Article

Psychological Impact of Maternal Deaths and Fresh Stillbirths on Midwives in the Khomas Region, Namibia

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Abstract

Due to the nature of their profession, midwives often work autonomously and are frequently exposed to traumatic experiences, such as maternal deaths (MDs) and fresh stillbirths (FSBs). This article discusses the results of the study of the psychological impact on midwives who experienced maternal deaths and stillbirths in the Khomas Region, Namibia. Results revealed that midwives experienced a range of psychological effects, including vicarious trauma, symptoms associated with generalised anxiety disorder (GAD) and emotional responses like depression, sadness and heightened empathy. The study concluded that maternal deaths and stillbirths have significant psychological impacts on midwives, emphasising the necessity for targeted interventions. It is recommended that hospitals in Namibia develop and implement wellness programmes to support midwives who experience these traumatic events.

Keywords: psychological impact; midwives; maternal death; stillbirth; support programmes

UNISA university of south africa PRESS
New Voices in Psychology
Volume 15 | 2025 | #17136 | 14 pages

https://doi.org/10.25159/2958-3918/17136
ISSN 2958-3918 (Online)

Introduction and Background

Maternal mortality and stillbirth are regarded as public concerns around the world, particularly in the global south (UNICEF 2020). Maternal deaths and stillbirths are therefore prioritised as one of the United Nations' sustainable development goals. Maternal mortality has been reduced in the global north but remains a high burden of maternal deaths. In 2016, maternal mortality was reduced by nearly half compared with the 1990 rate, however, significant discrepancies remain between regions (Alkema et al. 2016)

Africa recorded the highest Maternal Mortality Rate (MMR), with the sub-Saharan Africa region alone recording a total of 546 deaths, which accounted for 62% of global deaths in 2015 (Heemelaar et al. 2020). Sub-Saharan Africa reported the highest stillbirth rate of 28.7% per 1 000 total births and an estimated 1.10 million stillbirths. These deaths are believed to lead to psychological effects among midwives, which could be prevented if correct measures are followed by individual African countries (Dartey et al. 2017a). These effects can result in dysfunctional health organisations and counterproductive behaviours since a person's psychological well-being affects the person's work performance. A study carried out in Australia revealed that midwives suffer grief after witnessing MDs, which results in some of them suffering from illnesses such as depression and anxiety (Toohill et al. 2018). Midwives were further reported to be paranoid of their death because death ends dreams and an individuals' ambitions. They were also found to warry of litigation, which exacerbated perceptions of trauma and created bleak future employment (Dartey et al. 2017a, Alexander and Bogossian 2018).

Some studies conducted around the world also showed that stress and anxiety were escalating in maternity wards. (Toohill et al. 2018, Sheen et al. 2016). A survey of health professionals in Australia indicated that suicidal ideation, anxiety, depression, trauma and concern about the ability to perform one's job were experienced by health professionals, including midwives, after MDs (Leinweber et al. 2017a). Trauma memories might certainly not be "erased' and are anticipated to resurface when the midwife is faced with a comparable traumatic incident, such as maternal death or stillbirth (Leinweber et al. 2017b). In Uganda, midwives were found to experience psychological distress after witnessing maternal deaths (Muliira and Bezuidenhout 2015).

Moreover, Australian midwives were found to have experienced emotional distress because of their inability to manage the impact of maternal deaths and this had negative consequences on their work performance (Johnson and Panagioti 2016). Furthermore, other researchers provide evidence that proves how numerous health professionals working in maternity sections who periodically encountered maternal and perinatal deaths developed negative emotional ill-health as they felt depressed and burned out (Calvert and Benn 2015, Shorey et al. 2017). A supportive environment is thus deemed

essential for the psychological effects to be translated into a modified practice (Dartey et al. 2017a).

In Namibia, MDs account for 9% of all deaths among women aged 15 to 49 years (Ministry of Health and Social Services (MoHSS) and ICF International 2014). Namibia did not reach the previous Millennium Development Goals (MDGs) target of achieving a reduction of MMR to 56/100 000 by 2015 (WHO 2018). The stillbirth rate in Namibia stood at 17 per 1 000 total births, and this rate was higher than the target of 10 deaths per 1 000 births in 2015 (MoHSS 2016). It is thus vital to take measures to address these deaths.

