

# Psychological Experiences of Midwives Regarding Maternal Deaths at Two Selected Public Hospitals in Lesotho

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## Abstract

Maternal deaths are a pervasive problem that frequently occurs in developing countries, driven by socio-economic issues, healthcare service-related issues, pre-existing health conditions, health professional-related issues, and socio-cultural issues.

This paper describes the psychological experiences of midwives regarding maternal deaths at two selected public hospitals in Lesotho. A qualitative, phenomenological inquiry was employed to collect data from a purposively selected sample of 10 midwives through face-to-face interviews. Audiotapes were used to record the interviews, and the data were transcribed verbatim. The qualitative content analysis method was used to analyse the data. Permission to conduct the study was sought and granted by the Ministry of Health Lesotho (ID58-2022). Participants' identities were confidential, and they were allowed to withdraw from the study without any prejudice. Psychological experiences such as trauma, shock, fear, stress, depression, loss of trust, helplessness, bad dreams, and insomnia were reported by the midwives after the occurrence of maternal deaths. They resorted to individual coping strategies such as crying, alcohol and other substance-related use, and recreational activities. Unfortunately, these strategies were not guided, hence the need for trained healthcare professionals who will take care of midwives' psychological and emotional problems emanating from maternal deaths.

**Keywords:** Psychological; experiences; midwives; maternal death; Lesotho, public hospital

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## Introduction

Maternal deaths are one of the leading causes of death in Sub-Saharan Africa, often consequent to preventable causes at pre-conception, antenatal, and intrapartum stages. In the past decades, much research has focused on the causes of maternal death and the experiences of maternal death by family members (Dartey et al., 2017). According to WHO et al. (2019), globally, an estimated 295,000 maternal deaths occurred in 2017, portraying an overall maternal mortality ratio (MMR) of 211 maternal deaths per 100,000 population for 185 countries. The global lifetime risk of maternal mortality was estimated to be 1 in 190. The overall proportion of deaths in women of reproductive age that were due to maternal causes was estimated at 9.2%, and the MMR had declined by 38% since 2000 globally (WHO et al., 2019).

It remains unclear why the experiences of midwives were not researched in the past decades as in African countries, mostly in rural areas, midwives, who are based in the delivering health facilities, often experience maternal deaths because of the scarcity of resources (Amukugo & Nghitanwa, 2021). Research exploring the experiences of midwives regarding maternal deaths remains very limited, especially in rural health facilities where the majority of deaths occur (Amukugo & Nghitanwa, 2021). The midwives' continuous exposure to incidents such as maternal deaths interferes with their mental well-being, thus impacting their ability to cope (Dartey et al., 2017). Dartey et al. (2017) further appeal that exposure of midwives to maternal deaths has led to low performance and lack of mental attentiveness, thereby interfering with the services provided to other pregnant women.

Amukugo and Nghitanwa (2021) stated that often, the midwives responded to experiencing maternal death through flashbacks, nightmares, anger, a sense of self-blame or guilt, and denial. The extent of the impact of trauma on midwives has led developed countries to develop a stress-prevention manual to guide coping with stress, grief, anxiety, and depression experienced by midwives post-experiencing trauma secondary to being exposed to maternal death (Dartey et al., 2017). In Lesotho, strategies such as this have not been adequately explored and implemented. Muliira and Bezuidenhout (2015) reiterated in their study that the majority (94%) of midwives had experienced maternal death, 93% of them experienced moderate to high anxiety, 71% had mild to moderate death obsession, and 53% experienced mild depression.

## Problem Statement

In discourse, it has been observed that midwives have their own experiences with maternal death. Similarly, maternal death is a pervasive problem for society that needs to be addressed in Lesotho. However, as widespread as this problem is, far too little attention has been paid to the experiences of midwives concerning maternal death in Lesotho's context. The midwives experience trauma after experiencing maternal death, and often, they employ unhealthy coping strategies as there is no algorithm and or standard procedure to guide their recovery. In addition, there has been very limited

literature about the experiences of midwives concerning maternal death as opposed to the experiences of grieving families, society, and the general population. For this reason, this study was an effort to bridge the knowledge gap and sought to explore the midwives' experiences regarding maternal death at the two regional hospitals of the Thaba-Tseka district.

