

SCHOOL OF NURSING AND MIDWIFERY

COLLEGE OF HEALTH SCIENCES

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**WOMEN'S EXPERIENCES OF SURVIVING SEVERE OBSTETRIC
COMPLICATIONS: A STUDY AT 37 MILITARY HOSPITAL, ACCRA**

BY

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AWARD OF MPhil NURSING DEGREE**

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DECLARATION

I, Ruby Elikem Afi Amegavluiie attest that this thesis is the result of a study conducted by me towards the Award of Master of Philosophy Degree in Nursing at the School of Nursing and Midwifery of the University of Ghana, Legon. The materials reviewed from other authors as literature have all been duly acknowledged. The study was undertaken with the supervision and guidance of Dr. Mary Ani-Amponsah and Dr. Florence Naab, both of the School of Nursing and Midwifery of the University of Ghana, Legon.

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ABSTRACT

Women who survived severe obstetric complications (SOC) have health and well-being issues even up to one year postpartum as far as their quality-of-life (QoL) and well-being were concerned. However, health care professionals do very little to know what their predicaments are. The study objective described the impact of severe obstetric complications on their QoL and well-being. Using the WHO standards for near-miss, twelve (12) women who survived severe obstetric complications were recruited between January and March 2019. The study adopted a qualitative approach with an exploratory descriptive design to explore the experiences of women who survived SOC in the Accra Metropolis. Participants were purposively sampled and eligible participants who agreed to be part of the study were interviewed in their homes and others in the healthcare facility after discharge from 37 Military Hospital. Recorded interviews were transcribed and later analyzed using a thematic analysis. Four (4) themes and twenty-seven (27) sub-themes were formulated based on the study objectives and constructs of the theoretical framework used and, two (2) other themes and six (6) sub-themes emerged. The findings were inability to perform functional activities, financial constraints, residual hypertension, anaemia, pain, difficulty to sleep due to the sudden change in sleep pattern and fear of death when they fall asleep. Other findings include anxiety, sadness, and post-traumatic stress disorder. From the findings, there is a need for sequence of procedures to improve the care of survivors of SOC in order to minimise the liabilities that such complications impose on these women.

DEDICATION

I dedicate this work to my dear husband Pharm Emmanuel Kwame Amegavluie for taking charge of the home to enable me embark on this academic journey to a successful completion.

I also dedicate this study to my children (Makafui, Fafali and Eyram) for their support and understanding.

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TABLE OF CONTENTS

DECLARATION..... i

ABSTRACT.....ii

DEDICATION..... iii

ACKNOWLEDGMENTiv

TABLE OF CONTENTS v

LIST OF TABLESix

LIST OF FIGURE x

LIST OF ABBREVIATIONSxi

CHAPTER ONE 1

INTRODUCTION..... 1

 1.0 Background to the Study 1

 1.1 Statement of the Problem8

 1.2 Significance of the Study 10

 1.3 Purpose of the Study 11

 1.4 Objectives of the Study 11

 1.5 Research Questions 11

 1.6 Operational Definitions 12

 1.7 Organization of the Thesis 12

CHAPTER TWO 14

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW 14

 2.1 Justification for the Choice of Theoretical Framework 14

 2.2 Core Assumptions and Statements of the Health-Related Quality-of-Life Model ... 15

 2.3 Literature Review Related to the Objectives of the Study 17

 2.4 Literature Search 17

 2.5 Physical Well-Being..... 18

 2.6 Psychological Well-Being.....20

 2.7 Social Well Being.....24

 2.8 Spiritual Well Being.....27

 2.9 Coping strategies used by Women with Severe Obstetric Complications28

 2.10 Antenatal Care Education.....33

2.11	Summary of Literature Review	34
CHAPTER THREE		36
RESEARCH METHODOLOGY		36
3.1	Research Approach and Design	36
3.2	Research Setting.....	37
3.3	Study Population	37
3.4	Sampling Technique and Sample Size.....	37
3.5	Inclusion criteria.....	38
3.6	Exclusion criteria.....	39
3.7	Pretesting.....	39
3.8	Data Collection.....	39
3.9	Data Management	41
3.10	Data Analysis	42
3.11	Methodological Rigor	42
3.12	Ethical Considerations.....	45
2.13	Summary of Research Methodology.....	46
CHAPTER FOUR.....		48
STUDY FINDINGS		48
4.1.1	Socio-Economic Status.....	49
4.1.2	Socio-Demographic Data	49
4.2.1	Physical Well-Being	52
4.2.1.1	Functional Activities.....	52
4.2.1.2	Strength/Fatigue.....	53
4.2.1.3	Sleep and Rest.....	53
4.2.1.4	Overall Physical Health	54
4.2.1.5	Pain	55
4.2.1.6	Fertility.....	56
4.2.2	Psychological Well-Being	57
4.2.2. 1	Anxiety.....	57
4.2.2. 2	Depression.....	58
4.2.2. 3	Distress of Control	59
4.2.2. 4	Fear of Recurrence.....	60
4.2.2. 5	Loss.....	62

4.2.2. 6 Ruminative Thoughts.....	63
4.2.2. 7 Rehabilitation.....	64
4.2.3 Social Well-Being.....	65
4.2.3. 1 Family Distress	65
4.2.3. 2 Financial Challenges	66
4.2.3. 3 Roles and Relationships.....	67
4.2.3. 4 Sexual Function	68
4.2.3. 5 Appearance	69
4.2.3. 6 Enjoyment.....	70
4.2.3. 7 Social Isolation.....	71
4.2.3. 8 Impact on Work	72
4.2.4 Spiritual Well-Being.....	73
4.2.4.1 Linking Survival to God	73
4.2.4. 2 Meaning of Illness and Relevance to Self.....	74
4.2.4. 3 Religiosity.....	75
4.2.4. 4 Hope.....	76
4.2.4. 5 Inner Strength.....	77
4.2.5 Antenatal Care Experience	78
4.2.5.1 ANC Education	78
4.2.5.2 Care Providers Support	79
4.2.5.3 Participants’ Expectations from Health Care Providers.....	80
4.2.6 Coping Strategies.....	82
4.2.6. 1 Personal Coping Styles	83
4.2.6. 2 Spousal Support	84
4.2.6. 3 Family Support.....	85
4.2.6. 4 Use of Religion	86
4.3 Summary of Findings	87
CHAPTER FIVE	89
DISCUSSION OF FINDINGS	89
5.1 Socio-Demographic Data of Participants.....	89
5.2 Physical Well-Being.....	91
5.3 Psychological Well-Being.....	93
5.4 Social Well-Being	96

5.5	Spiritual Well-Being	98
5.6	Antenatal Care Experience.....	100
5.7	Care Providers' Support.....	101
5.8	Coping Strategies	103
5.9	Summary of Discussion	106
CHAPTER SIX		107
SUMMARY, CONCLUSION AND RECOMMENDATIONS		107
6.1	Summary of the Study.....	107
6.2	Implications of the Study	108
6.3	Lessons Learnt from the Study.....	110
6.4	Limitations of the Study.....	111
6.5	Conclusion for the Study.....	111
6.5	Recommendations	112
REFERENCES.....		115
APPENDICES		139
Appendix A: Letter of Introduction		139
Appendix B Introductory Letter to 37Military Hospital		140
Appendix C Ethical Approval Letter by Noguchi Memorial Institute for Medical Research		141
Appendix D Ethical Approval Letter by 37 Military Hospital Review Board.....		142
Appendix E Individual Informed Consent Form.....		143
Appendix F Interview Guide.....		147

LIST OF TABLES

Table 1 List of Obstetric Complications at 37 Military Hospital.....	10
Table 2 Details of all the Themes and Sub-themes.....	51
Table 3 Profile of Participants.....	54

LIST OF FIGURE

Figure 1 Health Related Quality of Life Model.....17

LIST OF ABBREVIATIONS

AFE	Amniotic Fluid Embolism
ANC	Antenatal Care
APH	Anti-Partum Haemorrhage
BPCR	Birth Preparedness and Complications Readiness
CINAL	Cumulative Index to Nursing and Allied Health Literature
CPS	Care Providers' Support
DIC	Disseminated Intravascular Coagulopathy
DSSP	Dangerous Signs and symptoms in Pregnancy
ERC	Ethics Review Committee
FANC	Focused Antenatal Care
FME	Feto-Maternal Outcome
GHS	Ghana Health Service
HELLP	Syndrome of haemolysis, elevated liver enzymes and low platelet count
HCP	Health Care Providers
HDP	Hypertensive Disorders of Pregnancy
HDU	High Dependency Unit
HIC	High-Income-Countries
HRQoL	Health-Related Quality of Life
HRF	Health-Related Functioning
ICU	Intensive Care Unit
IRB	Institutional Review Board
LMICs	Low-income and Middle-income Countries
MGCSP	Ministry of Gender Children and Social Protection
MMR	Maternal Mortality Rate

MM	Maternal Morbidity
MNM	Maternal Near Miss
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
NMIMR	Noguchi Memorial Institute of Medical Research
PPH	Post-Partum Haemorrhage
PTSD	Post-traumatic Stress Disorder
QoL	Quality of Life
SDGs	Sustainable Development Goals
SOC	Severe Obstetric Complications
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation
WIPO	World Intellectual Property Organization
SSCE	Senior Secondary Certificate Examination
SSS	Senior Secondary School
JSS	Junior Secondary School

CHAPTER ONE

INTRODUCTION

This chapter gives an in-depth description of the background to the study, the problem statement, and purpose of the study, study objectives and significance of the study. Also, included in the chapter are the operational definitions and organisation of the study.

1.0 Background to the Study

Pregnancy, usually seen as a normal process, is now frequently experienced as a period of real or potential risk to both the expectant mother and the unborn child (Tyer-Viola & Lopez, 2014). Although majority of women may say that pregnancy is a joyful and blissful period in their lives, the hassles and changes that accompany it can produce undesirable experiences for some expectant mothers (Guardino et al., 2017). Research has shown that high-risk pregnancy can result in a typical process of grieving that makes the adaptation process of pregnancy extra difficult in women suffering with complications during pregnancy and labour (Fiskin, Kaydirak, & Oskay, 2017).

Pregnancy is a key and momentous occasion in the life of a woman and it comes with excitements, but some may be very distressing and traumatic for some women (Aneja et al., 2017). An obstetric complication is said to be any new pathological changes that are experienced by an obstetric patient with a worsening severity and the manifestations of higher number of signs and symptoms which are related to her state of pregnancy (Fiskin et al., 2017). Some obstetric complications include; Pre-Eclampsia/Eclampsia, Haemorrhages, syndrome of haemolysis, elevated liver enzymes and low platelet count (HELLP syndrome). Thrombosis, Threatened Abortions, Uterine rupture, Gestational diabetes, Placental Praevia/Infarction, Cephalo-pelvic disproportions, congenital malformations, cord prolapse and prolonged labour among others (Slade., 2003).

Recently, the World Health Organization's (WHO, 2015) standardized definition of any dangerous or life-threatening, severe and acute obstetric complications within the concept of near miss that is "a woman who almost died but survived a complication that arose during pregnancy, childbirth or within 42 days of termination of pregnancy, (Liyew, Yalew, Afework, & Essén, 2017). Hence, severe obstetric complications (SOC) and maternal near-miss event will be interchanged. Severe obstetric complication, also referred to as "near-miss" is characteristically defined by the clinical benchmarks which rely on disease specific or clinical interventions specific such as laboratory results indicative of organ dysfunction, interventional radiology intensive care admission and monitoring, laparotomy leading to hysterectomy and blood transfusion greater or equal to four units (Lubotzky-Gete, Shoham-Vardi, & Sheiner, 2017). Also, the WHO measurements for near-miss inclusion criteria disease specific are; Eclampsia, severe-Eclampsia, ruptured uterus, postpartum haemorrhage, sepsis and severe complications of abortions (Adanikin et al., 2019).

Near-miss, is a condition in which a woman nearly dies from a complication of pregnancy or child birth or within 42 days of termination of pregnancy regardless of location, duration of pregnancy but survives either due to the care she received or due to chance (Kasahun & Wako, 2018). According to Zhang and Covey (2014), usually intensive care unit admission, blood transfusion greater or equal to four units, arterial embolization and emergency peripartum hysterectomy at any period during pregnancy. Physically, maternal near-miss or severe obstetric complications such as Eclampsia is accompanied with high ratio of perinatal death and significant maternal morbidity. When this occurs especially in low-income countries it can result in multiple complications that can affect important organs, as well as undesirable maternal and foetal outcomes (Fairbrother, Young, Zhang, Janssen, & Antony, 2017).

In a research by Shaw et al. (2017), it was found that expectant mothers with complicated pregnancies who are admitted to healthcare facilities for durations of time due to

their conditions will most often than not go through experiences leading to additional anxiety state which is already in existence. Severe obstetric complications can affect the well-being of the woman even during post-partum (Assarag, Dujardin, Essolbi, Cherkaoui, & De Brouwere, 2015).

According to Assarag et al. (2015), the magnitudes of maternal near-miss events have not been explored enough. The near-miss women's care stops after she leaves the hospital, and health care professionals do very little to know what their predicaments are. This has created a substantial absence of information on the degree of the physical, psychological, social and spiritual problems that affect the well-being of these women during the post-partum period up to one-year after delivery (Begum, 2018). It has become necessary that checking the progress of near-miss women will aid in finding solution to avert these consequences and advance the care that these women and their newborns obtain after discharge from the hospital.

In total, it has been found that there is a significant cognizance of the predicament of women who survived near-miss obstetric complications, (Filippi, Ganaba, Calvert, Murray, & Storeng, 2015). However much is not known about the long-term problems or experiences these women go through due to such complications. Filippi et al. (2018), in a study of the new conceptual framework for maternal morbidity, asserted that the health of these women and their capability to accomplish socio economic tasks were fundamental to the SDGs, (Langer et al., 2015). After surviving a maternal morbidity like a near-miss, some conditions may occur, which include; physical, social, spiritual and emotional ill health as well as sexual dysfunctions (Andreucci et al., 2015). A study by MacKinnon et al. (2017), found that women who suffered complications during pregnancy, childbirth or complications of abortion may possibly experience clinical and psychological disorders that may last for an extended duration,.

Globally, 800 women die every day (Påfs et al., 2016) and nearly 99 per cent of 289,000 women died from pregnancy-related causes in 2013 in low and middle income countries

(Lawani et al., 2016). Obstetric complications are of great public health concern, and universal statistics shows that maternal morbidity and mortality in the last 25 years in some settings have made slight or no improvement as women are still dying from obstetric complications (Lawani et al., 2016). This implies a serious violation of women's reproductive rights, (Mannava, Durrant, Fisher, Chersich, & Luchters, 2015a; Moyer, Dako-Gyeke, & Adanu, 2013). The Sustainable Development Goals (SDGs) three (3) projections for the year 2030 is to have fewer than 70 maternal mortalities per 100 000 live births universally (Alkema et al., 2016). There is a likelihood of higher number of women suffering from severe obstetric complications for each maternal death.

In the Sub-Saharan Africa region, Nigeria accounts for 15% of the universal burden of maternal deaths, with an estimate of 45,000 maternal mortalities each year and women in Nigeria have a lifetime risk of 1 in 22 of maternal death (Bohren et al., 2017). To every maternal mortality, there is an associated maternal morbidity and as much as 1.5 million mothers survived severe obstetric complications every year. Tunçalp, Hindin, Souza, Chou, and Say (2012), asserted that, for every one maternal death, six (6) near miss events are thought to occur. Studies by Fottrell et al. (2010), revealed that, the most vulnerable population in any nation were women who survived SOC because of the physical, psychological, social and financial consequences these women suffer even up to one year post-delivery. Morocco, studies by Assarag et al. (2015) indicated that many of the women who survive severe obstetric complications are most often than not discharged from the hospital before full recovery. Also, there is inadequate knowledge on the extent of the physical, social, emotional and spiritual consequences that could eventually affect the quality-of-life of the woman during the puerperium.

The psychological well-being of this vulnerable population is of great importance for every nation's health need. Fiskin et al (2017), observed that, there was more depression and

anxiety in women diagnosed with an obstetric complication due to fright of losing the pregnancy and concerns about their own health. Although some other factors such as poverty, marital difficulties, family violence, unplanned pregnancy, absence of social or partner support, increased life stress, maladaptive coping strategies and anxiety about the foetus may cause the expectant woman to have unpleasant situations (Gourounti, Anagnostopoulos, & Lykeridou, 2013) . Besides these negative experiences which affect their psychological well-being, some women tend to have positive attitudes, especially when they have live babies and have survived the severe complications (Furuta, Sandall, & Bick, 2014b).

The physical well-being of these women in relation to disease, treatments they have received and its impact on other general bodily concerns like pain, discomfort, inability to sleep and fatigue can affect their activities of daily-living and hence their quality of life. Prada et al. (2015), posited that, the overall physical health of women who survive SOC tends to be affected. Also, the most common health consequences of women with abortion related near-miss experience were severe abdominal pains and bleeding. A study by Lindqvist, Persson, Nilsson, Uustal, and Lindberg (2018), found that severe injury to anal sphincter muscle during childbirth may cause physical and psychological complications and suffering which include; pain, urinary and faecal incontinence. It was further established by LaCross, Groff, and Smaldone (2015) that women with third-or-fourth-degree perineal laceration leading to faecal incontinence have poor emotional health and depression postnatally (Lindqvist et al., 2018). According to (Priddis, Dahlen, & Schmied, 2013) these problems may lead to social isolation and changes in sexual intimacy, feelings of guilt, shame, frustration and poorer quality of life even up to one year postpartum.

A Lawani et al. (2016) study on obstetric near-miss and socio-cultural factors of ruptured uterus in Nigeria, revealed that most women from low-income backgrounds suffer from ruptured uterus during childbirth due to lack of access to skilled birth attendants and

quality healthcare. Ajah et al. (2016) study of Feto-Maternal consequence of Pre-Eclampsia indicated that much more women and babies die from hypothetically avoidable obstetrical problems. Expectant mothers with medical complications have uncertainties associated with pregnancy because of their expectations to have good outcome for themselves as well as their unborn babies, which sometimes turn out to be the opposite (Starkey, 2017). In a study by Currie (2016), on 'Pregnancy gone wrong', it was concluded that maternal near-miss complication is a vital medical concern expected to be addressed by all countries.

The spiritual well-being of the survivors of severe obstetric complications play roles as far as quality-of-life of survivors of SOC are concerned. Faith and spirituality has been a source of comfort and calmness for some of the survivors of near-miss events (Furuta et al., 2014b). While some of them have reflected on life and death and have tended to appreciate life, others also attribute the cause of their morbidity to spiritual forces (Prada et al., 2015). These spiritual purviews have both negative and positive impact on the well-being of the individual and hence their quality of life after surviving the near-miss event. Individuals draw on their inner strength and hope in God as a means of coping with the situations that they find themselves in and draw to the positive side of spirituality (Abu-Raiya & Pargament, 2015).

Besides the psychological, physical and spiritual impact of maternal near-miss events on these women, there are some social experiences which affect the social well-being. Fottrell et al. (2010) asserted that a near-miss complication resulting in prenatal loss or adverse pregnancy outcomes increases the risk of abuse of these vulnerable population. The social well-being of these women is imperative to ensuring a good quality of life. However, some of these women tend to have strained relationships with their spouses and in-laws because of disappointment in the outcome of their pregnancies as the identity and value of an African woman is defined directly by her fertility (Fottrell et al., 2010). Other social problems are due to financial burdens like huge hospital bills. Some of these social implications of severe

obstetric complications can be reduced when these women have enough education on birth preparedness and pregnancy complications during antenatal care as this will contribute significantly to quality antenatal care (Afulani, 2016). They however, need the support from their spouses and family during the times of complications and after being discharged from the hospital.

Social support is said to be any kind of help or assistance available to a person from either the state or other people in times of difficulty. Inadequate social support from friends and family members has been found to contribute to stressful experiences by the women who on their own were unable to cope with their distresses (Robinson, Benzies, Cairns, Fung, & Tough, 2016). Guardino and Dunkel Schetter (2014) in their study found that women who had higher social or marital support and satisfaction from significant others are less likely to experience higher anxiety levels than obstetric patients without any such social supports. On the other hand, due to economic hardships, the high cost and economic burdens incurred by family members during obstetric complications are blamed or attributed to the patient. This affects the postpartum health outcome of these women, as any further health consequence reported by them are left unattended to (Khan et al., 2014).

Khan et al. (2014), study of women experiencing obstetric complications requiring emergency care found that women were not given up-to-date information related complications and emergency care before delivery. Sufficient birth preparedness and complication readiness (BPCR) planning would ensure the survival of a pregnant woman and her baby as any unforeseen occurrence could effectively be handled. Studies have shown that lack of knowledge on BPCR are contributing factors to maternal mortalities and negative experiences during obstetric complications (Kuganab-Lem, Dogudugu, & Kanton, 2014).

The knowledge of health literacy being incorporated in focused antenatal care (FANC), as recommended by WHO, is a strategy to control obstetric complications. Nonetheless, in a

study by Lori, Dahlem, Ackah, and Adanu (2014) in Ghana, which explored pregnant women's knowledge and ability to recognize the danger signs in pregnancy, birth preparedness and complication readiness, they established that women had difficulty in interpreting and personalising the information they received during antenatal care (ANC) visits.

1.1 Statement of the Problem

Globally, 800 women die every day (Påfs et al., 2016) and nearly 99 per cent of 289,000 women died from pregnancy-related causes in 2013 in low and middle income countries (Lawani et al., 2016). Studies in Africa by Assarag et al. (2015) indicated that women who survive SOC are most often discharged from the hospital before full recovery. In Ghana, the major obstetric complications experienced by expectant mothers are haemorrhage (22%), septic abortion (11%) and hypertensive disorders of pregnancy (9%), were the three(3) principal causes of maternal deaths caused by such complications ,(Antwi et al., 2016). Maternal mortality resulting from obstetric complications remains high despite interventions put in place to lower it (Atuoye et al., 2015). That is, the current ratio of 319 deaths per 100,000 live births (2015) estimates, compared to the target of 185/10000 by 2015. Maternal morbidity and mortality are still high in Ghana, despite record of increasing institutional ANC coverage and supervised deliveries. These are key indicators of the SDG 3 acceleration framework that is aimed at reducing mortalities due to obstetric complications. It is expected that, decline in obstetric complications will be at a faster rate than it is currently. On the contrary, that is not the case in Ghana (Atuoye et al., 2015).

A study in Ghana indicated that obstetric admissions due to obstetric complications had increased from 4793 in 2006 to 11,032 in 2012, this is two times more than the previous figure, (Coleman, Srofenyo, Ofori, Brakohiapa, & Antwi, 2014). Lots of women in Ghana are living with the effects of SOC and many of these women live in the cities in Ghana where they could get access to treatment. Those who survived these near-miss events have experiences to share.

However, after they have survived the complication and discharged home after treatments, very little research has been done to find out about their experiences. There is therefore a need to understand the experiences of women who survived severe obstetric complications and actually saw death but missed it narrowly due to the prompt medical interventions or chance. Literature reviewed suggests that only few studies on women's experiences of surviving severe obstetric complications have been reported in Ghana.

A Ghana Demographic Health Survey, 2015 statistics indicated that, the risk of losing a woman due to pregnancy-related complications in LMIC is fourteen (14) times higher than in HIC (UNICEF, 2008). In a Ghana health service report of the year 2016, a total of 955 maternal deaths due to SOC were recorded nationwide with haemorrhage 65 per cent as a major leading factor. In a retrospective study at the Komfo Anokye Teaching Hospital, Ghana it was found that 322 maternal deaths were recorded due to severe obstetric complications with 30,269 live births within the period from 1 January 2008 to 30 June 2010 (Tunçalp, Hindin, Souza, et al., 2012). For every maternal death, there is an associated maternal morbidity. Hinton, Locock, and Knight (2015b), asserted that for every maternal mortality, nine (9) women develop severe maternal morbidity which will need care in an intensive care unit (ICU) or high dependency unit (HDU). The incidence of maternal near-miss for Ghana is 28.6 cases per 1000 livebirths (Tunçalp, Hindin, Adu-Bonsaffoh, & Adanu, 2013).