The dearth of literature on maternal deaths and stillbirths and its effects on the healthcare system in Africa, somewhat lessen the urgency to address issues of perinatal events among midwives. Moreover, there are no documented studies conducted in Namibia to explore the psychological effects of maternal deaths and stillbirths on midwives. Hence, this study envisioned identifying the psychological effects of maternal deaths and stillbirths on midwives in the Khomas Region of Namibia.

Methods and Design

A qualitative approach using a descriptive, exploratory and contextual design was used during research. This design is used to study the lived experience of participants in their working environment, and it assisted the researcher in gaining meaningful information and insight into the subject under investigation. It is, therefore, pivotally used when little information is known about the problem under investigation.

Study Participants and Sampling Strategy

The samples consisted of midwives from the Khomas Region: 169 midwives and eight senior midwives from the two state hospitals. Non-probability-purposive sampling was used until saturation was reached. These midwives were invited for semi-structured interviews and focus groups discussions (FGDs). An FGD involves a researcher leading a small group of people in a discussion about a specific topic. The researchers explained the study's aim and read the information sheet to prospective participants, including the benefits and risks of the study. Twenty-nine midwives consented and participated in the study.

Data Collection

Four FGDs with midwives working in different maternity wards were conducted. Focus group discussions comprised six to seven participants (n = 6–7). Four individual interviews were conducted. Separating ward-level midwives from senior midwives was essential to avoid possible intimidation from senior midwives. Interviews and FGDs were audiotaped and lasted for 35 to 60 minutes. Interviews and FGD guides were used

during the study. One central question was asked: What is your experience with maternal death and stillbirth? Probes were used as follow-up questions and saturation was reached when no new information could be yielded from the participants.

Data Analysis

Data analysis was conducted concurrently with data collection. This assisted the researchers in picking up data saturation and the data was transcribed verbatim before the analysis process. Data analysis followed the interpretive steps of qualitative data, according to Creswell (2014). Researchers read the transcribed data to get a general sense of meaning and understand what participants stated. The topics were condensed as codes and arranged in corresponding sections. The researchers identified new topics and codes. Coding was done to extract categories and subcategories. The researchers developed themes and sub-themes from the identified codes. Similar themes were placed together to reduce data. Researchers were permitted to change their themes based on discussion to ensure that all themes and sub-themes could be linked with the quotes from the participants.

Trustworthiness

Trustworthiness was applied during the study according to the criteria of Creswell and Creswell (2018). The researchers ensured credibility by using source triangulation of data (FGDs, in-depth interviews and field notes) to enhance the data collection. Verbatim transcription and literature control were used to develop themes and to confirm the data during interpretations. Interviews were audio recorded to ensure referential adequacy, followed by transcribing data verbatim to ensure no data was lost during analysis. Transferability was ensured by providing a thick description to convey the findings and participants were selected until data saturation. Dependability was enhanced by maintaining an inquiry audit during data collection and transcripts were sent to the supervisors for quality control. Participants were given a summary after each interview to evaluate the researchers' understanding of the interview and to check and confirm the information to enhance confirmability.

Ethical Considerations

Ethical approvals for the study were obtained from the University of Namibia's Human Research Ethics Committee (HREC) and the Ministry of Health and Social Services before data collection (Ref no: OSHC/484/2018). All ethical principles were ensured during the research.

Findings

Demographic Characteristics

A total of four FGDs and four interviews were conducted. Table 1 below shows the number of participants per group in FDGs.

Table 1: Demographic Characteristics of Participants

FGDs	Age	Number of participants
FGD 1	25, 37, 59, 55, 27, 36	6
FGD 2	23, 26, 28, 25, 34, 24, 40	7
FGD 3	45, 52, 30, 23, 26, 33	6
FGD 4	28, 26, 47, 54, 30, 27	6
Interviews		
Interview 1	40	1
Interview 2	50	1
Interview 3	48	1
Interview 4	47	1

The key findings indicate that midwives experienced psychological effects after exposure to MDs and FSBs. Three main themes emerged from this study, namely vicarious trauma, GAD-related feelings and emotional effects on midwives.