## Aim of the Study

This study aimed to explore the psychological experiences of the midwives regarding maternal death in two regional hospitals in the Thaba-Tseka district, Lesotho.

## Methodology

A qualitative phenomenological research design was used to collect data from 10 midwives at two hospitals in the Thaba-Tseka district. Twenty-five midwives were working at each hospital and within its catchment area. At each facility, the researcher purposively selected the first participant, who referred the interviewer to another participant until data saturation was reached. Data was collected in July 2022 using in-depth face-to-face interviews, which took 40 to 60 minutes. An audiotape recorder was used, field notes were taken, and the data was transcribed verbatim.

## Trustworthiness

To ascertain the trustworthiness of the interview guide, a pilot study was conducted using three participants who were interviewed, and results demonstrated that common maternal mortality causes were the use of concoctions, non-clinic use, inaccessible health facilities as they are very far, poor attitudes demonstrated by midwives, and their judgmental attitudes. The results continue revealing that midwives suffered depression, loss of hope, trauma, stress, sleeping disturbances and nightmares after experiencing maternal death. As there is no standard algorithm guiding their recovery from the trauma, they end up finding comfort in employing unhealthy coping strategies as well as interventions to cope and recover from the trauma, for instance, substance use, alcohol use, and self-isolation. The results, together with the absence of a standard care management plan or guiding algorithm for the victim of occupational hazards like maternal death, further heightened the need for further research.

## Data Analysis

Qualitative content analysis was used to analyse the data and is presented using themes and categories. The data analysis revealed two themes, six categories, and twelve sub-categories.

## Ethical Considerations

Permission to conduct the study was sought and granted from the National University of Lesotho Institutional Review Board (IRB) and the Ministry of Health Research and

Ethics Committee for approval (ID 58-2022). Gatekeeper permission was also sought from the management of the selected regional hospitals. Written informed consent was sought from the participants who took part voluntarily. The participants were kept anonymous with codes, and the interviews were conducted privately. The data was kept securely and only used for the study. No harm was anticipated from participation in the study. If this did occur, a contingency plan was in place for counselling to be provided at the hospital.

## Results

### Participants' Socio-Demographic Characteristics

As shown in Table 1, 6 (60%) of the participants were aged between 31 and 35 years, followed by those between 25 and 30 years 2(20%). In terms of gender distribution, 7 (70%) were males compared to 2 (20%) who were females. With regards to marital status, 8(80%) were married. Five (50%) participants worked in the maternity department, followed by equal proportions who worked in primary health care and theatre 2(20%). Seven (70%) had a diploma in midwifery compared to 3 (30%) with a degree in midwifery. Regarding the years of experience as midwives, 8 (80%) had between 1–4 years, while 2 (20%) had between 5 but less than ten years of working experience.

**Table 1:** Socio-Demographic Characteristics of Participants (N=10)

Characteristic of participants	Frequency	Percentage
<b>Age in Years</b>		
25–30 years	2	20%
31–35 years	6	60%
36–40 years	1	10%
41–45 years	1	10%
<b>Sex</b>		
Males	7	70%
Females	2	20%
Other	1	10%
<b>Marital Status</b>		
Single	1	10%
Married	8	80%
Does not want to disclose	1	10%
<b>Residence</b>		

Maseru	4	40%
Botha-Buthe	2	20%
Leribe	2	20%
Thaba-Tseka	1	10%
Barea	1	10%
<b>Place of Employment</b>		
SJMH	5	50%
PMH	5	50%
<b>Allocated Department</b>		
Primary Health Care	2	20%
Maternity	5	50%
Theater	2	20%
Maternal and Child Health	1	10%
<b>Period of Employment</b>		
1–4 years	8	80%
5–8 years	2	20%
<b>Race</b>		
Mosotho	10	100%
<b>Qualification Level</b>		
Diploma in Midwifery	7	70%
Degree in Midwifery	3	30%

### Participants' Description of Psychological Experiences

This theme refers to participants' descriptions of their psychological experiences regarding maternal deaths. Categories that emerged were trauma, stress, depression, loss of trust, hopelessness, as well as bad dreams, and those referred to as affecting the sleeping pattern were insomnia.