In a study by Tunçalp et al. (2013) in Ghana on assessment of maternal near-miss and quality of care, they found severe Pre-Eclampsia (41.5%), severe Postpartum Haemorrhage (45.7%), and Sepsis (45.9) to be the common of cases of potentially life threatening in Ghana. A statistical data from 37 Military hospital revealed that among the obstetric complications recorded from January to December 2017 Eclampsia was leading by 168 cases, followed by postpartum haemorrhage, which also recorded 99 cases, and then sepsis and emergency hysterectomy.

Table 1.1 List of Obstetric Complications at 37 Military Hospital

Diagnosis	2017	2018	2019	Total
Hypertensive Disorders of Pregnancy/Eclampsia	168	172	88	428
Haemorrhage	99	44	27	170
Sepsis	14	19	8	41
Emergency Hysterectomy	11	6	3	20
Pulmonary Embolism	6	8	5	19

Source: Statistical Report form 37 Military Hospital

In my 22 years' experience as a midwife, I have recognised that intrapartum and postpartum haemorrhage, hypertensive diseases in pregnancy, and infections were the causes of SOC. Women who experienced these complications have negative experiences that has an effect on their emotional health. These include; lack of confidence, shame, and guilt especially when there is a loss of baby, frustration, financial burden, and lack of spousal support, lack of sexual intimacy, poorer quality of life, and social isolations.

There seems to be paucity of knowledge on the experiences of the impacts of SOC on women in Ghana. Most of the literature found was on maternal morbidity and mortality, also no theory or models were used to explain the concepts that look at the well-being of the survivors. Thus, this study explored women's experiences of surviving severe obstetric complications in 37 Military Hospital using the health-related quality of life (HRQoL) model by Ferrell et al, 1991 as an organizing framework.

1.2 Significance of the Study

Women who experience SOC also go through experiences that concern their well-being. The care given to them, during and after the experience, significantly impacts on their well-being. The study consequently, offers the chance to explore women's experiences of surviving SOC and its consequences on their well-being. The findings of this study will contribute to the existing knowledge in midwifery education and practice in the area of maternal near-miss in Ghana. Furthermore, it will improve the institutional policy of our

various health institutions on how well to manage women who survived severe obstetric complications in Accra. The study findings will be useful to nongovernmental organisations that are interested in maternal health issues. Similarly, it will guide future research in this same area and enhance literature on SOC.

1.3 Purpose of the Study

The purpose of this study is to explore the experiences of women who survived severe obstetric complications in the 37 Military Hospital.

1.4 Objectives of the Study

The specific objectives of the study were to:

1. Determine the impact of severe obstetric complications on the physical well-being of women who survived severe obstetric complications.
2. Describe the consequences of severe obstetric complications on the psychological well-being of survivors.
3. Outline the implications of severe obstetric complications on the social well-being of survivors.
4. Describe the spiritual purview and its implications on the spiritual well-being of women who survived severe obstetric complications.

1.5 Research Questions

1. What is the impact of severe obstetric complications on the physical health of women who survived such complications?
2. What are the consequences of severe obstetric complications on the psychological well-being of survivors?
3. What impact does severe obstetric complications have on the social well-being of survivors?

4. What impact does the spiritual purview of women who survived severe obstetric complications have on their spiritual well-being?

1.6 Operational Definitions

Experience: Anything or situation women with obstetric complications went through.

Obstetric: Anything pertaining to pregnancy, labour and delivery.

Survive: Nearly died but continues to live due to care given or by chance.

Severe: Very intense or harsh.

Growing Lean: Becoming slender due to ill health or worry.

Near Miss- (clinical interventions specific) – an obstetric complication with clinical interventions such as laboratory results indicative of organ dysfunction, intervention radiology, intensive care admission and monitoring, laparotomy leading to hysterectomy and blood-transfusion greater or equal to four units (Kasahun & Wako, 2018).

Near Miss (inclusion criteria for disease specific) - Eclampsia, severe-Eclampsia, ruptured uterus, postpartum haemorrhage, sepsis and severe complications of abortions (Kasahun & Wako, 2018).

Obstetric complication – Any new pathological changes that are experienced by an obstetric patient with a worsening severity and the manifestations of higher number of signs and symptoms which are related to her state of pregnancy (Fiskin et al., 2017).

1.7 Organization of the Thesis

The whole work was organized into chapters as follows; In Chapter One, the background to the study was presented. Details on the Problem statement, purpose of the study, objectives of the study, both main and specific objectives were also provided with a focus on

the African context and research questions. Significance of the study, operational definitions and organization of the work were also presented.

Chapter Two examines the conceptual framework, the theoretical basis of the study and focused on the literature review based on the study objectives and literature supporting the study. Chapter Three also dealt with the methodology of the study and how participants were recruited to obtain data. It also examined the study design, setting, study population, sampling method, method of data collection and how data was managed, ethical considerations, and rigor. The findings of the study were presented in Chapter Four and Chapter Five focused on the discussions of the study findings. Finally, in Chapter six, the summary of study, implications, recommendations and conclusions were presented.

CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

This chapter is divided into two parts. The first part focuses on the conceptual framework and the second part presents a view of pertinent literature on Women's Experiences of Surviving Severe Obstetric Complications.

2.1 Justification for the Choice of Theoretical Framework

Three models were identified for the study, namely; the Transactional Model for Stress and Coping by (Folkman & Lazarus, 1980; Lazarus, 1998), which focuses on a person's assessment of a potential threat and appraisal of such events as stressful or positive, controllable or challenging and the individual's ability to employ coping strategies to mitigate such events. The second model identified was the Disease Resilience Model by Koen et al. (2011), which also discusses the ability to be resourceful and being able to use the available internal and external resources to handle diverse challenges in life. It needs a sense of coherence, optimism, hope, coping and self-efficacy. The third model explored is the Health-Related Quality-of-Life (HRQoL) model, which was chosen over the other two that could not address the research questions of the study of women's experiences of surviving severe obstetric complications. The researcher chose the HRQoL because most of the constructs in that model could address the research questions on the experiences of women who survived severe obstetric complications.

The theoretical approach of Health-Related Quality-of-Life by Ferrell, Grant, Padilla, Vemuri, and Rhiner (1991), which was now an ordinarily used framework for the assessment of the impact of illness on the individual, is also an important component of survivorship. The main constructs of this model are physical, psychological or emotional, social, spirituality and sexual well-being of the person.

To explore women's experiences of surviving severe obstetric complications the model of HRQoL for cancer survivors developed by Ferrell et al. (1991), was adopted and used

as an organizing framework. The scholars based on the assumption that the patients self-report is the means of assessing HRQoL.

2.2 Core Assumptions and Statements of the Health-Related Quality-of-Life Model

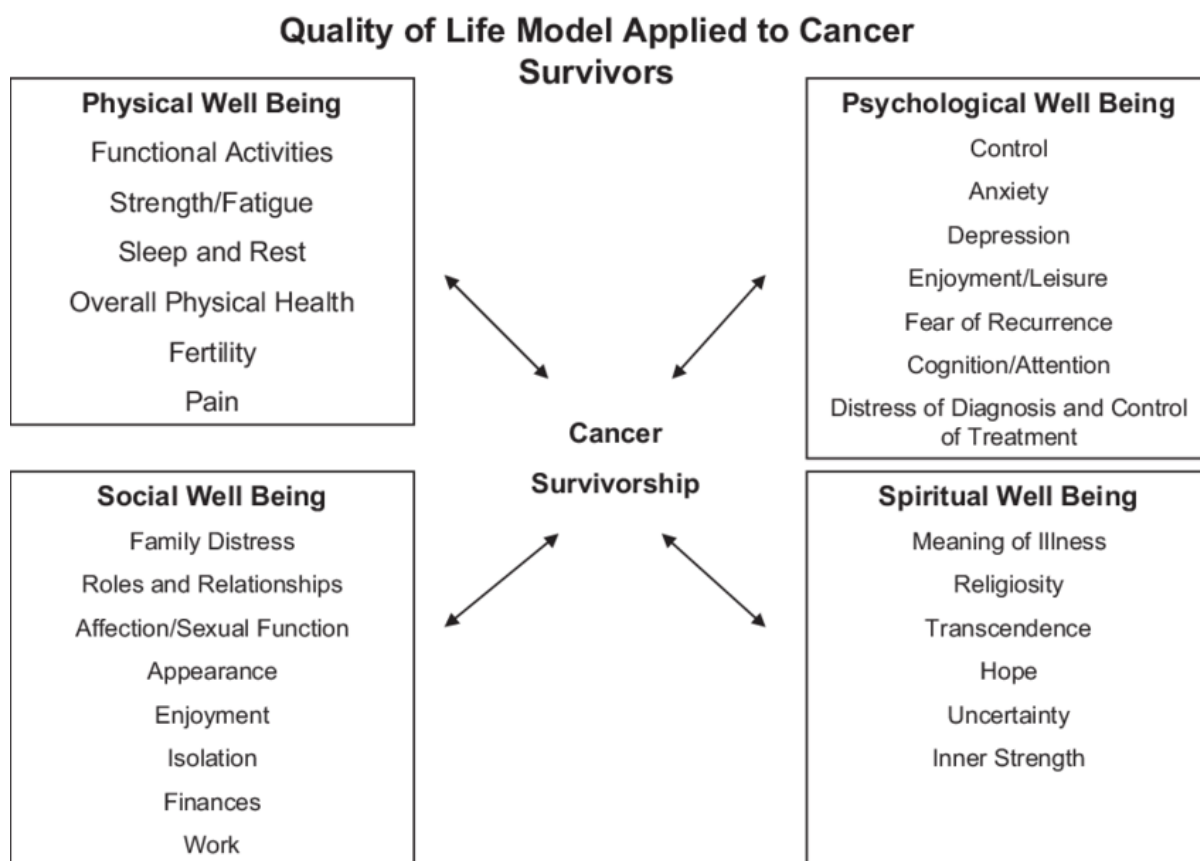
The HRQoL model is a framework for evaluating the processes of physical, psychological or emotional, social, spirituality and sexual well-being of a person (Ashing-Giwa, 2005). The assumptions are that, illness and treatment processes can have either positive or negative impact on a person's physical, psychological, social and spiritual well-being such as the quality of life. The HRQoL model was used to assess how the individual manages her day-to-day activities and her sense of well-being after surviving severe obstetric complications.

The physical aspect relates to concerns resulting from the disease, treatments being received and their impact on other general bodily concerns like pain, inability to sleep or fatigue (Klingaman, Lucksted, Crosby, Blank, & Schwartz, 2019; Norhayati, Hazlina, & Sulaiman, 2017a). The overall physical health of the woman after surviving obstetric complications and how it affected their fertility. The functional domain also measures the individual's capacity to work and accomplish usual activities-of-daily-living, whereas the overall physical health of the individual is very paramount. How the illness had impacted her sleep and rest pattern which is imperative to QoL.

Emotional or psychological domain also evaluates positive or negative dispositions such as control, depression or anxiety (Soma-Pillay, Makin, & Pattinson, 2018). These dispositions may also have some emotional health consequences like fear of recurrence or may also be positive where the survivor draws on her inner strength as a means of control or coping. The individual's quality of life and psychological well-being can be impacted by the illness or the treatment that is received.

The social, economic and cultural domain also delineates the person's capability to ordinarily participate in family, community or network activities that form the usual part of

every social being (Wilson et al., 2016). The cultural and socio ecological dimensions to the HRQoL framework have defined culture as a way of life which informs an individual's way of life and the appropriate ways to behave in the world. It also includes one's ethnic identity which is the extent to which a person's cultural heritage defines oneself. Economically, the disease condition and treatment can also affect the survivor's income, and her inability to take time off work to get treatment can also affect her recovery process and quality of life. The spiritual purview which evaluates the spiritual and existential dimensions of the survivors' experiences includes religiosity and the meaning the survivor has attached to her illness. It also addresses the things that give her hope or makes her feel uncertain, and how she can grow her inner strength to overcome the consequences of such negative impact through coping. Finally, the sexual domain also evaluates the impact of the disease or treatments on intimacy and sexual experiences of the survivor. How the severe obstetric complication has affected or improved the sexual habits of survivors.



Source: www.google.com

Figure 2.1: Health Related Quality of Life Model (Ferrell et al 1991)

2.3 Literature Review Related to the Objectives of the Study

Literature reviewed is on the concepts of the conceptual model of the study and the objectives.

2.4 Literature Search

A search for literature on the experiences of women living with the impact of obstetric complications was done. Databases used include, CINAHL, EBSCO Host, ‘ScienceDirect’, Jstor, ‘PubMed’, Hinari BioMed, Cochrane Medical Library, Google Scholar and Sage.

The following keywords were used to retrieve relevant literature: Maternal near-miss, severe obstetric complications, severe maternal morbidity, experiences of near-miss, near-

miss, Obstetric near-miss, surviving near-miss and implications of near-miss. Except for theoretical literature and a few milestone studies, articles included were from 2008 to present.

Quality-of-life (QoL) has been defined by WHO as an individual's awareness of their situation in life within the framework of their cultural values system with regards to their expectations and life goals, and standards, however, the magnitudes of SOC on post-delivery QoL is unknown (Soma-Pillay et al., 2018).

2.5 Physical Well-Being

Obstetric complications are any new pathological changes that are experienced by an obstetric patient with a worsening severity and the manifestations of higher number of signs and symptoms (Fiskin et al., 2017). A study by Kasahun and Wako (2018) on the factors of obstetric near-miss in South Ethiopia, discovered that dystocia and obstetric haemorrhage were the major causes of maternal near-miss (MNM) events. In their conclusion, they stated that, delays were associated with maternal near-miss. A study in New Zealand established that about (37%) of expectant mothers for one reason or the other have been referred by their healthcare providers for further management due to medical complications (Morgan et al., 2014). A study in Brazil, by Angelini et al. (2018), on the QoL after an episode of SOC, found that maternal morbidity conditions were associated with lower scores of patient perceptions of QoL in the domains of functionality, role-limiting physical, pain and general health status.

2.5.1 Overall Physical Health

In a study by Filippi et al. (2010a), the authors revealed that women who experience MNM would possibly have fever during postnatal period. Besides that, they had more than four times higher chances of developing hypertension compared to women whose births were not complicated. Likewise, women who survived SOC tend to have adverse maternal outcomes, coupled with loss of strength and stamina to go about their usual functional activities (Leonard,

Main, & Carmichael, 2019). Similarly, a systematic review by Machiyama et al. (2017), on consequences of maternal morbidity on health-related functioning (HRF), found that most studies revealed substantially undesirable effects of maternal near-miss events on HRF and well-being of women. A related study in Australia by Woolhouse, Gartland, Perlen, Donath, and Brown (2014), revealed that women suffer at minimum three (3) physical health complications during pregnancy or childbirth and have more health problems associated with depression.

2.5.2 Functional Activities

A study in Malaysia on experiences of women with MNM by Norhayati et al. (2017a), established that the women expressed loss of functionality in terms of powerlessness to walk and had various physical limitations. In a related study, Kuismanen, Nieminen, Karjalainen, Lehto, and Uotila (2018) discovered that, survivors of SOC tend to experience negative effects on their daily lives, as well as their QoL as far as the physical consequence of the illness and treatment were concerned. This occurs, as some survivors experienced pain, fatigue and inability to sleep which contributed to their distresses. They often experienced weakness which affected their abilities to perform household chores. Similarly, Norhayati, Hazlina, and Sulaiman (2016), found that the functional status of women with severe maternal morbidity was significantly affected during their early postpartum period, and the capacity most affected was in infant care.

2.5.3 Rest and Sleep Difficulties

A study by Kent, Yazbek, Heyns, and Coetzee (2015), revealed that women hospitalised for long period due to severe obstetric complications had sleep interruption problems because they were woken up by some hospital routines like four hourly blood pressure checks and also sharing rooms with other clients made them not feel relaxed and could

not sleep well. Another study in New Zealand, by Currie, Barber, and Carrie (2016) on experiences of having medical complications during pregnancy found that, the women's sleep were disrupted by the complications, medical care and the associated monitoring. Sleeping disorders were common in women who experienced life-threatening illnesses which may either be due to the disease condition or as a result of the treatment given. Similar studies on sleep abnormalities after episodes of severe illness revealed a relationship with disorders and lesions on the pathways regulating sleep and wake and the iatrogenic effects of the treatment given to the patients (Annema et al., 2017; De Cock, Girardot-Tinant, Woimant, & Poujois, 2018).

2. 5.4 Pain

In a study by Prada et al. (2015) it was found that, the most common health consequences of women with abortion related near-miss experience were severe abdominal pains and severe vaginal bleeding. Similarly, a study in Brazil on the QoL after a MNM event by Angelini et al. (2018), discovered that, mothers experience various levels of pain and discomforts during the post-natal period. Whiles some women reported having experienced severe injuries, others have just mild to moderate fever up to about 105 degrees Fahrenheit (40.55 °C). Furthermore, Assarag et al. (2015) studies conducted in Morocco to find out the extent of MNM events on women's health established that, physical impact like severe ill-health was associated with MNM. The authors also posited that, discomfort and serious pain postpartum tend to be higher among women with severe obstetric complication than the uncomplicated deliveries.

2.6 Psychological Well-Being

These women, aside the physical conditions they experience, also have some emotional health consequences too which make them to lack confidence in their ability to even attend to themselves or their babies. Also, having to accept a physical change like interventional hysterectomy can give rise to emotional distress, feeling sad and grief among these women.

2.6.1 Depression

Assarag et al. (2015) also found depression to be higher (38%) among women living with the impact of near-miss complications, than those with uncomplicated obstetric events. Women who experience SOC and perinatal loss have greater possibility of depression, poor health, urine leakages and pregnancy's negative effects on their lives (Filippi et al., 2010a). In a systematic review of women's perceptions and experiences of severe obstetric complications, Furuta, Sandall, and Bick (2014a), found that some women were shocked at seeing a large pool of their own blood. The psychopathological changes that occur depend to a large extent on the phase of pregnancy, the expectant mothers' concerns, the quality of social support systems available and go to determine her psychological well-being (Khavari, Golmakani, Saki, & Aghamohammadian Serbaf, 2018). A related study in Morocco by Assarag et al. (2015) posited that, depression was higher in near-miss events than those without any obstetric complications. Posttraumatic Stress Disorder has been discovered to be associated with SOC (Andersen, Melvaer, Videbech, Lamont, & Joergensen, 2012; Bastos, Furuta, Small, McKenzie-McHarg, & Bick, 2015a; Bastos, Furuta, Small, McKenzie-McHarg, & Bick, 2015b).

2.6.2 Ruminative Thoughts

Studies by Furuta et al. (2014b), in United Kingdom assessed the awareness of MNM experiences revealed that, women experienced increasing degrees of anxiety and depression. The authors also posited that, women who survived severe obstetric complications often have negative consequences such as ruminative thoughts, continuously blaming themselves and associating maternal morbidity with their mistakes like not taking very good care of themselves during pregnancy. Contrary to that, they further posited that, though severe maternal morbidity experiences were often negative, sometimes such experiences also gave opportunities for inner growth, which can subsequently impact on the women's lives positively. Similarly, a study by Ong et al. (2019), established that, separation from their babies during early postpartum due to

ICU admissions triggers a sense of regret, sadness and guilt for these women. Another qualitative study in UK on critically ill obstetric women, by Hinton et al. (2015b), found that, women who experienced SOC were overwhelmingly shocked to wake up and find themselves in the ICU instead of the maternity ward.

2.6.3 Anxiety

Xavier, Ferreira, de Santana Carvalho, de Araújo, and Cordeiro (2013) in a study conducted in Brazil on sickle cell anaemia in pregnancy posited that, lack of social support was related to anxiety. The research used a qualitative, descriptive and exploratory design which found that, owing to inadequate social support during pregnancy, the women experienced sadness and hopelessness and even thought of terminating their pregnancies. Conversely, the study did not indicate whether these already devastated women were given any form of psychological preparations prior to and during pregnancy considering the unforeseen complications and stresses of normal pregnancy. The result however, may not completely describe the stressful experiences of pregnant women with a chronic pre-existing complication. A similar study in Brazil by Angelini et al. (2018), found a strong association between SOC and PTSD among women who survived the event of maternal near-miss. Pregnancies that threaten the life the mother have proved to be anxiety provoking and also increases the probability of stress coupled with distress (Barber, Panettierre, & Starkey, 2017). A study in Canada, by (Robinson et al., 2016), on psychosocial stress in pregnancy revealed that, women in minority ethnic groups suffered from depression and anxiety due to insufficient social support.

2.6.4 Anxiety and Stress

Currie, Cornsweet, and Carrie (2016), in a study conducted in Waikato, New Zealand, using qualitative design to assess coping with complication related to pregnancy revealed that, SOC can be exceedingly stressful for women. In related studies, it was established that,

experiences of complications during pregnancy could be very devastating, and unexpected since it disordered the expectations of pregnancy (Angelini et al., 2018; Xavier, Ferreira, Carvalho, Araújo, & Cordeiro, 2013). Similar studies by Ashaba et al. (2017), on psychosocial challenges revealed that these women suffered various forms of psychological problems pertaining to their health, the future and health of the newborn, as well as a possibility that the disease could be transmitted to their babies. Similar studies by Cecatti et al. (2015) and Souza, Cecatti, Parpinelli, Krupa, and Osis (2010) on emerging MNM syndrome discovered that, the near-miss event aggravated extreme anxiety and fear among women and their anxiety levels increased because they were still having thoughts and perception of death as the ordeal reminded them of coming that close to death. There is an association between SOC and Post-traumatic Stress Disorder (Elmir, Schmied, Jackson, & Wilkes, 2012; Furuta, Sandall, Bick, & childbirth, 2012). Debriefing sessions have been found to be helpful in the management of PTSD (Bastos et al., 2015b; de Bruijn, AI Stramrood, Lambregtse-van den Berg, Rius Ottenheim, & Gynecology, 2019).

2.6.5 Fear of Recurrence

A study in USA, by Moaddab et al. (2017), on reproductive choices of women following the diagnosis of amniotic fluid embolism (AFE) discovered that, women diagnosed with AFE had increasing mortality and SOC. The women were also hesitant to get pregnant again due to fear of recurrence. It was also established that, these women had preserved their fertility after delivery and have not had further children. They further posited that; the women who wanted to have further children sought advices from experts before deciding to have further pregnancies. Contrarily, a study in Brazil, by Camargo et al. (2011), on succeeding reproductive choices of women who survived MNM established that women lost their fertility due to iatrogenic consequences like tubal ligations, or emergency hysterectomies. Similarly,

Norhayati et al. (2017a), posited that the experience of near-miss event did not despise women from getting pregnant again in the future.

2.7 Social Well Being

Literature reviewed revealed that, the social well-being of women who survived severe obstetric complication could also be affected as their QoL after the event is compromised. Several studies have revealed that in the ensuing sections.

2.7.1 Family Distress

Cultural identity of a woman who survived severe obstetric complications is mostly compromised, as the value of an African woman is in her having children. In an African society like ours, child birth is seen as a family and social responsibility, and women sustain efforts to have children in order to achieve social prestige and appreciation by their spouse's family (Fottrell et al., 2010). Similar to other studies, family's disappointments about the woman's pregnancy outcome has caused emotional ill health for these women (Hinton et al., 2015b; Khan, Blum, Sultana, Bilkis, & Koblinsky, 2012; Robinson et al., 2016). A study by Mbalinda et al. (2015), also concluded that, SOC has negatively impacted on the families and homes of women, as these women have experienced different levels of family tension. Equally, the family also experiences intense fears, loss of time where male partners and caregivers have to spend long periods in hospitals during hospitalization of their loved ones. Related studies by Dalaba et al. (2015) in Ghana on the impact of treating MNM on families concluded that, while maternal-health-services were without any charge in Ghana, women incurred exorbitant health bills. Similarly, a study in Burkina Faso, on 'beyond body counts' after MNM event by Storeng, Murray, Akoum, Ouattara, and Filippi (2010) established that there is disruption to social identity and family stability because there is intensified competition over the family's limited resources following a near-miss event.

