivery experience in the Municipality. Data saturation was achieved by the time the fifteenth participant was interviewed. The midwives were recruited from the health facilities within the municipality. Data were collected through individual face-to-face interviews of the midwives in the health facilities and homes depending on their choice of place.

Data Collection Procedure

The researchers obtained departmental approval to conduct the study. An introductory letter was sent to the District Director of Health Services and all the managers of the various health facilities used for the study. The researchers visited the selected facilities to meet the midwives to establish rapport and explain the purpose of the study to them. The date and time for data collection were scheduled with midwives that met the inclusion criteria and voluntarily agreed to participate in the study. Data was collected through individual interviews conducted after the close of work at the health facilities or homes of participants. The interviews were conducted in English and lasted between 35 and 60minutes. An interview guide developed by the researchers according to the purpose of the study was used to guide the interviews. The participants were asked questions such as "what memories do you have of that day?", " share how you were feeling upon realizing that the delivery was a stillbirth ?" "how did the stillbirth affect your relationship with the mother/family?", "what did you do to help you cope with situation?". Probes were used to clarify responses that were not clear. Permission was obtained from the participants to enable audio-recording of the interviews.

Data analysis

Data were analysed using content analysis. The content analysis helps the researcher to classify data and deduce patterns in the unrefined form (Miles & Huberman, 1984). Data analysis was done concurrently with data collection. Recorded interviews were transcribed verbatim. The transcripts were read several times to understand the participant's perspective of the issues raised. The data was coded individually by two of the authors who are experienced qualitative researchers (GNT and VNY). The researchers had a series of discussions to agree on the emerging main themes and subthemes. The themes were then revised severally until they were suitable for the presentation of the findings. The data was processed manually.

Ethical Considerations

The study was approved by the Department of Midwifery Research Committee. The Municipal Health Directorate also approved for us to recruit participants for the study. An information sheet containing background information on the study was given to participants to read and their consent was obtained before data collection. Participants were also informed of their right to withdraw from the study at any time without having to give any reasons. The anonymity of participants was ensured by using MW001, MW002, MW003, etc. to represent them based on their chronological recruitment into the study.

RESULTS

Demographics

A total of 15 midwives who have conducted stillbirth deliveries during their practice participated in the study. The study participants had varied ages with 25years being the youngest and fifty-eight years the oldest. Eleven of the participants were married, 2 were single and 2 were widows. Regarding work experience, 9 of them had worked between 1-5 years, 2 worked between 6-10 years and the remaining 4 had working experience of 15 years or more. Fourteen of the participants were Christians and one was a Muslim. With regards to the educational backgrounds of the participants, twelve had a diploma in midwifery and the remaining three had a certificate in midwifery.

Main Themes and Subthemes

Three main themes and their corresponding subthemes emerged from the data analysis.

Psychological Effect

Conducting stillbirth delivery has psychological implications for midwives afterwards. The midwives in this study used terms such as sadness, guilt, self-blame, bad feeling, sleeplessness, and loss of appetite to describe the psychological implications of encountering stillbirth deliveries in

Table 1: Main Themes and Sub-themes

Themes	**Subthemes**
Psychological effect	Sadness Guilt Sleeplessness Loss of appetite
Social effect	Social stigma Social withdrawal Altered relationship Difficulty communicating news
Coping strategies	Spirituality Diversional therapy Support from peers Support from family

their professional lives.

Sadness

When a stillbirth occurs it is a sad moment for the attending midwives. It affects their professional activities since as trained midwives they felt obliged to deliver live babies. Study participants presented these expressions of their sadness in most of the narrations they gave. The feeling of sadness lingers for a long and the midwife just wishes never to encounter such a case subsequently.

*"After conducting a stillbirth, one [midwife] becomes sad. You [midwife] do not know how to communicate with the mother or tell her that the child is dead. Naturally, it is so emotional" (**MW006**).*

*"My mind will be on that issue [SB] and if I wake up at midnight, my prayer will be that God should not let me deliver a dead baby again. I won't be happy. I am always disturbed after conducting a stillbirth" (**MW008**).*

Some of the midwives after conducting stillbirth delivery broke down emotionally. Some of the midwives expressed their feelings as;

*"It affected me emotionally, I was sad because I was crying while Ambu bagging. I was crying because I wanted the baby to survive. When I got home it was still in my mind because I was thinking the doctor should have sent the mother for a caesarean section". (**MW009**).*

*"I was sad because when you are to deliver the first time, you are always anxious to receive your newborn baby. So I kept myself in her shoes and it affected me for some time". **(MW004).***

Guilt

Guilt was one of the psychological problems of midwives associated with conducting stillbirth delivery. Guilt was expressed in the form of midwives feeling that they could have prevented the stillbirth if they had given more attention to the client. The feeling of guilt makes the midwives even forget all the successful deliveries they have conducted in the past.