#### *Maternal Deaths and Emotional Trauma*

Participants claimed to have experienced trauma following exposure to maternal death. As trauma is a big word that entails a whole lot of emotional and psychological expressions, most reiterated to have experienced this trauma to differing extents. They further highlighted that the duration of trauma differed among individuals.

The participants demonstrated that they experience trauma after experiencing a maternal death.

...All the time, I felt shocked after experiencing the tragedy of maternal death to the extent that my mind became occupied with fear of re-experiencing it whenever I am

conducting a delivery. We cannot deny the fact that all healings come from the Almighty God, and we are just the servants facilitating the healing. It is very tearing and psychologically draining... (Participant SJMH001)

One participant experienced trauma, depression, and shock all at the same time after experiencing maternal death.

...I was shocked, traumatized, and depressed at the same time after experiencing a maternal death. Even at night, I encounter challenges while sleeping; at times, I do feel like it is our fault and something needs to be done... (Participant SJMH004)

### *Maternal Deaths Resulted in Fear*

Another participant experienced fear after their experience of maternal deaths.

...I was so frustrated and afraid that whenever I saw a pregnant mother, I re-experienced the trauma. It took me days although I could not remember well the number of days without a good appetite and a good rest. At times, I could wake up with my mood so low while the thought of a similar incident crossed my mind. I felt like the community, as well as my colleagues, were talking behind my back whenever I was among them... (Participant PMH001)

### *Psychological Stress from Maternal Deaths*

The participants explained that they had been stressed after experiencing maternal death; however, their duration of stress differed with the individuals. They iterated that maternal death is a very stressful occupational hazard one could ever be exposed to.

One participant never experienced a direct maternal death, but still, they were affected by its occurrence in their unit.

...I had never experienced a direct maternal death, but I have experienced a similar trauma to my colleague who happened under her watch. Since the previous day, I was nursing the same client, and I also participated in her resuscitation. It is quite a bad feeling, a painful, depressing, and shocking incident. The recovery differs with individuals as others take days while other takes more time... (Participants SJMH005)

On the other hand, one participant reiterated the kind of trauma that he experienced after his maternal death.

...I was traumatized. It was worse to imagine the pregnant lady arrived here at the hospital ambulant but dead at discharge from the hospital and the trauma of debriefing the family regarding the deceased mother. It is so boring also to imagine the humiliation in the maternal review meeting... (Participant PMH001)

### *Participants' Experiences of Depression Due to Witnessing Maternal Deaths*

Depressed in this category refers to the respondents detailing that they were the most affected and had experienced depression after witnessing maternal deaths. A participant experienced the maternal death of a mother who used herbal concoctions and delivered the baby at home, and another one delivered via the caesarean section. Both cases had a post-partum haemorrhage.

...In both scenarios, I was called to resuscitate the mothers, and we were a team comprised of medical officers: managers, and other midwives. After the death, I saw almost all members of the resuscitation team shocked and depressed, in denial that death had taken place to the extent that we kept on resuscitating for a while after the medical superintendent had announced the mother dead. We were all praying for her recovery, but it was too late, and it was very stressful. I felt so depressed after experiencing the tragedy of maternal death to the extent that my mind became occupied with fear of re-experiencing it whenever I was conducting a delivery... (Participant PMH001)

### *There was a Loss of Trust and Hopelessness*

This sub-category, loss of trust and hopelessness, emphasised that most participants who have experienced maternal death suffered some insecurities about themselves and the community. One participant who experienced the worst feeling that made them hopeless justified the view.