2.7.2 Roles and Relationships

Women who survived severe obstetric complications sometimes tend not to be able to perform their roles as a mother, wife, sister, and daughter in-law, which sometimes strains her relationship with some family members who expect more from her. Her relationship with her husband may also be affected. Storeng et al. (2010) study in Burkina Faso established that, interference to social distinctiveness of the individual was associated with MNM events. This was because the prevailing power-struggles over family's scarce resource may be escalated, as women recounted declining relationships with their in-laws and people they lived with on the same compound. Similarly, a study by Fottrell et al. (2010) found spousal abuse to commence six months after delivery and was worse for women who experienced near-miss event with perinatal loss. Another study in Australia by, Priddis et al. (2013) on the experiences of women following serious perineal tear concluded that, these women experience marginalization and other social issues which are worthy of note.

2.7.3 Sexual Function

Studies such as Andreucci et al. (2015) on sexual function after maternal near-miss. The authors used maternal near-miss concept to compare women without obstetric complications to women who experienced SOC and found that, women did not resume sexual activity due to painful sexual intercourse. In a similar study, McDonald, Gartland, Small, and Brown (2015) revealed dyspareunia as a major problem. It was found that, 98% of the postpartum women recommenced sexual intercourse by 18 months after delivery and 24% recorded painful sex. Contrary, a qualitative study in Malaysia by Norhayati et al. (2017a) established that, there was no difference in the desire or arousal in sexual functions among survivors of MNM.

2.7.4 Financial Challenges

The socioeconomic challenges of MNM on women and their families are enormous. Obstetric near-miss event experiences extend beyond period of puerperium, hence it is advisable for healthcare providers to do follow-ups on such cases (Assarag et al., 2015). The authors asserted that, the economic burden on the woman and her families after an MNM care has led to socioeconomic challenges for women and people within their immediate social network. Some of these social problems include negative social consequences like economic debts and tension among families and marital disputes. Also, Prada et al. (2015) study of 'unsafe abortion and socio-economic consequences in Nigeria, concluded that, women with SOC events sometimes delay in pursuing healthcare due to the socio-economic reasons and resort to herbal or alternative treatments.

Another study by Ilboudo, Russell, and D'Exelle (2013), on 'the long term economic impact of severe obstetric complications for women and their children in Burkina Faso' discovered an adverse influence on food security. The authors further asserted that, SOC have permanent impact for women who experienced the complication and their households. This was because it has reduced the quality of education and development in these households which needs to be addressed. Women who experienced SOC were poor and uneducated as compared to the uncomplicated or women who had normal births who were found to be significantly richer and well educated (Assarag et al., 2015). The authors established that, the experience of MNM had economic impact on their lives due to the debts incurred by their husbands during such complications. Some spouses were unable to reimburse their creditors and this led to family tension and marital disputes. Post-delivery expenditures had resulted in marital frictions, tensions, irritations, and disputes among family members, physical violence and sometimes divorce. In related studies, Filippi et al. (2015) established that, frequently, women used their minor personal savings to pay for emergency care, especially those active in informal

trading. Women were sometimes compelled to trade off their belongings in order to settle healthcare bills, and this made it tough for them to recommence livelihood activities after.

Similarly, a study by Wick (2017), on survival negotiations of neonatal near-miss in Lebanon discovered that, the illness caused the family serious financial burdens because of lack of governmental healthcare supports during medical complications. Similar study by Guardino and Dunkel Schetter (2014), conducted in Greece, which investigated social support and its impact on antenatal anxiety found that, income levels have relationship with anxiety. It also posited that, women with adequate spousal support have lower anxiety levels than women without such supports. A study in Bangladesh by Khan et al. (2012), on 'the examination of women experiencing obstetric complications requiring emergency caesarean sections, posited that, women that underwent C/S due to SOC suffered higher expenses. The complications they experience inflict financial burdens on the family members and these women are blamed for the financial distress of the family. The ensuing section discussed literature on the spiritual well-being of women who experienced SOC.

2.8 Spiritual Well Being

Faith and spirituality have been seen as a source of comfort and calmness in time of experiencing severe obstetric complications. Women who survived SOC with perinatal deaths were expressively likely to acknowledge the meaning of their life and also experienced fewer negative feelings about suicide, anxiety and depression (Abu-Raiya, Pargament, & Exline, 2015). This was because these women were satisfied with their lives and their capacity to find time to relax with their families because they had hope. Contrary, the same study found that in terms of their health and QoL, the women who experienced near-miss were possibly not satisfied with their QoL experiences as compared with women who did not have any obstetrical complications. A study by Lewis (2016), on the contributions of spirituality in coping concluded that, healthcare providers should recognize and understand the client's spiritual

beliefs and principles during chronic illnesses and its effects on decision making in healthcare delivery. Another study by Martz and Livneh (2016), on 'psychosocial adaptation to disability within the context of positive psychology', asserted that, optimism, benefit-finding, resilience, and making meaning out of the situation had helped in overcoming unpleasant situations.

On the contrary, Pâfs et al. (2016) study of experiences of obstetric complications found that, believe of witchcraft was attributed to actual or potential complications of childbirth. The women blamed their predicaments on witchcraft, jealousy, and hatred by people around them who want to harm them and their unborn child. On the positive side, the meaning attached to predicaments experienced made it easier for women to cope better as a form of posttraumatic growth. This was reported by Neimeyer (2016). A study by Fredrickson, Van Cappellen, Toth-Gauthier, Saroglou, and Fredrickson (2016) concluded that, giving meaning to life's situations and engaging in meaning-based behaviours have become mechanisms that have influenced well-being. The author further asserted that, a positive meaning can be obtained by finding benefits within adversities. Another study by Zamaniyan, Bolhari, Naziri, Akrami, and Hosseini (2016), on effects of spiritual group therapy on QoL and spiritual well-being discovered that, there was an improvement in the QoL and spiritual-well-being among patients. The study further asserted that, there was an association between religious health and existential health and that, spiritual group therapy was imperative to improving the QoL. A study by Scioli, Scioli-Salter, Sykes, Anderson, and Fedele (2016), on influences of hope in restoring health, emphasized that individuals who had hope were healthier and were with less worry.

2.9 Coping strategies used by Women with Severe Obstetric Complications

Coping has been defined by various scholars as things that people do to lessen the undesirable life vents and sometimes by expressing one's feelings in times of need to other people in order to have emotional support (Reed & Giacobbi Jr, 2004). Many people use

different coping styles such as venting, instrumental social support by looking for advice, assistance or information from others. The use of positive reappraisal by re-construing stressful events as, valuable, beneficial or not being harmful (Garland, Gaylord, & Park, 2009). Others resort to religion in times of stress (Folkman & Lazarus, 1980). Behavioural disengagement, denial, acceptance, keeping a sense of humour or a joke (Seyedfatemi, Tafreshi, & Hagani, 2007). Other ways by which people can cope during any stressful situation are distraction, whereby individuals divert their worries from the stressors. Self-blame and substance abuse are negative ways of coping with stress. In a similar study by Mbalinda et al. (2015), they established that people can improve their ability to cope with stressful situations by being positive minded, optimistic and having the ability to regulate one's own emotions. A negative coping style during a state of anxiety in pregnancy has adverse effect on expectant mothers and their unborn children (Robinson et al, 2016).

Fiskin et al. (2017) study conducted in Istanbul University medical school, Turkey, on adaptation and depression levels in high-risk women indicated that, depression was higher in pregnant women younger than 35 years old. The authors further posited that, women with pregnancy complications had a significantly lower psycho-social adaptation to stress as they have difficulty in adaptation. Although the study had revealed how poor women with high-risk pregnancies adapt psycho-socially based on their age and nature of pregnancy complications, it did not touch on how support from families and significant others can lessen their tendency toward depression. In related studies on coping strategies among Greek women, Gourounti et al. (2013) discovered behavioural disengagement as a challenge. The authors concluded that, self-blame, denial, self-distraction, substance use, acceptance, positive reframing, active coping, and looking for emotional assistance as coping strategies used by these pregnant women. Even though the differences in background were controlled in the study, other vital psychosocial influences like personality traits and support from significant others were not

controlled and they might influence their coping strategies. Thus, the results obtained may be influenced by other factors that were not uncontrolled.

2.9.1 Social Support

While the influence of social challenges might have an effect on the woman's risk for psychological distress and her overall HRQoL, there are other social factors that may mitigate the negative impact of SOC. Gourounti, Anagnostopoulos, and Sandall (2014) study have identified an association between depression and poor social support systems. These scholars are of the view that, when there is a good social support available, there would be a decrease towards the tendencies of depression. Bullock (2004), posited that, social supports are resources that individuals draw on in order to deal with a stressful situation, or any kind of help or assistance available to a person from either the immediate family members, friends, the state or other people in times of difficulty.

Faller et al. (2017), study in Germany, on the necessities for information and psychological support in relation to QoL opined that, the mainstream of the respondents felt needing psychosocial support during their life-threatening illness. Similarly, various studies on social support explained informational support to be related to the guidance, assistance, suggestions, information or opinions offered to a person in need of it (Cremonese et al., 2017; Dwarswaard, Bakker, van Staa, & Boeije, 2016). In a similar study, Cremonese et al. (2017) on social support and the adolescent viewpoint of postpartum asserted that, friendliness was related to emotional support, love, empathy and respect. Whereas monetary support, period dedicated to a person and accessibility of resources, goods and services were referred to as instrumental support which are all aimed at reducing stressful experiences.

2.9.2 Healthcare Provider Support

On care providers' support, Påfs et al. (2016) qualitative study found that, health care givers did not give their clients enough information concerning their health condition. The

authors further posited that, inadequate communication among patients and their caregivers resulted in unsuitable treatment for their clients. Similarly, Furuta et al. (2014a) posited that, absence of information or too much of it has an undesirable impact on the experiences of women with severe obstetric complications. Though women expect health care providers to help them understand what happened to them, this has not been the case most times, since routine postpartum care does not include that. Another study in Australia, by Priddis, Keedle, and Dahlen (2018) on women who experienced birth trauma revealed that, women's health outcomes were determined by the ways these women were cared for during childbirth and postpartum. These include practical support from family members and emotional support from healthcare professionals and peers.

In the same way, Mbalinda et al. (2015), in their study found that healthcare providers did not make available enough information to the clients and also their spouses, as this affected the way the male partners of these women perceived the severe obstetric complications. Amirehsani et al. (2017), in their study of US healthcare experiences with Hispanic clients, found that inadequate communication was higher where culture and language differences existed among clients and their healthcare provider, as participants wanted more health information which were denied them because of those barriers. Another study in UK by Hinton et al. (2015b), on supports women received from healthcare providers after severe illnesses determined that, supports women received assists in their timely recovery. They asserted that, social support in the form of good care and providing an assistance after discharge where their healthcare providers gave them health visits and kept in touch with them to give those reassurances was beneficial to them and their families as well. A good relationship with the staff and their continuous support during the period of care reduces feelings of anxiety and fear, which enables patients to concentrate on their recovery.

2.9.3 Friends and Family Support

In Cremonese et al. (2017) study of stillbirths; economic and psychosocial consequences conducted in a teaching hospital in Brazil between May and August 2016, investigated the social support received during antenatal and postnatal. Cremonese et al. (2017) posited that, instrumental support, informational and emotional supports were provided by people of households to adolescent women during postpartum periods. The family atmosphere is also referred to as a form of social support, since it plays significant roles in the coping for patients after surviving a life threatening illness (Salakari et al., 2017). In a related study, findings Kent et al. (2015) recommended that, there is the need for health care professionals to adopt additional unrestricted and flexible visiting hours for clients' family, close friends and significant others as increased social support plays a positive role in early recovery.

2.9.4 Spousal Support

A study in Rwanda, by Doyle, Kato-Wallace, Kazimbaya, and Barker (2014) on roles of gender in and care giving established that, men accepted to change from their old ways of socialization in order to assist their wives with household chores, as these men have identified their own cultures as barriers to change and their stand helped in improving social support for the women. A similar study in South Africa, by Van den Berg et al. (2013) on 'shifts in fatherhood beliefs and parenting practices, found that, many of these fathers saw the significant shift in their beliefs and fatherhood practices as beneficial. The authors asserted that, the fathers' shift from breadwinner and disciplinarian role to one that was of comradeship encouragement, participating in household chores, and affection has rather enhanced relationships and communication with their spouses. Anxiety and worries during pregnancy have been found to be associated with poor marital supports due to low marital satisfaction (Gourounti et al., 2014). Furthermore, low income levels were also considerably linked with uncertainties, and anxieties were also associated to low educational levels. In their study it

could be said that, the anxiety and worry levels of participants might have increased due to the fact that, questionnaires were administered just before antenatal care screening.

2.10 Antenatal Care Education

Lori et al. (2014) studied antenatal health literacy in Ghana and concluded that, women exhibited low health literacy on danger signs of pregnancy, birth preparedness and complications readiness planning. Previous undesirable encounters with health professionals and the absence of knowledge have contributed to underutilization of ANC and delivery services (August et al., 2015). The lack of money; unavailability of transport and unfairness of the healthcare providers are reasons for non-attendance of ANC, the elimination of these problem could increase ANC attendance among women. A study in Nigeria by Awowole, Omitinde, Arogundade, Bola-Oyebamiji, and Adeniyi (2018), on barriers to ANC use and its consequences for maternal health programming found three leading problems to why these mothers did not utilize ANC. Miller et al, (2016) study on respectful maternity care concluded that, healthcare providers and healthcare systems must ensure that women received accurate care and are offered the necessary services and these must be provided to them in a manner that compliments, protects, and encourages human rights. Similar studies on respectful care for women from healthcare providers during childbirth were also done by (Shakibazadeh et al., 2018; Tunçalp et al., 2015; Warren et al., 2013)

A study by Kuganab-Lem et al. (2014) and Yidana and Kuganab-Lem (2014) on 'birth preparedness and complication readiness among Ghanaian women' found that, women had fair knowledge of BPCR. Another study in Ethiopia by Chala, Asseged, Woldeyohannes, and Tekalegn (2018), revealed that women who had significant knowledge in the danger signs of complications during pregnancy, would usually prepare in anticipation for any unforeseen circumstances by saving money towards it and even let family members donate blood for keeping at the blood bank.

On the contrary, another related study in Bangladesh by Khan et al. (2014) on knowledge of birth preparedness of pregnant women experiencing complications which required an emergency care found obstetrical women not vividly informed about BPCR beforehand concerning their pregnancies and what to expect. The authors concluded that, due to the high cost incurred by family members which was later blamed on the obstetric women, most postpartum health consequences were not reported and were generally left untreated.

Another study by Iliyasu, Abubakar, Galadanci, and Aliyu (2010) on BPCR, and spousal participation in care, which studied spousal support and the reasons why some male partners do not involve themselves in the care of their obstetrical partners in time of pregnancy revealed that ignorance, poverty, cultural and religious factors were some of the reasons given.

2.11 Summary of Literature Review

Literature review relevant to the study was organized under themes according to the HRQoL model for survivors of severe illness and it was found that severe obstetric complications can affect the individuals' physical, psychological, social and spiritual well-being. The studies reviewed were qualitative, quantitative studies and mixed method approach of study designs done in high-income countries as well as low and middle-income countries to find out women's experiences of surviving SOC.

The physical well-being of these women who went through these complications was serious illness, pain/discomfort, inability to sleep well and weakness. Other physical consequences include functional inactivity which includes inability to do household duties due to fatigue and lack of strength to do any household chores.

The psychological well-being of women who experienced SOC has also been found by several studies to be affected either negatively or positively, depending on the disposition of these women. Both qualitative and quantitative studies done in high-income as well as low-

and-middle-income countries found psychological distress, episodes of depression, emotional stress, ruminative thoughts, self-blame, sadness and anxiety to be some of the consequences.

The social well-being and the QoL of survivors are also affected because of the exorbitant hospital bills which have economic impact on the family. While some experience marital tension/disputes, those who end up having hysterectomies with perinatal loss face negative social consequences as they lose their social status and recognition in their husbands' families. Others also lack spousal supports and experience lots of violence or disputes and subsequent divorce.

The spiritual well-being of women who experience near-miss event is consequential to their quality of life as some survivors use religion as a coping mechanism to overcome the impact of the complications. This notwithstanding, various coping strategies have been utilised to mitigate the impact of the complication and its treatment on the women who experienced the near-miss complications.

Considering the literature that were reviewed, there were only few studies on SOC that have used a qualitative research method to explore the lived experiences of survivors of SOC. Also, literature has not fully explored the experiences that these women go through, with regard to the physical, psychological, and social distresses significant to their wellbeing. This study explored women's lived experiences of surviving severe obstetric complications.

CHAPTER THREE

RESEARCH METHODOLOGY

This section presents a description of research method, research design and procedures that were used. It also describes the setting in which the study was conducted, study population, sample size, the sampling methods, tools used for data gathering, data collection procedure and how ethical considerations were observed.

3.1 Research Approach and Design

A qualitative research design was adopted to conduct the study, which also used a qualitative, descriptive exploratory approach. This approach presents a means of exploring and understanding the meaning that an individual gives to a social problem (Taylor, Bogdan, & DeVault, 2015). A descriptive qualitative research primarily seeks to explore and understand a phenomenon of interest (Mayer, 2015). In qualitative studies, the findings direct the understanding of a phenomenon that is being studied and new concepts can be generated (Tong, Flemming, McInnes, Oliver, & Craig, 2012). In this study, the qualitative method was chosen because it enabled the researcher to get deeper understanding of the lived experiences of women who survived SOC. This type of approach is a choice because the researcher seeks to understand the experiences of clients with a disease condition and how it affects their quality of life and well-being. A qualitative exploratory study is carried out in natural settings; therefore, the homes of participants were used as a natural setting and probing questions were used to elicit more answers to the questions posed and this was indicated in how the probes were changing over time. Considering the problem statement, there were only few studies on severe obstetric complications that have used a qualitative research method.

3.2 Research Setting

The study was conducted at the 37 Military Hospital, Accra. The 37 Military Hospital is a quasi-governmental and specialist hospital established on 4 July 1941 as the 37th Military hospital which was established by the British colony in their territories (Mensah, Mogale, & Richter, 2014). It is the third largest teaching hospital in Ghana after Korle Bu and Komfo Anokye Teaching Hospitals with about 3,000 deliveries annually and Eclampsia/other hypertensive disorders of pregnancy are the leading cause of maternal mortality in the facility. The hospital provides 24-hour maternity services to all clients in the country.

This hospital was chosen because it is a referral hospital and the third largest teaching hospital in Accra. It also serves as a referral hospital which accepts the national health insurance scheme. It is also strategically located and easy to access by most women within the Accra Metropolis. Obstetric complications are referred there, treated and discharged home but much is not known about the experiences of the women who survived these complications. Experiences of SOC survivors are of great importance to the nation and 37 Military Hospital is of no exception, but limited studies have been done in this hospital.

3.3 Study Population

According to Ormston, Spencer, Barnard, and Snape (2014), a population is a subset of the target population and is also known as the study population. The population in this study were clients who survived severe obstetric complications and managed at the 37 Military Hospital. It is worthy of note that not all clients who access healthcare from the hospital are from the Accra Metropolis since 37 is a referral hospital. Hence, the study population were participants who reside within the Accra Metropolitan area.

3.4 Sampling Technique and Sample Size

The sampling technique that was used for this study was a purposive sampling technique. It is a non-probability sampling technique in which the samples are selected based

on the characteristics of the population and the objective of the study (Etikan, Musa, & Sunusi, 2016). It is again said to be a thoughtful selection of participants, owing to the qualities the participants possess. In this study women who have survived severe obstetric complications were purposively selected from the maternity ward and intensive care unit (ICU) of the 37 Military Hospital. All participants were purposively identified to the researcher and owed their selection to the notions of near-miss, that is; a condition in which a woman nearly dies due to complications of pregnancy, childbirth or within 42 days of termination of pregnancy, but survived due to the treatment received or by chance. Purposive sampling technique was chosen because participants have lived experiences and they were in the best position to tell their experiences. The researcher, after gaining permission to conduct the study, visited the maternity and intensive care unit at least twice every week and stayed with the midwives to enable her establish rapport with potential participants. While with the midwives on the ward, consent was sought from all potential participants and anyone who expressed interest, the researcher obtained their detailed residential addresses and telephone numbers.

Sample size is however not central to qualitative research and the criteria needed to stop interviewing participants was dependent on saturation, which is when no new concepts or themes were emerging (Cleary, Horsfall, & Hayter, 2014). A saturation is said to have occurred when adding more participants to the study does not necessarily result in additional information (Fusch & Ness, 2015). The sample size of 12 participants was determined by data saturation when no new concepts or themes were emerging.

3.5 Inclusion criteria

The inclusion criteria for this study, which depicts eligibility for participation in the study entailed:

- a. Women who have survived severe obstetric complication from time of discharge from the health facility up to one year postpartum.

- b. Women who are 18 years and above.
- c. Having survived any one of the severe obstetric complications using the WHO near-miss inclusion criteria.
- d. Residing within the Accra Metropolis.
- e. Being able to give consent.
- f. Could speak either English, Ga, Twi or Ewe languages.

3.6 Exclusion criteria

The exclusion criteria for the study, which depicts the ineligibility for participation include:

- a. Women who survived severe obstetric complications but are not residing within the Accra Metropolis.
- b. Not emotionally stable to give informed consent.

3.7 Pretesting

A pretesting of the research instrument was done at the Police Hospital, Accra, to assess the reliability of the interview guide. An interview of four (4) women who have survived severe obstetric complications was done, after which the researcher, with the assistance of the supervisor and peers, assessed the questions that were not clear and not eliciting the expected answers after the pre-test and were appropriately reviewed for clarity and efficiency. Together with my supervisor and peers, the interview guide was reviewed as part of the preparations towards the start of the study and also, a peer debriefing was done to help refine the interview guide.

3.8 Data Collection

The researcher used semi-structured interview guide and nonparticipant observational method to elicit information from twelve participants. The interview guide was in sections. Section A elicited the demographic characteristic of the participants. Section B focused on the

experiences of women after severe obstetric complications (See Appendix F for interview Guide).

The researcher sought permission from the institutional ethical review board (IRB) of Noguchi Memorial Institute of Medical Research (NMIR) (Attached as Appendix A), and 37 Military Hospital (Attached as Appendix B). The researcher got access to the study participants by an introductory letter from the School of Nursing and Midwifery, University of Ghana, to the IRB of Noguchi memorial institute of medical research for ethical clearance. Subsequently, the ethical clearance was granted, (NMIR-IRB CPN 026/18-19 Attached as Appendix C) and (37MH-IRB IPN 250/2018 Attached as Appendix D). The researcher asked the midwives on the ward to assist in sensitizing the potential participants by telling them about the study. Those who willingly expressed the interest to participate in the study were recruited. Rapport was established to gain trust from potential participants, after which the researcher obtained detailed residential addresses and telephone numbers of the participants and contacted them later.

Most of the data were collected in participants' own homes and others at a suitable place within the healthcare facility which was convenient for both the researcher and participants. The interviews were audio recorded on participant's permission. The major tool for data collection in this study was the interview guide, combined with the use of memo and field notes, where any extra information like facial expressions or gestures were recorded and later referred to during the transcribing of the data. During the interview process, the researcher maintained a friendly but purposeful environment to elicit the needed responses and encouraged the participants to express their thoughts and feelings by the use of non-verbal cues such as nodding and facial expressions without interruptions from the researcher.

The researcher asked open-ended questions with the hope that all information anticipated was obtained and also offered the participants the freedom to give what response they think best describes the phenomenon (Kallio, Pietilä, Johnson, & Kangasniemi, 2016).

The use of observational method also made it possible for the researcher to record behaviours like facial expressions and gestures as they occurred (Merriam & Tisdell, 2015).

In-depth interviews have the advantage of getting detailed information which was full and rich from the subjects (Morse, 2015; Polit & Beck, 2012a). The interview lasted approximately between 45 minutes and 60 minutes. The researcher used interview guide to direct the questions that were asked, also a digital recorder was used with the consent of participants to record any information. A field note was kept for recording any detailed event about the contextual responses that were not expressed in the verbal information that was being recorded and these include occurrences that were seen, heard, experienced or thought about during the process of data collection (Dummer, Cook, Parker, Barrett, & Hull, 2008). The information in the field notes was used to support data collected from participants. It also helped the researcher to do a critical self-reflection and guide her to ask relevant questions pertaining to the study. Also, a reflexive journal was kept by the researcher and reflexivity was done by writing down any preconceived ideas and personal views of the researcher about near-miss experiences in the clinical area and was shared with my supervisor to prevent researcher bias.