*"Because they didn't come early, there was no time to check foetal heart rate. I should say that I should take the blame for myself because I didn't monitor the foetal heart rate as required. I felt guilty that it [SB] could have been prevented if foetal heart rate was monitored closely" (**MW010).***

*"Truly, I was guilty in this case. I felt I didn't do much for the labouring woman and that ended up being a stillbirth. Yes, I was guilty and that affected me seriously such that I was always thinking about it" **(MW007).***

Midwives after stillbirth delivery blamed themselves for being the cause of the stillbirth.

This position was expressed based on a feeling of empathy for the parents. Participants in the study had this to say about their SB delivery experiences;

"The woman was coming from Kumasi and said she wants to deliver here because the husband was here. That was the first child of the man. I regretted because I didn't know if it was due to my negligence it [SB] happened" ***(MW003)***.

"When the client comes with foetal heart rate and at the end, you deliver an SB, it is very embarrassing. As a midwife, I don't feel comfortable. I always feel during the delivery there was a problem I didn't detect early and that resulted in that" ***(MW012).***

Sleeplessness
Conducting a stillbirth was so worrisome to midwives that midwives had sleepless nights afterward. The midwives kept thinking about the stillbirth incidents at night and this kept them awake.

"It is worrying to have such experience. Sometimes it worries you such that you even find it difficult sleeping in the night. You cannot sleep when you remember it" ***(MW014).***

Participants had solemn reflections of the incidents at night. They stayed awake because of the psychological trauma and just wish they do not encounter such incidents in their working life.

"You will be imagining how the mother and the mother-in-law will feel at home. If I go home, I can't sleep. My mind will be on that issue and if I wake up at night, my prayer will be that God should not let me encounter such experience again" (MW008).

Loss of appetite
Stillbirth delivery affected midwives to the extent that some midwives lost appetite for food afterward. The inability was yet an emotional expression of the psychological effect of the incident on the mothers. Some midwives in the study narrated their ordeal as follows;

"I won't be happy the whole time on duty and I can't even eat food. Because I always put myself in the shoes of the mother who lose the baby and when I get home I cannot eat" ***(MW008).***

The loss of appetite in some cases was deemed to emanate from thinking of the situation. A participant explained that:

"It even affected me such that I lose appetite for food for some days. I spent time thinking about the dead child" ***(MW002).***

Social Effects of Conducting Stillbirth
Conducting stillbirth deliveries comes with social problems for the attending midwives. The participants in this study revealed that they faced several social problems after conducting SB deliveries ranging from stigma, social withdrawal, being labeled bad luck label and altered relationships.

Stigma
Participants described having faced some form of stigmatization after conducting SB deliveries. Participants indicated that having conducted stillbirth they were labeled and associated with the situation.

"People will take you as a midwife who doesn't deliver live babies especially if the baby was to be delivered alive and something happened. You feel very bad and it affects your relationship with people". ***(MW005).***

"I didn't get any form of stigma myself but I saw how my colleague midwives were stigmatized as midwives who kill babies on duty". ***(MW001).***

A bad luck label was also suggested as a social consequence faced by midwives who conduct SB deliveries in society. Findings from the study revealed that some midwives were viewed as bad luck professionals.

"I have conducted quite many stillbirths in my practice. Some People will say you are a bad luck midwife that is why you are always delivering dead babies. So I don't always get happy when I deliver SB even though it is not always my fault" ***(MW008).***
"Everywhere in the community you are seen as a bad luck midwife. People will talk a lot about you and call you names especially when they see you walking" ***(MW004).***

Social withdrawal
Some midwives after conducting SB deliveries stopped talking to people and avoided the public. The social withdrawal was expressed in the form of

avoiding phone calls and remaining quiet even at home.

"I kept my phone on silence afterward; I didn't want to talk to anyone. I was just indoors till I overcame it" ***(MW001).***

Other participants exhibited withdrawal by refusing to interact freely with their family members. This got the family members asking as shared by MW007.

"When I got home, I was sitting quietly and didn't want to talk to anyone. So my children asked me what went wrong at the worksite and I came home and was keeping quiet" ***(MW007).***

Altered relationship

The aftermath of SB delivery affected the way and manner attending midwives relate with their colleagues and other people in general. The study revealed that midwives could not relate well with their colleagues and other people after their stillbirth delivery encounter.