...I was affected to the extent that I was traumatized and could not sleep at night. I was very restless shocked and depressed. I almost felt like quitting my job as well as my profession. It was indeed a horrible experience that I felt like I did not need to meet people, that I felt guilt all over me, and that I nearly committed suicide. I felt that the community around us did not have trust in us since we were their hope to recover... (Participant PMH004)

### *Participants' Experiences of Nightmares from Witnessing Maternal Deaths*

This sub-category, bad dreams, refers to other participants emphasising that they experience weird dreams after experiencing a maternal death trauma. They further emphasised that the dream extends from minor to major, including re-experiencing trauma in a dream. They even explained that the extent of dreams differs among individuals and their previous experiences.

...I could not sleep for days after experiencing maternal death, at times I could wake up in the middle of the night awakened by bad dreams to sit down and think about the trauma to the extent that I would call my friend and or family members to disclose and discuss the matter with them to get some form of support from them which sometimes work and at times do not work at all... (Participant SJMH004)

On the one hand, participants claimed that even the dreams differ with the individual and their extent.

...I have re-experienced the dream of experiencing a maternal death for weeks and up to months such that at times, I ended up using sedatives and requesting relief from the duty to try to get well... (Participant SJMH001)

On the other hand, some participants claimed to have not experienced those nightmares at all.

...I did not experience any bad dreams at night, but I could not sleep at night all without using any sedatives or over-the-counter medication. I found talking about the incident very stress-relieving... (Participant PMH001)

### *Participants Reported Experiencing Insomnia*

Insomnia is a sub-category that refers to many participants who claim to have been experiencing insomnia after experiencing maternal death for a period of days up to weeks, and some up to months. They explained that they have difficulty getting asleep, staying asleep, and maintaining a steady sleep. They further elaborated that not being able to sleep even when one feels like one's body needs to rest is quite a bad experience in life.

...I could not sleep well for quite a long time after I experienced a maternal death. All that I tried has never been able to get me to sleep until I finally opted for extreme measures of using sedatives to induce some sleep. At times those sedatives could not induce sleep as expected until I found myself at a point where I had to take a couple of them to try to get the desired effect which promoted the dependency as well as the side effects due to over dosage on me... (Participant SJMH002)

Some participants elaborated that it took them a very long time to return to their sleeping pattern.

...It took me almost weeks and up to months to get back to my sleeping pattern as whenever I am about to sleep, my memory retrieves the experiences, and then, I end up having sleeping disturbances... (Participant PMH004)

On the contrary, the others stated that they had never experienced any sleeping disturbance.

...Since the thresholds differ with individuals, I did not experience any sleeping disorders, and as such, I woke up the next morning attending the duties as always although I will still suffer trauma, shock, and hopelessness... (Participant PMH003)

### **Participants' Coping Strategies for Witnessing Maternal Deaths**

The theme refers to the respondents describing the coping strategies that the midwives use post-experiencing maternal deaths in the two referral hospitals in Thaba-Tseka. The researcher has observed four categories and five sub-categories under this theme. The



researcher has also observed the coping strategies to be positive, negative, alcohol-related, and substance-related.

### *Finding the Cause*

Finding the cause is the sub-category that refers to most respondents pointing out that in most cases, after the incidence of maternal death, they embark on a search to find the cause of the death, whether individually or collectively, as colleagues, before sitting on the maternal death review committee. Participants emphasised that conducting their research on the cause of maternal death satisfies their inner being, speeds their recovery, and informs their knowledge in the future.

...Often, I ask myself what went wrong resulting in a loss of life. I did my search to highlight where the problem could have been. In most cases, we searched the departmental level and wrote the incidence report about what transpired to the head of the department so that the head of the department takes the report to present to the maternal death review committee before the institution as well as the district to have a take in discussing the maternal death case... (Participant SJMH002)

Another participant stated that finding the cause of maternal death was another effective coping measure.