3.9 Data Management

Data gathered from participants in the form of voice recordings of participants' experiences and other electronic copies of transcripts have been kept in the researcher's Google drive for safe keeping and password protected for at least five (5) years after the completion of the study and to be destroyed afterwards. Also, the hard copies of transcripts and field notes have been stored in a locked cabinet in the researcher's room. All participants were given pseudonyms by the researcher to ensure confidentiality of data collected.

3.10 Data Analysis

In data analysis, the researcher reflects on the data collected by asking herself some analytical questions and consequently writing memos on the process of the research (Evers, 2016). The data analysis was done concurrently with data collection to allow for adjustment of instruments during data collection and all deficiencies detected were corrected. Thematic analysis offers flexibility to the researcher to work within the chosen theoretical framework and be able to identify, analyse and report patterns in the data collected (Silverman, 2016). Data analysis involves clustering related types of narrative information into coherent scheme with the purpose of organising, providing to, and eliciting meaning from the data. Using Braun and Clarke (2006a) steps of thematic analysis framework, data was analysed in six stages. The stages of thematic analysis identified were; familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. The researcher listened to the recorded interview over and over and transcribed it verbatim, then later read several times to give directions on how subsequent questions would be conducted to elicit the expected response. Data were coded based on the sub-themes of the conceptual framework. The codes were then collated into various themes of the framework and relevant data to the theme were grouped together. The interpretation of the findings was done, and conclusions drawn based on the frame of reference guided by the research questions. Thematic analysis assisted the researcher to provide response to the research questions posed through a meticulous process of data familiarization, coding, theme development and revision.

3.11 Methodological Rigor

There are diverse schools of thought on how to measure the trustworthiness of data in qualitative studies (Cope, 2014). To ensure rigor and trustworthiness of the study, Lincoln and Guba (1985) in their study of methods and meanings of maintaining credibility and

trustworthiness in a qualitative research come out with five criteria which were considered: credibility, transferability, dependability confirmability, and authenticity.

3.11.1 Credibility

Credibility of the study was ensured by adopting a purposive sampling technique, spending extended time in the field; working in the ward and familiarizing with the participants and asking probing questions. The interview guide was pre-tested and reviewed accordingly and the researcher visited participants and follow up visits were made to obtain more information and clarification. This gave the researcher the opportunity to familiarize with the study site and to also have interactions with the participants.

Triangulation was ensured using multiple methods of data collection by the use of semi-structured interview guide, observing gestures and facial expressions recorded infield notes (Houghton, Casey, Shaw, & Murphy, 2013). The researcher reported the truth, explored the meanings, clarified issues with the participants to ensure that the information gathered was truly the information given by the participants and the raw data was made available to her supervisor. All the techniques employed were monitored by supervisors in order to provide external checks on the research process, which is known as audit trail, after which an accurate report on the experiences of participants was produced.

3.11.2 Transferability

Transferability is another criterion for ensuring rigor in research. It denotes the applicability of research findings to other locations or groups with similar conditions (Houghton et al., 2013; Polit & Beck, 2012b). The researcher gave adequate information on the participants and on the research context to assist any reader or future researcher to assess the findings' competence of being convertible to other settings with similar conditions. This was done by keeping records for audit trail, giving a thorough description of the setting and the use of direct quotes from participants.

3.11.3 Dependability

Dependability or consistency of qualitative data is defined as the constancy of the participants' data over time and similar conditions by another researcher agreeing with the decision trails at every stage of the research process (Houghton et al., 2013; Polit & Beck, 2012b; Tobin & Begley, 2004). This can be ensured through the use of stepwise replication, which involves using two groups of researchers and different data sources and comparing results (Polit & Beck, 2012b). The researcher ensured dependability by using same line of questioning (consistency) and the use of a detailed description of methodology and findings. An audit trail was also developed, by systematically collecting material and records of all processes to enable an independent auditor to come up with same or similar conclusions. No statements have been added or discarded from the data, all notes and audiotapes have been kept unedited for use by other researchers for confirmation purposes.

3.11.4 Confirmability

Confirmability is the researcher's ability to establish that the data collected truly represents the participants' responses and not the researcher's viewpoints/biases (Polit & Beck, 2012b; Tobin & Begley, 2004). The researcher ensured confirmability by describing to readers and future researchers how findings, conclusions and interpretations were established from data of participants. The researcher ensured this by providing rich quotes from the participants' data and how each theme emerged from the data gathered. A reflexive journal was kept by the researcher and reflexivity was done by declaring her biases by first looking at herself as a woman, a professional nurse, midwife, as an individual, a mother with children and as a researcher whose previous knowledge might influence the work, if not carefully bracketed (Tufford & Newman, 2012).

3.11.5 Authenticity

This refers to the ability and the extent to which the researcher expresses the emotions and feelings of the participants' experiences in a faithful manner for readers to grasp the essence of their experiences through the participants' quotes (Polit & Beck, 2012b). The researcher ensured this by quoting the exact words of the participants with the exclamation signs indicating their feelings and emotions during data collection.

Conclusions from the study were taken back to participants to review for accuracy and representativeness to enhance respondent validation. The researcher revisited three (3) participants for clarification of issues also known as member checking/verification and for more information. This also promoted close contacts with participants as well as the setting to promote trustworthiness of the study. Also, scripts were given to peers to read through for corrections and inputs. Feedbacks and suggestions from supervisors also helped in shaping the study. The various sequence of actions by several stakeholders assisted in ensuring that the study is trustworthy.

3.12 Ethical Considerations

In any research study that involves human participants, the safety and dignity of participants are paramount and as such various precautionary measures were taken to ensure that. First and foremost, it is important to consider whether a study is ethical or not before commencing the study. This is to ensure safety of participants (Petrova, Dewing, & Camilleri, 2016). A research proposal was submitted to the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana for ethical clearance and approval. An ethical clearance was given (NMIR-IRB CPN 026/18-19- Attached as Appendix C).

In addition, another proposal was sent to the Institutional Review Board of 37 Military Hospital for clearance and approval to use their facility for the research and as well

have access to the patients' records with the consent of the participant (Attached as Appendix D). Also, permission was sought from the gatekeepers on the various wards to recruit participants for the study. Legal and ethical considerations must be addressed before, during and after the conduct of research to ensure that the researcher does not harm the participants (Obijiofor, Colic-Peisker, & Hebbani, 2018).

In order to respect the participants' rights to information and dignity, the researcher prepared an information sheet for the participants which stated clearly the research topic; purpose of the research and the issues on the consent form, which include the confidentiality, anonymity, risks, benefits and compensation, (Information sheet and Consent Form attached as Appendix E). Participants were guided to understand all the information on the information sheet and consent form, after which they were allowed to ask any questions to clarify any doubt before the start of the interview. Participants were also informed about the voluntary nature of the study and made to understand that they have the right to refuse to take part or opt out of the study at any point in time without being punished or it affecting the care that was being given to them at the healthcare facility. In anticipation, the researcher also planned for the services of a clinical psychologist at the 37 Military Hospital, (Maj Emmanuel Yobanya, contact: 0548592991/0501276788) to assist any participant, who in the process of recounting any stressful experiences, feels emotional discomforts as a result of the sensitive nature of the events. Nonetheless, no participant had emotional discomfort or breakdown during the interview sessions. All data collected has been kept safely in a confidential manner and used only for the purpose of this research and participants have been assured of this as well.

2.13 Summary of Research Methodology

Guided by the study objectives, a qualitative research design was adopted to conduct the study, which used a qualitative, descriptive exploratory approach. The study setting was the 37 Military Hospital, Accra, with a study population of obstetric women who experienced

SOC. Twelve (12) participants were purposively sampled based on the inclusion and exclusion criteria. The sample size of 12 participants was determined by data saturation when no new concepts or themes were emerging. Participants were interviewed in their own homes and others within the health facility, using a semi-structured interview guide; in-depth interviews which lasted between 45 to 60 minutes were conducted by asking participants open-ended questions. A digital recorder was used with the consent of participants. Data were analysed using thematic data analysis framework of (Braun & Clarke, 2006b). Methodological rigor and trustworthiness of the study were ensured. Ethical clearance was obtained from NMIMR and 37MH IRB. Participants were guided to sign the informed consent form and their confidentiality was assured as well as the voluntary nature of the study.

CHAPTER FOUR**STUDY FINDINGS**

This chapter presents the results of the study and is divided into sections. The first section focuses on the accounts of the demographic characteristics of respondents. The remaining subdivisions present the results according to the study objectives and research questions. Four (4) themes in all and twenty-seven (27) sub-themes were formulated based on the constructs of the theoretical framework used and the study objectives. Two (2) other themes and seven (7) sub-themes emerged based on the responses of participants using thematic analysis.

Table 4.1 below is presenting the details of all the themes and sub-themes.

Themes	Sub-themes
1. Physical Well-being	<ul style="list-style-type: none"> i. Lack of stamina ii. Increasing weakness iii. Fatigue iv. Residual Hypertension v. Low haemoglobin levels vi. Incisional pain vii. Sleep disruption viii. Permanent infertility
2. Psychological well-being	<ul style="list-style-type: none"> i. Feeling sad and worried ii. Loss of confidence for subsequent pregnancies iii. Post-traumatic stress disorder iv. Lack of knowledge of condition
3. Social Well-being	<ul style="list-style-type: none"> i. Family distress ii. Strained family relationships iii. Social Isolation iv. High hospital bills v. Loss of income generating businesses vi. Inability to meet financial demands
4. Spiritual Well-being	<ul style="list-style-type: none"> i. Saved by God ii. Blamed others for their predicaments
5. ANC Experience (Emerging Theme)	<ul style="list-style-type: none"> i. Inadequate knowledge on danger signs of pregnancy ii. Poor attendance to pregnancy school iii. Mixed reactions by healthcare providers towards patients
6. Coping (Emerging Theme)	<ul style="list-style-type: none"> i. Use of diversionary strategies ii. Care providers' support iii. Family and spousal support iv. Doing activities at own pace

Narrations from participants which represent the descriptions given by the participants on their experiences of surviving severe obstetric complications were used to highlight the themes and sub-themes in the table above.

Each theme in the findings was stated and reinforced with verbatim quotes from the respondents that reveal their survived experiences as a result of the complications. In order to ensure anonymity of the respondents, pseudonyms were used. For example, respondent 1 (R1) is identified by the name Amara, R2 as Baraka, R3 as Canne, R4 as Danlu, R5 as Ezeyaa, R6 as Fluke, R7 as Granga, R8 as Hamdara, R9 as Indiana, R10 as Jumak, R11 as Kasio and R12 as Lima.

4.1 Socio-Economic Status

With their socio-economic status eleven (11) participants belong to the middle class and only one participant is in the lower class. For occupation/employment six (6) participants are employed with various institutions, five (5) of them are traders and one (1) student who is unemployed. The 12 participants have two major religious affiliations, eleven (11) of them are Christians and the remaining one (1) is a Muslim. They all have people living with them in their households ranging between two (2) and eight (8) people. These women experienced various forms of severe obstetric complication within the Accra Metropolis and out of the 12 participants, 5 participants were referrals from other health care facilities within the Accra Metropolis to 37 Military Hospital.

All 12 participants experienced either one (1) or two (2) of the following near miss condition; Severe haemorrhage, Eclampsia, uterine rupture leading to interventional hysterectomy and complications of abortion.

4.2 Socio-Demographic Data

The ages of all 12 participants were within the range of 22 to 41 years and with a mean age of 33.5. Ten (10) of the participants are married and one of the participants is

cohabiting and the other is having a boyfriend. All 12 participants have had formal education, six (6) participants have high school education (SSCE), and two have first and second degree and the remaining four (4) have qualifications in nursing and teaching. Table 4.2 depicts the profile of participants:

Tale 4.2. Profile of participants

Ps	Age	Marital status	Educational background	Occupation	Religion	Ethnic group	Cause of complication	Lost Baby	Household income	Perceived socio-economic status
Amara	29	Married	2 nd Degree	Manage an eye clinic	Christian	Akan	Haemorrhage/Blood Transfusion	No	GH¢30,000.00	Middle Class
Baraka	35	Married	SSCE	Health Assistant	Christian	Dagbani	Eclampsia	Yes	GH¢12,000.00	Lower Class
Canne	41	Married	SHS	Trader	Christian	Ewe	Haemorrhage/Ruptured Uterus/Hysterectomy	Yes	GH¢3,600.00	Middle Class
Danlu	29	Cohabiting	1 st Degree	Radiographer	Christian	Akan	Haemorrhage/Blood Transfusion	No	GH¢32,000.00	Middle Class
Ezeyaa	35	Married	SHS	Trader	Moslem	Hausa	PIH/Ruptured Uterus/Hysterectomy	Yes	GH¢3,600.00	Middle Class
Fluke	37	Married	HND	Operations Officer	Christian	Fante	Eclampsia	No	GH¢12,000.00	Middle Class
Granga	28	Married	Tertiary	Community Health Nurse	Christian	Ewe	PIH/Pulmonary Embolism	No	GH¢11,856.00	Middle Class
Hamdara	38	Married	Tertiary	Teacher	Christian	Akan	Eclampsia	Yes	GH¢7,200.00	Middle Class
Indiana	33	Married	JSS	Trader	Christian	Ga Adangbe	Eclampsia	Yes	GH¢4,800.00	Middle Class
Jumak	39	Married	SSCE	Trader	Christian	Fante	Eclampsia/Renal Dialysis	No	GH¢2,400.00	Middle Class
Kasio	22	Boy Friend	SSCE	Student	Christian	Akan	Septic Abortion/Laparotomy	Yes	No Income	Middle Class
Lima	36	Married	SSCE	Sales Personnel	Christian	Ewe	Pre-Eclampsia/ Gaped C/S wound	No	GH¢4,200.00	Middle Class

4.3 Physical Well-Being

This section presents the results of the impact of surviving a near-miss on the physical well-being of participants. The study revealed that physical well-being of all participants of the study was impacted by the experiences of the complication they survived in various forms, as their physical well-being has been compromised in one way or the other.

4.3.1 Functional Activities

Another issue raised by many participants as a result of the complications they survived was that they are no longer able to do hard work as compared to previously. As some of these women have lost their strength and stamina for their usual functional activities of household chores and some have to be assisted in performing such activities. They recounted the following:

Eeerrr! currently I can't do any hard work, yes, because things like lifting of heavy things, washing and all those hard household chores is like somebody has to be doing it for me now. And this thing affected me to the extent that I couldn't even carry my own daughter. (Fluke R6)

Similarly, Ezeyaa expressed her experiences this way:

For instance, today when I was coming here I had some of my goods I have been selling and I wanted to bring some to sell, I did all that I could but couldn't carry the bag so I left it at home and came without it, I left it on the bed and came. Hmmm! Oh! The strength is not coming. I felt so dizzy and then just sat down quietly. Oh! It is not easy at all, at first, I could do everything by myself but now, not at all. (Ezeyaa R5)

Granga R7 also narrated:

I am able to do some household chores, but I easily get tired at the smallest exertion. My husband assists me sometimes, also my mother came to assist me for some time but now she has gone back to her house, so my husband is the only person assisting me now. Coughing. (Granga R7)

Aside this, participants had concerns about their strength and fatigue levels as a result of the near-miss event. The succeeding section presents results of the strength and fatigue levels of the participants.

4.3.2 Strength/Fatigue

Many of the women interviewed expressed weakening strength and exhaustion at the smallest exertion. In these women's narratives, surviving a near-miss was associated with weakness, lack of strength and an accompanying fatigue. Indiana, a 33-year-old woman who survived Eclampsia presented it this way:

Since after my discharge home I have realised that when I talk too much, I become tired and also, I cannot stand heat at all and when I go to a place that there is heat, I become very uncomfortable and uneasy. Also, my heart beats very fast when I walk a short distance and now, I cannot do too much of my household chores because I easily get tired when I try to do that. (Indiana R9)

Hitherto, Jumak R10, a 39-year-old woman who was so used to doing all her household chores by herself narrated:

At first, I use to do everything for myself, even if I go to the market to buy stuffs, I don't give it to the female porters ('kayaye' local parlance) to carry for a fee, I carry the loads myself. But now I am not able to even go to the market, when I start, I will be very cautious of how I go about my things. (Jumak R10)

Similarly, Ezeyaa R5, a 35-year-old woman who is also very worried and looking forward to regaining her strength said:

This thing happened to me almost 12 months now but the strength has been on and off, this has become a big problem that has set me into thinking. Sometimes I can wake up and be very strong going about my daily chores well, but sometimes too I just become very weak and cannot do anything. (Ezeyaa R5)

4.3.3 Sleep and Rest

The rest and sleep pattern of some of the participants were affected, inasmuch as some women could not sleep due to fear of dying or to some other physical changes, others could not sleep simply because their babies cry at night and so they find it difficult to sleep.

Granga a 28-year-old woman who survived Eclampsia and Pulmonary Embolism reported:

Since I was discharged from the hospital (ICU), I had difficulty in sleeping because almost one week in the ward from the ICU I was so much afraid that if I close my eyes I wouldn't be able to wake up again, I might die in my sleep so I didn't sleep. (Granga R7)

My baby can also worry me at night by crying a lot and during the day time too she doesn't sleep so I have to see to the baby until she sleeps before I can also sleep. (Granga R7)

Baraka a 35-year-old who survived Eclampsia narrated her experience as follows:

But it has been there ever since, I sleep, wake up and then I can't sleep again meanwhile I don't sleep early too, sometimes I sleep around 11:00 pm and by 12:00 and 01:00 midnight I am awake, 03:00 am, I am already awake and I can't sleep. I was referred to the clinical psychologist, but he told me with time it will resolve by itself. He said maybe is because I am thinking that is why am not sleeping at night. (Baraka R2)

Further, this participant accentuated:

When I am asleep, I am woken up by palpitations, then my heart will beat. So, when this happens, I just have to get up from the bed and get some water to drink in order to relax myself then I go back to sleep but it takes time. (Hamdara R8)

This notwithstanding, participants had issues with their overall physical health as a result of the near-miss event. The ensuing section presents results of the overall physical health of the participants.

4.3.4 Overall Physical Health

The overall physical health of some of the participants is improving as the days go by however others are compromised due to the severe nature of the complication they survived. Some who suffered hypertensive disorders of pregnancy are still dealing with high blood pressure (B/P) and others with anaemia or other related residual illness as a result of their near-miss event. For instance, these participants described their ordeal:

I feel dizziness and sometimes too when I go for check-up, they tell me my B/P is too high. My B/P has been high during pregnancy and I have been put on medication which I am still taking. (Ezeyaa R5)

Lima R12, a 36-year-old who survived Pre-Eclampsia and gaped abdomen after C/S also narrated:

Sometimes I do feel dizzy, it seems that the blood loss replacement is still not enough that is why, so I do feel dizzy sometimes and also, I feel pains at the incisional site, it pinches me. (Lima R12)

Indiana a 33-year-old woman who survived Eclampsia also narrated:

My only problem is the high B/P which makes my heart to beat very fast when I walk a lot. So, since I left the hospital my general health is not as how it was at first, I feel very weak and tired. (Indiana R9)

Aside the impact on their overall physical health which has affected their quality of life, majority of the participants complained of pains which were related to the complication that they have survived.

4.3.5 Pain

This theme reflected the discomfort, aches or agony that the participants experienced as a result of the near-miss event. Several women mentioned pain as a result of either surgery or a different pain in other parts of their bodies. Some described the incisional pain as abdominal cramps which were often relieved by pain relievers and other participants also experienced other pains related to their complication as recounted by the following participants:

Amara R1, a 29-year-old woman who survived post-partum haemorrhage stated:

It's like menstrual pain, it starts with crumps, so I don't want to wait for it to become severe. Once it starts then I know that the potency of the first dose of the medication has passed and I have to take the next dose to prevent the severity of the pain. (Amara R1)

Another participant who experienced other pains aside the incisional pains has this to say:

I have chest pains; I feel the pains sometimes radiating through my back. The pain in the chest is as if hot water has poured on it and it comes with this sharp sensational pain. When the pain comes, I drink water and I feel better for a while, the pain comes once in a while. (Hamdara R8)

Baraka R2 a 35-year-old woman who survived Eclampsia also narrated:

Eeerrh! Since that time, I still limp. I delivered in July last year is about six months now and I still have the pain in my right knee and I still limp. I don't remember ever falling on my knees, but I still have pain in them, which has affected my movements and walking. (Baraka R2)

In addition to the pain experienced by the survivors of the near-miss complication, the fertility of most of the participants has also been compromised due to the complication they have suffered.

4.3.6 Fertility

The majority of the participant stated that they had not yet resumed their menses, however the two (2) women who had interventional hysterectomies done recounted how they have lost their fertility as a result of their complication of ruptured uterus during labour.

Ezeyaa R5 who has no children had her uterus removed due to ruptured uterus during labour and receiving psychological support has this to say:

Hmmm! I have not been having my menses again. They told me that when they were doing the C/S they found out that my uterus had ruptured and was beyond repairs, so they took it out. The doctor told me that since he has removed my uterus, I would not be able to have my menses again. (Ezeyaa R5)

Hamdara R8 a 38-year-old woman who survived Eclampsia also recounted how she had lost her fertility and her baby:

So, when that happened, I felt I have lost my fertility for that period, I have lost something and I have lost my baby too. I feel I have lost something. (Hamdara R8)

Canne R3 who has one child and survived ruptured uterus during labour and referred for Clinical Psychologists consultations also recounted:

I don't have a uterus again and I have lost my baby too..... (Sobbing with tears in her eyes) my doctor said she wanted to repair the uterus for me but the way it had ruptured was difficult and she couldn't repair it. Also, she told me the way I was bleeding too, if they try to repair it, they would lose me so they have to take it out. (Canne R3)

The psychological well-being of participants was also affected in various ways. The subsequent section presents findings on the impact of near-miss on the psychological well-being of participants.

4.4 Psychological Well-Being

This section presents the impact of the near-miss event on the psychological well-being of participants and how it is affecting their quality of life many weeks and months after discharge from the hospital. All participants had their psychological well-being compromised in one way or the other due to the severity of their condition and some actually came very close to death and this experience has created anxiety and discomforts in them.

4.4.1 Anxiety

Most of the participants recounted having levels of anxiety due to the severe obstetric complications they experienced, however those who lost their babies through the process experienced heightened levels of anxiety, sadness and worry. Also, those who lost their baby but did not get the opportunity to see the dead baby did not have much anxiety. She narrated:

I was asking of the baby at the operating theatre, so they brought the dead baby for me to look at. I touched her and I didn't cry, talked to her and I thought that would have given me some relief, but when I came to the ward and everybody who had delivered were holding their babies and mine wasn't there, I became sad and worried. (Canne R3)

Ezeyaa R5, a 35-year-old woman who ruptured uterus during labour and subsequent interventional hysterectomy also stated:

Hmmmm! Sometimes, I just couldn't control the sadness, I become very sad. Sometimes I talk to myself that if they had not removed my womb like by now me too, I should also be expecting a baby or better still if my baby had survived before they took my womb out. (Ezeyaa R5)

Indiana R9, a 33-year-old woman who survived Eclampsia with a perinatal loss narrated:

I was worried when I was in the ward seeing other mothers holding their babies, also when I went home people see me and congratulate me ('Wutri nkwah' in Akan language meaning congratulations) and how is the baby doing? These make me feel very uneasy, worried and sad because at every instance I have to repeatedly tell them my baby did not survive it. (Indiana R9)

Granga R7 28-year-old woman expressed her anxiety this way:

I used to feel that someone was standing on me and trying to strangulate me and during that time my temperature goes high and I feel a very deep heat paa..!(In Akan language laying emphasis on the statement made), within me from down to up and sweating at the same time, Hmmm! Also, after sleeping for a while, just before I wake up, I had a feeling like smoke was all around the room but after a while I get to realise that there was nothing there. (Granga R7)

Notwithstanding, some of the participants indicated how they felt depressed due to the complications they suffered and the various issues that led to them becoming depressed. The subsequent section presents findings on the issue of depression.