Table 2: Themes and Sub-themes that Emerged from The Study

Themes	Sub-themes
Vicarious trauma	Trauma and shock
GAD-related feelings	Stressed
	Fear and distress
	Difficulty in forgetting events
	Confused
Emotional effects on midwives	
	Depression-related feelings
	Sadness
	Compassion

Theme 1: Vicarious Trauma

Sub-theme: Experience of Trauma and Shock

During the FGDs and interviews, participants verbalised that witnessing death was traumatic and shocking for them. This was also expressed through non-verbal cues during the discussions, as illustrated in the following extracts:

> The stillbirth was sudden and quite traumatising, and I was so sad and shocked to have a patient gravida 3 and no alive baby at al1, very young, and her condition was improving.

> We sat them in, and oh, the whole breakdown, you. Me, myself, I was so traumatised. I could not think properly and just wanted to go home.

Theme 2: GAD-related Feelings on Midwives

Some participants expressed signs of GAD-related feelings such as stress, fear, distress, and confusion. These signs are described below.

Sub-theme: Stressed

Many midwives verbalised stress symptoms after they witnessed MDs and FSBs. This is illustrated in the following statements:

> That was my worst nightmare, as I am telling you. It is very sad. You feel sad, and sometimes you want to scream. Maybe you will feel better.

> You feel sad and stressed; sometimes you just want to scream. Maybe you will feel better. It was a dramatic event for me.

Sub-theme: Fear and Distress

Some midwives shared that they had fears of lawsuits for negligence from the patients and their family members. In addition, midwives narrated that they feared consequences such as ruined reputation, losing their jobs, caring for patients they knew and being labelled in the community. This is evident in the participant's verbatim responses below:

> But now also coming on duty, if you just hear a phone call, your heart goes like doef doef [heartbeat sound], and when someone is calling me at the office, even just for off-duties, as long as you are told the office is looking for you my heart is already up. You will be thinking about what they will say about last week's/or last night's case.

> Yaah, you work in fear and just waiting. So, it is a lot of mixed feelings. Those incidents inflict fear in me, and I was not at peace.

Midwives who were pregnant during the time of the study shared their they were afraid that MDs and FSBs would happen to them, as presented in the verbatim responses below:

> To make matters worse, I was also pregnant, and I was thinking of myself that maybe one day I will also go through those things.

> I was affected, and I was always freaking out when I did not get foetal kicks after some time. I was asking for foetal monitoring with a CTG from my colleagues, and I ended up delivering prematurely, 2 weeks before time. However, I demanded a C-section as I was terrified of delivering vaginally.

Some midwives stated that they feared both lawsuits due to negligence; and revocation of their practising licences. This degree of fear is demonstrated in the quote below:

> You first think of the health profession council. Am I going to lose my job? How about my kids or all those people that I am taking care of? You think of all those questions.

Sub-theme: Difficulty in Forgetting the Event

Midwives articulated that they found it difficult to forget the death events and end up with emotional distress. The excerpts below exemplify this explicitly.

> It took me years to stop seeing her face when I entered the ward. I was on my own throughout this process.

> Like for me, I am just recovering. Now it is only when I feel like the incident is going away slowly, but all these years I could, I could not forget the event.

Sub-theme: Confused

Some participants expressed confusion after experiencing MDs and FSBs, as demonstrated in the verbatim extracts below:

> That day, my mind went blank, confused; it's traumatising.

> I was confused. I did not know what to do next, seeing her with all the intubation tubes and drips plus drains. I was speechless and everyone left me there after the failed resuscitation.

Theme 3: Emotional Effects on Midwives

It was evident from the study that midwives experienced emotional distress in the form of depression, sadness and empathy after MDs and FSBs.

Depression-related Feelings

The feeling of depression can be observed in the following narration:

> This one was much hurting because I developed this personally hurting relationship with the patient. I felt very, very bad.
>
> But until now, that thing still hurts me like it did not happen. Sometimes, I felt like it was a dream and did not happen.
>
> I would say sometimes when we go through such incidences as midwives, you get to be kind of depressed.