...I conducted my search to find what could be the cause of maternal death, and where I might have gone wrong in the management of the pregnant mother. I identified that magnesium sulphate and ketamine had a respiratory depressive effect, and the woman was given both medications with respiratory depressive effects, hence her death... (Participant SJMH004)

Another participant emphasised that he researched to establish the cause of maternal death.

...I also searched to investigate the cause of maternal death to highlight where we might have not done well so that in the future such could be avoided... (Participant PMH001)

One other participant stated that he commonly participated in researching the cause of maternal death as a way of recovering from the incidence.

...After I have participated in the search and discussion of maternal death through the maternal review committee, I normally get well and forget the trauma. I have never been in a state where I would need to be called counsellors or even priests to pray for me. Lastly, I would like to emphasize that I have found finding the source for a maternal death incident very useful as it enables me in most maternal death cases that I experienced that they did not happen due to my omission. Instead, they occur due to the client's advanced HIV status, as well as due to the crippled health system, which has not decentralized the blood bank services to the district level in cases there is a raising need to transfuse the bleeding mother... (Participant PMH003)

### *Use of Recreational Activities*

This sub-category refers to other participants claiming to have experienced their recovery speeding up by participating in recreational activities, such as sports and taking trips. They further claimed that recreational activities refresh their minds and change their worldview.

...I have found partying as an intervention effective for me to help me to forget and recover from the incidence of maternal death. I have also found mingling with other people through recreational activities, like, taking trips, partying, attending gala dinners, and playing soccer, snooker, and games very effective throughout my recovery from a serious trauma secondary to experiencing a maternal death... (Participant PMH004)

Another participant emphasised that they have found relief from engaging in recreational activities.

...At times, I go to mingle with friends at parties trying to shift my mind from the stress of maternal death... (Participant SJMH 005)

### *Crying as a Coping Strategy*

Crying as a coping strategy refers to another participant reporting that she always cried after a traumatic incident of maternal death. She further stated that crying relieves her tension and pain.

Another participant also stated that crying has been working for him to recover from the traumatic incident of maternal death.

...I have found crying very stress relieving. Whenever I am stressed, I go into a private room, sit down and cry that pain comes out until I feel a little bit relieved... (ParticipantPMH004)

Another participant stated that crying helped her recover from the trauma of maternal death.

...I locked myself indoors and cried all weekend as some of the trauma is not easy to talk about and share with friends... (Participant SJMH005)

### *Alcohol Use as a Coping Strategy Used by Participants*

The alcohol use category refers to almost all the participants reporting to have used alcohol as a way of forgetting the trauma resulting from incidences of maternal death. It is also used as a way of getting their minds intoxicated, meaning that they can have their minds occupied with something that will shift their attention away from thinking about the incidence of maternal death.

One participant accentuated had used alcohol to cope with maternal death.

...Most often after experiencing maternal death, I use alcohol excessively to get my mind away from thinking about the matter. In most cases, I do not plan to get drunk I only use it to ease tension. Unfortunately, in most incidences, I find myself drunk and re-experiencing a similar trauma the next day and even regretting many things. This coping mechanism provides relief for a moment and often time it promotes dependence and addiction due to recurrent use to try and relieve tension... (Participant SJMH001).

Another participant stated that the use of alcohol can induce some mind relaxation.

...I sometimes go to the nearest bottle store to buy some beer, and after having taken two cots, I normally feel easy-minded and get a good sleep... (Participant SJMH004)

One more participant stated that while not on duty, he used alcohol to cope with the incidence of maternal death.

...While I'm not on duty, I normally go to buy some alcohol to suppress my mind and shift my mind from thinking about maternal death... (Participant PMH 003)

Another participant stated to have seen a rise in alcohol consumption after experiencing maternal death.