4.4.2 Depression

Findings of the study showed that most of the participants suffered some levels of depression. Depression was expressed by some of the women in various forms and due to different reasons. Some recounted becoming depressed upon hearing the news of their babies' death. Others said the huge hospital bills made them depressed whereas others became very depressed because of their illness. Other participants felt very depressed when the doctor informed them about the removal of their uterus in order to save their lives. Some of the women expressed their depression by avoiding people or associating with society. Others were even referred to the clinical psychologist for management. They recounted:

Canne R3 a 41-year-old who suffered a ruptured uterus during labour with a subsequent hysterectomy and perinatal loss had this to say with tears in her eyes:

When I go out and people start to ask me of my baby, I feel too sad and depressed. Some will ask if the baby is in the house and I just don't know what to tell them. Hmmmmm! I don't know what to do. So, I have chosen to wear black clothes, so if you see me wearing black you would not ask me of my baby and I prefer that. (Canne R3)

Jumak R10 a 39-year-old who survived Eclampsia/renal dialysis also has this to say:

Usually is the economic hardship (money issues), the money issues make me feel so depressed because we don't have any support from anywhere and it's like it is just me and my husband who have to shoulder all the economic burden, we are the only people who go and come back with something. (Jumak R10)

Danlu R4, a 29-year-old who survived severe Post-partum haemorrhage recounted her feeling of being depressed:

Right now, I don't feel depressed, but during that time the circumstances that made me depressed was that, I have 2 sisters, one was getting married and the other one had a baby and it was like everybody's life was moving forward and then there I was bed ridden and was being carried around from place to place. That made me feel very, very depressed. (Danlu R4)

Nevertheless, most of the participants were not able to control their feelings of depression, anger and distress which made them to be emotionally imbalanced.

4.4.3 Distress Control

The study revealed that some participants could not control their distresses and this has affected their psychological well-being. As a result of the complication these women survived, majority of them have expressed some level of distress of control and this was expressed in the form of emotional distress like anger, worry and isolation which they felt they could not control. Others also felt that they did not have any control over situations when they were happening, and this made them worried and angry.

Canne R3 a 41-year-old woman presented it this way:

The doctor also shared her personal experience with me, so anytime I want to cry, I just remember what she experienced, and I just hold myself up but sometimes too I cry (she laughed a little) since I cannot control it. (Canne R3)

Jumak R10 also recounts:

I asked myself that, me paaa (in Akan language putting emphasis on a word) lying in an ambulance? Then that must be a very serious issue, I became very sad and asked myself what I did wrong that made things to go that way? Me lying in an ambulance and also going for a dialysis. Whenever, I look at the dialysis machines and the way they are so complicated, I tell myself that, then, I have really been through something very terrifying 'eeiii, mako aa ba' (in Akan language meaning, I have gone and come) hahaha! The kind of things they tell me that, I have been through makes me feel so sad, and I was told how my sisters even cried about what was happening to me. (Jumak R10)

Yet another participant who was able to control her level of feeling distressed had this to say:

.....because of my high B/P I was told not to think too much so I don't put my mind on the baby even though it worries me, I know if I add that one to it my sickness can become worse so I try to control that feeling. (Indiana R9)

Further, (Fluke R6) a 37-year-old who survived Eclampsia emphasized that, she did not have any control over what she experienced:

When I heard them say Eclampsia, I said aaaah, what is Eclampsia? What at all is Eclampsia because I was asking myself so all these antenatal check-ups my B/P was normal, and it was only on that day that my B/P was very high. And on that same day this headache too got so severe that there was nothing I could do about it. Hence, I was always thinking about where this could come from and how did it happen. So, this made me think a lot about it and I became worried. (Fluke R6)

Nonetheless, the succeeding section presents the impact that the near-miss event has on the participants' subsequent pregnancies as the majority expressed that a similar situation can recur.

4.4.4 Fear of Recurrence

The experience of near miss complication has made majority of participants to be afraid that a similar situation may occur in their subsequent pregnancies and feared to have more children or even hear the word pregnancy or anything associating with it. Less number of these women has expressed the desire for getting pregnant again. Furthermore, some of these women

said that they feel uncomfortable whenever they have to visit the hospital or the intensive care unit (ICU), or even talk about their experience as it reminds them of their ordeal. They experienced Post-traumatic Stress Disorders (PTSD). Others even said that they feel pity and uncomfortable for other pregnant women and pray that a similar incident should never happen to them. However, those who have read about their complication have had enough knowledge about their complications and have plans to seek specialist attention before they get pregnant again in order not to go through a similar complication again. For instance, Indiana R9 narrated her predicament:

The pains I have experienced during the complication were too much and I wouldn't like to go through a similar experience again so I will no longer have more babies. I have decided I won't be pregnant again, in fact ever since I came home when I see a woman pregnant, I become worried for the person because of my experience.
(Indiana R9)

Also, Lima R12 recounted her experience this way:

Anytime I remember what happened I feel uneasy, just like when you called me 3 days ago that you were coming to interview me, I was like eeeiii, everything just came back. Even this morning when you called me that you were coming, I was afraid of saying it again. So, it gives me discomfort whenever I try to talk about it. **(Lima R12)**

Jumak R10 also narrated:

Me, I have decided that I will not give birth again in any way, but I would not like this complication to happen to me again because it wasn't a good thing for me, it has delayed and stagnated most of my progress. Besides I think four (4) children are enough, I even wanted to stop at three (3) children, but it has become four (4) so it is okay, hahaha! **(Jumak R10)**

However, Fluke R6a 37-year-old woman who has just one child and has expressed the desire for future children also narrated:

Hmmm! Yeah, Eclampsia, I read about it and they said the chances of you getting it again is high and because of advancement in age too it can affect you so what I intend doing is when I want to get pregnant again that one it means I have to get a very good doctor. Yes, who will take a very good care of me so that I don't go through such experience the second time. **(Fluke R6)**

All the same, the ensuing section has also revealed that participants have feelings of loss, which has an impact on the quality of life and psychological well-being.

4.4.5 Loss

Even though these women have survived the severe complication of near miss and they are grateful for the fact that they are alive, they still have the feeling of having lost their health and their confidence to achieve another pregnancy. This feeling of loss and the weakness that they are experiencing have affected their ability to recover within a rational time limit to recommence their household chores or productive activity. Others also are traumatised and have lost the confidence to become pregnant again or even go in for any procedure similar to their experiences.

Lima R12 a 36-year-old who survived Pre-Eclampsia and gaped abdomen after C/S narrated her ordeal:

I have lost the confidence to give birth; I don't even have the confidence of giving birth again or even going to the operating theatre for any other procedure. Even I was telling myself that I should go and close my womb and I later realised that even that one 'kraaaa!' (In Akan language to put emphasis on a word) I still have to go back to the theatre and I just don't want to step at the theatre again at all. (Lima R12)

Similarly, Ezeyaa R5, a 35-year-old expressed her experiences of loss this way:

Hmmmm! I have lost 2 things, which are my child and my womb. What I would like to say is that, at times when I am there alone, I have the feeling that I am left alone since I am the only person and I don't have any child with me. So sometimes I feel that if I had my own child or even just one child that I can call my own. (R5 Ezeyaa)

Conversely, Indiana who has lost her baby has this to say:

The doctor called me and told me that my baby did not survive, but I consoled myself that so far as I have survived it is okay and besides it I didn't see him too, so even though I felt the pains, it wasn't very, very painful because my life too is very important here. (Indiana R9)

Indiana R9 again stated:

Right now, I feel I have lost my strength and I want to get back my strength like how I use to be strong at first, but I also know that with time it will come. (Indiana R9)

Besides the feeling of loss, the study also found that participants had ruminative thoughts of negative cyclical thinking and worrying.

4.4.6 Ruminative Thoughts

Majority of these women who survived the near-miss complication had continuous thoughts and reflections about the incidence, what might be the cause of their near-miss event and trying to find answers to their questions. Others also blamed their ordeal on people around them.

Kasio R11 a 22-year-old woman who suffered complication of abortion has this to say:

I was so surprised that when I went to the hospital the second time then things deteriorated for me to even end up at the Intensive Care Unit. I really believed that someone's hands are in it because sometimes when I sleep the places that my spirit goes to are not pleasant at all. (Kasio R11)

Canne R3 a 41-year-old woman who went through labour and ruptured her uterus during the process with a subsequent hysterectomy and perinatal loss also had these thoughts:

I always ask myself certain questions when I am alone, but I do not get the answers to my questions. I sometimes ask myself that at my age why didn't I opt for a Caesarean Section (C/S)? Then I again tell myself that may be if I had gone through the normal C/S and things do not go on well I may have other complications. Maybe I will bleed which can also cause my death. Also, I sometimes ask myself that why didn't the doctor ask me for the C/S herself? (Canne R3)

Hamdara R8 a 38-year-old woman who survived Eclampsia with perinatal loss also narrated:

I put the blame on my husband because he doesn't come home on time, every time he is out and is not his work, because if it is work, I wouldn't be worried. But I know weekends, he doesn't go to work so where does he go to and even weekends, he doesn't come home early? Also, I blame the doctor because he didn't check what the nurses wrote so if he had checked what the nurses wrote in the book, he would have detained me so that I wouldn't even go home at all, so these 2 people I will give the blame to. (Hamdara R8)

Fluke R6 also narrated:

I blame the nurses at the Private clinic, because when I became fat and still had a positive urine protein, they kept saying I should drink a lot of water and that was the only thing that I was doing. Then elevate your feet, if you keep on doing that the swell will reduce and you will be fine, says a nurse. Because I wasn't feeling any headache or stomach ache and my B/P too any time it was checked they said it was normal until I suffered this complication of Eclampsia. (Fluke R6)

Although participants had various issues that affected their psychological well-being and for that matter their quality of life, they engaged in some form of leisure activities to take

off their minds from such distresses. The ensuing section revealed some of the leisure activities that participants engaged in.

4.4.7 Rehabilitation

Almost all participants of the study had one or more leisure activities as a form of pleasure to overcome some stressful events or take their minds off their problems. At least they all had knowledge about the importance and relationships between leisure activities, health and well-being. The study found that participants used their own leisure activities to mediate between their psychological health and their well-being. These were some of the various ways they had leisure:

Let's hear Danlu R4 a 29-year-old who survived severe postpartum haemorrhage:

I watch movies, I like watching movies and going out, sometimes I go to the beach. I could just go sit there and just take time off from everybody else and just be in my own space for a while, this was advised by my psychologist and it is really helping me. (Danlu R 4)

Kasio R11 a 22-year woman who survived a complication of Septic Abortion had this to say:

I listen to music on television or converse with my siblings. Sometimes too we watch movies together and also when they come back from school, they share with me some of the interesting things that happened at school for us all to laugh so that I can take my mind off what I have experienced during my complication. (Kasio R11)

Indiana R4 a 33-year-old woman who survived Eclampsia with perinatal loss also said:

Sometimes I watch television and other times too I want someone to sit by me so we can have a conversation. This is because any time I find myself alone then I start to think about how the whole complication started. (Indiana R9)

Conversely 33-year-old Jumak R10 who is still owing hospital bills has this to say:

I am the type who likes reading books a lot, but ever since this thing happened to me whenever I take a book to read then my attention goes to the fact that I owe people and the hospital money. Because I have not finished paying my hospital bills, the thing tells me I am owing then I just put the book down and stop the reading because I can no longer concentrate on it and I am worried about the debts. (Jumak R10)

The study has revealed the impact of near-miss event on the psychological well-being of the participants and how it affects the quality of life of survivors. The following segment presents results of how the social well-being of participants is affected.

4.5 Social Well-Being

The study found that women who survived severe obstetric complication have both short-and long-term social problems which have affected their social well-being and the quality of life after the near-miss experience. These socio-economic, as well as other distresses from the family due to the impact of near-miss obstetric complication on these women can even last up to one year postpartum.

4.5.1 Family Distress

The impact of near-miss obstetric complications on some of the participants is enormous and these have led to family disputes and tensions in some families. Some of these women have experienced family disputes as a result of the huge hospital bills and their husband's family blaming them for other miss-happenings in the family.

Hamdara R8 a 38-year-old woman who survived Eclampsia had this to say:

After my complication he also got involved in an accident, so they put the blame on me that maybe he was thinking of what happened to me that was why he got an accident..... After I was discharged from the Intensive Care Unit, I went to my own parents for a while so when I wanted to go back to my husband, his family insisted I should not go back because he has spent so much money on me and now I should not go back so that he will regain his money. They said this through my mom. (Hamdara R8)

On the other hand, although it has not caused some of them any family dispute, they are experiencing some form of distress. Lima R12 also had this to say:

It has affected our way of living in the house because now if I ask my husband money for anything he tells me I know that he has used all the money to go and settle my huge hospital bills and that there is no money so I should wait, and I understand him in a way. (Lima R12)

Jumak R10 also narrated:

Hmmmm! Sometimes it does bring us some marital misunderstandings. Sometimes when I ask for something and he cannot afford it and tells me that I should know that he has too many responsibilities, so for now as for me I have been put aside, hahaha. Because I have also understood him now, taking care of all of us, 3 children going to school with school fees issues. (Jumak R10)

In addition to the enormous family distresses that survivors experience, the study found that there are financial implications of the complications they survived. The ensuing section explains the financial impact.

4.5.2 Financial Challenges

This section presents the financial implications of near-miss events on survivors and their immediate families. The majority of the participants have experienced some levels of financial challenges as a result of their complications. Some are in the form of a direct cost to them while others are indirect costs due to the huge expenses and hospital bills aside the NHIS for all expectant mothers. Some spoke of the fact that they had to purchase very expensive medication, ICU bills and those who had their babies admitted to the Neonatal Intensive Care Unit (NICU) also spoke about the expenses and the fact that NHIS did not cover every facet of their health care. These are some of the expressions of the participants:

Hmmm! It wasn't easy. Every medicine I have to buy and apart from the expensive medications I also had a huge hospital bill in addition. I spent eight (8) days and the bill was GH¢ 3,067.00, because I did not prepare for C/S it became a big problem for me but I talked to the authorities so they have allowed me to pay half and come and settle the rest by the end of this month. (Canne R3)

Ezeyaa R5 reported:

After I was discharged by the doctors, I couldn't leave the hospital immediately, I stayed on till the bills were settled, the bill was about GHC 3,000.00 plus. It wasn't easy at all for my husband because he bought a lot of expensive medications and he was left with nothing. (Ezeyaa R5)

Some of the indirect costs of the financial burden were that after spending so much on their complications which were not planned for, their families had to forfeit other projects since they were not adequately prepared for the unforeseen complications and some even had to borrow money from people. Others had to sell their properties or take their rent advances from their tenants even before their due dates in order to use the money to offset some of the hospital bills.

Baraka R2 expressed her views this way:

The plenty bills that came in, my husband and my mum paid it. My mother wanted to do her shop because where she is selling right now is a container and she wanted to bring the store to the house by building a store but because of the expenses, she had to stop with the building of the store. So, she is still using the container. (Baraka R2)

Lima R12 who had an emergency re-laparotomy also has this to say:

I planned for normal delivery and not for C/S so that is part of the reason why I couldn't do the naming ceremony for my baby. The expenses have also affected all the children's school fees because we didn't plan for extra money (expenses), I paid almost GH¢2,800.00 to GH¢3000.00 so it has really affected my finances because we didn't plan for that huge amount of money. (Lima R12)

Jumak R10 a 39-year-old woman who suffered Eclampsia and had a renal dialysis done due to an acute renal failure had this to say:

We have a house that we have rented out to people, though the tenants' rent advances were not yet due we have taken the rent advance earlier to offset some of the bills so this year we will not get any money from those who will be due for rent advance payment. (Jumak R10)

Indiana R9 also expressed her views:

Right now as I am talking to you, we are in a lot of debt, I had made a container around Achimota general area to start some business but since I was discharged home and looking at the debt and the people I am owing I have decided to sell the container so that we can offset some of the debts and also be able to take care of the children at home. (Indiana R9)

4.5.3 Roles and Relationships

The roles and relationships of some of these women and their families have rather improved as these relatives witnessed what these women have been through during their complications and have become more understanding. However, some also feel that they are not as they used to be before the complication and this has affected their quality of life. This was expressed as follows: (Fluke R6), a 37-year-old woman expressed herself:

Oh, the relationship between me and my in-laws is cordial; they are nice to me and always call to check up on me. Although they have not yet visited me at home after my discharge from hospital, they always call me on phone. (Fluke R6)

Hamdara R 8 also reports:

Hmmm! With my husband there was misunderstanding between the 2 of us on how he goes out and comes back late, eeerr, my in-laws, I have no problem with my mother in-law or my sister in-laws, but my husband's auntie sometimes says certain things I don't like. That was what I can say is disturbing me about them.... But the relationship between me and my husband has now improved since my survival of this complication. (Hamdara R8)

Jumak R10 also narrated:

The complication I survived has made all my family members to like me really well. It has improved our family relationships. Formerly when I need something and I ask my sisters they tell me they don't have it; they don't have it! But now even if they don't have it, they tell me something encouraging like when they get it they will give it to me. (Jumak R10)

Canne R3 also has this to say:

Eeeerrr! As for my family they are not always with me and we do not have any problem, the relationship is cordial. But for my husband, the only problem I have with him is the questions he has been asking me. That why am I growing lean? (Growing slender due to her inability to eat well as a result of the emotional status). That question is not helping me psychologically. And, apart from the questions my husband has been asking me which I did not like, every other thing is normal. (Canne R3)

4.5.4 Sexual Function

This section presents the quality of affection and sexual function of women who survived a near-miss complication and how it is impacting the quality of their social well-being. The study found that majority of these women have not resumed sexual activity even after being discharged home for reasons like, they have just recovered, and they were not thinking about that yet or have forgotten about that. Others too wanted it after the long while, but their husbands have not yet made any approach or asked them for a sexual intimacy which they think may be due to the stress that they went through during the complication. For instance, Jumak R10 has this to say:

My husband has not made any attempt yet, I am sure that the stress and the running helter-skelter that he did when I was in the hospital is still fresh on his mind and maybe he is now recovering from it 'hahaha' (laughs....), so it has cooled down his urge for it. Aside that we are still owing the hospital bills and he is the only one to take responsibility of it so he is working so much and comes back home rather very late and tired. (Jumak R10)

Canne R3 also states:

Haahahaha! As for that one I have forgotten about it long time ago (dadadaa! Emphasizing long time ago in Akan language). It's not in my mind! Why because I don't want to and not now. Even my husband will not try it because he knows what I am going through. Even if I will do it, not this time around hahahaha! (Laughs....). (Canne R3)

(Fluke R6) a 37-year-old woman who survived Eclampsia also recounts that:

It hasn't affected it, everything is fine. But currently eeerr I am not ready to have any sexual relationship, no not now. My mind is not even there that I should have a sexual relationship. I don't have any particular reason, but I just don't want any sexual relationship now. (Fluke R6)

On the other hand, Hamdara R8 has this to say:

It has improved the affection, eeerr we are closer to each other more, when he goes out and comes, he wants me to know that eeerr, he did not go to any place that I should be thinking negative so he will try to bring me together to have affection so that I will know that he didn't go anywhere that I should be thinking. (Hamdara R8)

This notwithstanding, the study found that the near-miss event affected the appearances of survivors, which has indirectly affected their social well-being. The subsequent section presents findings on how the complication had impacted on their appearances.

4.5.5 Appearance

The study found that appearance of some of the near-miss survivors has been affected and this has affected their quality of life since most of these women are bothered about their appearances and their husbands were also disturbed about their appearances. The following were some of the expressions of these women:

Canne R3 a 41-year-old woman who survived severe haemorrhage due to ruptured uterus with consequent emergency hysterectomy and perinatal loss expressed herself:

I have a problem with my husband, he knows very well that I have a problem, but he keeps on asking me every time that why am I growing lean?" Why are you lean?" So, I told him he knows my problem and I don't understand why that question. I was fat like you, so I became very angry because he is supposed to know but rather complaining always that I am growing lean. I am always thinking about it (Sobbing with tears in her eyes). (Canne R3)

Lima R12 who had a gaped abdomen after C/S had this to say:

It has affected my appearance, now I can't even tighten my tummy, I'm even afraid that if I tighten it, it will gape again. This affects me because there are some dresses I can't wear, now I have to be wearing very big dresses and you know us women when your stomach is big like this and you know the men don't like it. My husband will complain always (ena wu yefu a ye kesie saa, aden? (In Akan language meaning why is my stomach still big like that?) Baby is just 3 months and I hope it will come down, but this worries me a lot. (Lima R12)

Kasio R11 a 22-year-old woman with septic abortion and laparotomy stated:

My appearance has changed a lot, I use to be a chubby (plump) person but now have grown too lean because of my illness and have become a thin person 'hahaha' (Laughs....). I think it is because I am not able to eat that much, so I felt so sad and depressed because sometimes when I look at myself in the mirror and compare it to my previous pictures, I become very sad and worried. (Kasio R11)

Despite all these unpleasant experiences these women found time for enjoying themselves and the ensuing section presents some of the ways that they enjoyed themselves.

4.5.6 Enjoyment

Aside all their predicaments, the study found that most of these women found time to enjoy themselves either with their families or some of them found time to enjoy themselves aside the family. Here are some of the narrations:

Ezeyaa R5 a 35-year-old woman who survived haemorrhage due to rupture of her uterus during labour with subsequent interventional hysterectomy and perinatal loss said:

Sometimes too when my husband realises that I am becoming too quiet he takes me out to any place of enjoyment for me to have fun and after I am okay, he brings me home. He sometimes takes me to the mall or any restaurant to buy food or drinks after that we have a chat for a while and go back to the house. (Ezeyaa R5)

Jumak R10 also expressed:

Sometimes I read books, or I listen to gospel music and sing praises on my own. Sometimes I sing and dance or play the tape and do dance to the praise's song to just enjoy myself. I even started it whilst I was on admission here, I could walk outside to the car park and sing praises and dance till I became alright then go back to my room. (Jumak R10)

Kasio R11 a 22-year-old who survived complications of abortion also has this to say as a form of pleasure:

I listen to music on television or converse with my siblings. Sometimes too we watch movies together and also when they come back from school, they share with me some of the interesting things that happened at school for us all to laugh so that I can take my mind off what I have experienced during my complication. (Kasio R11)

Social isolation and stigmatization were some of the issues raised during the study. The following section presents how the participants felt.

4.5.7 Social Isolation

It was observed that majority of the participants did not feel stigmatized by people within their community or immediate environment; however, some of the participants rather isolated themselves for various reasons. Some did not want people to sympathize with them and the others did not like the kind of questions people were asking them, so they rather decided to avoid people in their communities by isolating themselves:

I was tired of people telling me 'ebe yeyie', ebe yeyie' (in Akan language meaning it will be well), I was tired of it. So, I cut all the links to people out so it was just the immediate family and they knew that I didn't like what I keep hearing sorry and it will be well. (Danlu R4)

Canne R3 a 41 -year-woman who had ruptured uterus (hysterectomy) and lost her baby too said, with tears in her eyes:

In my community, I am not going out because they ask too much questions, I feel stigmatized. Like I went to give birth and I did not get my baby. (Canne R3)

Lima R12 a 36-year-old woman who believed that she died and came back to life expressed herself this way:

I know it is God and I won't deny that it was God who did it but right now I don't want to tell people for them to say that, so this girl died and came back to life for me to feel stigmatized. I want to give it some time so that when I am out of it and I start telling people about it I will not think about it that much. (Lima R12)

Ezeyaa R5 a 35-year-old woman with hysterectomy due to ruptured uterus who lost her baby at birth also expressed herself like this:

Sometimes I become anxious and disturbed, but I have realised that when I do that I am rather adding on to my problems. Hmmm! Sometimes this makes me feel like I am not part of the people of this world hmmm. (Ezeyaa R5)

Kasio R11 22-year-old student with septic abortion also has this to say:

Hmmm! Sometimes I feel bad about it a little and I feel guilty, mmmh whenever I am alone, I think about the fact that I could not continue my schooling as all other colleagues of mine. Since I was about to go back to school when all these happened to me, so I have that feeling like I am lagging behind my colleagues in school.

(Kasio R11)

Furthermore, the study found that participants could not go back to their jobs immediately as expected of all normal deliveries.