"You will not feel comfortable sitting with your colleague workers after SB delivery. It will be like they are talking about the case and you will not be yourself the whole day". ***(MW 005).***

Sometimes traumatic experiences at work have effects on how midwives relate with their families even after work. One participant in the study narrated;

"My mood changed towards my family when I got home. The happiness they always see in me after work was lost that day. When they even welcomed me from work they saw that there was something wrong with me" ***(MW002).***

Difficulty communicating news

Communicating the news of stillbirth to the mother and family is challenging for most midwives. Most midwives in the study had difficulty communicating the news. The participants gave their narrations as follows:

"It was difficult for me to tell her. I kept myself in her shoes, so even telling her was not easy though it was my duty to tell her" ***(MW002).***

The midwives in some cases seek help of other people to break the news of the stillbirth to the mother. Getting the hospital chaplain to help in such a situation was suggested. However, one of the participants explained that she had to call the sister in-law.

"It is not easy, it is very hard to tell the woman unless you call the chaplain to come and tell her. We had one case like that and I had to also call the sister-in-law who was a co-worker to talk to her" ***(MW005).***

Coping Strategies

The study participants expressed varied activities that supported them to cope well after conducting SB delivery. Some of the activities that emerged from the study participants included spirituality, diversional therapy, support from peers and support from family.

Spirituality

Participants have faith in the fact that God existed and was in control over what situation they were encountering. The participants, therefore, accepted what happened based on their spiritual stance. This spiritual stance was described by some of the participants as follows:

"The baby is like water which is poured out of a pot, once the pot is not broken; you can still go to fetch water with it; so let's pray to God to give us a baby who will stay. This was how I consoled myself and the mother" ***(MW008).***

"I told myself that it was meant to happen. It was the doing of God. If the woman had come with a bad foetal heart rate, we would have known what to do. But she came with no foetal heart, so there was nothing we could do. So we gave everything to God" ***(MW011).***

Diversional therapy

Participants engaged in recreational activities in an attempt to divert their attention from the stillbirth experience. Their coping strategies seem to have made some impact in relieving them from constant thoughts of the incidents. Participants narrated what they did to lessen their emotional troubles after the SB experience as follows:

"I was just sitting at the clinic watching television and engaging myself in other activities so that I don't sit alone and think about how the whole thing

happened" ***(MW002).***
"I came in and was playing music just to console myself and also read books and other things" ***(MW006).***

"I am a fan of music, I listened to music and that helped me take away my mind from the issue" ***(MW010).***

Support from peers

A category of support that was available and important to some participants was the support from family members and peers. Some participants received support from peers who tried convincing them to avoid thoughts of self-blame.

"They (colleagues) were telling me, it is okay and that it is not my fault. They encouraged me" ***(MW013).***

"My friends on duty told me that it was not my fault. They rather blamed the woman for taking local oxytocin. That also helped me somehow" ***(MW011).***

DISCUSSION

The study participants were midwives who had conducted at least one stillbirth in the course of their practice. The study findings indicated that midwives experience both psychological and social trauma upon conducting a stillbirth. Midwives became sad and guilty after conducting stillbirth deliveries which impacted them negatively on their daily activities. Similarly, Gerow, et al. (2010) also reported that care providers felt guilty and sad after stillbirth delivery. In another study, Australian midwives instead of being sad and guilty of conducting stillbirth rather saw that moment as an opportunity to provide more professional care to mothers (Fenwick et al, 2007). Comparing the findings of the present study to that of Fenwick et al. (2007), it can be suggested that the level of empathy expressed by the midwife can affect the midwife's ability to remain in control of the situation and provide professional support for the mother and the family. Also, the situation of self-blame expressed by midwives in this study seems to suggest that they felt they contributed to the stillbirth situation.

The study also revealed that midwives after conducting stillbirth deliveries had difficulties sleeping at night. The midwives were always thinking about the stillbirth and probably wondering what went wrong and led to the outcome. This finding is consistent with that of a qualitative study in Israel that reported sleeplessness by midwives after stillbirth delivery (Slade, et al., 2009). Sleeplessness at night might indicate difficulty in overcoming the emotional effects of conducting a stillbirth. Thinking about it at night may also indicate an introspection of the whole situation that may lead to possible decision making that will avert subsequent occurrence if possible.

The midwives after conducting a stillbirth delivery lost appetite for food. The midwives are scandalized by the traumatic experience such that it affects their interest in food and eating patterns. This finding is in congruence with that of Cacciatore et al. (2008) in a study that revealed a loss of appetite by midwives when a baby dies. Loss of appetite is a common manifestation of emotional trauma and midwives' show of empathy puts them in the same situation as the grieving mother.