Some midwives shared signs of depression, such as crying, poor sleep and an inability to eat properly, as shown in the statements below:

> I could not eat well the first few days because I got sick.
>
> I do not sleep well; I wake up in the middle of the night.
>
> My dear, that day, my day was ruined. That is why I can remember that incident up to today. I went into the tearoom to cry.
>
> To me, after an incident of one patient who died on the table in theatre, I now and then find myself crying.

Sub-theme: Sadness

After witnessing MDs and FSBs, several midwives said they felt sad and heartbroken, as can be seen in the statements below.

> It made me so sad; it made me feel emotionally disturbed because she was also my colleague.
>
> It is unfortunate, and I was even crying. You feel sad, and sometimes you just want to scream. Maybe you will feel better.
>
> It is very saddening to come and tell someone who carried for nine months that the baby did not make it. So, it is it, you know because you are a midwife, it doesn't mean you do not have emotions.

Sub-theme: Compassion

The expression of empathy in this study was common. The participants narrated what could have happened if MDs were to happen to them or their loved ones and what would happen to the baby.

Below are some of the participants' statements.

> I also felt on behalf of the mother.

You feel too bad when you think of the family she left behind.

Seeing the baby lying there with no mother, I could feel it as a health practitioner.

Discussion

The findings in this study demonstrated that maternal death and stillbirth have an impact on midwives. The impact is categorised in different themes.

Vicarious Trauma

Death at the workplace because of MDs and FSBs are regarded as the primary factors that trigger psychological effects. This study found that midwives in the Khomas region have been affected by MDs and FSBs. Participants experienced trauma and shock because of death events and more so when it was a sudden death if the deceased was young and if the condition of the patient was improving. This was due to a general feeling among the midwives that the women who died young died too soon and still had long lives ahead of them. In their studies, Toohill et al. (2018) and Wahlberg et al. (2017) found that most participants experienced trauma after a severe event in the labour ward and midwives who experienced high fear levels reported professional practice concerns. Muliira and Bezuidenhout (2015) also affirm this study's findings when they report that midwives in Uganda expressed traumatic experiences of some events in their clinical practice. Moreover, Toohill et al. (2018) further argued that physicians and midwives viewed stillbirths as an unexpected tragedy, although several midwives considered stillbirth less traumatic than maternal death. Nuzum et al. (2017) challenged the above statement when they established stillbirth as the most traumatic experience for midwives in the Republic of Ireland. It is, therefore, necessary to realise the pain that midwives go through and give the necessary support.

GAD-Related Feelings

Stress and fear were other psychological effects experienced by midwives. In another quantitative study, 43.7% of midwives reported that they consulted their family physicians because of stress- or anxiety-related symptoms, with 37 of these midwives (79%) having received treatment (Nightingale et al. 2018). Other studies concur with this sentiment, as they establish that participants experienced fear and distress because of maternal death (Wahlberg et al. 2017). Alexander and Bogossian (2018) found that midwives had a fear of their deaths because death ended the dreams and ambitions of individuals. This creates a high level of perceived distress, as observed in studies in the United States of America and the United Kingdom (Bánovčinová 2017, Wallbank and Robertson 2016). Fear of death was not surprising, as most of the participants were females, not yet at the peak of their careers and still within their reproductive years. The older participants could also be observed to be afraid of their deaths, as they have children and grandchildren to look after. It is evident from this study that experiencing FSBs brings fear among expectant midwives, as they do not know what will happen to

them during their labour. Anderson et al. (2017) concede that pregnant women were affected the most and some were traumatised as they were unable to tell how their pregnancy would end. This, therefore, warrants the need for pregnant midwives to be provided with constant support after a death case to prevent pregnancy and delivery complications.

A similar concept on the issue of fear was validated in Ghana and Australia, where midwives' fear of litigation was observed (Alexander and Bogossian 2018, Dartey et al. 2017a). Litigation is a critical issue in the midwifery profession as the maternal death review committee reviews every maternal death and if there are malpractices observed in the case, midwives end up at the professional inquiries where they may be found guilty and lose their jobs or get a hefty fine. Overall, MDs and FSBs lead midwives into fear and distress, which could impact their work performance.