4.5.8 Impact on Work

This section presents the impact of a near-miss event on work. The functional activities of these women were found to be poorer and most of them could not go back to work immediately or were unable to participate in or contribute to society as usual after their near-miss events. Some of the participants have this to say:

Hamdara R8 a 38-year-old teacher who survived Eclampsia with perinatal loss narrated:

Hhhmmm! I am not all that active like at first how I used to be jumping, shouting, singing and dancing with my Kindergarten (KGs) school children and God being so good when I resumed work I have been posted to class one (1) since that class is less stressful compared to KG where I have to use more physical strength. I sometimes try to do it with the class 1 children because they are also not all that grown but find it difficult and I get tired earlier than before. (Hamdara R8)

Baraka R2 a 35-year-old woman who survived Eclampsia narrated:

Hmmm! There are certain things I don't do. Almost a year now I don't climb the ladder to do my decorations business. And then eeerrrh, there are so many things I don't do. Like lifting heavy things in the house, no I don't do that anymore, or stress myself up in the house and when I go to work too my colleagues help me. (Baraka R2)

Jumak R10 also narrated:

Hmmm, we are managing with the help of God. It isn't like how it was at first because at first, I use to work to support my husband but now because I become too tired when I go to the market, I have stopped working so all the burden is on my husband alone. I have closed down my provision shop, I sold some of the things and the rest of the commodities we ate them ourselves **Jumak R10)**

4.6 Spiritual Well-Being

This segment presents the results of the impact of near-miss event on the spiritual well-being of the survivor and how it has affected their quality of life. Almost all the participants had affiliation of their lives in a relationship with God as their creator and controller of their lives and they were motivated by this to search for meaning of their survival of the complication they experienced. However, some participants also think that what happened to them was basically by chance or it was an accident.

4.6.1 Linking Survival to God

The study found that majority of the participants referred to God in all that they have experienced. While some of the participants attributed their experience of the complication to someone wanting to harm them spiritually using external forces, others also think that it was the will of God and their survival means that it was not yet time for them to die or leave this earth. This was narrated as follows:

If it wasn't God who was on my side, I would have been dead by now, I knew I was dead but God brought me back, it wasn't because of anything I did right but just because God knew my time was not yet due. **(Lima R12)**

Danlu R4, a 29-year-old expressed herself:

As for me I believe that what has happened to me is by chance or is an accident and I wouldn't say that it is someone who wants to harm me or witchcraft causes. I know that everything happens by the permission of God, so it's the doings of God. **(Danlu R4)**

Hamdara R8 also expressed herself this way:

It was God who saved me because what they said happened to me, how I went off and all that. Even the doctor said my husband and one of our pastors were under the tree out there and they said that, oh! These Pastors have prayed and now Hamdara can move her body and then the Pastor said, no is Hamdara's, prayers that she has prayed before the complication that has saved her. (Hamdara R8)

This notwithstanding, the study revealed that participants expressed themselves by giving meaning to their predicaments. The ensuing section presents results on meaning that participants gave.

4.6.2 Meaning of Illness and Relevance to Self

Looking at the spiritual well-being dimension, the quality of life of the participants in the study was found to be expressed by the meaning they gave to their experience and their survival of the complication. One of the participants expressed what her survival of the complication she experienced means to her. She believed that God spared her life in order to change her and that there was a reason why she survived it since others experienced the same complication and did not survive it.

Danlu R4 a 29-year-old woman expressed herself:

Hmm! I think it changed me a bit, previously I used to be very petty like I won't talk to this person again but right now it made me grow a little and then begin to appreciate a few things, and appreciate a few people around you and it's like you just have to, and yes, I think I became a little bit more spiritual too. (Danlu R4)

(Fluke R6) also has this to say:

I have realised that God is really there, yes and if you put your trust in Him, He will not let you down. No matter what you go through He will always be there for you. Because they were all saying that I was not going to survive the complication but at the end of the day God did it, I survived, and my baby also survived it. (Fluke R6)

Ezeyaa R5 narrated:

Hmmm! I have come to realise that in this world that we are in, anything can happen to anybody. I didn't know that something like this could happen to me, so all what I can say is that I leave everything in the hands of God; He knows the good and the bad. May be what happened to me I could have given birth to the child and he/she would become a problem child with all sorts of sicknesses or will grow up to become a troublesome child to worry my heart. (Ezeyaa R5)

Nevertheless, the succeeding segment found that most of the women were alienated by their faith in a Superior Being who has control over the process. They all had strong religious feeling or belief which impacts on the spiritual well-being in one way or the other.

4.6.3 Religiosity

The study found that all participants had different religious orientations which influenced their belief systems of behaviour, cognition in the mind and feeling. Three participants believed that their complications might have been caused by some supernatural powers manipulation by their haters and have attributed their predicaments to their doings. Some said that bad eyes have looked at them when they were pregnant, and others also suspect people around them because of the behaviours those people have shown to them when they were discharged home. Others attributed their survival to God.

Indiana R9 expressed herself:

I don't know if someone wants to harm me because in the world, we are in you wouldn't hurt anyone but just that people can do bad things. When I was pregnant people really talked about it and I believe part could be from them and the bad eyes that looked at me ('eni boni' in Akan language meaning evil eye), I think that spiritual external forces are also the cause of my problem. (Indiana R9)

Baraka R2 also expressed her worries:

Hmm! When this complication happened, many people said a lot of things as the cause; some said that it may be external forces or someone wanting to harm me. They have always said that; my husband too will say that is from my family and he says that your family don't want you to have children. Anytime you give birth you have to suffer, why? Your family members, some of them are witches. (Baraka R2)

Granga R7 also expressed herself this way:

As for me initially because of somebody's attitude towards me it made me believe that it is that person who wants to harm me spiritually using external forces or who is doing it, but in all hahaha, I can't be so sure of that. (Granga R7)

Conversely, Hamdara also has this to say:

I don't think that any external forces can have power over me, but I am thinking that it is God who saved me because what they said happened to me, how I went off and all that. Even the doctor said my husband and one of our pastors were under the tree out there and they said that oh these pastors have prayed and now Hamdara can move her body. (Hamdara R8)

Besides their religious orientations, the study found that all participants had hope in God or a superior being, and these were expressed in the ensuing section.

4.6.4 Hope

Commonly, it was perceived that majority of the participants had hope in something and their hope was either in God or their children that have also survived despite the complications they have been through. Majority of the women had hope in God and were so thankful to God for their survival; likewise, those whose babies also survived were even more thankful and were wondering what was so special about them that God has shown them so much mercy.

Lima R12 a 36-year-old woman who was returned to the operating room after C/S due to gaped surgical wound in the abdomen and believes that she died and came back to life because of her children also narrated:

Hmmm, the hope 'die!' (Akan language means call to action when emphasis on a statement is made), oh I have hope. I have hope in God and I will say that my children also gave me hope because if I wasn't looking for them in those towns in my deep sleep, I wouldn't have been alive by now. I wasn't looking for my husband ooo! I was just looking for my children and I know that God really brought me back to life for my children. (Lima R12)

Indiana R9 who survived Eclampsia with a perinatal death also narrates:

I have hope and faith in my prayers. When I was initially pregnant, I used to go for prayer sessions and I prayed against anyone that will block my labour progress, I really prayed about that. So, when I had the complication even though I was not yet due for labour I then reminded God that the prayers I have been praying this is the time for Him to prove Himself as God of all flesh and truly He did it even though I lost my baby. (Indiana R9)

Granga R7 stated:

My hope is that, so far as I am not dead, and I am alive God will take care of me to recover fully so all my hope is in God. (Granga R7)

Having hope gave participants a form of soundness within and it helped them to overcome their worries.

4.6.5 Inner Strength

This section presents results on how participants used their inner strength to overcome future problems. Almost all the participants have built resilience and the tenacity for any other event that may come their way in the future. Participants reported to draw their inner strength from their experience and the fact that they have survived such critical and life-threatening complications they have an inner strength to overcome life's challenges and believed that they can also survive any other event that may come their way. Participants reported having the inner strength:

Ezeyaa R5 a Muslim, who survived Eclampsia, ruptured uterus with subsequent hysterectomy and perinatal loss.

Mmmmh! Eeeerr! I cannot say that nothing evil can happen to me, but what gives me the inner strength to overcome such thoughts is my little prayers that I have been praying to God and my faith in Him. (Ezeyaa R5)

(Fluke R6) has expressed herself:

Oh, I realised that eeerr, what I went through was very serious but I have been able to survive it at the end of the day. I am alive and my baby also survived it. So anytime I see my baby I have the hope and the inner strength. (Fluke R6)

Kasio R11 also stated:

My inner strength is also from my siblings who always comfort me that it is well and that God is with us and He will do it for me, so I shouldn't think too much about it. (Kasio R11)

The following subdivision will address the emerging themes which came up during the interview sessions with participants.

4.7 Antenatal Care Experience

This section presents the results of participants' ANC experience, which was a common emerging theme that came up during participant's interview. The study found that all participants had various experiences regarding ANC education, expectations from healthcare providers and care providers support. Out of the 12 participants 11 of them shared similar views regarding the kind of education and care they received from the various health care facilities during their ANC visits. Almost all participants received the routine ANC care and education.

4.7.1 ANC Education

The findings of the study showed that majority of participants had similar education on the dangerous signs and symptoms in pregnancy (DSSP), birth preparedness and complications readiness. Out of the 12 participants in the study, eleven (11) were able to state the danger signs in pregnancy and mentioned that they were asked to donate blood in readiness of any unforeseen complication that may warrant a blood transfusion. This was recounted by the following participants:

I have heard of the danger signs of pregnancy, some of which are when you have a swollen foot, when you are bleeding, when you are not feeling well, yes you have to come. So that one 'die!' (In Akan language means, call to action when emphasis on a statement is made) I know, that was why when I was having the pain in my stomach I went to the hospital because on that day they weren't working but they told us that in case of anything at all that we don't feel comfortable with we have to come. (Lima R12)

Danlu also recounted:

We were taught some danger signs of pregnancy which needs prompt attention such as bleeding, severe abdominal pains and the other ones were if you are vomiting excessively and if you start feeling a vigorous movement of the baby and then suddenly the baby's movement starts slowing down or stopping. (Danlu R4)

Lima R12 also narrated:

They told us to donate blood down in readiness for any emergency and that one I did that was why when they gave me 4 units, I only had to replace 3 units because I already had one unit of blood in readiness for any complication. (Lima R12)

Hamdara also expressed:

They also spoke about the danger signs of pregnancy that when you are feeling pain anywhere in your body or you see any sign of delivery or you are not feeling well come and see your healthcare provider. Every time too, you must make sure that your antenatal book and clothes should readily be in your bag so that in case of any emergency anybody available can send you to the hospital. Also, any abdominal pains, or pain anywhere, swollen feet or seeing blood are dangerous signs so you have to rush to the health facility. Eeerr! they said we should donate blood eeerrr! Before our time, so that eeerr if you need blood or you have lost blood so that they can eeerr they can replace it for you quickly. (Hamdara R8)

During the interviews, some participants expressed how they felt with the care they received from the healthcare facility. The resulting section found that they were satisfied with the care they received.

4.7.2 Care Providers Support

The results of the study showed that some participants were happy and satisfied with the quality of care and support given to them and without exception, these women recounted being grateful to the care givers for their survival and attributed it to the care that they have received. They said:

My doctor is a very good doctor she talked to me about how she also went through a similar thing and she even shared her experience with me about how she also lost her baby. This made me to calm down and relaxed a bit. (Canne R3)

Similarly, Kasio also expressed her experiences this way:

At the ICU, through the comforting words given to me by the health providers, I had some courage and hope that as for me die! (Akan language means call to action when emphasis on a statement is made) I will go to the ICU to recover and come back alive. I believed that once there is God who is always by my side nothing negative would happen to me. So, I had the courage there and the nurses also used to converse with me when they come around..... When I entered the theatre too the nurses there talked to me that I should have courage and that I would definitely come back so because of that I mastered some courage which helped me during the second surgery. (Kasio R11)

Indiana R9 also narrated:

When things became difficult for me, I mean during the complication I opened my eyes and saw how all the healthcare providers were all around me, and I asked myself so is it me 'paa!', (Akan language means call to action when emphasis is on a statement is made), that so many doctors and midwives have surrounded me like this? So, when I think of anything negative, then at the same time I think positive too, I thank you all. (Indiana R9)

In contrast some women were not motivated by some of the procedures and processes at the ANC as they did not find what they were expecting from their healthcare providers. The next section presents findings on expectations of participants that were interviewed.

4.7.3 Participants' Expectations from Health Care Providers

The study revealed that participants were expecting their healthcare providers to follow some laid down procedures that could be easily understood by them. They also wanted to see the same care provider at each ANC visit, however, they kept meeting different doctors at each visit which they feared that there would not be track records or that may also mean that they have to keep repeating their history taking each time they meet a new doctor.

Whereas others also recounted that they did not have adequate information about their conditions. They narrated:

I would say my antenatal care was normal, but I wasn't so enthused because throughout my antenatal I kept on seeing a different doctor on each visit so I felt no one could actually track what was going on. 'Eeerrr! So apart from that it was okay I had a smooth pregnancy, so I didn't have any issues. (Amara R1)

Similarly, this participant also expressed her experiences this way:

Where I attended my Antenatal care (ANC), they didn't explain to me that I had a high B/P so maybe if they had given me some B/P medicine there I may not have had this complication, because they never gave me any B/P medication. (Jumak R10)

Fluke R10 a 37-year-old who survived Eclampsia also narrated:

So is like there is no laid down structure where everybody knows that when you finish from here you go there, and nobody tells you anything. You would have to ask otherwise things will bypass you and you know Ghanaians' attitude of when you ask too many questions you become annoying but that is not what is supposed to be. There are times when you must ask from people which is not the best because you are supposed to ask from the professionals themselves. (Fluke R6)

The respondents who were referred from other healthcare facilities showed dissatisfaction about their ANC experience at the various healthcare facilities prior to their admission. They mentioned the fact that the healthcare providers did not take the necessary actions as deemed fit. A participant shared her experience:

Hamdara R8 had this to say:

The nurse that took my vital signs was saying that it seems my urine is positive plus (++) and my B/P too was a little bit high so maybe I will be admitted, that was what the nurse said. But when I entered the consulting room the doctor told me everything was fine so I can go home and come back in two weeks' time. (Hamdara R8)

Fluke R5 recounted her experience:

So, I became fat and still had a positive urine protein but they kept saying I should drink a lot of water and that was the only thing that I was doing. Then elevate your feet, if you keep on doing that the swelling will reduce and you will be fine, that was what the nurse said. (Fluke R6)

Jumak R10 narrated her experience:

I did not have any complication during my ANC because none of the health care providers noticed that I had a high B/P, it was here that I was diagnosed of it. All that I realised was that I had grown very big (oedema) but I thought that it's the pregnancy that has made me become very big; I had put on weight. (Jumak R10)

Granga R 7 a 28-year-old woman who survived severe Pre-Eclampsia also narrated:

I was attending clinic at 1 MRS Mitchel Camp before I was referred here, but when I came, they told me everything was normal, they didn't tell me I can't deliver by myself and that everything was normal. (Granga R7)

Although all participants were educated on birth preparedness and complications readiness as well as the danger signs of pregnancy, the majority of participants said that they did not have any complications during the ANC visits to the healthcare facility and became surprised of the complication that they experienced when they were first diagnosed. Those who survived Eclampsia fits said that they grew very big (oedema) suddenly and thought that it was part of the pregnancy process or they had put on the weight and felt that their complications were diagnosed rather too late.

The succeeding segment presents some of the coping strategies adopted by the participants in order to improve on their quality of life.

4.8 Coping Strategies

This section presents the various coping strategies by the participants after surviving a near-miss event. The study found that all participants used various coping strategies to overcome the various stressful situations they found themselves in. Some used personal coping styles or religion as a form of coping, while others had supports from significant others like family, spouses, friends and healthcare providers. Through supports from their spouses, family members, friends and other social support networks they were able to manage well with the situations they found themselves in. The majority of participants found the near-miss complication they survived to be traumatising to them and some did not even want to talk about it so they used avoidance strategy as their personal coping style, whilst others also used other coping strategies.

4.8.1 Personal Coping Styles

The following section revealed the personal coping styles adopted by the participants. Almost all the participants had their personal coping strategies to handle the problems they were faced with in their day-to-day lives. While some used problem solving as an active coping strategy, others also used the avoidance technique or social withdrawal to cope with the stress. Danlu R4 who initially had difficulty in sleeping because her baby would not sleep in the night said she was able to cope by studying her baby:

I will say my sleep is normal now since it's around his (baby's) clock so when he falls asleep then I also have to organize some sleep around that time. (Danlu R4)

Amara R1, a 29-year-old woman who experienced postpartum haemorrhage, has this to say:

My baby cries a lot at night, and I find it very difficult to sleep so, when baby sleeps, I have to sleep because that is the only time I get to relax. (Amara R1)

Granga also narrated:

I have been studying my baby and play it her way, whenever she sleeps then I also organize myself to sleep before she wakes up otherwise, I wouldn't have any sleep at all, so whenever she sleeps then I also sleep. (Granga R7)

Hamdara R8 has also expressed views of her personal coping strategy for her routine house chores:

Now I have limited my time interval of doing things, if I used to scrub every week now is not every week any longer, now I do it every 2 weeks and sometimes too if I don't feel comfortable, I leave it and do it the following week. (Hamdara R8)

Jumak R10 stated:

So now that I have seen the cause of my tiredness, I have reduced the number of house chores I do in a day, I just do the little I can do at a time, I do just that one and leave the rest for another time. (Jumak R10)

Ezeyaa R5 used avoidance by walking a long distance to ease some undesirable thoughts from her mind:

At times I go to my in-law's shop at Doku behind Madina market to while away the time, I usually walk from our house to that place though it's quite a distance, since I want to ease off some of the thoughts in my mind by the time I get there. (Ezeyaa R5)

Lima R12 also recounts:

Hmmm! talking about it again! Hmmm, it puts some fear in me; I don't want to talk about it. I don't know, eeeh what I went through eeeh! I was telling myself that if it wasn't for God I wouldn't be here today. (Lima R12)

Indiana R9 narrates:

Those who knew I was pregnant and did not know the outcome of the pregnancy always try to ask how baby was doing and when I try telling them that baby did not survive, it makes me feel sad so sometimes I just respond that baby is doing well in order to avoid any long stories. (Indiana R9)

In addition, some participants had supports from their spouses, and this made them to cope easily with their predicaments.

4.8.2 Spousal Support

This segment found that some participants received some form of support from their husbands, while others did not have such supports.

Ezeyaa R5 expresses herself this way:

I know family and friends' supportiveness is when you have friends or family members who come in to help you in time of trouble in order for you to become comfortable once again. But in my case my only support was my husband since he does everything in time of trouble although I have my family and my husband's family, my husband is the one who shoulders every responsibility. (Ezeyaa R5)

Indiana R9 also expressed herself this way:

My husband is the only one who supports me in everything; he did well to spend all his money on my health. I thank God that, although we didn't have such an amount of money in our savings but when I fell sick, he was able to raise all the monies by the help of God. He is a good man because up till now he has never complained of spending that much on my health or treatment. (Indiana R9)

Granga R7 also recounts her experience of support she got from her spouse:

My husband assists me sometimes, also my mother came to assist me for some time but now she has gone back to her house, so my husband is the only person assisting me now ...coughing. In addition, he gives me a lot of emotional support, I get it from my husband and apart from him no one else is there to give emotional support to me. (Granga R7)

Lima R12 who has some form of support from his spouse, but feels it's not good enough also has this to say:

Hmmm! Men, anyway he does sweep the room and now I don't do his laundry he does it himself. But the children's laundry I do it. Madam you know men, sometimes when they feel like helping, they do but when they don't feel they don't. (Lima R12)

4.8.3 Family Support

Family support was also utilised by majority of the participants of the study. Some of the participants had their families around them to assist them in their time of difficulties and these include their husbands, siblings, parents and other significant others like the extended family members and friends or in-laws. The participants expressed how they were supported by their families:

I'm coping with life very well. My family and friends did very well during the time I was having the complication. They were there for me and they really accommodated me during the time I was in difficulties. They made me feel very comfortable as possible and under the circumstances that I found myself they were very understanding. (Danlu R4)

Amara R1 also recounts:

I have a lot of family support. I was staying with my husband but since I gave birth, I moved in to stay with my parents in order to get the necessary support from them. So, I have a lot of support from my parents and siblings here. (Amara R1)

Ezeyaa R5 a 35-year-old woman with PIH/Ruptured uterus and emergency hysterectomy stated:

These thoughts come in my mind and it makes me to think a lot and cry, but when I think for a while then I stop. My husband sometimes consoles me to stop thinking and crying and that with God nothing is impossible. (Ezeyaa R5)

Amara R1 is also coping in this way:

I hope it will resolve. I am coping with it because as at now I have no choice, I just have to manage with the pain and to take care of myself the way they taught me to do. In addition to that, the family has also been assisting me in caring for the baby. Amara R1

Baraka R2 has this to say about the support she received from her spouse and other family members:

My mum and my husband do assist me. When my husband is around, he supports me and my mum takes care of my small child (first born), I am very lucky because one of my cousins is there together with my sibling so when I can't do something she does it for me. Sometimes my mother does most of my household chores for me. (Baraka R2)

Aside family support as a form of coping strategy used by the participants, the study discovered that participants made use of religion as a form of coping strategy to improve their health-related quality of life and well-being.

4.8.4 Use of Religion

This section presents results of how religion was used by the participants as a form of coping strategy. Religion was found to be used by most of the participants in the study as a means of coping with their illness and even during the time they were experiencing the life-threatening situation. In this study, the two religions found were basically Christian and Islam. The participants relied on their prayers and the faith they had in their prayers and were able to cope with the situation they experienced.

Hamdara R8 a Christian expressed herself:

God is going to give me double, double of what I have lost, and it will marvel everybody and that high B/P kraaa! (In Akan language meaning a call for action laying emphasis on a statement made) would not come again. At first, they said if somebody survives a severe complication and comes back from ICU or hospital they go home and they die. Me! Minus me, as a Christian God has delivered me and what God has delivered, nothing can take it away again. (Hamdara R8)

Indiana R9 also stated:

At the time when I was lying on the hospital bed with many doctors around me, I really prayed, I realised the doctors were all quiet and allowed me to pray. I believe the prayer that I prayed God has really answered. (Indiana R9)

4.9 Summary of Findings

Surviving severe obstetric complications has implications for the women who suffered the life-threatening event, as there are consequences which affect their quality of life and well-being. Due to the various challenges affecting their physical, psychological, social and spiritual well-being, they adopted various coping strategies to manage their situations.

The physical well-being issues that were found included; the inability to perform functional activities due to the lack of stamina, increasing weakness, fatigue, difficulty to fall asleep due to the sudden change in their sleep pattern and fear of death when they fall asleep. Most participants were left with residual illnesses like postpartum hypertension, low haemoglobin levels, pain at the incisional sites and other parts of their bodies which affected their quality of life.

The psychological well-being concerns were anxiety, worry, sadness, fear and loss of confidence to have subsequent pregnancies due to the fear of recurrence of the complication. They also experienced loss of control over events as they became surprised of their diagnosis, because they did not have any knowledge about their illness and subsequent complication. This affected their psychological well-being and quality of life.

The financial challenges were encountered by the majority of women as the complication affected their ability to immediately resume their usual income generating businesses. This coupled with the huge hospital bills and family distress, strained family relationships, and social isolation were some of the social well-being issues that affected their quality of life. Some women felt isolated due to the negative outcome of their pregnancy and the feeling of disruption in their appearances as a result of the complication they survived.

Religiosity, the use of inner-strength, hope and reference to God helped these women to give meaning to their illness and the survival of the complication as far as their spiritual well-being and quality of life was concerned. While some attributed their survival to divine intervention by God, others also attributed their ordeal to negative supernatural power manipulations by their haters.

The utilization of coping strategies supported the survivors to modify the adverse effects of their predicaments. Some coping strategies like religiosity, hope, drawing on inner strength, diversionary therapy, by having leisure activities, enjoyments, and the supports they received from the healthcare providers, family and friends as well as spousal support also helped in the timely recovery of these women.