The loss of a baby to stillbirth has some profound social effects on the attending midwives (Cacciatore, 2013). The midwives in this study reported suffering social stigma after conducting stillbirth deliveries. The midwives were associated with bad luck and this label could contribute negatively to their social image. The negative image of society on these hardworking midwives who might have tried their best to avert the stillbirth is rather demoralizing. This also points to the fact your professional life does contribute to your social image. The midwives in this study reported social isolation or withdrawal after conducting stillbirth deliveries. This was due to the demoralizing experience of the loss of babies and its corresponding social stigma. Participants indicated that they found themselves withdrawn from the public anytime they recounted the loss and the stigma. The midwife remaining connected to the mother and giving them the necessary support will be important at this stage. However, the social stigma will make the midwife look unfit to get close to the mother. Also labeling the midwife could indicate that society does not think the stillbirth could have happened out of her control.

Difficulty in communicating the sad news of the stillbirth to mothers was also uncovered in the study. Midwives upon realizing they had delivered a stillbirth especially when where the mother came with foetal heart present and expecting a successful outcome. This was so because mothers in labour had high expectations of live babies and midwives are aware that breaking the news of stillbirth will be very disappointing. This finding agrees with that of other studies which reported avoidance of the bereaved mothers by midwives after stillbirth delivery (Ben-ezra et al., 2014; Cacciatore, 2013). Midwives in this study devised various ways of coping with the event of conducting stillbirth delivery. These coping strategies are considered noteworthy to the emotional well-being of the midwives. Diverse among them were spirituality, diversionary therapy, support from peers and family members. They had comfort from the word of God which had control over whatever trouble the midwives faced and through prayer the midwives believed and hoped that the almighty God will comfort them. These findings are consistent with some findings of Shorey et al. (2017) who reported that the spiritual beliefs of the midwives helped them to cope well after stillbirth delivery. The role of spirituality and religiosity in grief care should therefore not be underestimated in the care of mothers after stillbirth and this should also be extended to the attending midwives.

Diversional therapy was revealed in this current study as a strategy midwives employed to cope with the emotional trauma associated with the stillbirth delivery. The midwives resorted to watching television, playing and listening to music, readings books and engaging themselves in other forms of activities that will keep their minds off the constant thought of the stillbirth delivery experience. Similarly, Shorey et al., (2017) reported that engaging in activities is a form of coping with a loss. The midwives in these difficult times were also consoled and encouraged by their peers. Support from peers is a very important dimension of helping midwives cope since they are colleague professionals and know exactly how feels like in such a situation. This finding supports the findings of Puia et al. (2013) who also reported that professional colleagues helped midwives to cope after stillbirth. Midwives in this study also received support from family members, particularly mothers and children. The support helped the midwives cope well and to adjust faster to normal life after encountering stillbirth delivery. The support the midwives received was in the form of companionship, prayer support and words of encouragement. Since the midwives spend a considerable amount of time at home with the family, this support is very necessary to decrease the tendency of the psychological effects of the incident.

CONCLUSION

The study pointed out that midwives are emotionally connected to the work they do. They often expect a successful outcome when conducting labour and will share happiness with their clients. Conducting a stillbirth equally negatively affects the attending midwife just as it does to the affected mother. The study also indicates that the societal view of a good midwife depends on the outcome of labour she conducts. This view of society unfortunately does not seem to consider the circumstances that lead to the outcome. Health facilities should therefore have a formal psychological support system to help midwives and the affected mothers in times of stillbirth.

Strengths and Weaknesses of the Study

The study is the first to explore the psychosocial experiences of the midwives upon conducting stillbirth in northern Ghana. This study will pave the way for further research in the area to provide adequate research findings upon which evidence-based recommendations can be made.

The qualitative approach allowed for exploration and a deeper understanding of the issue under investigation. The midwives were able to share their experiences as much as possible providing extensive insights. The weakness of the study is the fact that the qualitative approach will not allow the generalization of the study findings.

Abbreviations

WHO: World Health Organisation
EMM: East Mamprusi Municipality
LMIC: Lower Middle-Income Country
SB: Stillbirth

Declarations

Consent for Publication

All the authors gave their consent for the study findings to be published.

Availability of Materials

The original transcripts from which the paper emanated are available upon request.

Competing Interest

The authors declare that there is no competing interest.

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Authors Contribution

AMR, AJA and AJA conceptualised the study and had series of discussions with GTN and VYY which resulted in writing a proposal. AMR, AJA and AJA went to the field for data collection. GTN and VNY analysed data. GTN drafted the manuscript and it was critically reviewed by VYY. All authors read and approved the final manuscript.

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