Some midwives took longer than others to forget these traumatic events. The difficulties in forgetting the events could be attributed to the emotional attachment and bond the midwives develop with the women under their care. Moreover, the poor recovery of the participants could be attributed to poor work support. Lack of social support, especially from friends, was also a significant factor in a study in Australia (Shorey et al. 2017). This underscores the need for support to speed up the recovery process for affected midwives. Calvert and Benn (2015) showed that midwives in New Zealand still found it difficult to forget the traumatic event after they were offered support by colleagues and even after having gone through a counselling process. It can thus be concluded that midwives need to be supported to help them forget the death events. Therefore, midwives need to be supported to help them forget the death events.

Emotional Effects on Midwives

One of the emotional states reported in this study was the feeling of sadness among midwives. The sadness observed in the study could be attributed to the fact that midwifery is a profession that mainly expects happiness because it involves bringing life to earth. When this is not achieved, it plunges midwives into despair, with negative energy and not knowing what to do next, as observed in another study (Pezaro 2016). It is thus essential to neutralise the sad feelings experienced by midwives to uplift their enthusiasm and sense of belonging.

The degree of depression-related feelings was most likely due to variations in age, support after the incident and the nature of the personal relationship between the participant and the deceased. Shorey et al. (2017) found that numerous health professionals working in maternity sections who periodically encounter maternal and perinatal deaths endured a negative impact on their emotional well-being as they felt depressed and burned out. It was evident from the study that the duration of depression-related feelings varies among midwives and ranges from three weeks to longer than ten

years. Dartey et al. (2017b) argue that depression decreases midwives' productivity and workplace morale, hence the need for a sound support system.

Almost every participant in the study indicated that they cried a lot after a death event. A death event is naturally an emotional event, and an MD or FSB could even be more depressing to midwives, as sometimes it gives a sense of failure to care. Jarvis (2016) avers that healthcare practitioners, including midwives, experienced much grief, crying and lack of sleep. The same sentiment is shared by Dartey et al. (2017b) in their observation that participants usually cry after an MD. This could be seen as another coping method, as crying after an adverse event was found to comfort health professionals (Austin 2017).

Midwifery professionals deal with very critical patients and eventually, death cases. This requires midwives to avoid sympathy but rather exhibit empathy. Cohen et al. (2017) have proven that difficulties, an inability to provide empathy and challenges in communicating with patients can push midwives into becoming avoidant and distant practitioners. The feeling of empathy is thus a vital component of care provision among midwives.

Dartey et al. (2017a) affirm that emotional confusion could endanger other patients and the midwife, as a confused midwife is susceptible to making errors such as giving the wrong medication and imposing self-injury due to poor concentration. This may result in job insecurities as the chance of losing the job increases when faults are made.

Conclusion

This study indicated that all midwives experienced psychological effects after going through MD and FSB events in their workplace. This led to feelings of vicarious trauma, shock, GDA-related feelings and emotional effects. The psychological effects were deemed mainly harmful, impactful to the work environment and ended up creating a non-conducive working environment for midwives. This led to the poor delivery of maternal health services to the women who were in the hands of these midwives. Therefore, midwives need to be supported to enable them to cope effectively with maternal deaths and fresh stillbirths in their workplaces.

Recommendations and Implications for Future Research

Based on the study's findings, recommendations for practice, education and future research are hereby made. The researchers recommend that the MoHSS establish and execute trauma-informed support networks within healthcare environments to cater to the emotional and psychological requirements of midwives who have encountered maternal death or stillbirth. Moreover, mental health services should be provided and made accessible in practice, including frequent counselling or debriefing sessions, to assist midwives in managing traumatic situations and discussing their emotional

reactions and confusion. In addition, midwives should be equipped with in-service training on legal protocols, malpractice prevention and litigation management to alleviate concerns over lawsuits and licence revocation. The should be development of programmes to prevent compassion fatigue, burnout and stress reduction techniques. Furthermore, midwives' professional bodies and MoHSS should advocate to provide legal and professional support for midwives facing potential litigation or threats to their professional reputations. Future similar research should be conducted in other regions of the country, predominantly rural and semi-rural areas, and in the private sector to make a comparison.

Limitations

The main limitation is that this study was only conducted in one region of Namibia and at public hospitals; thus, the findings cannot be generalised as the views of all midwives in the country. Other limitations are related to the available literature. Limited literature on the topic was encountered in SADC.

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