Chapter 4 presented findings of the study with the description of themes and their sub-themes from the theoretical framework and also those that emerged from the interviews of participants. These findings were supported with verbatim quotes from the study participants. Chapter 5 will discuss the findings of the study with the existing literature regarding women's experiences of surviving severe obstetric complications.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter discusses the findings of the study in relation to relevant literature. The discussions are centralised on the main themes and sub-themes that were in the constructs of the theoretical framework and those that emerged. The socio-demographic background of participants will first be discussed and the rest of the section will focus on the physical well-being, psychological well-being, and social well-being. Also, the psychological well-being in relation to the quality of life, ANC experiences and coping strategies related to near-miss events would be discussed.

5.1 Socio-Demographic Data of Participants

The age range of participants was between 22 and 41 years making the mean age to be 33.5 years old. However, eight (8) participants were aged 35 years and above. Women aged 35 years and above and pregnant have higher risk of labour and delivery complications. This is supported by the study of Cavazos-Rehg et al. (2015). They opine that advanced maternal age was associated with age related risk for incidence of eclampsia. In this study all participants were urban dwellers. Ten (10) out of the twelve (12) participants, were married and reported spousal support during ANC visits. In Wai et al. (2015) women who had spousal support recounted the benefit of spousal support. The remaining two (2) were in relationships leading to marriage. Similarly, Manda-Taylor, Sealy, and Roberts (2017), in study of factors associated with delayed antenatal attendance asserted that such a situation made it difficult for women not married to get the necessary support during ANC.

Out of the twelve (12) participants in the study, eleven (11) were Christians and one (1) was a Muslim. Religion did not influence their ANC seeking behaviours. This is contrary to the findings by Kifle, Azale, Gelaw, and Melsew (2017) in Ethiopia who argued Islamic religion followers were less likely to seek maternal healthcare services, compared with

Christians. They attributed the less ANC seeking behaviours of Muslims to the nudity and religious restrictions that allows only their husbands to see their nakedness. This assertion could only be confirmed by personal experiences of Muslim participants in the study. However, only one participant was a Muslim.

Eleven (11) of the participants indicated they were in the middle class, and only one participant was in the lower class. The African Development Bank defined the middle class as persons with yearly incomes exceeding \$3,900 (or per capital expenditure of \$2 to \$20 a day) (Ncube & Shimeles, 2012). All participants were employed either in the formal sector or self-employed and were earning incomes above GH¢10.65 per day which is the daily minimum wage for Ghanaian workers. This gave them some level of financial freedom to access skilled ANC services. This is supported by several studies (Akhter, 2015; Asiedu, 2017; Neubert, 2014; Powell, 2016).

Four (4) of the participants had post-secondary education in nursing and teaching. Whereas two (2) participants had first and second degrees from the University, the remaining six (6) had high school education. The educational level of an individual has a direct effect on the income level of the person and this creates a class system (Lentz, 2016). On the contrary, Kroeker, O'Kane, and Scharrer (2018) and Spronk (2018), on the concept of middle class in Africa, argue that it is important to use indicators such as well-being and not merely income as suggested by Lentz.

Eight (8) out of the twelve (12) participants were diagnosed with Eclampsia or hypertensive disorders of pregnancy. This is supported by Oppong et al. (2018) and Tolera et al. (2018), who found Eclampsia to be the most dominant obstetric complication. Three (3) out of the twelve (12) were Post-Partum Haemorrhage (PPH). However, other studies have found PPH as the foremost cause of maternal near-miss and death (Al-zirqi, Daltveit, & Vangen, 2019; Geller et al., 2018; Maswime & Buchmann, 2017). The WHO (2015) statistics

found PPH as the principal cause of severe obstetric complications, followed by infections, hypertensive disorders of pregnancy (Pre-Eclampsia and Eclampsia), complications from delivery and unsafe abortions.

All participants of the study utilized antenatal care because they knew about its importance. This was also reported in Nepal and Ethiopia by Deo et al. (2015) and Gebremeskel, Dibaba, and Admassu (2015) respectively, that pregnant women with no knowledge and no advice about when to start ANC were more likely to start ANC late.

Out of the 12 participants only one participant did not attend ANC, 10 participants commenced ANC during the first trimester and one participant commenced ANC visit during the second trimester due to financial constraints. In Fagbamigbe and Idemudia (2015) study of barriers to utilization of ANC in Nigeria, they identified lack of finance, unavailability of transport and negative attitude of healthcare providers as reasons for not attending ANC. Similarly, Ali and Adam (2011) findings identify that lack of ANC services were predisposing factors to maternal ailment and mortality. In this study, it was found that, antepartum haemorrhage, ruptured uterus, eclampsia, and HELLP syndrome were attributable to neonatal deaths. Timely referral of obstetric complications to tertiary healthcare facilities achieved optimal healthcare outcomes (Awowole et al., 2018; Singh, Doyle, Campbell, Mathew, & Murthy, 2016). Fifty per cent (50%) of participants were referred from other peripheral institutions to the 37 Military Hospital for expert obstetric management and the remaining 50 per cent were regular ANC attendants of the 37 Military Hospital.

The ensuing section will discuss results of this study according to the objectives and themes in the theoretical framework and the themes that emerged.

5.2 Physical Well-Being

The effect of severe obstetric complications on the physical health of the woman is enormous. Survivors of obstetric near-miss lose their strength, stamina, and experience

sleeplessness. Angelini et al. (2018) asserted to a similar phenomenon that the health problems borne by women throughout prenatal period, labour and post-delivery period contribute immensely to the overall burden of poor maternal health. The researcher found that almost all the women who survived SOC had some form of health problems after discharge from the hospital. There is evidence that, poor health was associated with SOC. Morgan et al. (2014) and other studies have also identified poor quality of life after the experience of near-miss event (Machiyama et al., 2017; Zhang & Covey, 2014). The participants of the study reported various health-related physical well-being issues such as general weakness, residual hypertension, anaemia, pain, sleeping difficulties and general body pain that affects their QoL. This conforms to several studies (Angelini et al., 2018; Assarag et al., 2015; Filippi et al., 2010a; Leonard et al., 2019; Norhayati et al., 2017a).

The overall physical health of survivors of severe obstetric complications depends on the severity of the complication suffered. The study revealed that participants experienced ill health, abdominal pain and lack of stamina to carry out activities or household chores. This conforms with various studies (Filippi et al., 2010a; Norhayati et al., 2016; Woolhouse et al., 2014). The women who experienced SOC reported ill health, loss of blood, general body weakness, dizziness, low haemoglobin levels, frequent headaches and inability to perform their usual tasks, such as cleaning, cooking, doing laundry and taking care of their children. This confirms assertions by Assarag et al. (2015) and Prada et al. (2015), who established that, the amount of bodily impact like severe ill-health, discomfort and serious pain during postpartum tend to be higher among women with severe obstetric complications than the uncomplicated deliveries.

In Filippi et al. (2010b) the authors opined that women who experienced near-miss were more likely to have fever during postnatal period and also had four times higher risk of developing hypertension. The authors again reported that the magnitude of bodily ailment

(serious illness) was greater among near-miss cases than deliveries that were uncomplicated. This was cited by several studies (Angelini et al., 2018; Simpson, 2018; Sivertsen, Petrie, Skogen, Hysing, & Eberhard-Gran, 2017; Soma-Pillay et al., 2018). In this study, no participant reported to have fever, however, those who survived hypertensive disorders of pregnancy were left with residual hypertension and sleep difficulties. They further indicated that the weakening strength and exhaustion was accompanied by palpitations which made them require assistance from significant others to accomplish their activities of daily living. This is consistent to the assertion of Leonard et al. (2019) who posited that near-miss survivors tend to have adverse maternal outcomes, coupled with loss of strength and stamina to go about their usual functional activities.

Owing to their life-threatening complications, participants suffered sleep disruptions, difficulties to initiate sleep, and daily face the dangers of insomnia. This conforms to the findings of Annema et al. (2017), Currie (2016) and De Cock et al. (2018) that sleeping disorders were common in patients who have newly experienced life-threatening illnesses which may either be due to the disease condition or the treatments they received. The assertion by Kent et al. (2015) that, women hospitalised for long periods due to SOC had sleep disruption because they were woken up by hospital routines was reiterated in this study. Women in this study attributed their insomnia to the fear of dying in their sleep, or hearing their babies crying at night. Also, their new roles as mothers who woke up to breastfeed and care for their babies was revealed as a cause of alteration in their sleeping patterns, as they found it difficult to go back to sleep after attending to their newborn babies.

5.3 Psychological Well-Being

Similar to Hinton et al. (2015b), Khan et al. (2012) and (Robinson et al., 2016), family's disappointments about the woman's pregnancy outcome has caused emotional ill health for these women. The study discovered that, women who suffered perinatal loss as a result of

obstetric complications experienced intense anxiety, sadness and worries as compared with those with live babies. This subsequently led them into Post-traumatic Stress Disorder (PTSD), as having the thoughts and perception of death made it difficult for them to discuss challenges associated with their experiences. In this study, some participants have been traumatised to the extent that, they would not want to narrate their stories again as it kept reminding them of their ordeal. This supports Elmir et al. (2012) findings which posited that, being close to death, bleeding and fear, having hysterectomy were devastating to these women, as they kept on having flashbacks and memories of their predicaments. This was equally reported by Andersen et al. (2012) and (Bastos et al., 2015a); Bastos et al. (2015b) . From this study, it could be inferred that, SOC was associated with PTSD.

On the contrary, Angelini et al. (2018), posited that there was no significant association between PTSD and previous near-miss experience as there were no changes in the occurrences. In this study, not all women who suffered SOC experienced PTSD, and this could be due to factors such as adequate social support from healthcare providers, family members and spousal support. Carroll, Daly, and Begley (2016) and Furuta et al. (2014b) respectively, iterated that, experience of near-miss events and its consequent treatment were bodily and mentally disturbing for the women. Since it brought about negative feelings and sentiments which could eventually lead to poor postnatal consequences.

In this study, women who experienced emotional trauma and PTSD were referred to the Clinical Psychologist for treatment sessions which took the form of debriefing management sessions. This assertion is in line with Cirino, Knapp, and Survey (2019) which focused on detecting risk factors and treatment choices, and concluded that, individual-trauma-focused psychotherapy and non-trauma-focused psychotherapy were helpful. Similar assertions were made by (Bastos et al., 2015b) and (de Bruijn et al., 2019) that, debriefing sessions were helpful to women when they personally request for it following a traumatic childbirth.

The study found that, traumatic delivery, death anxiety and their concerns about a potential or actual harm to their babies influenced their way of perception of their predicaments. These were sighted in several studies (Assarag et al., 2015; Roberts, Davis, & Homer, 2017; Tunçalp, Hindin, Adu-Bonsaffoh, & Adanu, 2012). The researcher again found that, women who suffered perinatal loss and interventional hysterectomies had more depression than near-miss women whose babies survived. In Soma-Pillay et al. (2018) and Kuismanen et al. (2018) studies, they found traumatic birth events provoked severe anxiety and distress for both the survivors and their spouses as well as other family members. In these studies, they concluded that women who experienced perinatal loss have reduced QoL and their psychological well-being are compromised

The study again, revealed that, the fear of recurrence of the same complications in subsequent pregnancies deterred some of these women and they were hesitant to have future children. They often felt uncomfortable narrating their experience or visiting the hospital, because they lost the confidence to resume their reproductive activities within a reasonable time frame. This conforms to the statements of Andreucci et al. (2015) and Moaddab et al. (2017) respectively. They asserted that women who survived life-threatening complications become hesitant to have sexual intimacy. They attributed this to pain during sexual intercourse or the fear of recurrence of the complication. On the contrary, Norhayati et al. (2017a) established that, survivors of severe obstetric complications were not hesitant to become pregnant in the future. This was again confirmed by Soma-Pillay et al. (2018) that, women who survived severe obstetric complications desired future fertility.

The study indicated that, while these women's lives were saved through prompt medical and obstetric interventions, they still had feelings of loss of their fertility. These women experienced ill health, weakness, residual hypertension, anaemia, and loss of strength. These findings have been recounted by a number of studies (Lindqvist et al., 2018; Maguire et al.,

2015). Additionally, participants expressed how they could not control their sadness, and having to wake up in the ICU without a baby gave them ruminative thoughts. This is reiterated by Hinton, Dumelow, Rowe, Hollowell, and childbirth (2018) that, women with SOC were traumatised to wake up and find themselves in the ICU instead of the maternity ward. This was because of the change in the anticipations of birth place and they wondered what essentially might have ensued for them to be sent to the ICU. On the contrary, Furuta et al. (2014b), posited that, though severe maternal morbidity experience were often negative, sometimes such experiences also gave opportunities for inner growth, which can also impact the victims' lives positively. In Hinton et al. (2015b), they established that, separation of mothers from their babies during early postpartum period due to ICU admissions triggered a sense of regret, sadness and guilt for these women. However, the participants of this study did not experience that. The researcher found that, the women in this study had a feeling of loss which has affected their ability to recover within a rational time limit. They were constantly thinking and reflecting over the incident and trying to find answers. This affected them physically and socially, as depression made them become lean.

5.4 Social Well-Being

The study revealed that, participants' capabilities to ordinarily participate or play their usual roles in their families, communities or network activities that form part of their everyday social well-being were found to be compromised. Majority of the participants experienced family distresses in various forms like marital disputes, misunderstandings, blamed for mishaps in the family, and strained relationships with in-laws as a result of the huge hospital expenses. This resonates with the findings of Storeng et al. (2010) that, women with obstetric complications experienced worsening relationships with people in their immediate community, like in-laws. Contrary to this assertion, the current study further revealed that, other participants

enjoyed cordial relationship with their family members, as their experience of the near-miss events had rather improved their family's relationships.

The financial challenges faced by the women who experienced near-miss and their families are enormous. The high treatment costs have led to financial burdens on their families (Khan et al., 2012). The financial challenges were in a form of direct costs, while others were indirect costs due to the relatively huge medical care expenses and hospital bills ranging between GH¢2,800.00 to GH¢3,000.00. The National Health Insurance Scheme (NHIS) in Ghana, which commenced in the year 2003, covers antenatal and free normal delivery services for all women in 2005. However, in the event of severe obstetric complications, the NHIS does not cover certain charges and this escalates the hospital bills for these women and their families. The current study further revealed that, even though, participants had knowledge about complications readiness, they had under-estimated the cost of complications and did not plan adequately, which contributed to some of these social problems. This finding has been reported by Assarag et al. (2015) that, economic challenges for women and their families after a near-miss care had contributed to social problems among the women and their immediate families. Similar findings have also been reported by several studies (Dalaba et al., 2015; Filippi et al., 2015; Iboudo et al., 2013; Wick, 2017). The researcher found that, women who could not go back to their usual economic activities due to the severe illness have their income generating ability compromised and have financial insecurities which affected their quality of life. They could not fend for themselves and their families as they had to reduce their expenses. The children of some of these women had to wait at home till their parents were able to pay their school fees. Some of these women had to delay the naming ceremony of their babies due to financial constraints.

Additionally, the findings of this study revealed that some women tend to be socially withdrawn because they did not want people within their communities to empathize with them.

They also felt physically isolated because they did not feel healthy enough to go out to see people who may stigmatize them. However, none of these women were stigmatized by people within their communities. Consequently, the traumatic nature of their experience restricted their sexual intimacy. This finding opposes the assertion of Norhayati, Hazlina, and Sulaiman (2017b) who stated that, sexual desires of women with severe obstetric complications did not vary from that of women who had uncomplicated deliveries.

5.5 Spiritual Well-Being

The experience of near-miss events had impacted the meanings the women gave to their ordeal. The mutual meaning that came up was that God spared their lives for a reason and this essentially changed their meaning to life and they appreciated life better. In Young, Nadarajah, Skeath, and Berger (2015) study of 'spirituality in the context of life-threatening illness and life transforming changes', they found that spirituality helped patients to get greater meaning and purpose to their lives and facilitated their adjustment to their life-threatening illnesses. This experience caused participants to re-evaluate their life priorities. Women in this study had a sense of peace, purpose and a deeper connection within religion, people around them and in themselves which facilitated their spiritual well-being. These findings have also been reported by several studies (Lewis, 2016; Wachelder et al., 2016; Zamaniyan et al., 2016).

Most of these women had belief in a superior being who they believed had control over processes, but at the same time some also believed that someone could be responsible for their predicaments. They blamed their predicaments on people around their neighbourhood who were jealous of them and want to harm them or their unborn babies using supernatural forces or witchcraft. They further believed that "evil eyes" had looked at them during the time of pregnancy which had caused them the complications that they had experienced. The findings support the work of Påfs et al. (2016) which found that the concept of witchcraft was understood and described by some women as the reason for potential complications during

pregnancy. Nevertheless, the belief in such supernatural external forces could be there. This belief system of behaviour can have negative implications on the well-being of the near-miss women who believed in that, as it becomes very challenging to manage them.

In White (2015) study of the perception of illness and African traditional religion healthcare in Ghana, they asserted that, traditional followers belief there are some sicknesses that Western Medicine cannot cure and therefore need a spiritual attention. Women in this study believed that there were forces which influence events in their lives, so they relied on their faith in God through their pastors to get their spiritual help. Similarly, Croucamp (2013) study on traditional African divination systems as information technology, asserted that individuals sought hidden information about their lives in the spirit world through Diviners. Although the women in this study believed there were spiritual forces which could influence events, none of them resorted to divination. Croucamp (2013) further postulated that African traditional medicine is holistic, as it addresses issues of the soul, spirit and body and also easily accessible and affordable. This finding has been reported by (Asamoah-Gyadu, 2014; Cumes, 2014; White, 2015). The World Intellectual Property Organization (WIPO) asserted that traditional medicine is the only affordable source of healthcare for the world's poorest patient (WHO, 2000, 2016). Women with SOC events sometimes delay in pursuing healthcare due to the socio-economic reasons and resort to herbal or alternative treatments (Prada et al., 2015). In this study, women who experienced SOC did not resort to alternative or herbal treatment. This may be due to their proximity to orthodox medicine and also their knowledge in them.

The study again found that, the women had hope in God and in their children, who survived with them; despite their traumatic experience, faith and hope were important sources of their well-being. They had feelings of expectations with confidence that things will turn out for the best. This finding confirms the positive contributions of hope to maintaining and restoring health (O'Shaughnessy, Laws, & Esterman, 2015). The above findings correspond

with the findings of Scioli et al. (2016), who asserted that, there was a link between hope and physical well-being. These findings have also been reported by a number of studies (Burden et al., 2016; Faller et al., 2017; Jenkinson & Cantrell, 2017; Viglund, Jonsén, Lundman, Nygren, & Strandberg, 2017). From the current study findings, one can infer that the women who had hope and optimistic attitude had stress free lives and relaxed minds, hence had a good quality of life.

5.6 Antenatal Care Experience

Antenatal care (ANC) was utilized by the women prior to their complications. They indicated that the healthcare providers educated them on the danger signs and symptoms in pregnancy that would require them to seek immediate care from a health facility. Some of the signs and symptoms they mentioned included bleeding per vagina, reduced foetal movements, headache, blurred vision and severe abdominal pain. Others include dizziness, oedema, excessive weight gain during pregnancy, protein in urine and increased blood pressure. This conclusion resonates with the assumptions by Yidana and Kuganab-Lem (2014) which states that expectant women who have knowledge on the danger signs and symptoms during pregnancy will seek immediate care from their health care providers.

The researcher found that, the women sought immediate medical attention when they experienced complications. They had knowledge about the danger signs of pregnancy and prepared for any unforeseen complications. However, their preparations were not enough as they could not adequately cater for the expenses of their care and management. Antenatal health literacy, understanding and identification of danger signs of pregnancy, BPCR has been reported by several studies (Kakaire, Kaye, & Osinde, 2011; Kuganab-Lem et al., 2014; Lori et al., 2014). Any expectant mother who attended ANC at least 4 times, and has received health education on pregnancy and danger signs of labour, made plans for where she would want to deliver and had saved money for emergencies was considered to have a plan towards birth

(Affipunguh & Laar, 2016; August et al., 2015; Chala et al., 2018). On the contrary, it can be inferred that, though, participants had birth plans, they were inadequate to provide them with the necessary timely use of skilful maternal care during their time of emergency. There are two studies that have identified the importance of birth preparedness and complications readiness (Endeshaw, Gezie, & Yeshita, 2018; Sabageh, Adeoye, Adeomi, Sabageh, & Adejimi, 2017). However, some women who experienced near-miss were found to be inadequately prepared and shocked at the events at that time.

5.7 Care Providers' Support

Perception of care varied from each individual and this might have been influenced by the woman's state of health and outcome of delivery. While some felt that the support they received from their care providers was excellent, they required extra support from the midwives. In Miller et al. (2016) study, they concluded that healthcare staff and health systems need to ensure that all women receive high-quality care. They must be provided with evidence-based, impartial and respectful care, with the accurate amount of care that is expected to be offered at the right time, and delivered in a manner that protects, respects, and promotes human rights. Women with near-miss had good perceptions of the support they received from health workers during ANC visits and delivery. These were in the form of counselling, encouragement, nice communication, caring words and actions by nurses, midwives and doctors. This finding conforms to (Priddis et al., 2013; Priddis, Schmied, Kettle, Sneddon, & Dahlen, 2014; Priddis et al., 2018).

Study findings suggested that respectful maternity care was implemented by some healthcare providers as the women who experienced SOC were happy and satisfied with the quality of care offered them which led to their physical and emotional recovery. This is contrary to de Groot, Bijma, Bonsel, and Lambregtse-van den Berg (2018) assertions that vulnerable clients would usually remember previous hostile experiences from caregivers. Women who

experience SOC were often pleased with the quality of care and support they were provided by the healthcare providers and commended them during the interviews (Amirehsani et al., 2017). There are two studies that have identified the importance of good communication (Estrada, Ramirez, Gamboa, & Amezola, 2018; Miller et al., 2016). It could be inferred that, the care and support the women received made them develop a trusting bond with their care providers and had the assurance that the care providers were readily available and would take up responsibilities when the need arises. An effective midwife-mother relationship and support could promote optimal maternal health and positive newborn outcomes. These findings of respectful maternity care have been reported by several studies (Asefa & Bekele, 2015; Miller et al., 2016; Molina, Patel, Scott, Schantz-Dunn, & Nour, 2016; Shakibazadeh et al., 2018; Tunçalp et al., 2015; Warren et al., 2013).

In contrast, some women were demotivated with the procedures and processes they received during ANC. This is in line with several studies (Ardey & Ardey, 2015; Tunçalp, Hindin, Adu-Bonsaffoh, & Adanu, 2014; Tunçalp et al., 2013). These studies asserted that women's experiences depicted both positive and undesirable encounters with staff. The current study again found that, women expected their healthcare providers to provide them with relevant and timely information about their deteriorating health. There is therefore a need to intensify pregnancy schools at the primary healthcare level. This was also reported by Amirehsani et al. (2017) who posited that patients expect healthcare providers to provide them with information, better care and respectful relationship.

Knowledge of signs and symptoms of Pre-Eclampsia can help mothers have modifiable lifestyle. The women who suffered Eclampsia or Hypertensive disorders of pregnancy did not have much knowledge about the condition. This finding contradicts Maruf, Chianakwana, and Hanif (2017) who argued that patients had good knowledge about Pre-Eclampsia. The current

study found that Pre-Eclampsia was not diagnosed early, hence resulting in severe complications of Eclampsia.

5.8 Coping Strategies

From the results of this study it could be determined that, the women used various coping strategies to deal with their situations in a calm and adequate manner. Personal coping strategies such as leisure, diversionary or avoidance strategies were used by some women, while others also had various supports from significant others such as spouses, friends and family. This corroborates the conclusions by Szabo, Ward, and Jose (2016) that, individuals who employ dynamic strategies and actions to take control over their stressful circumstances are better able to eradicate such stressors. The current study found that the near-miss event was traumatizing to these women so, they did not want to talk about it. Crowe, Gillon, Jordan, and McCall (2017) asserted that people under stressful conditions used various strategies that brought them relief. It is therefore postulated that, when several coping strategies are employed by women who survived SOC it could help mediate the effect of their complications, leading to their recovery and well-being.