I am not a routine alcohol user under normal circumstances, but for a while, after my experience of maternal death, I had seen my alcohol consumption pattern becoming regular and more frequent. (Participant PMH005)

### *Substance Use as a Coping Strategy by Participants*

Substance-related strategy refers to other participants reporting to have used substances like over-the-counter sedatives. In contrast, others claimed to have used dagga and high grades to induce sleep and to get their minds shifted from thinking about the traumatic maternal death incidences.

One participant stated that he used over-the-counter medications such as sedatives to induce sleep and get his mind occupied.

...Normally, after I have experienced a stressful incident like that of maternal death, I buy some sedatives like diazepam from the nearby pharmacy and drink it to induce sleep. On some other days when the desired effects are not achieved, I couple the sedative with any other available substance at that moment, a drug like dagga and/or high-grade. Their effect is temporary as re-experiencing the distress soon follows the reduction of intoxication... (Participant SJMH001)

Another participant still stated that a substance relaxed his mind as well and gave him a positive effect post-maternal death exposure.

...I went to my local pharmacy and got some medications that induced sleep, and a few days later I was ok... (Participant SJMH003)

One more participant specified having used substances to suppress her mind from thinking about maternal death.

...I found sedatives and drug use an effective way to induce sleep and to relieve the mind from stressing about the incident... (Participant PMH002)

## Discussion

The findings presented in this paper demonstrate that all participants were aware of their experiences regarding maternal deaths at the two referral hospitals. They mentioned psychological effects and insomnia as their experience. These findings are similar to those of Amukugo and Nghitanwa (2021), who stated that often, the midwives responded to experiencing maternal death by experiencing flashbacks, nightmares, anger, a sense of self-blame or guilt, and denial. However, Levin *et al.* (2021) in their study argued that for midwives who have experienced trauma as a result of witnessing a maternal death for the first time, as well as those who experienced it several times, the impact, together with the intensity of nightmares and insomnia are equally experienced.

Most of the participants demonstrated that they experienced trauma following the incidence of maternal death. The findings conformed to Amukugo and Nghitanwa (2021), who concluded that the occurrences of trauma, depression, stress, and hopelessness responses are time-bound and intensified with duration; hence, they could lead to post-traumatic stress disorders (PTSD). Levin *et al.* (2021) in their study reiterated that trauma may persist until the midwives advance to clinically qualifying to fit the diagnostic criteria for PTSD, depression, and other stress-related conditions.

A minority of participants demonstrated that they had bad dreams, which involved re-experiencing the trauma of maternal death. They further stated that the duration of those nightmares of re-living the trauma differs with the individual as well. The findings are also consistent with those of Amukugo and Nghitanwa (2021), who affirmed that the mind normally brings to consciousness what was suppressed or forced to go to the unconscious mind. The midwives who witnessed maternal death often encounter episodes of disturbing dreams as their minds retrieve and reflect on their experiences. Most participants expressed having had difficulty maintaining a steady sleep after their experience of maternal death. They emphasised that they spent most of their sleeping time awake and thinking about their traumatic experience of maternal death. They also stated that the duration of insomnia differs among individuals. The study is consistent with Fafa *et al.* (2017), who iterated in their study that midwives encounter episodes of experiencing difficulty in sleeping due to the fear of the continuation of nightmares. Levin *et al.* (2021) also observed that for the midwives who experience trauma because of witnessing a maternal death for the first time, as well as those who experience it several times, the impact and the intensity of nightmares and insomnia were equally experienced.

All the midwives who participated in this study were aware of the coping mechanisms that the midwives employ after experiencing a maternal death in the two referral hospitals in Thaba-Tseka. They mentioned positive adaptive strategies, negative adaptive strategies, alcohol-related strategies, and substance-related strategies as the coping mechanisms they frequently use. The study confirms Kasuma *et al.*'s (2018) results that health professionals, particularly midwives, often experience trauma after witnessing maternal death. As a result, they consciously or unconsciously invite the negative coping strategies to help them get along with their stressors, and those commonly invited are avoidance, drug abuse, bottling-up, self-isolation, and self-medicating because little is known that careers need twice as much professional care as the clients.