The study further found that, women have devised means of diverting their attention through measures such as watching movies, listening to music, chatting with people or siblings and going to the beach. There is evidence that the utilization of various coping strategies reduces the impact of the stressful events (Bayrampour, Vinturache, Hetherington, Lorenzetti, & Tough, 2018). Other avoidant strategies used by them were social isolation, avoiding people whose presence kept reminding them of their predicaments. Individuals could improve their ability to cope with stressful situations by being positive minded, optimistic and being able to regulate their own emotions (Kaye et al., 2014; Mbalinda et al., 2015). Others chose to wear black clothes to prevent people asking about the outcome of their pregnancy. However, a woman who lost her baby and requested to see the demised baby alluded to the fact that holding

and talking to the dead baby gave her a form of relieve. This finding resonates with Kiruja et al. (2017) assertion that beliefs concerning stillbirth for women were that, touching or holding the dead baby helps these women to adequately cope with the loss. While social support has been very instrumental in the prevention and treatment of some psychosocial problems, the study yet found that, women were able to overcome their emotional traumas when they received adequate social support from significant others. This conforms to several studies (Bruijn, Stramrood, Lambregtse-van den Berg, & Ottenheim, 2019; Furuta, Sandall, Cooper, & Bick, 2016; Yildiz, Ayers, & Phillips, 2017).

The study again found spousal support to be instrumental to coping with the impact of near-miss. Women who received assistance from their spouses during the time of their complications had physical, social and emotional support needed for their recovery. Salakari et al. (2017) iterated that, inadequate social support was concomitant to a decline in quality of life. They further asserted that, spousal support was a well-known determinant of well-being, as women who received support from their male partners recovered within a short period of time. The support these women received continued even after they had been discharged from the hospital. Participants still had the support of their husbands in caring for them at home, assisting in domestic responsibilities, and helping in the care of other children. This finding supports Doyle et al. (2014) who found that, when men accepted to assist their wives with household chores, it improved communication as well as the relationship between them and their spouses, as they have identified their own culture had put unfair burden on women. This presumes that, the support has helped in improving the well-being and QoL of the women. The study revealed that, supports received by these women from their spouses helped in their relationships in the family. This supports the conclusions of Van den Berg et al. (2013) and (Doyle et al., 2014) who posited that, there was enhanced relationship and communication with spouses when male partners offer support to their wives. Additionally, Mbalinda et al. (2015)

asserted that, the care and support that women receive from their male partners during postnatal period improves their health and coping capacities. Similarly indicated by Gourounti et al. (2013) as worries and poor coping was associated with lack of marital support. This study again found that women had marital satisfaction and got the needed assistance from their spouses during their complications, contrary to Gourounti et al. (2014) who discovered that, women suffered low marital satisfaction and indicated a correlation between poor social support and depression as inadequate spousal support could cause low marital satisfaction.

Family support was utilized by these women, as their family members came around to offer financial, physical, social or emotional support during their times of difficulties. Findings revealed that support from family members, friends and significant others was a collective key that provided them with strength and encouragement needed for their timely recovery. This finding was recounted by several studies (Salakari et al., 2017; Williams & Jeanetta, 2016). Others had their parents, mother in-laws, siblings, extended family members and or friends who came in to assist them with their household chores and caring for the newborn babies. This form of social support helped them to cope well with their stressful times. This finding conforms with the conclusions of Cremonese et al. (2017) who determined that, social support received by perinatal adolescents had the majority of instrumental support, informational and emotional support that were usually provided by their family. Patients had invaluable supports from their family members, friends and relatives during the time of their predicaments and its aftermath. This was also reported by several studies (Faller et al., 2017; Fong, Scarapicchia, McDonough, Wrosch, & Sabiston, 2017; Hinton, Locock, & Knight, 2015a). It can be argued that, the participants however, sought this support because they knew how beneficial it was to their well-being and those who received social support had better health outcome than those who did not receive any support. Support and information from healthcare providers is very imperative to coping.

5.9 Summary of Discussion

In summary, obstetric near-miss women have health and well-being issues even up to one year postpartum as far as their quality-of-life (QoL) and well-being are concerned. The study found health-related problems such as lack of stamina, general weakness, residual hypertension, anaemia, pain, sleeping difficulties pain and permanent infertility to be some of the physical well-being issues that affected the survivors even after being discharged from the hospital. Psychological and social challenges like lack of finance, family distress, marital disputes, anxiety, sadness, post-traumatic depression, fear of recurrence and ruminative thoughts were also discussed with existing literature. Discussions on the spiritual well-being, coping strategies used and the kind of social supports that were available to women who experienced SOC were done alongside existing literature.

Although the HRQoL model by (Ferrell et al., 1991) did not spell out the coping strategies to mitigate their predicaments. The ramifications of SOC are enormous and had influenced the quality of life and well-being of survivors in various ways. Hence, survivors of near-miss complications need to have instrumental support to address some of these challenges. There is a need for the creation of the awareness and sensitization of women's support groups on the various life-threatening complications related to childbirth and how they can be mitigated.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This concluding chapter presents the summary of the study, the implications of the findings to nursing and midwifery practice, research, education, and administration and health policy. It further gave an insight into lessons learnt, limitations, conclusions, and offered suggested recommendations.

6.1 Summary of the Study

Severe obstetric complications are of great public health importance to every nation. The experiences of obstetric women after surviving a near-miss event have most often been overlooked by healthcare givers after their discharge from the healthcare facility. The study explored the experiences of women who survived SOC in a quasi-government hospital, 37 Military Hospital, within the Accra Metropolis. The Theory of Health-related Quality of life (HRQoL) by Ferrell et al. (1991) was used as an organizing framework for this study.

Guided by the study objectives, a qualitative research approach was used to explore twelve (12) women's experiences of surviving severe obstetric complications within the Accra Metropolis. After meeting all the ethical requirements to recruit participants into the study, the researcher purposively selected and interviewed participants. A semi-structured interview guide designed according to study objectives was used to collect data. Interviews were recorded with a digital audio tape recorder after the written informed consent of participants was obtained. The transcribed data were analysed by means of thematic analysis (Braun & Clarke, 2006b). The objectives of the study were designed based on the constructs of the model. The conceptual framework had four (4) themes with twenty-seven (27) sub-themes. Two (2) other themes emerged based on the responses of participants using analysis.

The study findings discovered the impact of severe obstetric complications on the well-being of women who experienced SOC. This had an impact on their physical, psychological,

social and spiritual well-being. It further found that, participants encountered several financial, socio-economic and inter-personal challenges which disrupted the roles and functionality of women. Other findings were that, healthcare workers provided counselling and appropriate communication to clients during times of hospitalisation. These women adopted their personal coping strategies such as watching television, social isolation, and listening to music. They also had support from family and spouse. The study again found that, participants had expectations such as the right to information, better care and respectful relationships that were not met by the healthcare providers. It is suggested that appropriate information should be given to women during ANC period to minimise the occurrence of severe obstetric complications.

6.2 Implications of the Study

The findings from this study have implications for nursing and midwifery practice, as well as for research, nursing education, administration and health policy.

6.2.1 Implications for Nursing and Midwifery Practice

Women in the study elucidated that, some healthcare professionals do not provide them with adequate information on their health conditions. The results from this study are expected to contribute to the development of knowledge in nursing and midwifery practice. The professional responsibilities of every nurse are the delivery of compassionate and humane care. Respectful maternity is imperative for improving the experiences of women with SOC. This will provide the opportunity for nurses to incorporate holistic care approach that will consider issues related to quality of life. The study has revealed the importance of reviewing the care of women who experienced a near-miss event, since the impact of SOC has frequently been left out of public deliberations. It will raise the awareness of the associated ongoing complications for all healthcare providers to embark on, giving quality care which will focus on the physical, psychological, social and spiritual well-being of women. This will aid in reducing the burden

often imposed on survivors of near-miss events. The outcome of the research will also help nurses and midwives to improve their clinical practice.

6.2.2 Implications for Nursing and Midwifery Research

The study findings have identified gaps in the health-related quality of life of women who survived severe obstetric complication such as lack of attention from healthcare providers and their own family members after discharge from the hospital. It is suggested that further qualitative research is conducted on women who survived severe obstetric complications to explore intervention measures, as research would provide the evidence-based practice for nurses to develop the confidence to approach tasks that need critical decision making.

6.2.3 Implications for Nursing and Midwifery Education

Nurses play educative roles in any given environment they find themselves in. The nurse as an educator needs to have knowledge on severe obstetric complications and its impact on the women who experience such complications. The study revealed healthcare providers did not give the necessary related health information to the women during the initial diagnosis of their complications, and the well-being needs after surviving such life-threatening obstetric complications. Given participants' perspectives about their experiences, it is suggestive that, the perception of participants about their diagnoses and treatment at the primary healthcare facilities were less complimentary.

There is a need for a review of the nursing and midwifery curriculum to integrate healthcare needs of women who survived severe obstetric complications, in order to give holistic care to the survivors even up to one year after discharge from the hospital. There should be regular in-service training for all healthcare professionals, especially nurses and midwives at the primary healthcare levels on the prevention, management and the consequences of severe obstetric complications. Nurses need to be furnished with sufficient knowledge and the necessary abilities in order for them to educate women on the danger signs and symptoms of

pregnancy, birth preparedness and complications readiness to adequately prepare for any unforeseen occurrences. As nurses, we need to contribute to the existing body of knowledge on obstetric complications.

6.2.4 Implications for Administration and Health Policy

Administration of nurses is an important role that cannot be over emphasised. These roles include supervision, management and monitoring of nurses at all levels. The study findings have discovered that NHIS is supposed to provide free obstetric care for women of child bearing age in Ghana. However, the scheme does not cover certain aspects of healthcare for obstetric complications, as women had to pay exorbitant amounts of money for their care during the obstetric emergencies. These include medications, fluids, supplies, imaging, diagnostic investigations and transport fees to referral sites. The coverage of NHIS should encompass transportation, medications, diagnostic investigations, admission bills and not just women in the other wards but ICU bills as well. Highly subsidizing pricing for women who are admitted to the ICU is recommended in order to prevent exorbitant health expenditures as a result of an obstetric emergency.

6.3 Lessons Learnt from the Study

The lessons I have learned from the study of women's experiences of surviving severe obstetric complications were that, it has broadened my horizon in research. I have also gained much insight on resilience from people going through the experiences of a life-threatening illness and still surviving it. The diverse coping strategies utilised by people who experienced SOC were insightful and could be applied in every given situation. Furthermore, the qualitative research design has given me an understanding of how to conduct in-depth interview through concurrent data analysis and probing questions in order to elicit more answers.

6.4 Limitations of the Study

The limitation of this study is that it was conducted in one quasi-governmental hospital in the Greater Accra Metropolis., therefore women's experiences in other facilities were not studied. The findings may differ in other facilities that are different from this facility. Another limitation is that, it only focused on women who survived severe obstetric complications. The study did not compare the experiences of women with uncomplicated pregnancy or childbirth; however, findings may be transferable. Again, the use of an existing conceptual framework (Ferrell et al., 1991) made it difficult to explore other areas of these women's lived experiences, however, other themes emerged from the data analysis which gave a broader insight of the study.

6.5 Conclusion for the Study

The study explored the experiences of women who survived SOC in a quasi-government hospital, 37 Military Hospital, within the Accra Metropolis. The Theory of Health-related Quality of life (HRQoL) by Ferrell et al. (1991) was used as an organizing framework for this study. Women who suffered severe obstetric complications mostly reported poor quality of life after discharge. There is therefore the need to improve family support, healthcare access, financial capacity, psychological well-being and functional ability of survivors of severe obstetric complications. In order to lessen the healthcare burden that these complications impose on women, support must be sustained at the community and at all levels of healthcare. Staff should be trained on how to identify PTSD symptoms in women who have experienced SOC and direct them appropriately for prompt management. It is also imperative that these women be provided with the necessary integrated care that embraces physical, psychological, social and spiritual support.

6.5 Recommendations

In reference to the findings of this study, the succeeding recommendations are made to the Ministry of Health (MOH), Ministry for Gender, Children and Social Protection (MGCSP), the Ghana Health Service (GHS), 37 Military Hospital, Nursing and Midwifery administration and leadership.

6.5.1 Recommendations to Ministry of Health (MOH)

The MOH should:

- i. Liaise with National Health Insurance Authority (NHIA) to extend NHIS coverage to all obstetric complications.
- ii. Provide funding for research in the area of maternal near-miss.
- iii. Support the training of specialised nurses in the care and interventions for women's health.

6.5.2 Recommendations to Ministry of Gender, Children and Social Protection

MGCSP should:

- i. Collaborate with MOH to create an awareness and sensitization of women's support groups including market women, women's groups existing at institutional levels like academic and corporate bodies on the various life-threatening complications related to childbirth and how they can be mitigated.
- ii. Extend financial schemes in job creation to empower women economically during pregnancy in a sustainable manner.
- iii. Collaborate with related agencies to create situational support groups for women who experience near-miss.
- v. Collaborate with women and religious groups to establish support systems.

6.5.3 Recommendations to Ghana Health Service

- i. Conduct monthly maternal near-miss audits in all major GHS facilities and use the data to inform practice and prevent future occurrences.
- ii. Establish effective monitoring and evaluation of the quality of obstetric care in every health facility.
- iii. Train staff on the prevention of severe obstetric complications.
- iv. Equip all hospitals with ICU facilities.
- v. Implement policies to intensify pregnancy schools at the primary healthcare level and also make pregnancy schools attractive for mothers to attend.

6.5.4 Recommendations to 37 Military Hospital

The 37 Military Hospital command should:

- i. Conduct weekly maternal near-miss audit and use data to inform and improve practice.
- ii. Support and implement respectful maternity care in order to ensure that women receive high-quality care.
- iii. Ensure that, critically ill obstetric clients are sent to the intensive care unit promptly.
- iv. Ensure that regular visits are made to obstetric near-miss women at home after discharge.
- v. Provide timely and accurate information on birth preparedness and complications readiness (BPCR) planning to all women during ANC.
- vi. Intensify pregnancy schools at the ANC level by making it more attractive.
- v. Train staff on recognizing PTSD symptoms in women who have experienced SOC and refer them appropriately to a clinical psychologist for further management.
- vi. Ensure adequate follow-ups on all women who have experienced severe obstetric complications.

6.5.5 Recommendation to Nursing and Midwifery Administration and Leadership

Administrators and Leaders at all levels of healthcare should:

- i. Encourage nurses and midwives to function as team units to educate women about the life-threatening complications related to pregnancy and childbirth.
- ii. Ensure that there is adequate skill mix at the wards and departments at all times through monitoring and supervision.
- iii. Ensure the availability of equipment and making sure that they are functioning well.
- iv. Collaborate with the other disciplines within the healthcare setting to ensure optimal care of the clients.

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APPENDICES

Appendix A: Letter of Introduction



UNIVERSITY OF GHANA
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING

Ref. No.:SON/A.12.....

October 18, 2018

The Chairman
NMIMR - IRB
P.O. Box LG 581
Univ. of Ghana
Legon.

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Ruby Elikem Amegavluie, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: "Women's Experiences of Surviving Severe Obstetric Complications: A Study in Accra Metropolis".

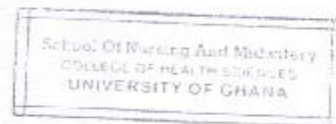
I hope that the Institutional Review Board will consider the proposal to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Mary Ani-Amponsah
SUPERVISOR



COLLEGE OF HEALTH SCIENCES

• P.O. Box LG 43, Legon, Accra, Ghana. • Telephone: +233 (0) 302 513 250 / 0289 531 213
• Email: mch.son@chs.ug.edu.gh • Website: www.nursing.ug.edu.gh

Appendix B Introductory Letter to 37Military Hospital



UNIVERSITY OF GHANA
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING

Ref. No.:.....SQN/A.12.....

October 1, 2018

The Chairperson
Institutional Review Board
37 Military Hospital
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Ruby Elikem Amegavlue, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: **"Women's Experiences of Surviving Severe Obstetric Complications: A Study in Accra Metropolis"**.

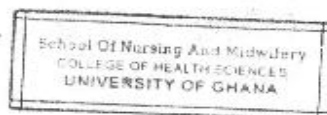
I hope that the Institutional Review Board of the Hospital will approve the proposal to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Mary Ani-Amponsah
SUPERVISOR



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Appendix D Ethical Approval Letter by 37 Military Hospital Review Board



Institutional Review Board
37 Military Hospital
Neghelli Barracks
ACCRA

Tel: 0302 769667
Email: irbmilhosp@gmail.com

12 November 2018

ETHICAL CLEARANCE

37MH-IRB IPN 250/2018

On 25th October 2018, the 37 Military Hospital (37MH) Institutional Review Board (IRB) at a Board Meeting reviewed and approved your protocol.

TITLE OF PROTOCOL: Women's Experiences of Surviving Severe Obstetric Complications: A study in Accra Metropolis

PRINCIPAL INVESTIGATOR: Ruby Elikem Amegavlue

Please note that a final review report must be submitted to the Board at the completion of the study.

Please report all serious adverse events related to this study to 37MH-IRB within seven (7) days verbally and fourteen (14) days in writing.

This certificate is valid until 24th October 2019.

DR EDWARD ASUMANU
(37MH-IRB, Vice Chairman)

**37 MILITARY HOSPITAL
INSTITUTIONAL REVIEW BOARD**

D^o 12-11-18

Cc: Brig Gen MA Yeboah-Agyapong
Commander, 37 Military Hospital

Appendix E Individual Informed Consent Form

CONSENT FORM

Title: Women's Experiences of Surviving Severe Obstetric Complications: A Study 37 Military Hospital.

Principal Investigator: Ruby Elikem Afi Amegavluie (MPhil Nursing Candidate)

General Information about Research

You are kindly requested to participate in the study that is to explore women's experiences of surviving severe obstetric complications. The experiences that you have after surviving a severe obstetric complication and how it has affected your general well-being after discharge from the hospital (Physical, Psychological, social and spiritual). Finally, the study will also seek to explore how the pain was managed. I will like to interview you to recount an in-depth experience you have had because you have experienced a severe obstetric complication in recent past. **With your permission, the interview will be tape recorded and will last for about 45 minutes to an hour.**

If you agree to participate, you will be required to sign this form and the interview will be conducted. I assure you that no one will get to know you took part in this study and also have access to what you said.

Note that your participation in this research study is strictly voluntary and you can decide to opt out at any given period without fear of punishment if you feel uncomfortable to continue.

Possible Risks and Discomforts

The study focuses on exploring the experiences of surviving the complication you encountered and recounting these experiences may cause you some emotional discomfort since some of the questions may touch on sensitive issues. You are free to withdraw at any point in the course of the interview by just telling the researcher whenever you feel uncomfortable to continue with the study. Take note that you are obliged to alert the researcher about any item in the interview that raises or invokes an emotional discomfort like being anxious or sad. The researcher will refer you at no cost to a clinical psychologist for management and after which the interview would continue based on the advice of the experts (Maj Yobanya, contact number: 0548592991/0501276788).

Possible Benefits

Your participation in the study has the potential to enable health professionals to formulate or alter nursing practices or policies to the benefit of all obstetric clients in Ghana. The study aims at exploring the



experiences of women diagnosed with severe obstetric complications, what they go through and how these experiences affect their health and well-being. Also note that no financial support is given to the participant since the study is self-funded by the researcher.

Confidentiality

You are assured that all information obtained from you would be protected and treated as confidential. The audio recorded and transcribed interview would be devoid of your names and other identifying information and you would not be named in any report. All data collected from the research participants would be used purposely for academic reasons, including publications. All information we gather from you may be used in anonymous way and jointly to the other volunteers. **It will be kept and well protected with a password in the researcher's email and the hard copies under lock and key by the researcher for a duration of five years and destroyed after the five years.**

Compensation

After each session of interview each participant will be given a snack, which include fruit juice and pie amounting to twenty Ghana cedis (GHc 20.00). In the event that you experience any psychological trauma during the interview, you will be referred to a psychologist to manage you and the cost will not be on you the participant.

Voluntary Participation and Right to Leave the Research

Your participation in this study is entirely voluntary. You will be free to withdraw your participation in this study without suffering any negative consequences at any time you want. However, you are welcome to discuss any concerns with us before taking any decision.

Termination of Participants by the Researcher

Your inability to effectively communicate your experiences or in the event where you have difficulties in responding to the interview questions and/or the experience of emotional discomfort, the researcher has the right to terminate your participation in the study, with or without your consent.

Contacts for Additional Information

If you have further questions or concerns about this, kindly contact the following:

1. Ruby Elikem Afi Amegavlue (Principal Investigator)



Department of Maternal and Child Health School of Nursing and Midwifery,
University of Ghana. P.O Box LG, Legon, Accra. 242036500, Email:
clikemafi2000@yahoo.com

2. Dr. Mary Ani-Amponsah (Supervisor)
PhD, RN, Neonatal Health (Cert), MPhil Nurs, Bach Nurs/Psychology, New born
Care and Breast Feeding Specialist, Department of Maternal and Child Health, P.O
Box 25, University of Ghana, Legon, 244368205, Email:
mary.aniamponsah@gmail.com
3. Dr Florence Naab (Second Supervisor)
PhD, RN, Midwifery, Infertility Specialist, Department of Maternal and Child
Health, P.O Box 25, University of Ghana, Legon, 0204522332, Email:
fnaab@ug.edu.gh

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research titled "*Women's Experiences of Surviving Severe Obstetric Complications: A Study at 37 Military Hospital*" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name and signature of person who obtained consent



Appendix F Interview Guide

INTERVIEW GUIDE

TOPIC:

WOMEN'S EXPERIENCES OF SURVIVING SEVERE OBSTETRIC COMPLICATIONS:
A STUDY IN THE ACCRA METROPOLIS.

Name of Principal Investigator: Ruby Elikem Afi Amegavlue (MPhil Nursing Candidate)

Pseudonym:

Date of Interview:

SECTION A:

Demographic Data

Age.....

Religion.....

Educational Background.....

Ethnicity.....

Marital Status.....

Socio-Economic status

Employment/Occupation.....

Annual household Income.....

Social support networks.....

Type of obstetric complication

Number of people in the household:



SECTION B:

1. Please can you share with me your antenatal care experience? (probe)
 - Number/ place of visits
 - Education received esp. danger signs of pregnancy, birth preparedness
 - Care rendered to you
 - Any problems/ concerns identified

2. Please how is the complication you survived influencing your daily functional activities and general health? (probe)
 - Sleep and rest patterns
 - Walking (movement)
 - Household chores
 - Care of the baby/family
 - Occupation/ career – related activities
 - Pain (location, intensity, quality)
 - Forgetfulness/ cognition
3. Please how are you coping with these issues due to the complication? (probe)
 - Family/ friends support
 - Analgesic/ medication use (abuse)
 - Physical activities
 - Relaxation
 - Religious activities
4. Please can you share with me how your menstruation and subsequent pregnancy has been affected by the complication?
 - Menstrual cycle
 - Pregnancies attempts and reactions to failures
5. Please concerning the complication you experienced, how did you understand it?
 - Negligence on the part of the hospital staff at ANC or other units
 - Personal fault
 - Ineffective medications/ inadequate medication
 - Complication which will eventually resolve
 - Treatment failure
 - External forces (divine interventions)
6. Please what were you reactions towards the complication(s) you experienced? (probe)
 - Anxious
 - Confused
 - Depressed (suicidal thoughts)
 - overwhelmed
 - Calm
 - Afraid (recurrence)
 - Angry
 - Restlessness
 - Crying



7. Please can you brief me on how you were manage at the hospital when you were diagnosed with the complication? (probe)
 - Medications (details)
 - Any surgical interventions
 - Other interventions
8. Please how has your experience of the complication affected your relationships with family and community? (probe)

 - Stigma
 - Cost burden on the family/ community
 - Marital challenges
 - Family's quality of life due to socioeconomic issues
9. Please what education were you given concerning your complication during and after? (probe)
 - Medication regimen
 - Causes and prevention of complications
 - Other available interventions
 - Coping strategies
 - Influence on subsequent pregnancy/ obstetric care
10. Please in what ways do you think your present state has affected your sexual relationship with your partner? (probe)
 - Appreciate each other's sexuality
 - Encourage conversations about their bodies
 - Explore the partner's body and try new styles/positions.

Please is there any other thing you would like to add?

THANK YOU!!!