Most of the participants further demonstrated that since they take a long time to forget about the incidence of maternal deaths, they ensure that they find the cause of maternal death. The study findings were consistent with Fafa *et al.* (2017), who attested that difficulty in forgetting means that the midwives still remember what happened to the clients who died in their care and find it uneasy to let go of the memories. As a result, they find the core to establish if the cause could have been avoided or resulted from their omissions.

In addition, some participants demonstrated that they employed recreational activities as their preferred health intervention after experiencing maternal death in the two referral hospitals in Thaba-Tseka. The findings correlate with Bastos *et al.* (2015), who assert that avoidance of health interventions like recreational activities reduces the impact of trauma amongst midwives as it shifts their attention from thinking about the trauma.

Fewer participants demonstrated to have cried the pain out after experiencing maternal death incidences as a way of helping them forget the incident. The findings are uniform with the previous studies; for instance, researchers such as Lee and Tzeng (2019) pointed out that this strategy is the most dangerous and debilitating ever as it finally leads to self-distracting behaviour and perpetrates occurrence of PTSD and the midwives used this coping strategy in their occupational exposure hazard or risks challenges, it does not require any kind of effort other than venting out.

Many participants demonstrated to have used alcohol after experiencing maternal death incidences as a way of helping them forget the incident. The results are harmonious with the already existing literature. According to Tesfaye (2018), drug abuse is an addiction coping mechanism that individuals who suffer stress resort to as it can provide a temporary respite from reality and everyday life. Drugs like alcohol enhance pleasure and decrease inhibition and anxiety. Tesfaye (2018) also concurs with the findings as he reiterates that midwives also incorporate this kind of coping strategy since the support system in many developing countries in the case where maternal death exposure was weak and or optional.

Other participants demonstrated to have used substances after experiencing maternal death incidences as a way of helping them forget the incident. The study findings are consonant with Karimy *et al.* (2019), who avow that self-medicating in trauma cases is found beneficial in that it relieves stress, promotes a sense of independence and empowerment, and is cost-efficient. However, it may be associated with high risks of misdiagnosis, substance abuse, drug interaction, toxicity, polypharmacy, and medical conditions and promote relapse. The midwives are engaged in self-medicating after experiencing maternal death, exacerbating the behaviour of not seeking professional help. The National Health Service (NHS, 2018) also concurs with the finding by reiterating that it is a common practice globally for people who do not want to seek professional help and who are weak to face their stressors.

## Conclusion

The researchers are of the notion that psychological experiences vary due to the frequency of deaths that the nurses encounter. This necessitates psychological programs designed for midwives to alleviate these experiences in Lesotho. Dartey *et al.* (2017) reiterated that since the midwife's ability to cope with maternal deaths is challenged, occupational workplace programs such as the Employee Assistance Programme (EAP) should be employed in hospitals to help midwives get to debrief after maternal death occurs which may be remedial in Lesotho's case. The authors conclude that mental health programs in the workplace are necessary for midwives who witness maternal deaths. Such programs would not only alleviate psychological strain but also improve coping mechanisms. From this study, most midwives were quite aware of the causes of maternal death in the two referral hospitals in Thaba-Tseka. They included the contribution of cultural practices, terrain, limitation in resources and skills, negligence, attitudes, poor communication, lack of love for the midwifery profession, and pregnancy-induced conditions.

## Limitations:

The study was limited to the experiences of midwives regarding maternal deaths in one district, and the results are not a complete reflection of the rest of the country. Other healthcare professionals who were affected by maternal deaths were not included in this study.

## Recommendations:

The midwives should get professional care through the wellness centres, which are staffed with psychologists to assist them in dealing with and developing health coping mechanisms after exposure to a traumatic event like a maternal death.

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